



Provider Bulletin

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June 2013

colorado.gov/pacific/hcpf

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Did you know...?

1. The Department of Health Care Policy and Financing (the Department) has released the [2012 annual report](#): A Year of Transformation, Creating a Culture Coverage
2. The State of Health has released: [Colorado's Commitment to Become the Healthiest State- May 2013](#).
3. The following legislative bills have been signed: [Medicaid Adult Dental](#), and [Medicaid Expansion](#).

All Providers

Medicaid Provider Rate Increases Effective July 1, 2013

Medicaid provider rate increases were approved during the 2013-2014 legislative session and are effective July 1, 2013. The fee schedule located on the bottom of [Provider Services](#) web page of the Department's website (colorado.gov/pacific/hcpf) is being updated to reflect the following rate increases.

- 2% increase for most fee-for-service benefits including, but not limited to:
 - Physician and clinic services;
 - Non-physician practitioner services;
 - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services;
 - Emergency and non-brokered non-emergent medical transportation;
 - Inpatient hospital services;
 - Outpatient hospital services;
 - Laboratory and radiology services;
 - Durable medical equipment, supplies, and prosthetics;
 - Federally-Qualified Health Centers (FQHC);
 - Fee-for-service mental health;
 - Ambulatory surgery center services;
 - Dialysis center services;
 - Physical, occupational, and speech therapy, and audiology services;
 - Outpatient substance abuse services;
 - Vision services; and
 - Drugs administered in the office setting including vaccine administration.



(Rates paid to certain managed care organizations may also include corresponding increases, as the Department will pay the rates based on fee-for-service expenditures.)

- 4.5% increase for dental services.
- The greater of current rates or 105% of Medicare rates for certain family planning services.
- 8.26% increase for:
 - Home health services;

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

Billing and Bulletin Questions
 1-800-237-0757

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

Correspondence, Inquiries, and Adjustments
 P.O. Box 90
 Denver, CO 80201

Enrollment, Changes, Signature Authorization and Claim Requisitions
 P.O. Box 1100 Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

- Private duty nursing services;
- Some HCBS waivers including:
 - HCBS – Elderly, Blind, and Disabled (EBD);
 - HCBS – Community Mental Health Supports (CMHS);
 - Children's HCBS (CHCBS);
 - HCBS – Persons Living with AIDS (PLWA);
 - HCBS – Brain Injury (BI);
 - HCBS – Spinal Cord Injury (SCI); and
 - HCBS – Children with Life-Limiting Illness (CLLI).
 - Colorado Choice Transitions (CCT) Qualified Services

The rates for services provided under the HCBS waivers operated by the Colorado Department of Human Services (DHS), Division for Developmental Disabilities (DDD) will increase as noted below effective July 1, 2013. Providers must submit claims with the new rates in order to receive the increase. Any claims submitted after July 1, 2013 with the old rates must be adjusted by the provider.

- Other increases for the following HCBS waivers include:
 - 4% increase for HCBS – Developmentally Disabled (DD);
 - 4% increase for HCBS – Supported Living Services (SLS);
 - 4% increase for HCBS – Children's Extensive Support (CES); and
 - 2% increase for HCBS – Children's Habilitation Residential Program (CHRP).
- 2% increase for Single Entry Point (SEP) Service Management and Prepaid Inpatient Health Plan Administration.

Please refer to the Department's website → Provider Services → [Billing Manuals](#) → HCBS or UB-04 section for the Home and Community-Based Services (HCBS), Home Health, Private Duty Nursing, and Hospice rate schedules.

The legislature also passed the following rate decrease effective July 1, 2013:

- 1.5% decrease for Class I Nursing Facility per diem rates
(The Department anticipates that both Hospice room and board and Program of All Inclusive Care for the Elderly (PACE) rates will be affected by this reduction, as these rates are tied to the nursing facility rates.)

Please contact the Department's fiscal agent, Xerox State Healthcare, at 1-800-237-0757 with questions.

Children's Medical Home Reimbursement and the Accountable Care Collaborative (ACC) Program

Effective January 1, 2013, Section 1202 of the federal **Affordable Care Act** raises Medicaid rates for Evaluation and Management (E&M) procedure codes and vaccine administration up to **Medicare** rates. These new rates are referred to as "1202 Supplemental Reimbursement." Supplemental reimbursement rates are higher than currently what a provider receives even when the Medical Homes for Children pay-for-performance "bump" is added to the regular fee-for-service Medicaid claims payment.



Beginning June 1, 2013, well child visits will be reimbursed at the standard Medicaid fee schedule rate. The Colorado Medical Assistance Program will pay attested providers the difference between the fee-for-service claims rate and the Medicare rate in quarterly lump sum payments for calendar year 2013 and 2014. Providers who have attested for 1202 Supplemental Reimbursement may also earn an additional \$3 per-member per-month payment by contracting with a Regional Care Collaborative Organization (RCCO) in the ACC program.

More information on 1202 Supplemental Reimbursement for Primary Care Physicians is available on the Department's website → [Providers](#). For more information about the ACC Program please refer to the Department's website → Client's & Applicants → Medicaid Programs → Accountable Care Collaborative → [ACC Provider Information](#).

2013 Healthcare Common Procedure Coding System (HCPCS)

The Ambulatory Surgical Centers (ASC), Dental, Durable Medical Equipment (DME) and Supply, Immunization, and Telemedicine manuals have been updated and include the 2013 Healthcare Common Coding System (HCPCS) procedure codes. The manuals are available in the Provider Services [Billing Manuals](#), Colorado 1500 section of the Department's website. The [2013 Practitioner HCPCS](#) Provider Bulletin is also available in the Provider Services, Provider Bulletins section of the Department's website. Please contact the Department's fiscal agent at 1-800-237-0757 with questions.

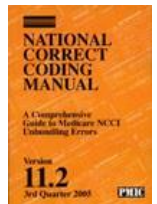
National Corrective Coding Initiative (NCCI) Quarterly Update

Providers are encouraged to monitor the Centers for Medicare and Medicaid Services (CMS) for updates to the NCCI rules and guidelines. The updates for the Procedure to Procedure (PTP) and Medically Unlikely Edit (MUE) files are completed quarterly, with the next file update available in July 2013. A link to the CMS NCCI website is also available on the [NCCI](#) web page located on the Department's website.

Billing Reminders for NCCI

Use of Modifiers

Modifiers may be appended to HCPCS/Current Procedural Terminology (CPT) codes only when clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass NCCI editing. Please refer to the NCCI Policy Manual on the CMS [Medicaid.gov](#) website for specific guidance on proper use of modifiers. The use of modifiers affects the accuracy of claims billing, reimbursement, and NCCI editing. In addition, modifiers provide clarification of certain procedures and special circumstances. Below is a summary of key modifiers used in billing and general guidance for the use of:



Modifier 59 – Refer to the article on the CMS Medicaid website. Modifier 59 should be used only when there is no other modifier to accurately clarify the procedure or service. See the list of valid modifiers in the NCCI Policy Manual, Chapter 1 at [Medicaid.gov](#).

Modifier 50 – Bilateral procedures performed during the same operative session on both sides of the body by the same physician. Clarification: bilateral procedures are billed on separate lines; therefore, the units for each line are one (1), and modifier 50 should be appended to the second line.

Modifiers LT and RT – The modifiers LT (left) and RT (right) apply to codes that identify procedures that can be performed on paired organs such as ears, eyes, nostrils, kidneys, lungs, and ovaries. Modifiers LT and RT should be used whenever a procedure is performed on only one side to identify which one of the paired organs was operated on. The Centers for Medicare and Medicaid Services requires these modifiers whenever appropriate.

Correct use of modifiers is essential to accurate billing and reimbursement for services provided.

The Centers for Medicare and Medicaid Services provides carriers and other payers with guidance and instructions on the correct coding of claims and using modifiers through manuals, transmittals, and the CMS website.

Updates on NCCI are provided quarterly by CMS for correct modifier usage for each CPT code. Please refer to the CMS [Medicaid.gov](#) website for further updates.

NCCI Requirements and Billing Endoscopy Procedures

In the November 2008 Provider Bulletin ([B0800254](#)), the Department instructed providers to bill certain colonoscopies and biopsies using a combination of codes not permitted under NCCI methodologies.

As a result of NCCI implementation, these prior instructions are no longer valid. The billing guidelines for upper gastrointestinal endoscopy or colonoscopy will now follow the same guidelines as Medicare and most health insurance companies. To account for NCCI methodologies, reimbursement rates for three (3) procedure codes have been changed. Now providers can bill the comprehensive code alone.

Please note the following rate changes effective July 1, 2013:

Procedure Code	Total CO Medicaid Allowable (Current)	Total CO Medicaid Allowable (Effective July 1, 2013)
43239	\$ 19.48	\$ 155.86
45380	\$ 9.74	\$ 220.80
45385	\$ 58.45	\$ 269.50

Effective July 1, 2013, these codes cannot be billed with certain other codes for the same client on the same day by the same provider. For an exhaustive list of these codes, please refer to the [NCCI](#) web page on the Department's website. Most commonly billed code pairs that will not be allowed effective July 1, 2013:

Code Will Pay	Code Will Deny
43239	43235
45380	45378
45385	45378

For more information about NCCI edits, please refer to the March 2013 Provider Bulletin ([B1300334](#)) and/or the Department's [NCCI](#) web page.

ColoradoPAR

Care Web QI (CWQI) Training

The ColoradoPAR Program offers online training on the use of CWQI via WebEx for providers needing additional instruction on electronic PAR submission. Trainings are available for the following providers:

1. All other Medical
2. Dental/Orthodontic
3. Pediatric Long Term Home Health (LTHH)

For more information, including updated training materials and schedules, please visit [coloradopar.com](#), email RES_ColoradoPAR@apshealthcare.com, or call 1-888-454-7686.

CWQI Access

Each individual submitting PARs through [CWQI](#) must have their own User Identification (UID). The UID can be requested by completing the CareWebQI User Access Form located on the ColoradoPAR Program's website ([coloradopar.com](#)) → CareWebQI → [CareWebQI User Access Form](#). When requesting a UID, please allow one week for processing. If a UID is not received within a week, please check the junk mail folder and/or contact the ColoradoPAR Program for technical support at 1-888-454-7686, Option 1. Please do not submit duplicate requests, as this can slow the process.



Planning for International Classification of Diseases Tenth Revision (ICD-10)

The health care industry's payers, providers, vendors, and all Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis and inpatient procedure code sets starting October 1, 2014.

The Department has an ICD-10 web page available with helpful information links for Medicaid Providers. To view the web page, please visit the Department's website → For Our Providers → What's New → Provider Implementations → [International Classification of Diseases - 10th Edition \(ICD-10\)](#).

Provider Communication Survey Reminder

Reminder, the Department is conducting a survey to assess the Department's current communication vehicles used to provide information to providers. The answers will help the Department identify communication vehicles that are working well, along with ideas on how they can be improved. This survey is anonymous and should only take 5-10 minutes to complete. Please [click here](#) to complete the survey.

Independence Day Holiday

Due to the Independence Day holiday on Thursday, July 4, 2013, the receipt of warrants will be delayed by one or two days. State, the Department's fiscal agent, and ColoradoPAR Program offices will be closed on Thursday, July 4, 2013. Offices will re-open during regular business hours on Friday, July 5, 2013.

Durable Medical Equipment (DME) and Supply Providers

Continue Positive Airway Pressure (CPAP)/ Bilevel Positive Airway Pressure (BiPAP)

The rental period requirement for all CPAP/BiPAP requests are two (2) to three (3) months for download time of the client's time tracking compliance for use. Approvals for purchase will not be granted for requests that have a compliance download period of less than two months.

During the rental period, adult clients must demonstrate either 80% overall compliance or average nightly use of five (5) hours or more for the duration of the rental period.

If compliance is not met within the two to three month download time, requests for purchase will be denied for not meeting medical necessity requirements. Providers have the option to request a peer-to-peer review or reconsideration on medical necessity denials. Upon denial, additional requests for rental units will also be denied. Exceptions may be made if there is a change in the client's condition or if a CPAP/BiPAP machine is required prior to the hospital discharge. These circumstances will be reviewed by a physician prior to final determination.



The purchase requirement for humidifiers (procedure code E0562) has been updated. Approval will be granted one time per client purchase when renting a machine.

DME Reimbursement Rates and Manually Priced Items

A rate increase has been approved for DME and supplies for Fiscal Year 2013-2014. Pending final approval by the Medical Services Board (MSB), all DME and supply codes in the fee schedule will reflect an overall 2% increase effective July 1, 2013. The rate for manually priced items will be reimbursed as follows:

- Manufacture Standard Retail Price (MSRP) less 21.43%
- Invoice plus 14.96%

Upon approval by the MSB, the new rates will be reflected in the Durable Medical Equipment and Disposable Medical Supplies rule, 10 CCR 2505-10 8.590.7.I.

Reminder: For items requiring manual pricing, all claims should be submitted using the MSRP reimbursement rate. Reimbursement based on invoice price should only be used when the item does not have an available MSRP published or is not available. Manufacture Standard Retail Price claims must include the SC modifier, and invoice claims must include the UB modifier.

DME Billing Manual Updates

The [DME and Supplies Billing Manual](#) has been updated. Please note the following changes:

- 2013 HCPCS additions:
 - A4435, E0670, E2378
- Updated unit limits for the following procedure codes:
 - NCCI MUEs: E0463, E0464, B4087, B4088, E0202, E0600, L1240, L2275
 - Other: A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045
- Updated coverage comments:
 - E0562 and E0601
- Wheelchair Equipment Repair Section

Note: The update to the Wheelchair Equipment Repair section has been made to omit dated limitations on repair. The update should not have any effect on current processes. Please send an email with *Wheelchair Equipment Repair* as the subject to HCPF_DME@hcpf.state.co.us with questions.

DME NCCI Edits

The Colorado Medical Assistance Program compared a sample of claims to the NCCI edits and found that most claims are compliant with CMS expectations. The potential exists that these edits may impact claims payments for DME.

The following procedure codes were identified in the NCCI Medically Unlikely Edits (MUEs) to limit the maximum allowable units per client per day. Updates were effective for all claims with dates of service as of April 1, 2013.

Procedure Code	Maximum Allowable Units	Notes
E0463 and E0464	1	

Procedure Code	Maximum Allowable Units	Notes
B4088 and B4087	1	
E0202	31 units/month	1 unit = 1 day. Claims may be date spanned using the KR modifier for the rental period.
E0600	1 units/month	1 unit = 1 month. Capped rental item. Rental includes suction tubing.
L1240	1	
L2275	2	Maximum allowable units are indicated for each lower extremity orthotic.

Reminder: Prior authorization determinations do not consider the number of units being requested. Approvals authorize medical necessity only and do not guarantee reimbursement for the requested number of units, including DME/supply codes that are manually priced.

Family Planning Services Providers

Medroxyprogesterone Acetate Injection (“Depo Shot”)

Beginning June 1, 2013, HCPCS procedure code J1055 will no longer be reimbursed for injections of medroxyprogesterone acetate (the Depo shot). Effective for dates of service between January 1, 2013 and June 1, 2013, that are still within timely filing requirements, the new HCPCS code, J1050 (injection, medroxyprogesterone acetate, 1mg) should be used. Reimbursement will be made at a maximum allowable rate of \$0.37 per unit with a maximum unit limit of 150. Continue to submit usual and customary charges. Please contact Ginger Burton at Ginger.Burton@state.co.us with questions.

Skyla – New Long-Acting Reversible Contraceptive Method In



February 2013, Skyla, a new long-acting reversible contraceptive method, came on the market. Skyla is a three-year levonorgestrel-releasing, intrauterine system, and is a covered Medicaid benefit. Providers should use the miscellaneous HCPCS code, J3490, the appropriate diagnosis codes and the family planning modifier, FP, to receive reimbursement until an assigned code is available. All claims must include an invoice and be submitted on paper. Providers should continue to submit usual and customary charges; however, the maximum allowable reimbursement for J3490 is cost plus 10%.

Please contact Ginger Burton at Ginger.Burton@state.co.us or Kirstin Michel at Kirstin.Michel@state.co.us with any questions.

Federally Qualified Health Center (FQHC) Providers

Acceptable Application Documents for FQHC

In place of other Medicare documentation, FQHCs applying for a Provider Identification (ID) number with the Colorado Medical Assistance Program can submit a copy of the Electronic Grant Handbook pages that identifies the addresses of facilities. By December 2013, every FQHC site in Colorado must have a separate Provider ID number. A copy of the documentation should accompany each application with the specific location highlighted on the SITES IN SCOPE table. This documentation will serve as verification from the Health Resources and Services Administration that the applying organization meets the appropriate requirements to be a FQHC provider type with Colorado Medical Assistance Program.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436, for more information.



Waiver Providers

Colorado Access Transition

Beginning July 1, 2013, the Single Entry Point (SEP) agency contract for Home and Community Based Services (HCBS) and Long Term Home Health (LTHH) care management and utilization review will transition from InnovAge Longterm Care Options to Colorado Access, doing business as (dba) Access Long Term Supports Solutions (ALTSS). The transition plan developed by the Department emphasizes the importance of protecting case manager-client relationships and services. Clients and providers with transition questions are encouraged to review the [Frequently Asked Questions](#) located on the Department's website. Please contact Laura Kiel at Laura.Kiel@state.co.us or 303-866-3659 with questions not addressed in the FAQ.

HCBS Non-Medical Transportation (NMT) Providers

The Department has revised the payment methodology for NMT providers. The revised rate methodology consists of three (3) mileage bands for the Mobility Van and Wheelchair Van vehicle types. Each mileage band has a unique rate.

The procedure code T2001, Non-Medical Transportation, and procedure code A0425, Wheelchair Van Mileage, cannot be billed for dates of services on or after July 1, 2013. Case managers began making revisions to client Prior Authorization Requests (PAR) in March 2013. All revisions moving clients to the new mileage bands will be complete by July 1, 2013. Mileage bands and rates will be effective July 1, 2013. Please include the appropriate mileage band modifiers when billing. The revised rates and mileage bands are below.



NMT Rate Schedule							
Service Type	Procedure Code	Mod #1	Mod #2	Mod #3	Mod #4	New Rate	Unit Value
Non Medical Transportation							
All types except Adult Day are limited to 208 trips, or 104 round trips per service plan year							
Taxi	A0100	U1,UA, U2, U6				PUC*	1 way Trip
Mobility Van							
Mileage Band 1 (0-10 miles)	A0120	U1,UA, U2, U6				\$ 8.14	1 way Trip
Mileage Band 2 (11-20 miles)	A0120	U1,UA, U2, U6	TT			\$ 14.98	1 way Trip
Mileage Band 3 (over 20 miles)	A0120	U1,UA, U2, U6	TN			\$ 22.30	1 way Trip
Wheelchair Van							
Mileage Band 1 (0-10 miles)	A0130	U1,UA, U2, U6				\$ 9.65	1 way Trip
Mileage Band 2 (11-20 miles)	A0130	U1,UA, U2, U6	TT			\$ 18.06	1 way Trip
Mileage Band 3 (over 20 miles)	A0130	U1,UA, U2, U6	TN			\$ 24.59	1 way Trip

*Public Utility Commission Determined Rate

Please contact Randie Wilson at 303-866-6199 or Nicholas Clark at 303-866-2436 with questions.

Hospital Providers

Inpatient Hospital ICD-9-CM Crosswalk Update

The Medicaid Management Information System (MMIS) changes have been completed. All claims affected by these remaining updates (diagnosis codes 649.81 and 649.82) have been mass adjusted.



Refer to the November and December 2012 Provider Bulletin ([B1200330](#), [B1200331](#)) for more information regarding the crosswalk. A copy of the crosswalk table is located on the Department's website in the Provider Services [DRG Relative Weights](#) section. Please contact Chris Acker at Chris.Acker@state.co.us or 303-866-3920 or Dana Batey at Dana.Batey@state.co.us or 303-866-3852 with questions.

Practitioners

Immunization and Vaccination Providers

NCCI Impact to Vaccine Administration Procedure Codes and 99211

Please be advised that NCCI prohibits the use of procedure code 99211 (office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician) with vaccine/immunization administration procedure codes 90460-90474.

Additionally, no NCCI bypass modifiers are recognized with these procedure code pairs. Procedure code 99211 and a vaccine/immunization administration procedure code will no longer both be reimbursed when billed together for the same client by the same provider on the same date of service. This bulletin article supersedes any previous articles that may have been written on the use of 99211 and vaccine administration codes. The [Immunization Benefit/Billing Manual](#) is being updated to reflect this national policy. Please contact the Department's fiscal agent, at 1-800-237-0757 with questions.

Pharmacy Providers

Pharmacy and Therapeutics (P&T) Meeting

Tuesday, July 9, 2013
1:00 p.m. - 5:00 p.m.
225 E. 16th Street
Denver, CO 80203
1st floor Conference Room



Preferred Drug List (PDL) Update

Effective July 1, 2013, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization (unless otherwise indicated):

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

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

Anticholinergic Inhalants: ipratropium nebulizer solution, Atrovent HFA and Spiriva

Anticholinergic and Short Acting Beta-2 Agonist Combinations: albuterol/ipratropium nebulizer solution and Combivent inhaler (MDI and Respimat devices)

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 and ProAir HFA

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

Skeletal Muscle Relaxants: baclofen, tizanidine and cyclobenzaprine

Topical Immunomodulators: No preferred products

The complete PDL and criteria for non-preferred medications can be found on the [PDL](#) web page.

June and July 2013 Provider Workshops

Provider Billing Workshop Sessions and Descriptions

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

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

Class descriptions and workshop calendars are also posted in the Provider Services [Training](#) section of the Department's website.

Who Should Attend?



Staff who submit claims, are new to billing Medicaid services, need a billing refresher course, or administer accounts should consider attending one or more of the following Provider Billing Workshops.

Courses are intended to teach, improve, and enhance knowledge of Colorado Medical Assistance Program claim submission.

June 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9	10	11 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	12 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM *WebEx – Dialysis 1:00 PM-3:00 PM	13 Provider Enrollment 9:00 AM-11:00 AM *WebEx – IP/OP Hospital 1:00 PM-3:00 PM	14 Basic Billing – Waiver Providers 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	15

July 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
14	15	16 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	17 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM *WebEx – OP Substance Abuse 1:00 PM-3:00 PM	18 *WebEx – Dental 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM Home Health 1:00 PM-3:00 PM	19 *WebEx – Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM WebEx – Practitioner 1:00 PM-3:00 PM	20

Reservations are required for all workshops

Email reservations to:

workshop.reservations@xerox.com

Or Call the Reservation hotline to make reservations:
1-800-237-0757, extension 5.

Leave the following information:

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

All the information noted above is necessary to process reservations successfully. Look for a confirmation by e-mail within one week of making a reservation.

Reservations will only be accepted until 5:00 p.m. the Friday prior to the training workshop to ensure there is adequate space available.

If a confirmation has not been received at least two business days prior to the workshop, please contact the Department's fiscal agent and talk to a Provider Relations Representative.

All Workshops presented in Denver are held at:

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

***Please note:** For WebEx training, a meeting notification containing the website, phone number, meeting number and password will be emailed or mailed to those who sign up.

The fiscal agent's office is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Free parking is not provided and is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between \$5 and \$20. Carpooling and arriving early are recommended to secure parking. Whenever possible, public transportation is also recommended. Some forms of public transportation include the following:

Light Rail Station – A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml.

Free MallRide – The MallRide stops are located on 16th St. at every intersection between Civic Center Station and Union Station.

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

Xerox State Healthcare at 1-800-237-0757.

Please remember to check the [Provider Services](#) section of the Department's website at: colorado.gov/pacific/hcpf