



Provider Bulletin

Reference: B1300341

September 2013

colorado.gov/pacific/hcpf



Did you know...?

The following forms, [Acknowledgement/Certification Statement for a Hysterectomy](#), [Certification Statement for Abortion to Save the Life of the Mother](#), and [Certification Statement for Abortion for Sexual Assault \(Rape\) or Incest](#) formally known as Appendix J, K and L should be attached to any hysterectomy or abortion claim.

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All Providers

Medicare Disallowance Update

On behalf of the Department of Health Care Policy and Financing (the Department), [HMS](#) issues regular Medicare disallowance listings to Colorado Medicaid providers. These listings identify claims paid by Medicaid for individuals with overlapping Medicare coverage on dates of service within the prior 12 month period. The disallowance listings instruct providers to submit the identified claims to Medicare for payment. Recoveries are made on the disallowance listings by HMS after the 60 day cycle is closed. Recoveries are shown as adjustments on the Provider Claim Report (PCR). These efforts help ensure Medicaid remains the payer of last resort as required by federal and state law.



Beginning September 2013, HMS will enhance its Medicare disallowance process to include claims with overlapping, retroactive Medicare entitlement. While Medicare typically enforces a timely filing limit of 12 months, the Affordable Care Act of 2010 (ACA) provides certain exemptions to this requirement. Cases of retroactive Medicare entitlement are exempt from the timely filing rule. Upon notification by HMS of retroactive Medicare entitlement, a provider will have up to six (6) months to submit claims to the Medicare Administrative Contractor (MAC) for dates of service back to the initial date of the recipient's entitlement (see Chapter 1, Section 70.7.2 of the Medicare Claims Processing Manual).



Specifically, HMS will identify any claims falling under a retroactive entitlement period on the Medicare disallowance listing. HMS will provide additional guidance for processing these claims on the disallowance listing, as well as in the accompanying cover letter. The Department and HMS ask that providers continue to process all claims included in the disallowance cycle in a timely manner. Please note the deadline for responding to claims falling within a retroactive Medicare entitlement period will be adjusted to accommodate any additional processing time required by the MAC. Please contact the HMS Provider Relations team at 1-877-262-7396 with questions regarding this change.

Medicare-Medicaid Enrollees

Providers are reminded that Medicaid is always the payer of last resort. Services for Medicare-Medicaid enrollees, clients with both Medicare and Medicaid coverage, must be billed first to Medicare. Providers must be able to show documentation that claims for Medicare-Medicaid enrollees, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program.

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

Per the Provider Participation Agreement, the documentation must be retained for six (6) years following the Medicare denial.

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

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

National Correct Coding Initiative (NCCI) Impacts on Vaccine/Immunization, Adolescent Depression, and Vision Services

This article is a correction to the July Provider Bulletin Article Titled: NCCI Impacts on Vaccine/Immunization Providers, Adolescent Depression Screening Providers, and Vision Service Providers

Immunization Codes

After further review of recent claims data, the Department has decided to delay implementing denials of preventive medicine counseling codes and behavior change intervention codes with a procedure-to-procedure (PTP) edit until October 1, 2013. The codes will no longer be reimbursed by the Department when billed in conjunction with vaccine/immunization administration codes (90460-90474) unless it is appropriate in each individual circumstance to append the NCCI modifier. The preventive medicine counseling/behavior change intervention codes subject to this policy include, 99401 [individual preventive medicine counseling; 15 min], 99402 [individual preventive medicine counseling; 30 min], and 99420 [administration and interpretation of a health risk assessment instrument – used for adolescent depression screening] among others. The Immunization Billing Manual will be updated to reflect these changes.

Vision Codes

The NCCI PTP editing will also be delayed until October 1, 2013 for CPT codes 99172 [visual function screening], 99173 [screening test of visual acuity, quantitative, bilateral], and 99174 [ocular photo screening]. These codes will no longer be reimbursed by the Colorado Medical Assistance Program when billed in conjunction with general ophthalmological services codes (92002-92014).

As a reminder, "Medically Unlikely Editing" (MUE) was effective August 1, 2013 for codes 92340, 92341 and 92342 (fitting of spectacles, except for aphakia – monofocal, bifocal; and multifocal, other than bifocal). The maximum allowable units per date of service are now one unit.

Modifiers

When the use of a modifier is appropriate, refer to the [CMS NCCI Policy Manual](#), Chapter 1, section E for specific guidance on proper use of modifiers.

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

Medicaid Primary Care Physician (PCP) Supplemental Payment Program Update

The Colorado Medical Assistance Program has made the PCP supplemental payments for the first two (2) calendar year quarters of 2013. The total amount of payments for the first two quarters exceeds \$16 million. Future payments will be made approximately four (4) weeks after the end of each quarter. The posting and depositing of payments follows the same financial cycle as other Medicaid payments.

To review payments, please refer to the PCR, available on the Colorado Medical Assistance Program Web Portal ([Web Portal](#)), for each quarter's payment. To access the reports login to the Web Portal, navigate to the File and Report Service, and select View Download Reports for the "77016 Provider Claims Report."



The PCP Supplemental Payment program will continue through calendar year 2014. Eligible physicians can attest their status as a PCP using the [Physician Self-Attestation Form](#) up until December 31, 2014. Only claims submitted after successful attestation will be evaluated for supplemental payment. Newly enrolled physicians must complete the attestation to participate in this program.

To receive the maximum supplemental payment, the billed amount for each procedure must be at least as much as the Medicare rate.

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

Additions to the Healthcare Common Procedure Coding System (HCPCS) / National Drug Code (NDC) Crosswalk for Billing Physician Administered Drugs

The following HCPCS and NDC combinations have been added to the Colorado Medicaid [HCPCS/NDC Crosswalk \(Appendix X\)](#). When submitting electronic claims for these HCPCS, the eleven digit NDC is required for payment.

HCPCS	Short Description	NDC ID
J0178	INJECTION, AFLIBERCEPT, 1 MG	61755000502
J2778	Ranibizumab injection	50242008201
J9042	BRENTUXIMAB, 1MG	51144005001
Q0090	Skyla 13.5mg	50419042201

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 with questions.

Record Retention

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include, but are not limited to:

- Treatment plans
- Prior Authorization Requests (PARs)
- Medical records and service reports
- Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
- Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers



Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements.

As stated above, records must be retained for at least six (6) years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Updated Provider Enrollment Applications

Effective September 1, 2013, providers must submit the updated enrollment applications marked with a revision date of July 2013. Several changes have been made to both the [standard](#) and [rendering](#) provider applications due to federal rules and regulations. Applications received on or after September 1, 2013 with a revision date other than July 2013 will not be processed and will be returned to the provider. Applications received prior to September 1, 2013 that have been processed and pended for missing documents will be denied and closed on September 1, 2013, requiring a replacement application with the revision date of July 2013. The new applications can be found on the Department's website (colorado.gov/pacific/hcpf) → Provider Services → [Provider Enrollment](#). Please contact the Department's fiscal agent at 1-800-237-0757 with any questions about completing the application.

September and October 2013 Holidays

Labor Day Holiday

Due to the Labor Day holiday on Monday, September 2, 2013, the claims processing cycle will include electronic claims accepted before 6:00 p.m. Mountain Time (MT) on Thursday, August 29, 2013. The receipt of warrants will be delayed by one (1) or two (2) days. State, the Department's fiscal agent, and the ColoradoPAR Program offices will be closed on September 2, 2013. Offices will re-open during regular business hours on Tuesday, September 3, 2013.



Columbus Day

Due to Columbus Day Holiday on Monday, October 14, 2013, the claims processing cycle will include electronic claims accepted before 6:00 p.m. MT on Thursday, October 10, 2013. The receipt of warrants may be delayed by one (1) or two (2) days. State and the ColoradoPAR Program offices will be closed on Monday, October 14, 2013. The Department's fiscal agent offices will be open during regular business hours.

Dental Providers

Dental Benefit Update

In Senate Bill ([SB13-230](#)), the Department was allocated dollars to acquire an Administrative Service Organization (ASO) to manage the Department's current Children's Dental Benefit. The Department is hosting a series of Dental Benefit Collaborative meetings to discuss services being offered in the current Medicaid Dental policies, which includes both the newly created Adult Dental Benefit ([SB13-242](#)) and a review of the Children's Dental Benefit. The Department welcomes all stakeholder input. Please visit the Department's website → Committees, Boards, and Collaboration → [Benefits Collaborative](#) for a meeting schedule and additional information.

Durable Medical Equipment (DME)/Supply Providers

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 the Centers of Medicare and Medicaid Services' (CMS) expectations. The potential exists that these edits may impact claims payments for DME.

Medically Unlikely Edits

The following procedure codes were identified in the NCCI MUEs to limit the number of units that could be billed for certain items on a single date of service.

Please note the procedure codes and how they should be billed in order to be compliant with the Department's billing procedures and NCCI regulations.



Procedure Code	Maximum Allowable Units	Notes
E0463 and E0464	1 unit/month	Clients may receive up to 2 units per month if a backup ventilator is required.
B4088 and B4087	1 unit/month	
E0202	31 units/month	1 unit = 1 day. Claims may be date spanned using the KR modifier for the rental period.
E0600	1 unit/month	1 unit = 1 month. Capped rental item.
L1240	1	
L2275	2	Maximum allowable units are indicated for each lower extremity orthotic.

Procedure to Procedure (PTP) Edits

Please note that some wheelchair code combinations have been identified on the NCCI PTP edit list that may currently affect provider claims.

The Department makes every effort to mitigate payment issues related to quarterly NCCI edit implementation. However, to ensure potential issues are not overlooked, we also ask that providers stay updated on the quarterly release of codes and notify the Department of any NCCI MUE or PTP edits that are anticipated to result in issues with payment or services provided to clients.

Please refer to [Medicaid.gov](#) → Medicaid → By-Topic → Data and Systems → [The National Correct Coding Initiative in Medicaid](#) web page for more information.

Providers may contact the Department at DME_HCPF@hcpf.state.co.us with questions.

Reminder: Prior authorization determinations are for medical necessity only and do not guarantee reimbursement for the requested number of units. This includes DME/supply codes that are manually priced.

DME Wheelchair Billing Requirements

The [DME and Supply Billing Manual](#) has been updated and is located in the Provider Services [Billing Manuals](#) section of the Department's website. Please note the following updates regarding wheelchair billing requirements:



- Modifier 76 is not an allowable modifier for DME claims and should not be used. Beginning October 1, 2013, claims submitted with modifier 76 will be denied.
- Primary equipment and backup equipment is identified by Make/Model/Serial number and the corresponding approved PAR ID. Effective October 1, 2013 the Department will begin to enforce that the above identifying information will be included on all new claims and claims for repair. Claims submitted without this information will be denied.

Alternative and Augmentative Communication Devices (AACD) Benefit Coverage Standard

The Department received final approval from the Medical Services Board (MSB) on the AACD Benefit Coverage Standard. This coverage standard will be effective September 30, 2013, and incorporated by reference into the Durable Medical Equipment and Disposable Medical Supplies section of the [Code of Colorado Regulations](#) (DME billing manual page 1).

The AACD Benefit Coverage Standard contains two notable updates to coverage of communication devices:

- ***Prior authorization requirements:*** Questionnaire #13 is no longer required for prior authorization submission. The ColoradoPAR Program does not require the questionnaire to determine medical necessity for communication devices. However, it will remain on the Department website for providers who would like to continue using it to capture evaluation information.
- ***Tablet computers:*** Tablet computers have been approved for addition to the AACD coverage standards, and will be available for coverage beginning September 30, 2013.

Please refer to the approved [AACD Benefit Coverage Standard](#) on the Department's website for coverage guidelines, limitations, and requirements.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Providers

EPSDT Services that Require Prior Authorization

Early and Periodic Screening, Diagnostic and Treatment is the child health component of the Colorado Medical Assistance Program. Federal statutes and regulations state that children and teens ages 20 and under, who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services. Early and Periodic Screening, Diagnostic and Treatment is designed to address problems early, ameliorate conditions, and intervene as early as possible.

Early and Periodic Screening, Diagnostic and Treatment also provides coverage for treatment. All types of child health conditions — medical, dental, mental, developmental, acute, and chronic — must be treated, including pre-existing conditions. Coverage is set by a federal standard and goes beyond what State's may cover for adults in Medicaid. Specifically, States are required by federal law to provide any additional health care services that are covered under the federal Medicaid program and found to be medically necessary regardless of whether the service is covered in a State's Medicaid plan. Early and Periodic Screening, Diagnostic and Treatment does not cover experimental or investigational diagnostic and treatment services. Some common EPSDT treatment and intervention services may be beyond what is typically covered for adults.



The Colorado Medical Assistance Program will not cover treatment for an enrolled child unless it is considered to be medically necessary. In most private health plans, this means the service must be justified as reasonable, necessary, and/or appropriate, using evidence-based clinical standards of care. For children, federal Medicaid law requires coverage of "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions." The EPSDT medical necessity standard assures a level of coverage sufficient not only to treat an already-existing illness or injury but also to prevent the development or worsening of conditions, illnesses, and disabilities. It is the responsibility of State's to determine medical necessity on a case-by-case basis. With the exception of managed care reviews, the ColoradoPAR Program processes PARs for EPSDT services using Milliman Care Guidelines and applicable Colorado Medicaid policies including EPSDT medical necessity rules and policies.

Please refer to coloradopar.com for specific instructions, training schedules and information regarding PAR denials. Urgent requests may be submitted through **CareWebQI (CWQI)** or by contacting the ColoradoPAR Program at 1-888-454-7686.

Please contact Gina Robinson at Gina.Robinson@state.co.us or at 303-866-6167 with questions.

Family Planning Services Providers

Skyla – Long-Acting Reversible Contraceptive Method

Effective for claims with dates of service on or after July 1, 2013, providers should use HCPCS code Q0090, appropriate diagnosis codes, and the family planning modifier, FP, to receive reimbursement from the Colorado Medical Assistance Program for Skyla. Additionally, providers must include the following NDC, 50419042201, for Skyla on all claims.



Note: When submitting claims for insertion of the device, please use the family planning modifier in addition to the appropriate CPT code.

Please contact Kirstin Michel at Kirstin.Michel@state.co.us with questions.

Hospice Providers

This article is a correction to the June Provider Bulletin Article Titled: Medicaid Provider Rate Increases Effective July 1, 2013

Hospice Rate Increase Update

In the June Provider Bulletin ([B1300338](#)), the Department outlined the different provider rate increases for Medicaid services effective July 1, 2013.

Included with this Provider Bulletin was an 8.26% provider rate increase to Routine Home, Continuous Home, Inpatient Respite, and General Inpatient Hospice services. However, because rates for hospice services are set at the Federal level by CMS, Hospice agencies will not receive the 8.26% rate increase.

Please contact Jeff Wittreich at Jeff.Wittreich@state.co.us with questions.

Laboratory Providers

Changed Billing Requirements for Selected Pathology Codes

Effective for claims with dates of service on or after October 1, 2013, procedure codes 88187, 88188, and 88189 will no longer require modifier 26 for reimbursement. The three (3) codes are all interpretations of the pathology, and by virtue of their narrative description, do not require the use of the 26 modifier. Claims for these codes submitted with the 26 modifier will deny. The reimbursement amount will not change.



Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 with questions.

Non-Medical Transportation (NMT) Providers

Billing Errors for NMT Services

The Department has recently become aware of billing errors for NMT services. As a result of these errors, several NMT providers were paid at a lower rate or had claims denied. As of August 13, 2013, all NMT billing errors have been identified and corrected. The Department apologizes for any inconvenience this has caused providers.

Providers **do not** need to revise PARs to receive the new NMT rates. Please do not re-bill any claims that reimburse incorrect rates. An adjustment will be made for incorrect payments. Providers can expect to see the adjustment for rates paid incorrectly in the next two (2) weeks.



All services provided on or after July 1, 2013 should reflect the rates listed below. Please ensure the modifiers are correct and present for each mileage band to pay appropriately. Please contact at Randie.Wilson@state.co.us with questions.

NMT Rate Schedule-EBD							
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				PUC*	1 way Trip
Mobility Van							
Mileage Band 1 (0-10 miles)	A0120	U1				\$ 8.14	1 way Trip
Mileage Band 2 (11-20 miles)	A0120	U1	TT			\$ 14.98	1 way Trip
Mileage Band 3 (over 20 miles)	A0120	U1	TN			\$ 22.30	1 way Trip
Wheelchair Van							
Mileage Band 1 (0-10 miles)	A0130	U1				\$ 9.65	1 way Trip
Mileage Band 2 (11-20 miles)	A0130	U1	TT			\$ 18.06	1 way Trip
Mileage Band 3 (over 20 miles)	A0130	U1	TN			\$ 24.59	1 way Trip

Radiology Providers

Radiology Prior Authorization Requests (PARs)

Beginning October 1, 2013, claims submitted with radiology procedure codes which require a PAR will be denied if the PAR does not list the correct Billing Provider ID number, the procedure codes do not match, or there is no record of a PAR. Please see the March 2012 Special Provider Bulletin ([B1200318](#)) for a complete list of radiology procedure codes which require a PAR. The Department will allow retroactive authorizations when imaging services must be modified after a PAR has been obtained. If a radiology procedure is prior authorized but the desired test was changed just prior to the time of the service, the provider is responsible for submitting a PAR revision with adequate documentation within 48 hours in order for the PAR to be processed by the [ColoradoPAR Program](#). Prior Authorization Request revisions can only be submitted using the [CWQI](#). Please contact the ColoradoPAR Program at 1-888-454-7686 for questions regarding how to process PAR revisions.



Waiver Providers

Update for Implementation of New Rates

Medicaid provider rate increases were approved during the 2013-14 legislative session and were effective July 1, 2013. Please refer to the June 2013 Provider Bulletin ([B1300338](#)) for a list of affected benefits. The July and August 2013 Provider Bulletins ([B1300339](#), [B1300340](#)) noted the rate increases cannot be implemented until the Department receives approval from CMS. However, the Department had already received CMS approval for all Home and Community Based Services (HCBS) in June 2013. All HCBS rate increases were implemented on July 1, 2013 and should be reflected on PARs and claims billed. The HCBS benefits for which rate increases have been implemented are listed below. For all other benefits, the Department is awaiting CMS approval.

Current rates will continue to be paid until CMS approval is obtained. Once approved, the Department will retroactively adjust the claims with dates of service on or after July 1, 2013 to reflect new rates. Adjustments will be present on future PCRs. The Department of Human Services (DHS), Division for Developmental Disability (DDD) providers do not have to submit claims with the new rates to receive the increase.

Claims submitted after July 1, 2013 with the old rates do not have to be adjusted by the provider. Please contact Randie Wilson at Randie.Wilson@state.co.us with any questions or concerns.

- 8.26% increase for:
 - 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
- 4% increase for:
 - DHS HCBS Waivers including:
 - HCBS-Developmentally Disabled (DD);
 - HCBS-Supported Living Services (SLS);
 - HCBS-Children's Extensive Supports (CES);
 - 2% increase for:
 - HCBS-Children's Habilitation Residential Program (CHRP)

Pharmacy Providers

Preferred Drug List (PDL) Update

Effective October 1, 2013, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Oral Anticoagulants: warfarin

Oral Bisphosphonates: Alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets

Biguanides: Metformin generic 500mg, 850mg, and 1000mg tablets; metformin XR 500mg tablets (this does not include generic equivalents of Fortamet)

Hypoglycemic Combinations: None

Meglitinides: None

TZDs: None

- Patients stabilized on Actos will continue to be able to receive the drug; however, a Prior Authorization (PA) will be required for new starts or interruptions in therapy.

Newer Diabetic Agents: Byetta, Januvia and Tradjenta

Erythropoiesis Stimulating Agents: Procrit and Aranesp

Overactive Bladder Agents: oxybutynin, oxybutynin ER and Toviaz

Protease Inhibitors for Hepatitis C: Victrelis

- Patients taking Victrelis will be subject to meeting clinical requirements

Stimulants and ADHD: mixed amphetamine salts IR, Adderall XR (brand), dexamethylphenidate, Focalin XR (brand), methylphenidate (generic Ritalin), methylphenidate SR (generic Ritalin SR), methylphenidate ER (generic Concerta), Strattera, Vyvanse

The complete PDL and prior authorization criteria for non-preferred drugs are available on the [PDL](#) web page.



Pharmacy & Therapeutics (P&T) Committee Open Positions Beginning 2014

The Department is currently accepting curriculum vitae (CV) for the following P&T Committee positions:



- Four (4) Physicians
- Two (2) Pharmacists
- One (1) Client Representative

These positions will serve a two year term from January 2014 through December 2015.

If interested in serving or know someone who would that is qualified, please submit a CV along with a completed Conflict of Interest form to:

Colorado Department of Health Care Policy and Financing

Attn: Robert Lodge

1570 Grant Street

Denver, CO 80203-1818

Fax: 303-866-3590

Email: Robert.Lodge@state.co.us

The [Conflict of Interest form](#) can be found under the *Contact Us/Join Us* section on the [Pharmacy & Therapeutics](#) web page.

Submission deadline is November 15, 2013. Please contact Robert Lodge at Robert.Lodge@state.co.us or 303 866-3105 with questions.

P&T Committee Meeting

Tuesday, October 8, 2013
 1:00 p.m. - 5:00 p.m.
 University of Colorado School of Pharmacy
 Anschutz Medical Campus
 Education 2 South Auditorium, Building 28
 Room 1102
 12631 E. 17th Ave.
 Aurora, CO 80045



Average Acquisition Cost (AAC) Rate Update Date Shift

As of August 12, 2013 the Department moved the day that the AAC reimbursement rate updates, used for outpatient pharmaceutical product prescriptions, from Wednesday to Friday of the previous week. The Department chose to move the rate update to the previous week’s Friday, five (5) days earlier, to increase response to changing pharmaceutical product cost and to better align Medicaid reimbursement to costs incurred by Colorado pharmacies. Please refer below for an example of the change.

New AAC Rate Update	Days Removed From Rate Update Process				Previous AAC Rate Update	
Friday (8/16)	Saturday	Sunday	Monday	Tuesday	Wednesday (8/14)	Thursday
New AAC Rate Update	Days Removed From Rate Update Process				Previous AAC Rate Update	
Friday (8/23)	Saturday	Sunday	Monday	Tuesday	Wednesday (8/21)	Thursday

September and October 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 Workshops](#) 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.



September 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8	9	10 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	11 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	12 Provider Enrollment 9:00 AM-11:00 AM *WebEx – IP/OP 1:00 PM-3:00 PM	13 *WebEx – Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	14

October 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6	7	8 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Vision 1:00 PM-3:00 PM	9 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Nursing Facility 1:00 PM-3:00 PM	10 Dental Billing 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM Pharmacy 1:00 PM-3:00 PM *WebEx – IP/OP 1:00 PM-3:00 PM	11 Basic Billing Waiver Providers 9-11:30 Web Portal 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	12

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.

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 – 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/pacific/hcpf for the most recent information.

