Provider Bulletin

Reference: B1100305 **September 2011**

colorado.gov/hcpf

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ACS A xerox Company

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

ACS Contacts

Billing and Bulletin Questions
1-800-237-0757 or 1-800-237-0044

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

Did you know...?

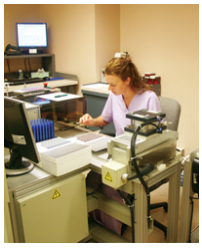
The new PAR vendor, ColoradoPAR, is only for **submitting** PARs that were submitted to CFMC. Providers must continue to utilize the Colorado Medical Assistance Program Web Portal located via the Department's Web site (colorado.gov/hcpf) to retrieve PAR letters and inquire about the status of a PAR. The PAR number provided on the PAR letter is the only number that will be accepted when submitting claims. Providers who have been submitting PARs through the Colorado Medical Assistance Program Web Portal should continue to do so until further notice.

All Providers

New Vendor for Prior Authorization Requests (PARs)

Effective August 31, 2011, PARs previously sent to the Colorado Foundation for Medical Care (CFMC) should be sent to the ColoradoPAR Program

The ColoradoPAR Program is the new Utilization Management Program for the Colorado Medical Assistance Program. Beginning **August 31, 2011**, the ColoradoPAR Program will be reviewing prior authorization requests that have previously been sent to CFMC for review. The first phase of changing to the new vendor requires that all PARs be mailed or faxed to the ColoradoPAR Program. The process and forms for submitting PARs that have been used in the past have not changed.



Please continue to send PARs that are currently reviewed by Affiliated Computer Services (ACS) for processing. **At this time, the change only applies to those PARs that have been sent previously to CFMC.**

The list of PARs to be sent to the ColoradoPAR Program includes:

- Durable Medical Equipment (DME) – Limited to orthotics/prosthetics, communication devices, power wheelchairs and power scooters
- Diagnostic Imaging– limited to non-emergent Computed Tomography (CT) Scans, Magnetic Resonance Imaging (MRIs), and all Positron Emission Tomography (PET) Scans
- Medical/Surgical Services
- Reconstructive Surgery
- 2nd surgical opinions
- Physical and Occupational Therapy
- Transportation - Limited to Meals and Lodging
- Out-of-State Non-Emergency Surgical Services
- Organ Transplantation
- EPSDT Home Health

Beginning August 31, 2011, please submit the above PARs via paper to the ColoradoPAR Program's servicing center at:

The ColoradoPAR Program
4545 N. Lincoln Ave., Suite 103 OR Fax: 1-866-492-3176
Oklahoma City, OK 73105

The ColoradoPAR Program will have the capability for providers to submit PARs electronically in the near future. The ColoradoPAR Program will provide a new web portal with enhanced functionality to ease the administrative burden on providers for PAR submission. There will be webinars and regional trainings to assist providers with navigation and use of the new Colorado PAR Web Portal. There will be additional information posted on the ColoradoPAR Web site soon regarding upcoming training schedules.

Beginning August 31, 2011, for additional assistance, please contact the ColoradoPAR Program information line at 1-888-454-7686.

If you have questions regarding this transition, please contact Erica Alikchihoo at 303-866-3385.

Department to Implement New Provider Rates for Fiscal Year (FY) 2011-12

The Centers for Medicare and Medicaid Services (CMS) has approved the Colorado Medical Assistance Program's reimbursement rate reduction for all services listed in the June 2011 Provider Bulletin (B1100302) for FY 2011-12. The new rates have been loaded into the Medicaid Management Information System (MMIS) and the fee schedule with the new rates is published at the bottom of the Provider Services Home page of the Department's Web site at colorado.gov/hcpf.

Reimbursement rates are being reduced for FY 2011-12 due to current state budget circumstances. The new rates are effective as of July 1, 2011. Therefore, the Department of Health Care Policy and Financing (the Department) will retroactively adjust all claims with dates of service on or after July 1, 2011 to reflect the new rate. Adjustments will be reflected on future Provider Claim Reports (PCRs).

Please contact Jeanine Draut at Jeanine.Draut@state.co.us or 303-866-5942 with any questions.

Program Integrity Fraud Reporting

Program Integrity has established an easy way to report suspicion of provider fraud, waste, or abuse in the Colorado Medical Assistance Program, Managed Care Organizations, Behavioral Health Organizations and Children's Health Program Plus (CHP+). Anyone can make a report through the confidential email address: ReportProviderFraud@hcpf.state.co.us.

All reports are investigated by Program Integrity staff. Please contact Sandi Barnes at Sandra.Barnes@state.co.us or 303-866-3535 with any questions.

Medicaid Clients and the Accountable Care Collaborative (ACC) Program

The ACC is a new Colorado Medical Assistance Program that unites providers, clinics, hospitals and social service organizations with the goal of improving the health of Coloradans while containing costs. Clients enrolled in the ACC receive services using the fee-for-service model, and also belong to a Regional Care Collaborative Organization (RCCO), that provides care coordination among providers and other community and government services.

This article explains the new eligibility screen for ACC members when an inquiry is made using the Colorado Medical Assistance Program Web Portal (Web Portal). It also explains the referral process for ACC members and how to submit claims for their services.

New Eligibility Screen for ACC Members on the Web Portal

When you check eligibility through the Web Portal for a client who has been enrolled into the ACC, the eligibility screen will look different. The results of the inquiry will show (1) that the client is a member of the ACC program; (2) the RCCO that the client belongs to; and (3) the client's Primary Care Medical Provider (PCMP).

The RCCO is responsible for the health and costs of the ACC members in its region. There are seven regions. The PCMP is the client's primary care provider/medical home, which works together with the RCCO to coordinate the client's care.

When you submit an eligibility inquiry for a client who is a member of the ACC, you will get a response that looks like the following:

Eligibility Request

Provider ID: XXXXXXXX National Provider Identifier: XXXXXXXXXXX

From DOS: XX/XX/2011 Through DOS: XX/XX/2011

Client Detail

State ID: XXXXXXXX DOB XX/XX/XXXX

ACCOUNTABLE CARE COLLABORATIVE PROGRAM (ACC)

ACC ENROLLMENT:	**UPDATED:** XX/XX/2011	
Regional Care Collaborative Organization	**Number: 12345678**	
Regional Care Collaborative Organization	**Name:** <RCCO NAME>	**Phone:** 888-555-5555
Primary Care Medical Provider	**Name:** <PCMP NAME>	**Phone:** 303-555-5555
Primary Care Medical Provider Address	1234 MAIN STREET DENVER, CO 80203	
Primary Care Practitioner	**Name:** <PRACITIONER NAME>	**Phone:** 303-555-5555

MESSAGE:

This is an ACC Medicaid Member!

This ACC Member has a Regional Care Collaborative Organization (RCCO) that provides care coordination support. All claims will be paid through the usual Medicaid fee-for-service claims system; most specialty services require a Primary Care Medical Provider (PCMP) referral, with the exception of the following:

- Emergency care
- EPSDT screening examinations
- Emergency and non-emergent medical transportation
- Anesthesiology services
- Dental and vision services
- Family planning services
- Behavioral health services
- Home and Community-Based Waiver services
- Obstetrical care

*If no Primary Care Medical Provider information is displayed above, please advise the Member to call HealthColorado to select one.

Denver Metro area: **303-839-2120**

Outside of Denver: **888-367-6557**

TDD: **888-876-8864**

HealthColorado.org

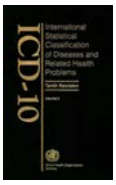
Providing Services and Submitting Claims for ACC Members

ACC members receive regular fee-for-service Medicaid, but the member's PCMP should provide a referral for most specialty services. The services that do not require a referral are listed above in the "Message" section of the eligibility screen.

Because ACC members receive regular fee-for-service Medicaid, claims are to be submitted the same way as other clients who receive fee-for-service Medicaid. However, if the claim you are submitting is for specialty care that is not one of the exempt specialty services listed on the eligibility response, it is strongly recommended that a referral be obtained from the client's PCMP before claims are submitted for that service. Contact the PCMP to explain the client's need, and if the PCMP approves the service, document the PCMP's provider number in the Referring Provider Number box.

A referral does not take the place of a PAR for a service that requires a PAR. If a PAR is required, it is recommended that the PCMP be indicated as the referring provider on both the PAR and the claim.

For questions or additional information, please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.



ICD-10-CM Clinical Documentation Improvement (CDI)

According to the American Academy of Professional Coders (AAPC), CDI will be fundamental to every practice. The AAPC July 13, 2011 newsletter gives examples of changes that may need to occur in documentation to comply with the specificity of ICD-10-CM code assignment. To read more about CDI, go to aapc.com then click on the *Resources* tab.

September and October 2011 Holidays

Labor Day Holiday

Due to the Labor Day Holiday on Monday, September 5, 2011, the claims processing cycle will include electronic claims accepted before 6:00 P.M. Mountain Time (MT) on Thursday, September 1, 2011. The receipt of warrants may be delayed by one or two days. Both State and ACS offices will be closed on Monday, September 5, 2011.

Columbus Day

Due to Columbus Day Holiday on Monday, October 10, 2011, the claims processing cycle will include electronic claims accepted before 6:00 P.M. MT on Thursday, October 6, 2011. The receipt of warrants may be delayed by one or two days. State offices will be closed on Monday, October 10, 2011. ACS offices will be open during regular business hours.

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 in the Provider Services Forms section of the Department's Web site. You may also use this same form to update bank account information by indicating "Change" in the top-right corner and complete the form as directed. Please allow 30 days to process an EFT request.

Paper warrants will be sent until the EFT has been established or the update request has been processed. After 30 days, check with the bank to verify that EFT has been set up. Please contact the Department at hcpfar@state.co.us with any EFT update questions.

Dual Eligibles

Providers are reminded that Medicaid is always the payer of last resort, therefore, services for dual-eligible clients - those with coverage from Medicare and Medicaid - must be billed first to Medicare. Please refer to the December 2008 Provider Bulletin (B0800255) for an example of exceptions for Home Health services.

Providers must be able to show evidence that claims for dual eligible clients, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program. Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial.

The Colorado Medical Assistance Program requires that a copy of the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible clients which are submitted for reimbursement.

Please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

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 services. Records must substantiate submitted claim information. Such records include but are not limited to:

- Treatment plans
- Prior authorization requests
- 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 years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Durable Medical Equipment (DME) Providers

DME Accreditation

All suppliers of DME, with the exception of Pharmacies (where DME/Supplies are less than 5% of total income), must have an up-to-date Medicare accreditation letter or certificate. Providers must submit either document to the Colorado Medical Assistance Program in order for claims to be paid.

Accreditation must be current and the letter or certification must have an effective time period. If a provider has multiple sites, the letter or certification must state that each site has been approved for each Medicaid provider number.

Please verify that the Department has the most current accreditation certificate on file. If a renewed certification has been obtained, please submit it as soon as possible to avoid gaps in coverage and payment delays.

Please send this information to:

Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203-1818
Attn: Anna Davis

Please contact Anna Davis at Anna.Davis@state.co.us or 303-866-2113 with any questions.

Home Health Providers

Appropriate Utilization and Billing of Acute and Long-Term Home Health Services

Per 10 CCR 2505-10 8.520, Home Health providers must adhere to the following guidelines when deciding whether to provide acute or long-term home health services to Medicaid clients:

- If the service is medically necessary and appropriate for the treatment the client requires, acute and long-term home health services are available to any client eligible for Colorado Medicaid or Old Age Pension.
- Acute home health services are provided for clients who experience an acute incident such as infection, pneumonia, heart attack, or discharge from an inpatient facility. Acute home health services are also provided for clients with a new diagnosis of a life-altering disease, such as diabetes or chronic obstructive pulmonary disease (COPD). Individuals who experience an acute incident related to a chronic disease, such as diabetes or COPD, may also be treated under the acute home health benefit. Acute home health services are allowed for up to 60 days or until the acute condition is resolved, whichever comes first. The services do not require a PAR and shall not exceed 60 days in duration.

- A client may only receive an additional period of acute home health services if at least 10 days have elapsed since the last acute episode *and* the acute episode is for a new acute issue. The new period of acute home health may not be used for continuation of treatment from a prior acute home health episode.
- Long-term home health is for clients who have long-term chronic needs that require ongoing home health services, and allow them to remain at home instead of nursing facilities. All long-term home health services require a PAR. If a client requires home health services for chronic

needs, the provider may not begin with acute home health services and transition to long-term home health later. Instead, the provider must submit a PAR for long-term home health so the client may begin long-term home health services.

- Long-term home health may be used for a client who has been receiving acute home health services but requires additional time and services to allow the client to be safely discharged from home health services, once the acute episode has ended. Long-term home health services require a PAR.
- A client who is receiving either long-term home health services for chronic conditions or Home and Community Based Services may receive acute home health services only if the client experiences an acute incident that makes acute home health services necessary.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 with any questions.

Items to Include in the Home Health Plan of Care

Home Health agencies must describe the following in a client's Home Health Plan of Care (also called the "485" document) or other documentation submitted with the PAR documentation:

- Whether the client is homebound, and
- The services the client or caregiver cannot perform, and therefore requires the services of a home health agency to perform the service (for example, bathing a child or administering insulin).

The 485 must include the reasons that the client or caregiver cannot perform these tasks. If the task falls within the usual and customary role of a caregiver of parent, the Plan of Care must contain an explanation of why a skilled caregiver is required to perform the task. Some examples include:

- A small child who requires a ventilator who must be bathed with special precautions that would be difficult or unsafe for an untrained person to perform the task; or
- A client is blind and lives alone, making sliding-scale insulin delivery impossible for the client to do safely.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 with any questions.

Nursing Facility Providers

Nursing Facility Post Eligibility Treatment of Income (NF PETI) Fee Schedules 2011 Update

Effective September 1, 2011, the reimbursement of PETI services will be in accordance with the updated NF PETI Fee Schedules published at the bottom of the Provider Services Home page of the Department's Web site. The new fee schedules reflect the new rates issued by the Department on July 1, 2011. The following is a summary of the key NF PETI program requirements.

- The NF PETI fee schedules list dental, hearing, and vision services by procedure code with the pertinent reimbursable amount. The NF PETI fee schedules are not all-inclusive, nor does the inclusion of any code imply that the service is a routinely approved request.
- Only non-Medicaid benefits are potential NF PETI expenses. For all procedures that are a potential adult Medicaid benefit, a Medicaid provider must determine whether a client meets the Medicaid criteria to qualify for the benefit. If a valid Medicaid claim is submitted and then denied reimbursement, the nursing facility may submit a PETI request to the Department with a copy of the denial notice.

- Medical necessity and the absence of other payment sources are two criteria that must be met to justify the use of PETI funds.
- Medically necessary services that are not listed on the fee schedules may be submitted to the Department for NF PETI consideration. A notation of 'MP' in the NF PETI Fee column indicates the procedure is manually priced by the Department. The nursing facility must submit a PETI

request to the Department for all such MP codes even when the billing amount is below the first $400 PETI expense for the year. Providers are not required to submit claims to Medicaid if the service is not a Medicaid benefit.

- The reimbursement amount is the same whether or not the provider is enrolled in the Colorado Medical Assistance Program.
- PETI requests are subject to additional verification of medical necessity as deemed appropriate by the Department. Failure to provide required documentation will result in the denial of the NF PETI request.

Please contact Susan Love at Susan.Love@state.co.us or 303-866-4158 with any questions.

Pharmacy Providers

Pharmaceutical Reimbursement Methodology Change

The Pharmaceutical Reimbursement Methodology rule change effective September 9, 2011 can be found at colorado.gov/hcpf > Boards & Committees > Medical Services Board > Program Rules and Regulations > 8.800-8.899 > 8.800.13 Pharmaceutical Reimbursement Calculations. The new methodology includes implementing the State Maximum Allowable Cost (MAC), which is the adjusted Average Acquisition Cost (AAC) of generic drugs available in the marketplace and Wholesale Acquisition Cost (WAC).

Reference materials regarding this change are available under the State Maximum Allowable Cost in the Pharmacy section of the Department's Web site by visiting the State Maximum Allowable Cost (State MAC) Web page.

Future Plans for Pharmaceutical Reimbursement

The Pharmaceutical Reimbursement Methodology change that is being implemented on September 9, 2011 is the first step in the process to gradually change how pharmaceuticals are reimbursed. The Department has contracted with a vendor to receive national Average Acquisition Costs (AAC) and is using this as a baseline. An additional percentage is being added to keep drug reimbursement cost neutral from the Department's standpoint.

In addition, the Department currently has a Request for Proposal (RFP) out to contract with a vendor to create and maintain an ongoing survey of pharmacies about their drug costs to create a new State MAC rate and conduct a cost of dispensing fee study. The Department's goal is that the new State MAC rate will create a fair reimbursement rate that will largely eliminate the pricing disparities in drugs that are over-reimbursed and under-reimbursed.

The Department has been working closely with a number of pharmacy stakeholders over the last several months and will continue to have on-going stakeholder involvement through this transition.

Next Pharmacy and Therapeutics (P&T) Committee Meeting

Tuesday, October 4, 2011
1:00 P.M - 5:00 P.M. This meeting will be held on the Anschutz Medical Campus in Aurora
Please visit the P&T Committee Web page for full location details.

Preferred Drug List (PDL) Update

Effective October 1, 2011, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Erythropoiesis Stimulating Agents
Procrit – Clients must meet eligibility criteria

Oral Bisphosphonates
Alendronate tabs in 5mg, 10mg, 35mg and 70mg

Meglitinides
None preferred

Biguanides
Generic metformin in 500mg, 850mg and 1000mg immediate release
tablets preferred; generic metformin extended-release 500mg tablets preferred

Hypoglycemic Combinations
Glyburide/Metformin generic products, Kombiglyze, Janumet – Please see PDL for additional information

Thiazolidinediones
Actos

Newer Generation Diabetes Agents
Byetta, Januvia, Onglyza, Tradjenta – Please see PDL for additional information

ADHD and Stimulants
Generic methylphenidate IR and SR, generic dexmethylphenidate, FOCALIN XR,
CONCERTA (brand name only), generic mixed amphetamine salts products in IR (generic Adderall),
ADDERALL XR (brand name only), STRATTERA, and VYVANSE

Overactive Bladder Agents
Oxybutynin,oxybutynin ER and TOVIAZ

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the Preferred Drug List (PDL) Web page.

For questions or comments regarding the PDL, contact Jim Leonard at Jim.Leonard@state.co.us.

Drug Utilization Review (DUR) Board Updates

The Department would like to welcome our newest DUR Board member, Kimberly Eggert. Kim will be serving in the capacity of Industry Representative for the Board. She is currently working for Gilead Pharmaceuticals, and she has previous experience with state Medicaid Drug Utilization Review.
We are currently looking for qualified applicants to serve in a pharmacist position on our DUR Board.

The members of the DUR Board shall have recognized knowledge and expertise in one or more of the following:

1. The clinically appropriate prescribing of covered outpatient drugs;
2. The clinically appropriate dispensing of covered outpatient drugs;
3. Drug use review, evaluation, and intervention;
4. Medical quality assurance.

To submit a curriculum vitae (CV) or for additional information, please contact Jim.Leonard@state.co.us or visit the DUR Board Web page.

Physician Administered Drugs

The Department would like to remind providers that drugs administered in a physician's office, clinic, dialysis unit or hospital are not pharmacy benefits of the Colorado Medical Assistance Program. For office, clinic or dialysis unit administered drugs, please refer to the appropriate service program rules, and if applicable, bill using the Colorado 1500 claim form or submit an 837 Professional (837P) transaction. Drugs administered in a hospital are included as part of the hospital fee. Keep in mind, that drugs such as (but not limited to) Synagis, Zometa, Depo-provera, Implanon and Remicade are not eligible for pharmacy benefit coverage unless they are administered in the client's home or eligible long-term care facility. Please refer to the Provider Billing Manuals for additional billing details. Additionally, a reminder of this information can be found in Appendix P (Prior Authorization Procedures and Criteria).

September and October 2011 Provider Billing Workshops

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

The September and October 2011 workshop calendars are included in this bulletin and are also posted in the Provider Services Training & Workshops section of the Department's Web site.

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 1-800-237-0044

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

All this information is necessary to process your reservation successfully. Look for your confirmation by mail within one week of making your reservation.

Reservations will only be accepted until the Friday before the training workshop. This will ensure that there is space available and enough training materials.

If you have not received a confirmation within at least two business days prior to the workshop, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops presented in Denver are held 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 completion of the UB-04 and the Colorado 1500 paper claim forms.

The Beginning Billing classes do not cover any specialty billing information.

The fiscal agent provides specialty training throughout the year in their Denver office.

Classes do not include any hands-on computer training.

September and October 2011 Specialty Workshop Class Descriptions

Dialysis
This class is for billers who bill for Dialysis services on the UB-04/837I and/or Colorado 1500/837P claim formats. The class covers billing procedures, common billing issues and guidelines specifically for dialysis providers. *(This is not the class for Hospitals – please refer to the Hospital Class.)*

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.

HCBS-EBD
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-DD
This class is for billers who bill on the Colorado 1500/837P claim format for the following: Comprehensive Services (HCBS-DD), Supported Living Services (SLS), Children's Extensive Support (CES), Children's Residential Habilitation Program (CHRP) and Targeted Case Management (TCM). The class covers billing procedures, common billing issues and guidelines for HCBS-DD providers.

Nursing Facility
This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues, PETI, Medicare Crossovers, and guidelines specifically for Nursing Facility providers.

Home Health
This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues, and guidelines specifically for Home Health providers.

Pediatric HH PAR Workshop
The Pediatric Home Health PAR workshop focuses on the PAR completion instructions for Pediatric Home Health procedures. This class is specifically for Pediatric Home Health providers.

Practitioner
This class is for providers using the Colorado 1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:

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

Provider Enrollment Application Workshop
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.

Transportation
This class is for emergency transportation providers billing on the Colorado 1500/837P and/or UB-04/837I formats. The class covers billing procedures, common billing issues, and guidelines specifically for Transportation providers.

Vision
This class is for ophthalmologists, optometrists, and opticians billing on the Colorado 1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for practitioners providing vision services.

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 **Welton St.**, 0.5 miles.
Turn **right** at **17th St.**, 0.2 miles.
The Denver Club Building will be on the right.

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_Map.shtml.

= Free MallRide - The MallRide stops are located at every intersection between 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 note: Email all WebEx training reservations to workshop.reservations@acs-inc.com.

A meeting notification containing the Web site, phone number, meeting number, and password will be emailed or mailed to providers who sign up for WebEx.

September 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5 *Labor Day*	6	7	8	9	10
11	12	13 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	14 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Dialysis 1:00 PM-3:00 PM	15 Provider Enrollment 9:00 AM-11:00 AM (WebEx) Practitioner 1:00 PM-3:00 PM	16 Pediatric HH PAR 1:00 PM-3:00 PM Home Health 3:00 PM-4:30 PM	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

October 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10 *Columbus Day*	11 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Vision 1:00 PM-3:00 PM	12 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Nursing Facility 1:00 PM-3:00 PM	13 Dental 9:00 AM-11:00 AM	14 Beginning Billing for Waiver Providers 9:00 AM-11:30 AM Web Portal 837P 12:00 PM-12:45 PM	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to

ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

Please remember to check the Provider Services section of the Department's Web site at:

colorado.gov/hcpf