



colorado.gov/hcpf

Provider Bulletin

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March 2013



Did you know...?

When submitting a PAR Inquiry through the Colorado Medical Assistance Web Portal (Web Portal) and a PAR cannot be found, please contact the ColoradoPAR program to double check the PAR type. A Supply PAR may have been submitted, but processed as a Medical PAR. In addition, all PAR letters are sent to the billing provider and may be retrieved through the Web Portal's File and Report Service (FRS).

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All Providers

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. 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.

Medicare/Medicaid Crossover Claims

Providers are reminded that if a Medicare crossover claim does not appear on the Medicaid Provider Claim Report (PCR) within 30 days of receiving the Medicare SPR, the provider is responsible for billing the claim directly to Medicaid. Crossover claims may be submitted on paper or electronically. The SPR is required as an attachment when submitting paper claims. Please contact the Department's fiscal agent's (Xerox State Healthcare) Provider Services Unit at 1-800-237-0757 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 support 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. 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.

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

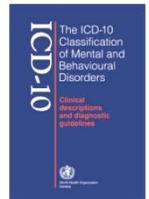
ColoradoPAR Program PARs
www.coloradopar.com

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

The health care industry's payers, providers, vendors, and all Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis and inpatient procedure code sets starting October 1, 2014. The Department of Health Care Policy and Financing (the Department) has started its policy and systems remediation processes in preparation for ICD-10 and will keep the provider community regularly informed with progress updates.

Please refer to cms.gov → Medicare → ICD-10 → [Provider Resources](#) for recommended resources for provider preparation. These resources include helpful information such as implementation guides and checklists to assist organizations with implementing these code sets.

Please contact Carolyn Segalini at Carolyn.Segalini@state.co.us for questions related to ICD-10.



Second Phase National Correct Coding Initiative (NCCI)

The purpose of NCCI edits is to prevent improper payments when incorrect code combinations are reported. Phase II will become effective for claims with dates of service beginning **April 1, 2013**.

NCCI-specific files, the NCCI Policy Manual, Modifier 59 article and other publications related to NCCI claim editing, are located on the Centers for Medicare and Medicaid Services (CMS) Medicaid.gov Web site. Providers not familiar with NCCI claim editing are encouraged to access the Web site for educational materials and download NCCI Column I/ Column II, and Medically Unlikely Edits (MUE) files.

Reminder

The second phase of NCCI will be limited to providers who submit claims that are reimbursed based on the Current Procedural Terminology (CPT) codes. Managed Care Organizations (MCOs) and any other provider type who may bill by encounter are excluded.

New Provider Claim Report (PCR) Messages for NCCI

The Department has developed new PCR messages that specifically identify when a claim detail has triggered an NCCI edit. The following table identifies the new PCR messages with a detailed description and purpose.

Edit Number	Description
2021	A National Correct Coding Initiative (NCCI) Procedure to Procedure Edit that is comprised of three scenarios: Comprehensive/Component (Column I/Column II) edits, Mutually Exclusive edits, and Action on History. These three scenarios are edits that compare procedure code pairs to identify coding logic conflicts.
2022	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a client would receive on a single date of service for a given HCPCS/CPT code.

New NCCI Action Reason Code (ARC)/Remark Codes

Claim Adjustment Reason Code	Description
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.
Remittance Advice Remark Code	Description
N20	Service not payable with other service rendered on the same date.

Claim Adjustment Reason Code	Description
119	Benefit maximum for this time period or occurrence has been reached.
Remittance Advice Remark Code	Description
N362	The number of Days or Units of Service exceeds our acceptable maximum.

NCCI Column I /Column II Edits

When NCCI was first established, the “Column I/Column II Correct Coding Edit Table” was termed the Comprehensive/Component Edit Table.” Although the Column II code is often a component of a more comprehensive Column I code, this relationship is not true for many edits. In the latter type of edit, the code pair edit simply represents two codes that should not be reported together.



Example of two code types that should not be reported together:

Line Number	From Date of Service	To Date of Service	Procedure Code	NCCI Editing
01	01/08/2013	01/08/2013	45380	Detail is allowed.
02	01/08/2013	01/08/2013	45378	Detail is denied with edit 2021 – see the PCR table for description.

Medical Unlikely Edits (MUEs)

An MUE for a Healthcare Common Procedure Coding System (HCPCS)/CPT code is the maximum number of units of service under most circumstances allowable by the same provider for the same client on the same date of service.

Example of a Medical Unlikely Edit:

From and To Dates of Service Incorrectly Billed

Line Number	From Date of Service	To Date of Service	Procedure Code	Units of Service Allowed	NCCI Editing
01	01/08/2013	01/08/2013	99223	6	Detail is denied with edit 2022 (see the PCR table above for description). The claim must be resubmitted with the correct units or span period of time.

Billing Reminders

Use of Modifiers

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

Modifier 59 – Refer to the article on the CMS Medicaid Web site. Modifier 59 should be used only when there is no other modifier to correctly clarify the procedure or service. See the list of valid modifiers in the NCCI Policy Manual, Chapter 1 at the link above.

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

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

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

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

Updates on NCCI are provided quarterly by CMS for correct modifier usage for each CPT code. Please refer to the Web site link above for further updates.

Colorado Medical Assistance Program Web Portal (Web Portal)

Changes due to Second Phase of the NCCI Implementation

As noted above, in the *Second Phase of the National Correct Coding Initiative (NCCI)* article, the second phase of NCCI will become effective for claims with dates of service beginning April 1, 2013. Web Portal users will notice that a response of “To be paid” and “To be denied” will no longer be an immediate response. The only two immediate responses will be “accept” or “reject” which apply to all claim types. Users will need to check the status of the claim(s) on the next business day by submitting a Claim Inquiry (276/277) transaction. The Claim Status Inquiry User Guide, online training, and help features within the Web Portal can be accessed for assistance. The Claim Status Inquiry User Guide may also be obtained through the Department’s Web site→Provider Services→[Colorado Medical Assistance Program Web Portal](#)→Web Portal User Guides.



In addition, two more PCR messages have been created to help identify the status if a claim is denied. As noted above, denial reasons 2021 and 2022 will appear on the PCR.

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

What is Payment Error Rate Measurement (PERM)?

The Payment Error Rate Measurement (PERM) is a federally-mandated audit that occurs once every three (3) years. The purpose of this program is to review claims payments and examine eligibility determinations made for the Medicaid and Child Health Plan *Plus* (CHP+) programs for accuracy and to ensure that states only pay for appropriate claims.

2013 PERM Cycle

The Centers for Medicare and Medicaid Services (CMS) will randomly select a set number of paid or denied claims from October 2012 to September 2013 for the PERM audit. Starting this summer, A+ Government Solutions, a CMS contractor, will request medical records from providers corresponding to those claims. Providers have 75 business days to provide documentation to A+ Government Solutions. If the initially submitted documentation is not sufficient, A+ Government Solutions will request additional documentation. Providers have 15 business days to provide the additional documentation. If documentation is not provided or is insufficient, the provider’s claim(s) will be considered in error, and the Department will recover the money associated with the claim from the provider, regardless of whether or not the service was provided. The Department will also investigate the reasons why the provider did not submit proper documentation.

Provider Education Calls

Providers can participate in provider education calls to learn more about PERM and provider responsibilities. The first CMS presentation is on May 21, 2013 from 1:00 p.m. – 2:00 p.m. MST. The same presentation will be on June 5, June 18, and July 2, 2013 from 1:00 p.m. – 2:00 p.m. MST. Providers can participate in a live question and answer session following each presentation. More information can be found at www.cms.gov/PERM → [Provider Education Calls](#).

For more information about PERM, visit the [Department’s Web site](#)→ Providers→ [Payment Error Rate Measurement \(PERM\)](#) or the [CMS PERM](#) Web site. Providers may also contact CMS to ask PERM related questions at PERMProviders@cms.hhs.gov or Matt Ivy at Matt.Ivy@state.co.us or 303-866-2706.

Physician Supplemental Payments

Physicians have until March 31, 2013 to submit a [self-attestation form](#) and receive the increased payment for primary care services rendered as of January 1, 2013. The amount of the increase is approximately \$25 per code for the most used Evaluation & Management (E&M) procedure codes.



Physicians eligible for the supplemental payment include Family Medicine, Internal Medicine, or Pediatric Medicine specialists. The status of an eligible specialty may be verified by:

- 1) Current board certification in the eligible specialty or a subspecialty of the main specialties; or
- 2) Having 60 percent (%) of Medicaid claims for E&M codes 99201 through 99499 or vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474.

Services rendered by Physician Assistants and advance Nurse Practitioners are eligible for the supplemental payment if the provider has been identified as being personally supervised by an attested physician.

Supplemental payments only cover those services paid for by Medicaid.

Previously published information can be found in the January 2013 ([B1300332](#)) and February 2013 ([B1300333](#)) Provider Bulletins.

Attestations received after March 31, 2013

For attestations submitted after March 31, 2013, the eligibility for supplemental payments will be from the date of an accepted attestation. If there is an error in the attestation, services provided after an attestation attempt, but before the errors in the attestation have been corrected, will not be eligible for the supplemental payment. Acknowledgement e-mails will be sent within one (1) week of the attestation.

More information is available on the Department's Web site → [Providers](#). Please email PCPSupplemental_Payments@state.co.us with questions.

ColoradoPAR

Mandatory Prior Authorization Request (PAR) Submission into CareWebQI (CWQI)

Effective March 4, 2013 all PARs and revisions processed by the ColoradoPAR Program must be submitted using [CWQI](#). After April 1, 2013, PARs submitted via fax or mail will not be entered into CWQI and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program. The following PARs are currently processed by the ColoradoPAR Program:

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

Until March 31, 2013, all PARs will continue to be processed in a timely manner, regardless of submission method.

Submitting Clinical Documentation with CWQI

Clinical information is imperative for prior authorization review. When submitting PARs, please answer the clinical questions in [CWQI](#) and attach the relevant clinical information needed for determinations.

It is the responsibility of the provider to submit all relevant supporting documentation so that medical reviews can be completed in a timely fashion. Suggested documents include clients' histories and physical reviews, progress and office notes, lab results, and current medications. If clinical information is missing or inadequate, messages will be sent to the submitter via the CWQI message system. Please review these messages in order to keep PARs moving through the process and before calling for information. Once the submitter has logged into [CWQI](#), there is help available on how to use the message section.



Missing or inadequate clinical information will result in lack of information (LOI) denials. PAR submitters have 24 hours to respond to requests for more information before LOI denials are issued.

When submitting PARs to CWQI, please submit all clinical documentation, including digital X-rays, in the following forms:

doc; docx; xls;xlsx; ppt; pdf; jpg; gif; bmp; tiff; tif; and jpeg.

If the clinical documentation cannot be submitted electronically, fax or mail to:

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

Electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month.

To request an exception or for more information, please contact the ColoradoPAR Program at 1-888-454-7686.

Synagis® PARs

When submitting Synagis® PARs in CWQI, please mark the PARs appropriately. For example, when selecting *Synagis- Office Visit* as the PAR type but are using Revenue Codes for home visits, then the PAR type of *Pediatric LTHH* should be used. Please call the ColoradoPAR Program at 1-888-454-7686 with further questions.

CWQI Training

The ColoradoPAR Program offers CWQI training via WebEx. For more information, including updated training materials and schedules, please visit coloradopar.com or call 1-888-454-7686.

Peer-to-Peer and Reconsideration Processes for PAR Submitted to the ColoradoPAR Program

If a denial for a PAR is issued, reconsideration can be requested through either of the processes noted below.

The Peer-to-Peer Process to discuss denial determination occurs when a:

- Request is made by the provider, within five (5) calendar days after a denial decision, for a verbal discussion with a ColoradoPAR physician to discuss that denial determination; or
- The provider submits additional clinical information for review within the first five (5) calendar days following a denial decision.

The Reconsideration Process is a second review by a non-ColoradoPAR physician that must be requested by the provider within ten (10) calendar days of the denial decision.

The process proceeds as follows:

- Review is completed by a physician of the same profession and specialty as the requesting physician;
- Review will include all information submitted and any additional information the provider wishes to submit;
- The reviewing physician may overturn or uphold the original denial decision.

Note: The Peer-to-Peer Process does not need to be utilized prior to the Reconsideration Process. The Peer-to-Peer Process is *not* currently available for Dental and Orthodontic Providers.

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

Expansion of Colorado Access into Two Additional Counties

The Department's Child Health Plan *Plus* (CHP+) is happy to announce the expansion of Colorado Access into two (2) additional counties effective March 1, 2013. The additional counties are El Paso and Teller.



The expansion into the two (2) additional counties will increase the services available to CHP+ participants. Colorado Access will be the Primary CHP+ plan in both counties.

The State Managed Care Network (SMCN) will continue to provide services to Pre-HMO and prenatal members.

Please contact Teresa Craig at Teresa.Craig@state.co.us or 303-866-3586 for questions.

Waiver Providers

Colorado Choice Transitions (CCT) Program Launch

Colorado Choice Transitions (CCT) Program launched on March 1, 2013. Provider enrollment began in November 2012 and continues on an ongoing basis. For more information on this program or provider enrollment please visit the [CCT](#) Web page.

Renamed Waivers:

Pediatric Hospice Waiver (PHW)

Waiver for Persons with Mental Illness (MI)

In response to feedback provided by CMS, as well as stakeholder and provider engagement, the "Pediatric Hospice Waiver" (PHW Waiver) is now the "Children with Life Limiting Illness" (CLLI Waiver). In addition and, with input from the same groups, the Waiver for Persons with Mental Illness (MI Waiver) is now the Community Mental Health Services Waiver (CMHS Waiver). New Prior Authorization Forms have been created for these Waivers, which can be found on the Department's Web site→Provider Services→[Forms](#)→Prior Authorization. PAR letters issued by the Department's fiscal agent will still bear the "MI Waiver" and "PHW" name, as will the Billing Manual. The Department is working to update these documents and will be providing more information in subsequent provider bulletins.

Please contact Candace Bailey at Candace.Bailey@state.co.us or 303-866-3877 with questions about the CLLI Waiver. Please contact Sarah Hoerle at Sarah.Hoerle@state.co.us or 303-866-2669 with questions regarding the CMHS Waiver.

Waiver Prior Authorization Request (PAR) Form Changes

Effective March 4, 2013, the Department will be requiring its Case Management Agencies to use new paper PAR forms for the Home and Community Based Services (HCBS) programs which it oversees. The new PAR forms are located on the Department's Web site→Provider Services→[Forms](#)→Prior Authorization. For content or format questions in regards to the new forms, please contact the appropriate case manager.

Pharmacy

Pharmacy and Therapeutics (P&T) Meeting

Tuesday, April 9, 2013
1:00 p.m.-5:00p.m.
225 E 16th Avenue
Denver, CO 80203
1st Floor Conference Room



Preferred Drug List (PDL) Update

Effective April 1, 2013, the following will be preferred agents on the Medicaid PDL and will no longer require a prior authorization (unless otherwise indicated):

Alzheimer Agents: Aricept (5mg and 10mg), Aricept ODT 5mg,10mg, generic donepezil tab, donepezil ODT, generic galantamine and galantamine ER, Namenda

Atypical Antipsychotics: Abilify, clozapine, Clozaril, Geodon, Latuda, olanzapine, risperidone, Risperdal, quetiapine, Saphris, Seroquel IR, ziprasidone, Zyprexa

Growth Hormones: Norditropin, Saizen, Omnitrope

Nasal Corticosteroids: fluticasone, Nasonex, Triamcinolone Acetonide (generic Nasacort AQ)

Leukotriene Modifiers: montelukast (generic Singulair)

MS Agents: Avonex, Betaseron, Rebif, Copaxone

Ophthalmic Antihistamines: cromolyn, Patanol, Pataday, Zaditor

Sedative Hypnotics: Lunesta, zaleplon, zolpidem

Statins: Crestor, atorvastatin, pravastatin, simvastatin

The complete PDL and criteria for non-preferred medications are located on the [PDL](#) Web page.

Atypical Antipsychotic Update

Beginning April 1, 2013 the minimum age requirement for certain atypical antipsychotics will be changing to be consistent with the Food and Drug Administration (FDA) approved minimum ages. This will affect the following drugs: Abilify, clozapine, Clozaril, Geodon, Latuda, olanzapine, quetiapine, Saphris, Seroquel IR, ziprasidone, Zyprexa. The minimum ages can be found in the FDA approved labeling for each product.

Indian Health Services (IHS) Pharmacies Billing Updates

It had been previously reported that effective January 1, 2013, the pharmacy claim system would be moving to an encounter-based reimbursement for claims submitted by IHS pharmacies. Due to unforeseen



circumstances, this implementation has been temporarily delayed. Upon full implementation, the Department will work with the individual entities currently registered as IHS billing pharmacies (with Colorado Medicaid) to adjust claims as necessary. Each IHS pharmacy registered with Colorado Medicaid will need to report the intended start date for encounter payment to the Department. Please contact Chris Ukoha at Angela.Ukoha@state.co.us with questions.

Updated Pharmacy Reimbursement Methodology

Please see the [Pharmacy](#) Web page for the recent presentation on the new reimbursement methodology which was effective on February 1, 2013. To request a reimbursement review for a drug actual acquisition cost, please refer to the [Average Acquisition Cost Inquiry Worksheet](#).

PDL Update

For the long-acting opiates class on the preferred drug list, the Department plans to phase out grandfathering prior authorizations for non-preferred medications. This proposed phase out is planned for the spring of 2013 and will include educational materials for provider reference. Please monitor the [PDL](#) Web page or the main [Pharmacy](#) Web page for updates.

Billing Update for Avonex

Pharmacy providers, please note that as of October 1, 2012, the National Council for Prescription Drug Programs (NCPDP) updated the unit of measure for the Avonex[®] Pre-filled Syringe from four (4) to one (1). Therefore, for NDC 59627-0002-05, on dates of service on or after October 1, 2012, please use the unit of measure of 1 kit. The Avonex[®] lyophilized vial units and Avonex[®] Pen unit remain unchanged.

Updates to Appendix P

[Appendix P](#) had been updated based on the recent P&T Committee and Drug Utilization Review (DUR) Board recommendations.

March and April 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 posted in the Provider Services [Training & Workshops](#) section of the Department's Web site.

Who Should Attend?

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

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.

March 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
10	11	12 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	13 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM IP/OP Hospital 1:00 PM-3:00 PM	14 Provider Enrollment 9:00 AM-11:00 AM Home Health 1:00 PM-3:00 PM *WebEx – Vision 1:00 PM-3:00 PM	15 *WebEx – Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	16

April 2013

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 *WebEx – Transportation 1:00 PM-3:00 PM	10 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	11 Dental 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM Practitioner 1:00 PM-3:00 PM	12 *WebEx – Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	13

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 or 1-800-237-0044 Extension 5

Leave the following information:

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

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

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

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

All Workshops presented in Denver are held at:

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

***Please note:** For WebEx training, a meeting notification containing the Web site, 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:

RTD 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 Civic Center Station and Union Station.

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

Xerox State Healthcare at 1-800-237-0757 or 1-800-237-0044.

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