



colorado.gov/hcpf

Provider Bulletin

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In this issue:

- All Providers..... 1
- Postpartum Depression Screening.....1
- New HCPF Website Coming Soon.....2
- Selecting Medicaid Health Plans and Providers Online2
- Medicaid Members are Looking for Providers..... 2
- ColoradoPAR Program.....3
- Dental Providers4**
- DentaQuest Provider Portal Updates4
- QMB and SLMB - Adult Dental4
- General Billing Instruction Updates4
- Qualified Medical Personnel5
- Children Ages 0-2, 3 and 45
- Rules and Regulations.....5
- Orthodontia Updates.....6
- Hospital Providers7**
- Correctional Facility Populations7
- PT/OT Providers.....7**
- Outpatient PT/OT Reminder7
- EI PT/OT Reminder7
- Transportation Providers.....7**
- NEMT Transition.....7
- Pharmacy Providers8**
- Other Drug Coverage Updates8
- Proton Pump Inhibitor Reminder8
- Smoking Cessation Reminder9
- P&T Committee Update9
- Provider Contact Info Update9
- DUR Board Update.....9
- Ann & Sent Provider Workshops 10**

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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



Did you know...?

As a result of the transition to the Department of Health Care Policy & Financing's (the Department's) new financial reporting system, Providers can now expect to receive Electronic Funds Transfers (EFTs) on Thursdays rather than Fridays. Also, the detail of the EFT transaction identifies the payment as being from the Department instead of Medicaid.

All Providers

Supplement to Postpartum Depression Screening & Payment in the Pediatric Primary Care Office

The Colorado Medical Assistance Program encourages screening of new mothers for postpartum depression. To facilitate screening in more settings, the provider seeing an infant for a well-baby visit is allowed to bill for the service using the Medicaid ID of the infant. The procedure code for postpartum depression screening is 99420.

Postpartum depression screening counts as an annual depression screening and Medicaid primary care providers are encouraged to screen new mothers at a well-child visit using the mothers' Medicaid ID number.

For additional information on billing this service using the mother's ID, please refer to the March 2014 Provider Bulletin ([B1400349](#)) as this article supplements the article presented in March 2014.

Postpartum depression screening is limited to one screening per year.

Postpartum Depression Screening Example using Medicaid ID of the infant

Validated Screening Tools	CPT coding	Positive Diagnosis Code to Use	Negative Diagnosis Code to Use	Medicaid Identification Number to Use
Edinburgh Postnatal Depression Scale PHQ-9	99420 (with HD modifier)	V58.89	V79.8	Infant

If a behavioral health need is identified after screening, the pediatric provider should assist with referring the mother to a Behavioral Health Organization (BHO), or [Regional Care Collaborative Organization](#) (RCCO) provider. Contact information for the BHOs, referral information, and Health TeamWorks depression guideline information can be found on the Department's website (colorado.gov/hcpf) → For Our Members → Healthy Living web page.

Providers may review the ‘Developmental, Depression, and Autism Screenings’ Benefit Coverage Standard found on the [Benefits Collaborative Approved Benefits Standards](#) web page of the Department’s website for more specific billing information.

Please contact Alex Stephens at Alex.Stephens@state.co.us with questions.

New Healthcare Policy & Financing (HCPF) Website Coming Soon

The Department will be upgrading its website in August 2014. The change means anyone linking to the current website will be redirected to the new homepage. The content, navigation, and layout of the new website will be very different from the old website. Please read the Website Migration Frequently Asked Questions (FAQ) located on the Department’s website (Colorado.gov/hcpf) → Initiatives→ Website Migration [FAQ](#) to find more information about the new website

Selecting a Medicaid Health Plan and Provider Online

New Medicaid members can now go online to select their Medicaid health plan and primary care medical provider through HealthColorado. First-time Medicaid Members who want to choose their primary care provider, and are not currently enrolled in a Medicaid Health Plan or the Accountable Care Collaborative (ACC), can use HealthColorado’s [online form](#) located on the HealthColorado.org website. All requests submitted by the 28th of each month will take affect the first of the following month.

Members may contact HealthColorado to select, change, or ask questions about their Medicaid health plan or primary care medical provider.

In Denver:	303-839-2120	Hours: Monday – Friday 8:00am – 5:00pm (Closed on State holidays)
Outside Denver:	1-888-367-6557	
TTY:	1-888-876-8664	

New Medicaid Members Are Looking for Providers

Please Update Provider Contact Information Maintained in the Medicaid Management Information System (MMIS)

The Department is asking all providers to verify and/or update their information in the Medicaid Management Information System (MMIS) as soon as possible. With the expansion of Medicaid benefits, Colorado has many new members looking for a health care provider. Please be reminded that it is the responsibility of each provider to update their contact information contained in the MMIS. Keeping the information updated also assures that payments and communication are sent timely and appropriately. Updating provider information on file with the Department’s fiscal agent, Xerox State Healthcare, is critically important as the information provided (address and phone number in particular) are used in the Department’s Find a Provider web search, which is information maintained in the MMIS. The information on file is only as good as what is provided. Updating the information in the Colorado Medical Assistance Web Portal ([Web Portal](#)) via the (MMIS) Provider Data Maintenance option is the easiest and most efficient method to keep information current. However, submission of a [Provider Enrollment Update form](#) is necessary for providers who do not have the capability to make updates through the Web Portal.

Assistance with this process is available by contacting the Department’s fiscal agent at 1-800-237-0757.

ColoradoPAR Program

ColoradoPAR Prior Authorization Request (PAR) Denial Options



When a PAR is denied, the ordering provider may work with the ColoradoPAR Program to request a Peer-to-Peer review and/or Reconsideration.

Peer-to-Peer Review	Reconsideration
A Peer-to-Peer review is a verbal discussion between the ordering provider and the ColoradoPAR Program reviewing physician. The Peer-to-Peer must be requested within five (5) calendar days of the denial notification and the review must be completed within ten (10) calendar days.	A Reconsideration is a second review by a different physician than the one who made the original PAR denial determination. A Reconsideration must be requested by the provider within ten (10) calendar days of the denial decision.
To request a Peer-to-Peer discussion, call the ColoradoPAR Program Provider at 1-888-454-7686.	Reconsideration requests can be faxed along with any additional information to the ColoradoPAR Program Provider Fax Line at 1-866-492-3176 Attn: Reconsideration Department.
The person requesting the Peer-to-Peer discussion will need to provide the name of the physician or nurse practitioner requesting the review, a contact phone number, and two (2) dates/times the physician or nurse practitioner is available (up to ten (10) calendar days after the denial notification).	The Reconsideration process: <ul style="list-style-type: none"> • The Reconsideration is completed by a ColoradoPAR Program physician of the same profession and specialty as the requesting physician. • The Reconsideration will include all information submitted and any additional information the requesting provider wishes to submit. • The ColoradoPAR Program reviewing physician may overturn or uphold the original denial decision.
The member’s physician or nurse practitioner must be notified and agree to participate in the review before the Peer-to-Peer request is made.	
For completion of the Peer-to-Peer discussion, the ColoradoPAR Program reviewing physician will then contact the requesting physician/nurse practitioner at one of the scheduled times	

CareWebQI (CWQI) Online Processing

Online PAR completion via [CWQI](#) requires that all of the appropriate boxes under Clinical Indications be checked and all clinical information attached to the PAR. Providers should verify that these checks have been made when processing PARs online for a faster PAR approval.

Note: Beginning September 1, 2014, PARs received that do not have all of the appropriate boxes checked will be denied for Lack of Information (LOI) since each PAR has different criteria in order to process correctly. In addition, clinical documentation must always be attached to the PAR when selecting “no guidelines apply” or “any clinical indications.”

Please contact the ColoradoPAR Program at 1-888-454-7686 with questions.

Dental Providers

Colorado Medicaid Adult and Children's Dental Benefit Administration Transition to DentaQuest – Updates

DentaQuest Provider Portal Updates

An updated provider Office Reference Manual (ORM) is available on the [DentaQuest Provider Web Portal](#). This revision contains more clarity and specific coverage information. The Department would like to thank all Medicaid dental providers for their patience as the document continues to be finalized. As the Provider ORM is being updated regularly, providers should continue to check the Provider Web Portal for updates.

As of July 1, 2014, The DentaQuest Provider Portal was populated with all the provider information that was available. Any corrections that need to be made are being completed quickly. If a provider feels they need to validate their information or need assistance using the provider portal, please contact DentaQuest Provider Services at 1-855-225-1730.

Qualified and Service-Limited Medicare Beneficiaries and the Adult Dental Benefit

Certain Medicaid programs pay Medicare premiums, deductibles, and co-insurances for Medicare beneficiaries with limited income and resources. Members eligible for these programs are referred to as Qualified Medicare Beneficiaries (QMB) and Service Limited Medicare Beneficiaries (SLMB). Such premium assistance is meant to ensure individuals have access to the Medicare benefit.

Though QMB and SLMB members have Medicaid ID numbers, only **some** of these individuals, due to income-eligibility guidelines, qualify for adult dental benefits. When verifying a member's Medicaid eligibility, if the provider receives a response that includes "Client has Regular Medicaid PLUS QMB" or "Client has Medicare & Medicaid Benefits," the member does qualify for the adult dental benefit. However, if the provider does not receive either of these messages, the member does not qualify.

The provider who checks a member's eligibility on the day of service and finds the member eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service.

General Dental Billing Instruction Updates

- A current Colorado Medicaid Dental Program [Fee Schedule](#) can be found under 'DentaQuest Resources' located on the [Dentist page](#) of DentaQuest's website.
- Prior to July 1, 2014, the D0999 (Unspecified Diagnostic Procedure) procedure code was used to bill dental screening services for children ages 3 and 4. Dental providers, including Direct Access/Independent dental hygienists, MDs, DOs, nurse practitioners and physician assistants previously billing this code should now begin billing using the D0190 (Screening of a Patient) procedure code for dental screening services rendered on or after July 1, 2014. The reimbursement rate for D0190 will be updated to reflect the same reimbursement rate that was used for the D0999 procedure code.
- All dental providers, including Direct Access/Independent dental hygienists and those providing services at a Federally Qualified Health Clinic (FQHC) or Rural Health Center (RHC), must now send all claims for all dental services, rendered on or after July 1, 2014, to DentaQuest for processing using the electronic ADA claim form found in the DentaQuest Provider Portal. For further assistance with billing, providers may contact DentaQuest Provider Services at 1-855-225-1730.

Qualified Medical Personnel – Dental Billing Updates

Qualified Medical Personnel must continue using the Colorado Medical Assistance Program Web Portal ([Web Portal](#)) using a Professional (837P) electronic transaction in conjunction with a well-child visit in order to submit claims for dental services. Providers may also continue using the Colorado 1500 paper claim form, if applicable, located in the forms section of the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → [Forms](#).

Medical Dental Services - Children Ages 3 and 4

- Private practices (MDs, DOs, nurse practitioners and physician assistants) billing procedure codes D1206 (fluoride varnish) and D0190 (dental screening) must bill using the Web Portal with an 837P electronic transaction. Providers may also continue using the Colorado 1500 paper claim form, if applicable.
- Federally Qualified Health Clinics and RHCs Medical Personnel billing procedure codes D1206 (fluoride varnish) and D0190 (dental screening) must itemize the services on the claim with a well-child visit, though reimbursement will be at the current encounter rate. Providers must bill using the Department's [web portal](#) with an 837I electronic transaction. Providers may also continue using the UB-04 paper claim form, if applicable.

Medical Dental Services - Children Ages Birth Through 2 Years Old

Qualified Medical Personnel billing for this age range remains the same.

- Private Practices (MDs, DOs, nurse practitioners and physician assistants) billing procedure codes D1206 (fluoride varnish) and D0145 (oral evaluation for a patient under 3 years of age and counseling with a primary caregiver) must bill using the Department's [web portal](#) with an 837P transaction. Providers may also continue using the Colorado 1500 paper claim form.
- Federally Qualified Health Clinics and RHCs Medical Personnel billing procedure codes D1206 (fluoride varnish) and D0145 (oral evaluation for a patient under 3 years of age and counseling with primary caregiver) must be itemized on the claim with a well-child visit, but reimbursement will be at the current encounter rate. Providers must bill using the Web Portal with an 837I electronic transaction. Providers may also continue using the UB-04 paper claim form, if applicable.
- DentaQuest has updated their systems to reflect that there is no Prior Authorization Requirement on Pre-orthodontic Treatment Visit (Procedure code D8660).
- DentaQuest has updated the Provider ORM to reflect that there is no Prior Authorization Requirement on Analgesia/Nitrous Oxide (Procedure code D9230).

Adult Dental Benefit – Rules and Regulations

Providers may view the final version of the Adult Dental rules and regulations, outlining the comprehensive adult dental benefit that became effective July 1, 2014, in section 10 CCR 2505-10 8.201 (Page 17) on the [Program Rules and Regulations](#) web page of the Department's website. The final rule includes a provision stating that the complete and partial dentures benefit will be subject to prior authorization, but will not be subject to the \$1,000 annual maximum for dental services for adults ages 21 and over. Although the complete and partial dentures benefit is not subject to the \$1,000 annual maximum, they will be subject to a set Medicaid allowable rate.

Description	Frequency
Complete Upper Denture	One time every 7 years. Includes initial 6 months of relines. PAR Required.
Complete Lower Denture	One time every 7 years. Includes initial 6 months of relines. PAR Required.
Removable Partial Upper Denture/Resin Based	One time every 7 years. PAR Required.
Removable Partial Lower Denture/Resin Based	One time every 7 years. PAR Required.
Removable Partial Upper Denture/Cast Metal Framework	One time every 7 years. PAR Required.
Removable Partial Lower Denture/Cast Metal Framework	One time every 7 years. PAR Required.
Removable Partial Upper Denture/Flexible Base	One time every 7 years. PAR Required.
Removable Partial Lower Denture/Flexible Base	One time every 7 years. PAR Required.

Children's Dental Benefit – Rules and Regulations

The Department would like to thank the dental providers, community members, and advocates who assisted the Department in revising its Children's dental policies. The Department has rescheduled the first presentation of the revised Children's Dental Benefit rule and will present it to the Medical Services Board (MSB) on August 8, 2014. If approved, the revised Children's dental policies are scheduled to take effect in the Fall 2014 and the Provider ORM will be updated to reflect the revised policy at that time. The Department and DentaQuest will continue to administer the Children's benefit as it existed prior to July 1, 2014.

Orthodontia Updates

A recent version of the DentaQuest Policy Manual sent to dental providers contained certain coverage information that differed from the Department's current policy. Providers should be assured that codes were neither intentionally closed, nor additional prior authorization requirements put in place. DentaQuest is currently working to update erroneous information in the policy manual and is working with the Department to ensure all covered services are updated correctly in DentaQuest's system.

The Children's Orthodontia Benefits Collaborative, as part of the original Dental Collaborative, will resume in late Fall 2014. At that time, the Department will discuss the independent review conducted by [The Medicaid Evidenced Based Decisions Project](#) of stakeholder feedback previously provided, and will present a revised children's orthodontia policy proposal, including a revised proposal regarding the scoring of the draft Colorado Modified Handicapping Labio-Lingual Deviation (HLD) Index.

Until a Colorado HLD form can be finalized and implemented, the Department has asked DentaQuest to evaluate prior authorization requests (PARs) for Orthodontia in the same manner as previously determined by the ColoradoPAR program. To accommodate these PARs, DentaQuest has created the *Colorado Orthodontic Criteria Index Form – Comprehensive Orthodontic Treatment*, which

has been published in the most current version of the Provider ORM. The updated DentaQuest Policy Manual will also include clear reference to this form.

Should providers have questions regarding the completion of this form, they may contact DentaQuest Provider Services at 855-225-1730.

Hospital Providers

Medicaid Coverage for Correctional Facility Populations - Billing Guidance

Medicaid will cover inpatient treatment for inmates admitted to a hospital outside a correctional facility for more than 24 hours if the inmate would have qualified for Medicaid in the community.

Additional information on billing for inmate hospitalizations can be found in the June 2014 Provider Bulletin ([B1400352](#)) located on the Department's website (Colorado.gov/hcpf) → For Our Providers → What's New → Provider Bulletins.

For additional general information, Providers may reference the [2014 Agency Letters](#) found on the Department's website; specifically, Agency Letter 14-010 as well as Agency Letter 14-006 concerning enrolling inmates in Medicaid.

Physical, Occupational, & Speech Therapy Providers

Outpatient Physical Therapy and Occupational Therapy (PT/OT) Reminder

Correct modifier use is required for all Prior Authorization Requests (PAR) and claim submissions. Modifier 'GP' must be attached to all Physical Therapy PARs and claims. Modifier 'GO' must be attached to all Occupational Therapy PARs and claims. Beginning August 1, 2014, providers billing outside of this guidance will be contacted and corrective action will be taken.

PAR/Claim Modifier	Rehabilitative	Habilitative
Physical Therapy	GP	GP + HB
Occupational Therapy	GO	GO + HB

Early Intervention PT/OT Reminder

Early Intervention PT/OT PARs are permitted to overlap with Outpatient PT/OT PARs that contain the same provider type and dates of service; however, duplicated services will not be reimbursed. All Early Intervention PARs must additionally indicate that the client has an Individual Family Service Plan (IFSP) and that it is current and approved. All Early Intervention PT/OT PARs and claims must have modifier TL attached in addition to modifier GP or GO. Providers may reference current PAR submission and billing guidance in the Physical and Occupational Therapy Billing Manual located in the Billing Manuals section of the Department's website (colorado.gov/hcpf) → For Our Providers → Provider Services → [Billing Manuals](#).

Please contact Alex Stephens at Alex.Stephens@state.co.us with questions.

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Vendor Transition

Effective October 1, 2014, the NEMT benefit will transition from FirstTransit to TotalTransit. The Department's NEMT services provide non-emergency transportation to and from Medicaid-covered health care appointments with Medicaid providers. This benefit covers NEMT services for Medicaid members living in Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer and Weld counties.

The Department, TotalTransit, and FirstTransit have begun work to ensure a smooth transition for Medicaid members and providers. More information will be forthcoming in subsequent Provider Bulletins and other Department publications.

Please contact Doug Van Hee at Doug.Vanhee@state.co.us or 303-866-4986, with questions.

Pharmacy Providers

Other Drug Coverage Updates

Effective August 1, 2014, short acting opioids will be limited to a total of 120 tablets per 30 days, per member. Exceptions will be made for members with a diagnosis of a terminal illness or sickle cell anemia. For members who are currently receiving more than 120 tablets and who do not have a qualifying exemption diagnosis, a grace period can be granted via the prior authorization process for providers to taper utilization.

Note: if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. The Department will provide details regarding the prior authorization criteria and clinical resources regarding opioids on the Department's website.

Long acting opioids will be discussed at the upcoming DUR board meeting for the institution of quantity limits.

Proton Pump Inhibitors Criteria Reminder

Prior authorization will be required for therapy beyond 60 days of treatment, per year, for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2-receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2-receptor antagonist.

Long-term therapy will be approved for members with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID therapy, Spinal Cord Injury members with an acid reflux diagnosis, or children under 18 years of age with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube. In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy.

Non-preferred proton pump inhibitors will be approved if all of the following criteria are met:

- Client failed treatment with two Preferred Products within the last 24 months,
- Client has a qualifying diagnosis, and
- Client has been diagnosed by an appropriate diagnostic method.

Qualifying Diagnoses	Appropriate Diagnostic Methods
Barrett's Esophagus	GI Specialist
Duodenal Ulcer	Endoscopy
Erosive Esophagitis	X-Ray
Gastric Ulcer	Biopsy
GERD	Blood Test
GI Bleed	Breath Test
H. pylori	
Hypersecretory Conditions (Zollinger-Ellison)	
NSAID-Induced Ulcer	

Pediatric Esophagitis	
Recurrent Aspiration Syndrome	
Ulcerative GERD	

Quantity Limits	Age Limits
Non-preferred agents will be limited to once daily dosing except for the following diagnoses:	Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age.
<ul style="list-style-type: none"> Barrett's Esophagus 	Prevacid Solutab will be approved for members under two (2) years old and two years or older with a feeding tube.
<ul style="list-style-type: none"> GI Bleed 	
<ul style="list-style-type: none"> H. pylori 	
<ul style="list-style-type: none"> Hypersecretory Conditions 	
<ul style="list-style-type: none"> Spinal Cord Injury patients with any acid reflux diagnosis 	

Smoking Cessation Therapy Criteria Reminder



Members should be referred to the QuitLine or another behavior modification program. The name of that program should be included on the prior authorization form. The Colorado Medical Assistance Program will pay for only one product at a time, but a member may receive multiple strengths of a product or multiple products during the two 90-day- paid benefit periods.

Pharmacy & Therapeutics (P&T) Committee Update

The P&T committee has two (2) member representative openings and one (1) physician opening. For more information regarding the committee please refer to the [P&T Committee web page](#) located on the Department's website (colorado.gov/hcpf) → For Our Providers → Get Info → P&T Committee. Any interested parties can send a resume or CV to Swanee Grubb at Swanee.Grubb@state.co.us or 1570 Grant Ave, Denver, CO 80203 or fax 303-866-3590.

Provider Contact Information Reminder

Providers are reminded to maintain their contact information with the Department as needed. All prior authorization outcome letters as well as appeal process letters are sent to the address on file with the Department's Fiscal Agent, Xerox State Healthcare. Updates can be made by completing a Provider Enrollment Update Form located in the Forms section of the Department's website (Colorado.gov/hcpf) → For Our Provider → Provider Services → [Forms](#). If a provider requires a duplicate approval or denial letter, the provider may contact Provider Services at 800-237-0757.

Drug Utilization Review Board (DUR) Meeting:

Tuesday, August 26, 2014

6:00-7:00PM Closed Session

7:00-9:00PM Open Session

This DUR Board meeting will be held at the Skaggs School of Pharmacy located at the Anschutz Medical Campus: 12850 E. Montview Blvd, Aurora CO, 80045.

DUR Board update:

The DUR board has one (1) opening for a pharmaceutical industry representative. This will be a non-voting position on the board and will be for one (1) year. Any interested parties can send a resume or CV to Robert Lodge at Robert.Lodge@state.co.us or to 1570 Grant Ave, Denver, CO 80203 or fax 303-866-3590. The deadline for this submission will be Friday, August 8th. This position will be attending DUR Meeting referenced above.

August and September 2014 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 & Workshops](#) section of the Department's website.



Who Should Attend?

Staff who submit claims, are new to billing Colorado 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.

August 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
3	4	5 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	6 All *WebEx – 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	7 *WebEx – DME/Supply 9:00 AM-11:30 AM Provider Enrollment 1:00 PM-3:00 PM	8 All *WebEx – Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM FQHC/RHC 1:00 PM-3:00 PM	9

September 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	10 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Dialysis 1:00 PM-3:00 PM	11 *WebEx – Provider Enrollment 9:00 AM-11:00 AM Pharmacy 1:00 PM-2:00 PM *WebEx – IP/OP 1:00 PM-3:00 PM	12 All *WebEx – Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	13
14	15	16 All *WebEx – Beginning Billing – CMS -1500- Waiver 9:00 AM-11:00 AM Beginning Billing – CMS -1500 1:00 PM-3:00 PM	17 Beginning Billing – CMS -1500- Waiver 9:00 AM-11:00 AM	18 Beginning Billing – CMS -1500 9:00 AM-11:00 AM	19	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 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.

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 – 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 the 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 Provider Services at 1-800-237-0757.

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