



[colorado.gov/pacific/hcpf](http://colorado.gov/pacific/hcpf)

# Provider Bulletin

Reference: B1200324

July 2012



## Did you know...?

Appendix M (Procedures Requiring Prior Authorization), Appendix R (Provider Claim Report Messages) and Appendix T (Community Mental Health Services Program - Covered Diagnoses and Procedures) have been updated. They are located in the [Billing Manuals Appendices](#) section. Specific changes are noted in the Revisions Log at the end of the Appendices document.

To avoid processing delays, remember to check Appendix D (Program/Services and Authorizing Agencies) to make sure services requiring prior authorization are sent to the correct authorizing agency.

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## All Providers

### Prior Authorization Request (PAR) Submission

The ColoradoPAR Program continues to process PARs 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



### Submitting Clinical Documentation with CareWebQI

Clinical information is imperative for prior authorization review. Please answer the clinical questions in [CareWebQI](#) when submitting a PAR and attach relevant clinical information needed for PAR determinations. Suggested documents include the history and physical reviews of the client, progress notes, office notes, lab results and medications being taken. With the exception of the codes listed in the June 2012 Special DME PAR Bulletin ([B1200323](#)), please submit all relevant supporting documentation with the PAR so that the medical review can be completed in a timely fashion.

It is the responsibility of the provider who submits the PAR to provide all relevant information. If clinical information is missing or inadequate, a message will be sent to providers via the [CareWebQI](#) message system. Please stay up to date on these messages in order to keep PARs moving through the process. Missing or inadequate clinical information will result in a lack of information (LOI) denial. PAR submitters will have 24 hours to respond to requests for more information before a LOI denial is issued.

### Fiscal Agent for the

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

### 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](http://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

For more information about the [ColoradoPAR](#) Program, CareWebQI training, and online PAR processing, please contact the ColoradoPAR Program at 1-888-454-7686 or [coloradopar.com](http://coloradopar.com). Information may also be found in previous provider bulletins by visiting the Provider Services [Provider Bulletins](#) Web page of the Department of Health Care Policy and Financing's (the Department's) Web site.

### Nurse Advice Line



Please remind Medicaid clients that the Nurse Advice Line is available 24 hours a day, 7 days a week at 1-800-283-3221. This is a triage call that is answered by a nurse to help clients determine the best level of care needed.

### Implementing the State Plan Amendment (SPA) for Targeted Case Management (TCM)

The SPA for TCM was approved by the Centers for Medicare and Medicaid Services (CMS) on May 8, 2012 with an effective date of April 1, 2012. The TCM SPA applies to Medicaid clients who are actively enrolled in Home and Community Based Services (HCBS) for persons with Developmental Disabilities (HCBS-DD), HCBS - Supported Living Services (HCBS-SLS), HCBS - Children's Extensive Support (HCBS-CES), and Early Intervention services (EI).

The SPA sets the requirements for TCM services. TCM services include:

- Assessment of client needs, including gathering information from the client, documentation, family, medical providers and others regarding the client's history, current status and change in needs at the time of enrollment and at least annually;
- Development and revision, as needed, of the care plan, including working with the client and authorized decision maker, as appropriate, to develop goals and action to respond to the assessed needs;
- Referral and related activities to help the client obtain medical, social, educational or other programs and services to address identified needs and obtain services;
- Monitoring and follow-up activities to ensure the care plan is implemented, client needs are addressed, and that adjustments to the care plan and services are made when the client's needs have changed; and
- Coordinating other non-developmental disabilities funded services, such as medical, social, educational and other services to ensure their effectiveness and non-duplication of services.

TCM does not include activities by a case manager that constitute the direct delivery of services that are a component of another Medicaid covered service.

Qualifications of Community Centered Board (CCB) staff providing TCM will have, at a minimum, a bachelor's level degree of education, five (5) years of experience in the field of developmental disabilities, or some combination of education and experience. Clients with TCM services have the choice of case management services and who their plan provider is. CCBs providing TCM must maintain case records.

Monitoring, including follow up, shall be completed as necessary to ensure the implementation of the care plan and to address the needs of the client, and shall occur as frequently as necessary. Monitoring includes direct contact and observation with the client in a place where services are delivered, at least once per quarter, for clients enrolled in HCBS-DD, HCBS-SLS and HCBS-CES. For clients receiving EI services, monitoring in the place where services are delivered shall occur at least once every 6 months.

The TCM unit limitations were effective as of April 1, 2012. One unit is equal to 15 minutes and the unit limits are 60 units from April 1, 2012 to June 30, 2012. Effective July 1, 2012, the total number of units per client is limited to 240 units per state fiscal year.

Please refer to the amended TCM SPA posted on the [Division for Developmental Disabilities'](#) Web site. Please contact Barbara Rydell, Case Management Specialist, at 303-866-7175 with 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.

## **Ambulatory Surgical Centers (ASCs)**

### **Billing Reminder**

ASCs are reminded that when billing the Colorado Medical Assistance Program, the billing provider number should be used in both the billing and the rendering provider fields. ASCs are not required to use a different rendering provider number when submitting claims. The Department is requesting that effective immediately, ASCs use the billing provider in both fields so that claims will no longer continue to suspend for manual review.

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

## **Dental and Orthodontic Providers**

### **Prior Authorization Request (PAR) Submission**

On June 25, 2012, the ColoradoPAR Program started 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 (DME) Providers**

### **Augmentative and Alternative Communication Devices (AACDs), Electrical Stimulation Devices, and Apnea Monitors Benefit Coverage Standards**

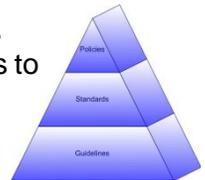
The Department will publish written Augmentative and Alternative Communication Devices (AACDS), Electrical Stimulation Devices, and Apnea Monitors Benefit Coverage Standards to clarify these services, effective August 1, 2012.

The AACDS, Electrical Stimulation Devices, and Apnea Monitors Benefit Coverage Standards clarify the type of services that are covered and the clients who are eligible to receive the covered services. To view the Benefit Coverage Standards, once effective, please click on the [Committees, Boards, and Collaboration](#) section at the top of the [Department's Web site](#), click [Benefits Collaborative](#), and click [Approved Benefit Standards](#) towards the bottom of the page.

The AACDS, Electrical Stimulation Devices, and Apnea Monitors Benefit Coverage Standards, which were approved by the Department's Chief Medical Officer, Dr. Judy Zerzan, in June 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 applicable billing manual in the Provider Services [Billing Manuals](#) section of the Department's Web site.

If you have questions about the AACDS, Electrical Stimulation Devices, and Apnea Monitors Benefit Coverage Standards, please contact Anna Davis at [Anna.Davis@state.co.us](mailto:Anna.Davis@state.co.us) or 303-866-2113.



## **Emergency and Non-Emergency Medical Transportation Providers**

### **1% Rate Reduction - Effective July 2012**

Effective July 1, 2012, a 1% rate reduction went into effect for all Medicaid emergency and non-emergency transportation services. These changes apply to all emergency and non-emergency medical transportation services *except* those provided under contract with the Department's transportation broker.

This reduction replaces the July 1, 2011 rate reduction that was not approved by CMS.

Please see Attachment A of this bulletin or the [Transportation Rates & PAR Requirements](#) in the Provider Services [Billing Manuals](#) section for the new rates.

Feel free to contact Chris Acker at [Chris.Acker@state.co.us](mailto:Chris.Acker@state.co.us) or 303-866-3920 with questions about the rate adjustments described in this notice.

## Home Health (HH) Providers

### **Prior Authorization Request (PAR) Submission**

Current policies for submission of HH PARs for clients 20 and under will continue with no changes at this time. Please refer to the HH PAR form to determine the appropriate authorizing agency.

### Practitioners

#### **Using CPT Code 11981 – Insertion of Non-Biodegradable Drug Delivery Implant**

Effective for dates of service on or after July 1, 2012, modifier 26 (professional component) will no longer be required when submitting claims for CPT code 11981 (insertion of non-biodegradable drug implant). This code will be reimbursed globally, without separation of professional and technical components, consistent with Medicare and with similar codes in the same range of surgery codes. The maximum allowable reimbursement for 11981 will remain at \$82.80.

When using 11981 for insertion of Implanon or Nexplanon (contraceptive implants), please use modifier FP (family planning).

Claims for 11981 with dates of service prior to July 1, 2012, must include modifier 26 in order to be reimbursed.

Please contact Ginger Burton at [Ginger.Burton@state.co.us](mailto:Ginger.Burton@state.co.us) if you have questions or concerns.

## School-Based Health Center (SBHC) Providers

### **Benefit Coverage Standard**

The Department will publish a written School-Based Health Center (SBHC) Benefit Coverage Standard to clarify this service, effective August 1, 2012.



The SBHC Benefit Coverage Standard clarifies the type of services that are covered and the clients who are eligible to receive the covered services. To view this policy, once effective, please go to the [Department's Web site](#), select the [Committees, Boards, and Collaboration](#) section at the top of the page, click [Benefits Collaborative](#), and then click [Approved Benefit Coverage Standards](#) towards the bottom of the page.

The SBHC Benefit Coverage Standard, which was approved by the Department's Chief Medical Officer, in June 2012, was developed with the participation of providers and other stakeholders using the Department's Benefits Collaborative process.

Questions about the SBHC Benefit Coverage Standard can be directed to Amanda Belles at [Amanda.Belles@state.co.us](mailto:Amanda.Belles@state.co.us) or 303-866-2830.

## Therapy Providers

### **Combined 48 Unit Limit Postponed**

The July 2, 2012 effective date for the Outpatient Physical Therapy and Occupational Therapy policy, including the combined 48 unit limit that was announced in the June 2012 bulletin ([B1200322](#)), is being postponed and will no longer take effect July 2, 2012.

Since the June 2012 bulletin was published, the Department has received many inquiries regarding how a provider will be able to track the number of units (PT and OT) for adult clients once the changes take effect. The Department wants to ensure that this mechanism is in place before the 48-unit limit is enforced.

Therefore, the effective date of the unit limit changes and policy described in the June 2012 provider bulletin will be postponed until further notice. The Department will inform providers once an effective date has been confirmed.

One item that the policy addressed was the scope of practice for Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (OTAs). Despite the postponement of the policy effective date, PTAs and OTAs will still be permitted to begin rendering services as of July 1, 2012, in compliance with the following:



## Rendering Provider

### 1. Physical Therapists

1.1. Must be licensed by the Colorado Department of Regulatory Agencies (DORA) pursuant to Title 12 Article 41.106 and may supervise up to four individuals at one time who are not physical therapists, including certified nurse aides, to assist in the therapist's clinical practice (§12-41-113(1) C.R.S.).

### 2. Physical Therapist Assistant

2.1. Must be certified by the DORA pursuant to Title 12 Article 41.204 and must work under the supervision of a licensed physical therapist as defined in the Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) and accompanying rules as promulgated by the State Board of Physical Therapy.

### 3. Occupational Therapist

3.1. Must be registered by the DORA pursuant to Title 12 Article 40.5.

### 4. Occupational Therapy Assistant

4.1. Must practice under the general supervision of a Colorado registered occupational therapist. A provider must be enrolled as a Colorado Medical Assistance Program provider in order to bill for procedures, products and services when treating clients who receive Colorado Medicaid benefits. The prescribing provider is the practitioner who orders the service. The rendering provider is the practitioner who can render the service within the scope of their practice, certifications, and licensure. The rendering provider may or may not be the rendering provider on the claim form, as not all provider types are able to enroll as a Colorado Medical Assistance Program provider.

PTAs and OTAs meeting the qualifications listed above will be approved by the Department to provide services under the supervision of a licensed therapist. PTAs and OTAs will **not**, however, be enrolled in the Colorado Medical Assistance Program and will **not** receive direct payment for services from the Colorado Medical Assistance Program.

Eligible providers may be individual practitioners or may be employed by certified or licensed home health agencies, therapy home care, children's developmental service agencies, health departments, federally qualified health centers (FQHC), or hospital outpatient services. The provider agency or the individual provider must verify that therapists are regulated by DORA and that the license or registration is current, active and unrestricted to practice.

Contact Amanda Belles at [Amanda.Belles@state.co.us](mailto:Amanda.Belles@state.co.us) or at 303-866-2830 with any questions.

## Vision Providers

### Coverage of Vision Therapy

As of August 1, 2012, the Department will no longer cover vision therapy services (CPT Code 92065). The Colorado Medical Assistance Program will continue to reimburse vision therapy services authorized on any currently active PARs, due to expire after August 1, 2012. However, as of August 1, 2012, there will no longer be approval of any new or additional PARs submitted to the Colorado Medical Assistance Program for vision therapy services.

The Department does not cover experimental or investigational treatments or services. After reviewing the available evidence on the clinical efficacy of vision therapy, the Department's Chief Medical Officer has concluded that this service is considered investigational, and that there is insufficient evidence to demonstrate clinical effectiveness.

The Department will periodically review the clinical literature on vision therapy as it becomes available, and re-evaluate the Colorado Medical Assistance Program's coverage of vision therapy.

For questions, please contact Amanda Belles at [Amanda.Belles@state.co.us](mailto:Amanda.Belles@state.co.us) or 303-866-2830.



## Pharmacy Providers

### Next Drug Utilization Review (DUR) Board Meeting

Tuesday, August 21, 2012  
7:00 p.m. - 9:00 p.m.  
225 E. 16<sup>th</sup> Avenue  
Denver, CO 80203  
1<sup>st</sup> Floor Conference Room



For the meeting agenda, please visit the [Drug Utilization Review \(DUR\) Board](#) Web page of the Department's Web site.

Please remember that the prescriber's National Provider Identifier (NPI) should be reported on each claim when submitting Medicaid Pharmacy claims to the Colorado Medical Assistance Program.

### Prior Authorization Updates

New prior authorization criteria have been posted in Appendix P for Kalydeco. The criteria for prior authorization require that documentation be sent to the Department's Medicaid Pharmacy section for review. For eligible clients, please submit the requested documentation by fax (303-866-3590) to:



Department of Health Care Policy and Financing  
ATTN: Medicaid Pharmacy Section

Additional criteria have been added to the Suboxone criteria regarding concomitant use of opiate products. For more information, please see the complete Appendix P by visiting the [Prior Authorization Policies](#) Web page.

Updates to the Proton Pump Inhibitor prior authorization criteria have been posted on the [Preferred Drug List \(PDL\)](#) Web page effective July 1, 2012. Please note that the prior authorization requirement for more than 60 days of therapy per year will not become active until September 15, 2012.

### COBManager Process for Pharmacy Claims

The Department is programming a new process to ensure commercial payors pay pharmacy claims prior to Medicaid for recipients with commercial pharmacy coverage. It is anticipated that this new process will be implemented in mid-late July. With COBManager, the Department's third party liability vendor, Health Management Systems (HMS), will match pharmacy claims on a daily basis with commercial eligibility data and submit claims to the commercial Pharmacy Benefit Manager (PBM) when there is coverage under a commercial plan. The pharmacy provider is then paid by the Commercial PBM as a separate transaction. HMS sends a rebill (NCPDP B3) claim to the Department showing the amount paid by the PBM in order to coordinate benefits. Please check the [Pharmacy](#) Web page of the Department's Web site for the latest information on this project.



### Preferred Drug List (PDL) Update

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:**

1<sup>st</sup> line: methadone and morphine ER; 2<sup>nd</sup> 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 Pharmacy & Therapeutics (P&T) Committee Meeting**

Tuesday, July 10, 2012

1:00 p.m. - 5:00 p.m.

225 E. 16<sup>th</sup> Avenue

Denver, CO 80203

1<sup>st</sup> Floor Conference Room

**July and August 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 July and August 2012 workshop calendars are included in this bulletin and are also posted in the Provider Services [Training](#) 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](mailto: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 number of people attending and their names
- The date and time of the workshop
- 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 17<sup>th</sup> Street, 4<sup>th</sup> 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.

**July and August 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 Dentists and Dental Hygienists.

**DME/Supply**

This class is for billers using the Colorado 1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for DME/ Supply providers.

**FQHC/RHC**

This class is for billers using the UB-04/837I and Colorado 1500/837P formats. The class covers billing procedures, Encounter Payments, common billing issues and guidelines specifically for FQHC/RHC providers.

**Hospice**

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

**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.

**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

**Occupational, Physical, and Speech Therapy**

This class is for billers using the Colorado 1500/837P claim format for therapies. The class covers billing procedures, common billing issues and guidelines specifically for Occupational, Physical, and Speech Therapy providers.

**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 17<sup>th</sup> 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 17<sup>th</sup> Street (Glenarm is a two-way street).

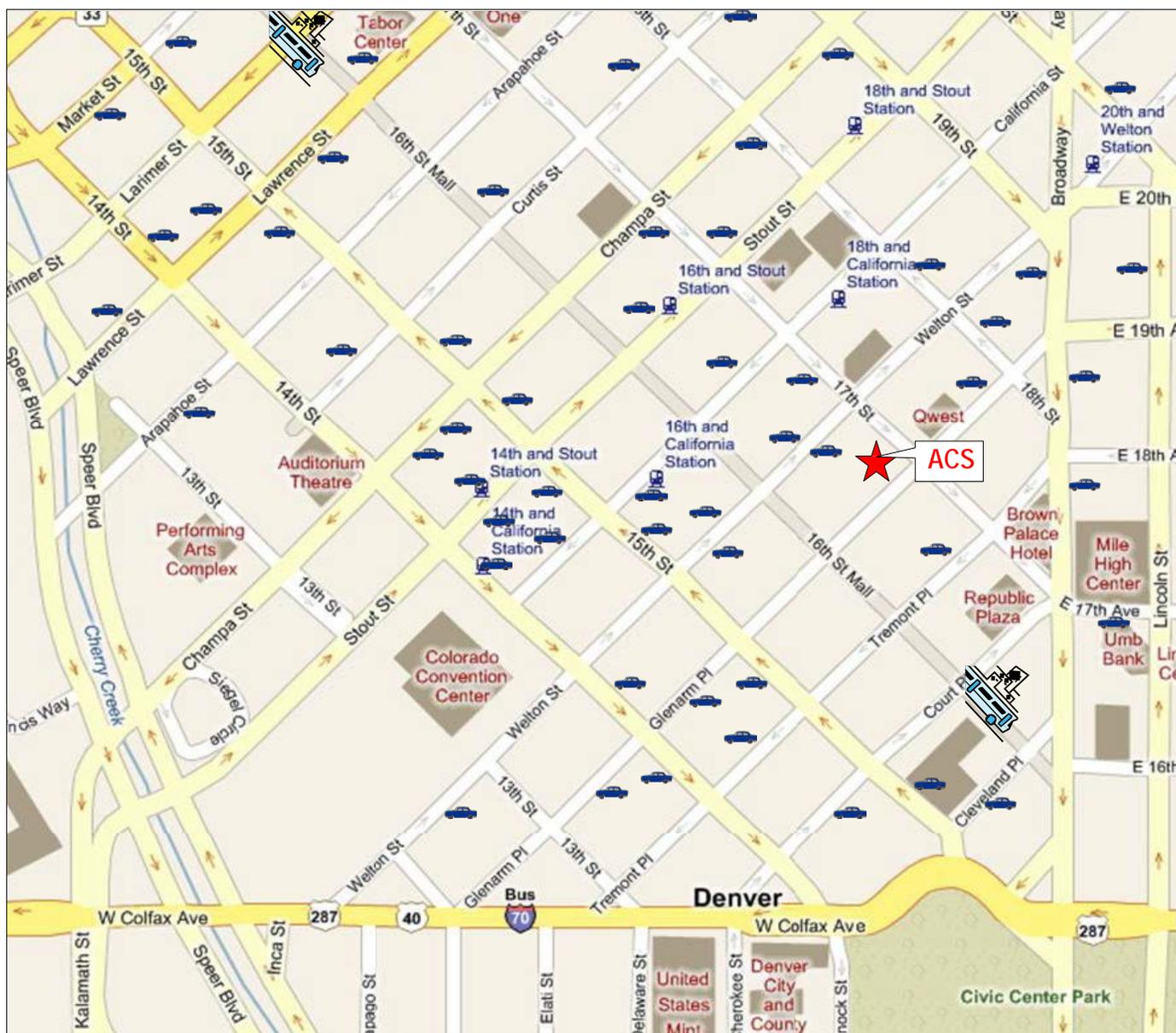
Parking is not provided by ACS and is limited in the downtown Denver area.

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](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](mailto: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.*

### 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	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				

### August 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM OT/PT/ST 1:00 PM-3:00 PM	8 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Hospice 1:00 PM-3:00 PM	9 DME Billing 9:00 AM-11:00 AM	10 WebEx - Beginning Billing – CO -1500 9:00 AM-12:00 PM FQHC/RHC 1:00 PM-4:00 PM	11
12	13	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/pacific/hcpf](http://colorado.gov/pacific/hcpf)**

### Transportation Rates & PAR Requirements

Code	Description	*Factor Code	Rates eff. through	Rates eff. 07/01/09	Rates eff. 09/01/09	Rates eff. 12/01/09	Rates eff. 07/01/11	Rates eff. 07/01/12	PAR
A0021	Ambulance service, outside state per mile, transport-Emergency	1	1.31	1.34	1.29	1.28	1.27	1.26	NO PAR
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	1	.38	.39	.37	.37	.37	.36	NO PAR
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	1	.38	.39	.37	.37	.37	.36	NO PAR
A0100	Nonemergency transportation; taxi	1	49.00	50.00	48.27	47.79	47.43	46.96	NO PAR
A0110	Nonemergency transportation and bus, intra- or interstate carrier	5	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	NO PAR
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	1	15.66	15.98	15.43	15.28	15.17	15.01	NO PAR
A0130	Nonemergency transportation: wheelchair van	1	19.5	19.9	19.2	19.0	18.88	18.69	NO PAR
A0140	Nonemergency transportation and air travel (private or commercial), intra- or interstate	5	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Colorado PAR ALWAYS
A0180	Nonemergency transportation: ancillary: lodging - recipient	1	36.28	37.02	35.74	35.38	35.11	34.76	Colorado PAR ALWAYS
A0190	Nonemergency transportation: ancillary: meals - recipient	1	15.97	16.30	15.73	15.57	15.45	15.30	Colorado PAR ALWAYS
A0200	Nonemergency transportation: ancillary: lodging - escort	1	36.28	37.02	35.74	35.38	35.11	34.76	Colorado PAR ALWAYS
A0210	Nonemergency transportation: ancillary: meals - escort	1	15.97	16.30	15.73	15.57	15.45	15.30	Colorado PAR ALWAYS
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	1	134.16	139.90	132.15	130.83	129.85	128.55	NO PAR
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	1	11.23	11.46	11.06	10.95	10.87	10.76	NO PAR
A0425	Ground mileage, per statute mile	1	1.65	1.68	1.63	1.61	1.60	1.58	NO PAR
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	1	100.65	102.70	99.14	98.15	97.41	96.44	NO PAR
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	1	135.27	138.03	133.24	131.91	130.92	129.61	NO PAR

Revised: 07/12

### Transportation Rates & PAR Requirements

Code	Description	*Factor Code	Rates eff. through	Rates eff. 07/01/09	Rates eff. 09/01/09	Rates eff. 12/01/09	Rates eff. 07/01/11	Rates eff. 07/01/12	PAR
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	1	100.59	102.64	99.08	98.09	97.35	96.38	NO PAR
A0429	Ambulance service, basic life support, emergency transport (BLS - emergency)	1	92.68	94.57	91.29	90.38	89.70	88.81	NO PAR
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	1	1901.68	1940.49	1873.15	1854.42	1840.51	1822.11	ColoradoPAR ALWAYS
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	1	1777.45	1813.73	1750.80	1733.29	1720.29	1703.09	ColoradoPAR ALWAYS
A0433	Advanced life support, level 2 (ALS 2)	1	162.34	165.65	159.90	158.30	157.11	155.54	NO PAR
A0434	Specialty care transport (SCT)	1	185.37	189.15	182.59	180.76	179.40	177.61	NO PAR
A0999	Unlisted ambulance service	5	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	NO PAR
S0209	Wheelchair van, mileage, per mile	1	.78	.61	.77	.76	.75	.75	NO PAR
T2001	Nonemergency transportation; patient attendant/escort	5	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	Manually Priced	NO PAR
T2003	Nonemergency transportation; encounter/trip	1	1.70	1.74	1.68	1.66	1.65	1.63	NO PAR
T2005	Nonemergency transportation; stretcher van	1	19.50	19.90	19.21	19.02	18.88	18.69	NO PAR
T2049	Nonemergency transportation; stretcher van, mileage; per mile	1	.78	.80	.77	.76	.75	.75	NO PAR

**\*Factor Code: 1= Fee Schedule, 5= Manually Priced**