Provider Bulletin

colorado.gov/hcpf

Reference: B1200322 **June 2012**

Did you know...?

The term *Case Management Agencies* (CMA) includes Single Entry Point (SEP) agencies, Community Centered Boards (CCBs) and other case management agencies. The agencies are designated by the Department to provide case management services (which include the state contracted fiscal agent and utilization management entity).

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All Providers

Prior Authorization Request (PAR) Submission

ColoradoPAR Program processes Prior Authorization requests for the following benefits:

- Audiology
- Durable Medical Equipment (DME)/Supply- All (including repairs)
- Diagnostic imaging – limited to non-emergency Computed Tomography (CT) Scans and Magnetic Resonance Imaging (MRI), and all Positron Emission Tomography (PET) Scans
- Medical/surgical services
- Reconstructive surgery
- EBI Bone Stimulator
- Second surgical opinions
- Physical and occupational therapy services
- Transportation
- Out-of-state non-emergency surgical services
- Organ transplantation
- EPSDT Extraordinary Home Health
- Private Duty Nursing
- Vision, including contact lenses

Online PAR Processing with CareWebQI

Please continue to use the ColoradoPAR Program CareWebQI online portal to submit PARs to the ColoradoPAR Program. PARs submitted through CareWebQI have faster processing times and allow for greater continuity of care. Submitting PARs through the CareWebQI portal allows the medical review staff to see medical documentation quickly and provide a decision faster than using faxed documents. All PARs will continue to be processed in a timely manner regardless of their submission method.

Message Section on CareWebQI

ColoradoPAR uses a message section in CareWebQI to communicate with providers. Please check the message section before calling for information, as ColoradoPAR uses this message section to communicate to users. For help using the message section, please visit www.coloradopar.com/carewebqi/carewebqi-access.

Training on CareWebQI

The ColoradoPAR Program offers CareWebQI using WebEx every Wednesday at 1:00 p.m. Mountain Standard Time.

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

ACS Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

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

Trainers are also available to provide training at the provider's office. If interested, please contact the ColoradoPAR Program at RES_ColoradoPAR@apsealthcare.com or visit ColoradoPAR.com.
For WebEx trainings, please be sure to log on prior to the scheduled time for online training to ensure correct software is available for viewing the presentation. For technical assistance with using the WebEx, please call 1-866-863-3910 or see https://www.webex.com/login/attend-a-meeting for more information.

Accountable Care Collaborative (ACC) Update

Incentive Payments for State Fiscal Year 2012-13

The Department of Health Care Policy and Financing (the Department) will soon begin the next phase of the ACC program, which includes an incentive payment structure. As of July 1, 2012, a portion ($1) of the Primary Care Medical Provider's (PCMP's) per-member-per-month (PMPM) reimbursement will be placed in an incentive pool. PCMPs will have the opportunity to earn incentive payments based on the Regional Care Collaborative Organization's (RCCO's) region-wide performance on reductions in three areas: emergency room visits; hospital readmissions; and high cost imaging.

During the initial phase of the program, PCMPs automatically received the $1 PMPM incentive payment in addition to the regular $3 PMPM payment. PCMPs will continue to receive the $3 PMPM payment during the next phase of the program, with the opportunity to earn an additional $1 PMPM as the incentive payment.

The ACC is the Colorado Medical Assistance Program's new program to improve client health and contain costs. Medicaid clients enrolled in the ACC receive full Medicaid benefits, and also belong to a RCCO that provides care coordination among providers and other community and government services.

Please contact Kathryn Jantz at Kathryn.Jantz@state.co.us or 303-866-5972; Greg Trollan at Greg.Trollan@state.co.us or 303-866-3674; or Leslie Weems at Leslie.Weems@state.co.us or 303-866-3393 with any questions.

Colorado Choice Transitions (CCT) to Launch in Fall 2012

The Department is launching a new, $22 million, 5 year grant program called Colorado Choice Transitions (CCT). The program is part of the federal initiative, Money Follows the Person. The goals of the program are to facilitate the transition of 500 Medicaid-eligible clients from long term care facilities to the community over the course of the grant. This will be accomplished using home and community based supports and services as well as streamlining and improving the long term care delivery systems here in Colorado.

In addition to Home and Community Based Service (HCBS) waiver services, CCT participants will have access to 14 additional demonstration services provided during an individual's enrollment in the program post-transition, including:

- Assistive technology
- Behavioral health counseling
- Caregiver services
- Community transition services
- Dental and vision services
- Enhanced nursing
- Home delivered meals
- Home modifications
- Independent living skills
- Intensive case management
- Mentorship
- Specialized day rehabilitation
- Substance abuse counseling

The Department is looking for existing and new Medicaid providers from across Colorado to be a part of this important program. For more information, please contact Nicole Storm at Nicole.Storm@state.co.us or 303-866-2858 or visit the Department's CCT web page at colorado.gov/hcpf/CCT.

Immunization Services Billing Manual

On July 2, 2012, an updated version of the Colorado Medicaid Immunization Services billing manual will be available in the Provider Services Billing Manuals section of the Department's Web site.

The Immunization Services billing manual gives billing instructions to Medicaid providers who administer immunizations to Colorado Medicaid clients. Please use the manual for reference when submitting claims for immunization services. The billing manual will be updated annually.

Please contact Amanda Belles at Amanda.Belles@state.co.us or 303-866-2830 with questions.

Non Payment for Provider Preventable Conditions (PPCs)

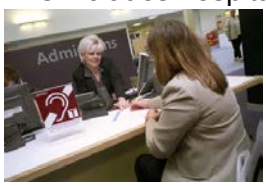
Effective July 1, 2012, Colorado is implementing a new non-payment policy for Provider Preventable Conditions (PPCs) for all providers. This is to comply with the requirements outlined in Section 2702 of the Affordable Care Act (ACA), and the final federal regulations (42 CFR Part 434).

There are two categories of PPCs identified by the Centers for Medicare and Medicaid Services (CMS): Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). HCACs apply only to inpatient hospital services; OPPCs apply to all services.

Inpatient Hospital: HCACs

The Department's policy regarding HCACs has been in place for Diagnosis Related Group (DRG) prospective payment hospitals since October 1, 2009. Under the new policy, **all** hospitals except for freestanding psychiatric hospitals are subject to the HCAC policy.

This includes hospitals paid per diem as well as Medicare crossover hospital claims.



If one of the diagnoses on the HCAC list (as defined by CMS) is present on admission (POA), claims related to the condition will be paid. If the condition is not POA, treatment related to these diagnoses will not be reimbursed. Because these events are preventable, the Department will not pay the additional costs of a higher DRG assignment that is the result of the HCAC.

Hospital claims must indicate the POA status for the principle diagnosis and **all** "other" diagnoses. It is not required for the "admitting diagnosis". Hospitals must indicate one of the following on the claims:

- **Y** = Yes = present at the time of inpatient admission
- **N** = No = not present at the time of inpatient admission
- **U** = Unknown = the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- **W** = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- **"Blank" (or "1" on UB-04)** = Unreported/Not used – diagnosis is exempt from POA reporting

Please refer to the September 2009 provider bulletin (B0900270) for a list of the HCACs and additional information regarding POA.

All Providers: OPPCs

OPPCs are conditions occurring in any health care setting. The Department will not reimburse for any treatment related to the following conditions:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive surgery performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Any reduction in payment is limited to the amounts directly identifiable as related to the OPPCs and the resulting treatment. The policy affects all Medicaid enrolled providers including physicians, inpatient and outpatient hospitals, and ambulatory surgical centers. This policy also applies to all services provided to Medicaid clients.

Providers are not allowed to bill clients for any treatment related to OPPCs. This includes copayments.

OPPC Codes for Inpatient and Outpatient Hospital

Effective for dates of service on or after July 1, 2012, inpatient hospital claims for avoidable errors should be submitted on a UB-04 paper claim form or as an 837 Institutional (837I) electronic claim transaction. For inpatient claims, indicate type of bill (TOB) 110 on the claim.

The non-covered claim must have one of the following ICD-9-CM diagnosis codes reported in diagnosis position 1-8:

- E876.5 – Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side or body part

OPPC Codes for Ambulatory Surgery Centers (ASC) and Practitioners

Effective for dates of service on or after July 1, 2012, ASC claims and practitioner claims for avoidable errors must be submitted using the Colorado 1500 claim form or as an 837 Professional (837P) electronic claim transaction.

The claim must include the appropriate modifier for all lines that relate to the erroneous procedure(s) using one of the following applicable National Coverage Determination modifiers:

- **PA** – Surgery wrong body part
- **PB** – Surgery wrong patient
- **PC** – Wrong surgery on patient

These claims must also be coded with one of three E codes:

- E876.5 Performance of wrong operation (procedure) on correct patient
- E876.6 Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 Performance of correct operation (procedure) on wrong side/body part.

Feel free to contact Dana Batey at Dana.Batey@state.co.us or 303-866-3852 with questions.

Recovery Audit Contractor (RAC) Program Update

Are there any groups or associations who would like to receive an outreach presentation on the Recovery Audit Contractor (RAC) Program?

The Department's RAC Program will soon begin its audits. The contractor, CGI Federal, has agreed to give outreach and educational presentations to any provider groups or associations who would like to know more about the RAC Program. The presentation is about an hour long. In addition to a formal in-person presentation, CGI Federal will be posting materials on-line that may be accessed at COHCPF.CGICLEVE.COM.

If interested in receiving a live presentation either in person or via webinar, please contact the CGI Federal Medicaid Service Center at 1-855-210-3438, Option 2, or by email at rac.medicaid@cgifederal.com to arrange a time.

Provider Status Verification

The Department has contracted with Peregrine Data Management Corporation for access to the MedicalQuest database. The MedicalQuest database is a searchable, online provider database, developed and maintained by the contractor and includes information regarding clinical specialties serving the health care industry.

Within the scope of the Department's contract, Colorado Medical Assistance Program providers and their staff are able to utilize the expanded dataset from MedicalQuest. Access to this data set includes both Medicaid and non-Medicaid providers, enhanced search options, and extended information. To access the extensive data set, simply become a registered user, which is free and restricted to the health care community.

To become a registered user, go to the MedicalQuest Home Page and select 'Become a Registered User' in the 'What Would You Like to Do Today?' column.

Contractual responsibilities include contacting all Colorado Medical Assistance Program providers via telephone, email, and/or postal mail, at least once every 90 days to accurately update the MedicalQuest database. Since clients will be able to access the database to search for a provider. provider information will be available for the client to view via the MedicalQuest Web site at medicalquest.com.

In late July 2012, the Department will be conducting an audit of the MedicalQuest Provider database. This is to verify that the information contained in the database is accurate and reliable.

The Department's goal is to minimize the client's frustration when locating a provider and encourage clients to seek health care services in the most appropriate settings. Providers may be contacted by the contractor in the near future. The Department appreciates the assistance and time given to ensure the data is accurate and up to date.

Feel free to contact Jan Bidgood at Jan.Bidgood@state.co.us or 303-866-2463 with any questions.

Independence Day Holiday

Due to the Independence Day holiday on Wednesday, July 4, 2012, the receipt of warrants will be delayed by one or two days. State, ACS, and ColoradoPAR Program offices will be closed on Wednesday, July 4, 2012. Offices will re-open during regular business hours on Thursday, July 5, 2012.

Child Health Plan *Plus* (CHP+) Providers

Important Notice to CHP+ Providers about Copay Changes

Beginning July 1, 2012, CHP+ will have changes in the amount members pay in copayments for certain health care services. These changes may affect how much will be collected from CHP+ members.

Members will receive a new CHP+ membership card with their copayment amounts by July 1, 2012. If there are any questions about the copayment amounts, please refer to the Copayment Summary Fact Sheet or contact the appropriate CHP+ Health Plan at the number below.

Colorado Access HMO: (local) 303-751-9021 or (toll free) 1-888-214-1101 or visit coaccess.com

Colorado Choice HMO: (local) 719-589-3696 or (toll free) 1-800 475-8466 or visit coloradochoicehp.com

Denver Health Medical Plan: (local) 303-602-2100 or (toll free) 1-800-700-8140 or visit denverhealthmedicalplan.com

Kaiser Permanente: (local) 303-338-3800 (TTY: 303-338-3820), or visit FindYourPlan.org

Rocky Mountain Health Plans: (local) 970-243-7050 or visit rmhp.org/members/how_to_use/chp_plan.aspx

State Managed Care Network: (local) 303-751-9021 or (toll free) 1-888-214-1101 or visit chpplusproviders.com

Dental and Orthodontic Providers

Prior Authorization Request (PAR) Submission

Beginning June 25, 2012, the ColoradoPAR Program will start processing Dental and Orthodontic PARs. Please submit Dental and Orthodontic PARs by fax or mail to ColoradoPAR at:

Fax: 1-866-492-3176 Mail: 2401 NW 23rd Street, Suite 2D
Oklahoma City, OK 73107

Durable Medical Equipment and Supply Providers

Revised Billing Manual

The Durable Medical Equipment (DME) & Supplies manual has been updated and includes the 2012 Healthcare Common Procedure Coding System (HCPCS) procedure codes. The manual is available in the Provider Services Billing Manuals section of the Department's Web site.

Home Health Providers

Home Health Prior Authorization Requests (PARs)

Home Health providers should continue to send Home Health PARs for clients 20 and under to the fiscal agent, ACS, for review. Please look for more information regarding these PARs in the near future.

Hospice Providers

Prognosis Required for Hospice

Effective May 30, 2012, the medical prognosis of life expectancy that is required for election of hospice is extended from six months to nine months. This allows clients to elect hospice with a medical prognosis of life expectancy of nine months or less.

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

Physical Therapy and Occupational Therapy, and Speech-Language and Hearing Services Providers

Outpatient Physical Therapy (PT) and Occupational Therapy (OT) and Speech-Language and Hearing Services Benefit Coverage Standards

The Department will publish written Outpatient PT and OT and Speech-Language and Hearing Services Benefit Coverage Standards to clarify these services, effective July 2, 2012.

The Outpatient PT and OT and Speech-Language and Hearing Services Benefit Coverage Standards clarify the type of services that are covered and the clients who are eligible to receive the covered services. Once effective, please visit the Boards & Committees section of the Department's Web site, click on Benefits Collaborative, then click on Approved Policies on the left-hand side of the screen to view the policy.

The Outpatient PT and OT and Speech-Language and Hearing Services Benefit Coverage Standards, which were approved by the State Medicaid Director in May 2012, were developed with the participation of providers and other stakeholders using the Department's Benefits Collaborative process.

For information regarding billing codes, prior authorizations, and other billing instructions, please refer to the Physical, Occupational, Speech & Language Therapy billing manual in the Provider Services Billing Manuals section of the Department's Web site.

If you have questions about the Outpatient PT and OT Benefit Coverage Standard, please contact Amanda Belles at Amanda.Belles@state.co.us or 303-866-2830. For questions about the Speech-Language and Hearing Services Benefit Coverage Standard, please contact Marcy Bonnett at Marcy.Bonnett@state.co.us or 303-866-3604.

Changes for the Colorado Medical Assistance Program's Outpatient PT and OT Benefit (includes Physicians)

As of July 2, 2012, the following changes will take effect for the Colorado Medical Assistance Program's Outpatient PT and OT benefit:

- Colorado Medicaid clients ages 21 and over may receive up to a combined total of 48 units of outpatient PT and OT services per calendar year (January through December). Prior authorization will not be required. However, once the 48 unit limit is reached for the year, additional PT and OT services cannot be rendered until the next calendar year begins.
- Colorado Medicaid clients ages 0 to 20 may receive up to a combined total of 48 units of outpatient PT and OT services per calendar year (January through December) without prior authorization. However, once the 48 unit limit is reached for the year, a prior authorization will be required for additional PT and OT services (49 units and up).
- The 48 unit limit does NOT include evaluation/re-evaluation codes 97001, 97002, 97003, and 97004.

A combined total of 48 units is defined as any combination of outpatient PT and OT services up to the 48 unit limit. For example, a client may require 40 units of PT services, and only 8 units of OT services.

Questions may be directed to Amanda Belles at Amanda.Belles@state.co.us or 303- 866-2830.

Skilled Nursing Facility (SNF) Providers

Colorado Medical Assistance Program 5615 for SNF Prior Authorization will be Processed by a New Vendor Starting July 2012

Effective July 1, 2012, Massachusetts Peer Review Organization (MASSPRO), will be processing all nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), and Swing Bed provider Prior Authorization Requests (PARs). Look for more vendor transition information by visiting the Department's Web site.

Ascend Management Innovations, formerly known as Dual Diagnosis Management (DDM) will continue to process PARs through June 2012.

Surgery Providers

Bariatric Surgery and Intersex Surgery Benefit Coverage Standards

The Department will publish written Bariatric Surgery and Intersex Surgery Benefit Coverage Standards to clarify these services, effective July 2, 2012.

The Bariatric Surgery and Intersex Surgery coverage standards clarify the clients who are eligible to receive these services. Once effective, please visit the Boards & Committees section of the Department's Web site, click on Benefits Collaborative, and click on Approved Policies on the left-hand side of the screen to view these policies.

The Bariatric Surgery and Intersex Surgery coverage standards were approved by the State Medicaid Director in June 2012. Coverage standards were developed with the participation of providers and other stakeholders using the Department's Benefits Collaborative process.

For information regarding billing codes, prior authorizations, and other billing instructions, please refer to the Medical/Surgical Services billing manual located in the Provider Services Billing Manuals section of the Department's Web site.

Questions about the Bariatric Surgery and Intersex Surgery coverage standards can be directed to Dana Batey at Dana.Batey@state.co.us or 303-866-3852.

Pharmacy Providers

Preferred Drug List (PDL) Update

The Pharmacy &Therapeutics (P&T) Committee met on April 10, 2012, and reviewed the following medications. Effective July 1, 2012, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Antihistamines (newer generation):
cetirizine and loratadine generic dosage forms

Angiotensin Receptor Blockers, Combinations and Renin Inhibitors:
Avapro (Only brand name Avapro), Benicar, Diovan, losartan, Avalide (Only brand name Avalide), Benicar-HCT, Diovan-HCT, losartan/HCTZ generic products

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:
Asmanex, budesonide nebulizer solution, Flovent HFA and diskus and Qvar inhaler

Corticosteroid and Long-Acting Beta-2 Agonist Combinations:
Advair diskus, Advair HFA, Dulera and Symbicort Inhaler
Fibromyalgia Agents
Lyrica and Savella

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

Long-acting Oral Opiates:
1st line: methadone and morphine ER; 2nd line: fentanyl patches

Skeletal Muscle Relaxants:
baclofen, tizanidine and cyclobenzaprine

Topical Immunomodulators:
Elidel and Protopic for clients age 2 years and older.

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the PDL web page.

Other PDL News

- Due to the release of quetiapine, the PDL has been updated to include the generic equivalent of Seroquel as preferred product as of June 1, 2012.

- Beginning July 1, 2012, only brand name Avapro and Avalide will be covered and Medicaid will not be paying for the generic equivalents.
- The fibromyalgia agents are a new addition to the PDL beginning July 1, 2012. The preferred agents will be Lyrica and Savella.

Next P&T Committee Meeting

The next meeting will be held:

July 10, 2012
1:00 p.m. - 5:00 p.m.
225 E. 16th Avenue, 1st floor conference room
Denver, CO 80203

June and July 2012 Provider Billing Workshops

Provider Billing Workshop Sessions

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 2012 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 for all workshops

Email reservations to:
workshop.reservations@xerox.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 to ensure there is space available.

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.

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.

June and July 2012 Specialty Workshop Class Descriptions

Audiology

This class is for billers using the Colorado 1500/837P format for audiology services. The class covers billing procedures, common billing issues and guidelines specifically for Audiologists.

Dental

The class is for billers using the 2006 ADA paper claim form. The class covers billing procedures, claim formats, common billing issues and guidelines specifically for the following provider types: Dentists, Dental Hygienists

IP/OP Hospital

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

Nurse Home Visitor Program (NHVP)

This class is for billers who bill on the CO1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Nurse Home Visitor 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

Waiver Programs

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

Web Portal

Web Portal classes provide an overview of the Colorado Medical Assistance Program Web Portal, a description of its functions and contact and support information.

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 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@xerox.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.

June 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	13 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM	14 Provider Enrollment 9:00 AM-11:00 AM WebEx – IP/OP 1:00 PM-3:00 PM	15 WebEx - UB-04 9:00 AM-12:00 PM WebEx - Basic Billing for Waiver Providers 12:00 PM- 2:30 PM Web Portal 837P 2:45 PM-3:30 PM	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4 Holiday	5	6	7
8	9	10 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Audiology 1:00 PM-3:00 PM	11 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM IP/OP 1:00 PM-3:00 PM	12 Dental 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM WebEx - NHVP 1:00 PM-4:00 PM	13 Basic Billing for Waiver Providers 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	14
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