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In this issue:

All Providers	1
ACC Phase II Update	1
New Look Medicaid Cards	2
Discontinued Codes	3
Tax Season and 1099s	3
New Members Looking for Providers	4
Dental Providers	4
DentaQuest ORM Update	4
Updates from DentaQuest	4
FQHC Providers	5
Cost Report Form/Instructions ..	5
Managed Care Accuracy Audit Report Forms/Instructions	5
Imaging Services	5
Pharmacy Providers	6
PDL Update	6
Morphine Equivalent Limits	7
Rural Health Clinic Providers..	7
Encounter Rate "Carve-Out"	7
LARC Device Provision	7
Speech Therapy Providers	9
Outpatient Speech Therapists ..	9
NCCI Webinar	10
Waiver Providers	10
CTS Rate Increase	10
HCBS Waiver Providers	11
Provider Workshops	12
March 2016	12
April 2016	12



Did you know...?

If you are an out-of-state Medicaid or Child Health Plan *Plus* (CHP+) provider, revalidation and enrollment begins Tuesday, March 1, 2016. Providers must utilize the new [Online Provider Enrollment \(OPE\) tool](#) to complete their applications. Current Medicaid providers who have not already begun the revalidation process should do so in March.

It is important that providers **complete revalidation and/or enrollment as soon as possible** in order to avoid payment delays when the new Medicaid Management Information System (Colorado interChange) launches on November 1, 2016. Starting on that date, claims and encounters submitted by providers who have not enrolled and/or revalidated will be denied. Additional provider resources, trainings, an enrollment reference guide, and several frequently asked questions are available on the [Provider Resources](#) website. You may contact Provider.Questions@state.co.us with questions, but please be patient as response times may take 10-14 days.

All Providers

ACC Phase II Update: Procurement Timeline & Behavioral Health Services Reimbursement

The Department of Health Care Policy and Financing (the Department) is committed to creating a high-performance, cost-efficient Medicaid system that delivers quality services and improves the health of Coloradans. The next iteration (Phase II) of the [Accountable Care Collaborative \(ACC\)](#) seeks to leverage the [proven successes](#) of Colorado Medicaid's programs to enhance the Medicaid member and provider experience. [Learn more about ACC Phase II.](#)



Procurement Timeline

In response to feedback from the community and evolving guidance from the Centers for Medicare & Medicaid Services (CMS), the Department has decided to adjust the procurement timeline for Phase II of the ACC and begin the next phase on July 1, 2018.

The Department weighed numerous internal and external factors when considering revisions to the procurement timeline. From the outset, the Department was aware that the originally proposed

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518 17th Street, 4th floor
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Contacts

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800-237-0757

Claims and PARs Submission
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Denver, CO 80201

**Correspondence, Inquiries, and
Adjustments**
P.O. Box 30
Denver, CO 80201

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

ColoradoPAR Program PARs
www.coloradopar.com

timeline was aggressive, given the time required to support a transparent procurement process, to identify and receive the appropriate federal authority for implementation, and to incorporate stakeholder feedback.

The Department is committed to continuing delivery system innovation as we work towards Phase II. Over the next two (2) years, the Department will work with providers, current Regional Care Collaborative Organizations (RCCOs), and Behavioral Health Organization (BHOs) to innovate and transform our delivery system. The Department is confident that the ongoing innovations and revised procurement timeline will help better meet the needs of our community.

For additional information about the ACC Phase II procurement timeline, visit Colorado.gov/HCPF/ACCPhase2 and read the [February ACC Phase II Update](#).

Behavioral Health Services Reimbursement

The Department has revised the proposal for reimbursing behavioral health services as outlined in the [ACC Phase II Concept Paper](#). A modified capitation payment methodology will be retained for core behavioral health services. The capitation will be directed to Regional Accountable Entities who will be responsible for managing the health needs of Medicaid enrollees in their region. The capitation will differ from the current capitation administered by the BHOs in order to better support whole person accountability.

For more information about this change, check out our [ACC Phase II Program Decision: Reimbursement for Behavioral Health Services fact sheet](#).

Opportunities for Engagement & Staying Informed

The ACC Phase II Team will continue to utilize the currently scheduled [ACC Program Improvement and Advisory Committee \(PIAC\)](#) and subcommittees meetings to solicit feedback. These meetings are open to the public and have a call-in option for participation. Notes will be available online following the meetings.

We encourage all interested parties to [sign up for the ACC Phase II Stakeholder Updates list](#). The Department will use this list and our [ACC Phase II](#) website as the primary sources to announce feedback opportunities and Phase II developments.



New Look Medicaid Cards Coming in March



Starting in May 2016, Colorado Medicaid will change its name to "Health First Colorado". The new name and logo, shown to the left, will better represent Colorado's fresh approach to public health care coverage. Over the past few years, program

enhancements have included new benefits, expanded eligibility to cover a greater number of Coloradans, member access to care information via mobile device, and more. The Department looks forward to sharing more information about Health First Colorado with you in the coming months.

Beginning as early as March 20, 2016, cards printed from Colorado.gov/PEAK will have the Health First Colorado



name and logo. In June 2016, all hard copy cards sent to newly enrolled members will reflect the Health First Colorado name and logo.

Current cards are still valid; members do not need to request new cards.

As a reminder, members are only required by the Department to furnish their **photo ID** at appointments; Health First Colorado cards are not required to receive services. Providers should verify a member's identity and eligibility at each appointment.

Please ensure that all front desk and billing staff are aware of this change.

Learn more about Health First Colorado at Colorado.gov/hcpf/hfc.

Discontinued Codes

01999	36299	64999
17999	38999	69399
20999	42299	69799
23929	43499	76499
26989	43999	78099
27599	46999	78399
27899	47379	78499
28899	47579	87999
29799	49999	93799
30999	51999	94799
31599	58578	96379
31899	58679	99199
33999	58999	99499

Please note: Effective May 1, 2016, the procedure codes listed in the table above will no longer be covered services under Colorado Medicaid. These rarely used procedure codes are for nonspecific services. Please contact Richard Delaney at Richard.Delaney@state.co.us with questions.

Tax Season and 1099s



Reminder: Please ensure all addresses (billing, location, and mail-to) on file with the Department's fiscal agent, Xerox State Healthcare, are current. 1099s returned for an incorrect address will cause the account to be placed on hold and **all** payments to be suspended, pending a current W-9. Payments that are held can be released once a current W-9 is processed. Claims for payments not released are voided out of MMIS twice during the year, once on June 30 and again on December 31.

The [Provider Enrollment Update Form](#) can be used to update addresses, National Provider Identifiers (NPIs), licenses, and affiliations. In addition, an email address may be added or updated to receive electronic notifications. The form is available in the [Provider Forms](#) section of the Department's website in the Update Forms section. With the exception of updating provider licenses and NPI information, the updates noted above may also be made through the Colorado Medical Assistance Web Portal ([Web Portal](#)), via the Medicaid Management Information System (MMIS) Provider Data Maintenance option. Providers who do not receive a 1099 should call the State Controller's office at 303-866-4090 for assistance.

New Medicaid Members are Looking for Providers: Please Update Provider Contact Information Maintained in the Medicaid Management Information System

The Department is asking all providers to verify and/or update their information in the MMIS as soon as possible. With the expansion of Medicaid benefits, Colorado has many new members looking for health care providers.

Please remember, it is the responsibility of each provider to update the contact information maintained in the MMIS. Keeping the information updated also ensures that payments and communications are sent in a timely and appropriate manner.



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) **is used in the Department's Find a Provider web search**, which utilizes 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 available for providers who do not have the capability to make updates through the Web Portal.

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

Dental Providers

DentaQuest Office Reference Manual (ORM) Update



An updated version of the Colorado Medicaid Dental Program DentaQuest [Office Reference Manual \(ORM\)](#) was released on Tuesday, February 9, 2016.

An important note for participating orthodontic providers: The Orthodontic Early Termination of Care policy remains as it existed in the Department's February 2010 Provider Bulletin ([B1000279](#)) and is referenced in the ORM (page 61). If a child member does not return for the completion of services

and there is documented failure to keep appointments by the child member, or for any other reason that orthodontic care needs to be terminated, the orthodontic provider must submit the Orthodontic Termination of Care Submission Form to DentaQuest (Appendix A, page 101). DentaQuest will recoup the balance of the current case rate based upon the amount of treatment completed as estimated on the form.

Billing and Program Updates from DentaQuest

The latest edition, Vol. 7 - Revised December 2015, of the [Colorado Summit](#), the DentaQuest quarterly e-newsletter for Colorado's Medicaid dental providers, is available on the DentaQuest Colorado Providers website. Please contact DentaQuest Provider Services at 855-225-1731 with questions.

Federally Qualified Health Center (FQHC) Providers

Cost Report Forms and Instructions for Freestanding FQHCs

The Department’s newly developed FQHC [cost report forms](#) and [instructions](#) are now available on the [Provider Forms](#) website in the FQHC Forms section or directly on the Department’s [Federally Qualified Health Center Forms](#) website. The cost report forms and instructions are to be used by freestanding FQHCs to submit their annual cost reports to the Department’s designated auditor. The Department will use the information provided in these forms to determine the per-visit encounter rate for FQHC facilities.

Please contact Zabrina Perry at Zabrina.Perry@state.co.us or 303-866-4370 with questions.

Federally Qualified Health Center Managed Care Accuracy Audit Report Forms and Instructions



Beginning with encounters on July 1, 2014, FQHCs were required to submit quarterly Managed Care Accuracy Audit Reports to the Department. These reports should document the number of encounters between the FQHC and managed care enrollees, as well as the payment received for these encounters. These reports help to ensure that FQHCs receive full payment based on the providers Medicaid encounter rates.

To facilitate in this process, the Department developed FQHC Managed Care Accuracy Audit Report forms and [instructions](#). These forms and instructions are available on the [Federally Qualified Health Center Forms](#) website. Each Managed Care Accuracy Audit Report submitted must include both the FQHC Data Section form and the FQHC Attestation Statement.

Please contact Zabrina Perry at Zabrina.Perry@state.co.us or 303-866-4370 with questions.

Imaging Services at Federally Qualified Health Centers

For FQHCs, Colorado Medicaid does not cover the professional component of an imaging service as a billable encounter. Colorado Medicaid only allows reimbursement for a visit, which is a face-to-face encounter between a Medicaid member and a provider listed at [10 CCR 2505-10 sections 8.700.6 and 8.700.1](#). A direct visualization by a physician without the member present is not billable as an encounter.



For the technical component of an imaging service, when free standing FQHCs own the equipment, the costs are accounted for in the Prospective Payment System (PPS) rate and the technical component is not billable. When free standing FQHCs order imaging from another provider, the technical component services are billed by the rendering provider. For hospital based FQHCs, the costs of imaging and labs are removed from the cost report when determining the encounter rate. Since the costs are removed from the cost report, the technical component of imaging may be billed separately to Colorado Medicaid by the hospital.

FQHC Type	Technical component	Professional Component (reading images without member present)	Guidance:

Free Standing FQHC	Not separately billable, costs included in PPS payments if the equipment is owned by FQHC	Not separately billable, costs included in PPS payments	Services done by external provider are billed by external provider (can bill both Technical Component and Professional Component)
Hospital Based FQHC	Not billable, costs excluded from PPS payments	Not separately billable, costs included in PPS payments	Technical component billable by hospital

Please contact Richard Delaney at Richard.Delaney@state.co.us with questions.

Pharmacy Providers

Preferred Drug List (PDL) Update

Effective April 1, 2016, these are the following drug classes and preferred agents:

Alzheimer's Agents: donepezil 5mg and 10mg, donepezil ODT 5mg and 10mg, galantamine and galantamine ER, memantine

Atypical Antipsychotics: Abilify, Abilify ODT, aripiprazole oral solution, clozapine, Clozaril, Geodon, Latuda, olanzapine, quetiapine IR, risperidone, risperidone ODT, Risperdal, Risperdal M-tab, Seroquel IR, zispradone, Zyprexa

Growth Hormones: Genotropin and Norditropin

Insulins:

- Rapid acting: Novolog vial and pen
- Short acting: Humulin R vial and pen
- Intermediate acting: Humulin N vial and pen
- Long acting: Levemir vial and pen
- Mixtures: Humulin 70/30 vial/ pen, Humalog Mix 50/50 vial/ pen, Humalog Mix 75/25 vial/ pen, Novolog Mix 70/30 vial/ pen

Intranasal Corticosteroids: fluticasone, Nasonex

Leukotriene Modifiers: montelukast tablet and chewable tablet

MS Agents: Copaxone 20mg, Avonex, Betaseron and Rebif will be preferred.

- All other agents will be subject to prior authorization.

Ophthalmic Allergy Agents: cromolyn, olopatadine 0.1% (generic Patanol), Pataday, Pazeo and Zaditor

Sedative-Hypnotics (non-benzo): eszopiclone, zaleplon, zolpidem

Statins/Statin Combinations: Crestor, atorvastatin, pravastatin, simvastatin

The April 1, 2016 PDL was posted on the Department's website on March 1, 2016. This can be found on the [Provider Forms](#) website in the Pharmacy section.

Morphine Equivalent Limitations Update

Effective February 17, 2016, the Department implemented a limit on total daily morphine equivalents to 300 milligrams (mg) to align with the Governor's initiative to decrease the misuse and abuse of prescription opioids. This includes opioid-containing products where conversion calculations are applied. Prescriptions that cause the member's drug regimen to exceed the maximum daily limit of 300 mg of morphine equivalents (MME) will be denied. In addition, the current policy that limits short-acting opioids to four (4) per day, except for acute pain situations, will continue to be in effect.

Prior authorizations for six (6) months will initially be granted to allow for tapering.

The Prior Authorization (PA) Help Desk can be reached at 800-365-4944.

Criteria:

- Diagnosis of sickle cell anemia will receive a preemptive PA for lifetime.
- A one (1) year PA will be granted for admission to or diagnosis of hospice or end of life care.
- A one (1) year PA will be granted for diagnoses of pain from metastatic cancer, bone cancer, or pain from recent cancer treatment.
- Medicaid provides guidance on the treatment of pain, including tapering, on our [Pain Management Resources and Opioid Use](#) website.
- **Only** one (1) long-acting oral opioid agent (including different strengths) and one (1) short-acting opioid agent (including different strengths) will be considered for a prior authorization.



Members should be counseled to not take opioids and drink alcohol concurrently. Also, concomitant use of benzodiazepines and opiates has been associated with a higher incidence of opioid-related overdose.

Functional and pain assessments should be performed during member visits. If a member has not shown clinically meaningful improvement, then continuing opioids is not considered appropriate care in most cases. Thirty percent improvement from the baseline assessment or at the time of dose change is considered clinically meaningful.

Rural Health Clinic Providers

Rural Health Center (RHC) Encounter Rate "Carve-Out" -

Long-Acting Reversible Contraceptive (LARC) Device Provision



For most women, LARC includes intrauterine devices (IUDs), and subdermal implants are recommended as the most effective first-line contraceptives by the American College of Obstetrics and Gynecology. Besides being efficacious, LARCs are also first-line due

to their ability to provide easily reversible, long-term protection against unplanned pregnancies. Colorado Medicaid currently pays for all Food and Drug Administration (FDA) approved contraceptive methods including LARCs.

Effective March 1, 2016, RHCs and their providers will be able to bill for LARC devices on a fee-for-service (FFS) basis, outside of the normal RHC billable encounter rate. Long-acting reversible contraceptive devices can be billed on the CMS 1500 claim form using the listed Healthcare Common Procedure Coding System (HCPCS) codes below. Current reimbursement

rates are listed below, but refer to the latest Fee Schedule for future rate updates on the [Provider Rates & Fee Schedule](#) website.

Long-Acting Reversible Contraception (LARC) Methods Fee-for-Service Billing:

HCPCS Code	Code Description	National Drug Code (NDC) number	Effective March 1, 2016, Fee-For-Service rates
J7300	Paragard, (Cu-T-380TA) copper intrauterine device – 10 year	51285020401	\$ 742.70
J7301	Skyla, levonorgestrel-releasing intrauterine system 13.5mg – 3 year	50419042201	\$ 715.85
J7307	Implanon//Nexplanon, Etonogestrel implantable device – 3 year	00052027201 00052027401 00052433001	\$ 777.37
J7297	Liletta, levonorgestrel-releasing intrauterine device 52 mg – 3 year	52544003554	\$ 656.25
J7298	Mirena, levonorgestrel-releasing intrauterine system 52 mg – 5 year (prior deleted code – J7302)	50419042101	\$ 892.99

Note: When submitting FFS claims for contraceptive devices when the intent of the LARC is to prevent an unintended pregnancy, continue to use the appropriate family planning diagnosis codes with the family planning “FP” modifier. Additionally with each HCPCS code, providers must include the appropriately associated NDC number on claims.

When providing LARCs to first-time users, please thoroughly educate and inform members of transitional effects or potential side effects that may be associated with LARC contraceptive devices. Providing members with comprehensive education related to any potential side effects, prior to insertion of these devices, has been shown to greatly diminish user dissatisfaction and requests for early device removal.

For additional information and ideas related to member education on LARCs and other contraceptives, see the following websites:

- [LARC FIRST Counseling](#)
- [LARC FIRST Provision Guides](#)
- [The American Congress of Obstetricians and Gynecologists](#)
- [Centers for Disease Control and Prevention](#)
- [Navy and Marine Corps Public Health Center](#)

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 or Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with questions.

Speech Therapy Providers

Attention Outpatient Speech Therapists

Pursuant to the Affordable Care Act (ACA) requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) NPI numbers be on the claim form ([42 CFR §455.440](#)), the following changes will be made to the Speech Therapy benefit:

1. Effective April 1, 2016, all Outpatient Speech Therapy claims must contain the valid NPI number of the OPR physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP) in accordance with Program Rule [8.125.8.A](#).
2. All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient Speech Therapy services for Medicaid members must be enrolled in Colorado Medicaid ([42 CFR §455.410](#)), in accordance with Program Rule [8.125.7.D](#). An OPR provider may enroll on the Colorado Medicaid [Provider Resources](#) website.
 - a. The new enrollment requirement for OPR providers does not include a requirement to see Medicaid members or to be listed as a Medicaid provider for patient assignments or referrals.
 - b. Physicians or other eligible professionals who are already enrolled in Colorado Medicaid as participating providers and who submit claims to Colorado Medicaid are not required to enroll separately as OPR providers.

Technical Details

1. The OPR NPI must be present on both institutional (UB-04) and practitioner (CMS 1500) claim types.
 - a. Electronic CMS 1500 claims must have the OPR NPI in field #17.b.
 - b. Electronic UB-04 claims may indicate the attending provider as the OPR provider in field #76.
 - c. Electronic UB-04 claims without an attending provider as the OPR provider must have the OPR NPI in field #78.
2. Only licensed or certified otolaryngologists and speech-language pathologists or supervised speech-language pathology assistants and clinical fellows may render speech therapy services to Medicaid members, in accordance with Program Rule [8.200.3.D](#).
3. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the outpatient speech therapy service being rendered, as indicated by the procedure code on the claim.
4. Claims without a valid OPR NPI number that are paid will then be subject to recovery.
5. Medical documentation must be kept on file to substantiate the order, prescription, or referral for outpatient speech therapy. This is in addition to other required documentation (notes detailing member progress and what was performed on that date) about the speech therapy service performed. Claims lacking such documentation on file will be subject to recovery.
6. Colorado Medicaid recognizes that outpatient speech therapy ordered in conjunction with an approved IFSP for Early Intervention may not necessarily have an ordering provider. Under



this circumstance alone, the rendering provider must use their own NPI number as the OPR NPI number.

- a. Early Intervention outpatient speech therapy claims must have modifier "TL" attached on the procedure line item for Colorado Medicaid to identify that the services rendered were associated with an approved IFSP.
- b. Any claim with modifier "TL" attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.
- c. If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier "TL" attached, the claim is subject to recovery.

Refer to the [Outpatient Speech Therapy billing manual](#) for further details.

Please contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us with further questions.

Speech Therapy National Correct Coding Initiative Webinar

Colorado Medicaid will host a webinar this March to address the National Correct Coding Initiative (NCCI) edits that will affect the Outpatient Speech Therapy benefit. Details about the webinar are posted on the [Provider Training](#) website in the Billing Training and Workshops section.

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

Waiver Providers

Community Transition Services (CTS) Rate Increase

ATTENTION: There were communication errors in the January 2016 provider bulletin ([B1600377](#)). Please review this new bulletin article as the errors have been corrected.



Effective January 1, 2016, rates for Community Transition Services (CTS) offered on the Colorado Choice Transitions grant program will be increased. The rate applies to the demonstration service of the CCT grant program only. Reimbursement for the qualified waiver service offered on the Home and Community Based Services (HCBS) waiver for persons who are Elderly, Blind, or Disabled has not changed.

Transition coordination service rates will increase. These are activities provided by transition coordination agencies (TCAs) through provider agreements. These services are provided to transition residents of nursing facilities and intermediate care facilities for Individuals with Intellectual Disabilities (ICF-IIDs) who desire to live in a less restrictive setting.

The following codes will be effected by the rate increase.

Code	Code Description	Previous Rate	New Rate	Reimbursement Unit
T2038 UC	Community Transition Services Coordinator - CCT	\$2,000	\$3,800	Per Transition
A9900 UC	Community Transition Services Purchase – CCT	\$1,500	\$1,500	Purchase

Please contact Nora Brahe at Nora.Brahe@hcpf.state.co.us with questions.

Home and Community Based Services (HCBS) Waiver Providers

Targeted rate increases for agency-based Homemaker, In-Home Respite, and Personal Care services that were approved during the 2015-2016 legislative session went into effect February 1, 2016. The Department has received CMS approval for the HCBS Elderly, Blind, or Disabled; Brain Injury; and Community Mental Health Supports waivers incorporating the targeted rate increases.



Approved Targeted Rate Increases:

Procedure Code	Service Description	Approved TRI	Unit	HCBS Waiver(s)
S5130	Homemaker	\$4.25	15 Minutes	EBD, CMHS, BI
S5130	IHSS Homemaker	\$4.25	15 Minutes	EBD
S5150	In-Home Respite Services	\$4.87	15 Minutes	EBD, BI
T1019	Personal Care	\$4.25	15 Minutes	EBD, BI, CMHS
T1019	Personal Care-Relative	\$4.25	15 Minutes	EBD, BI, CMHS
T1019	IHSS Personal Care	\$4.25	15 Minutes	EBD
T1019	IHSS Personal Care Relative	\$4.25	15 Minutes	EBD
S5165	Home Modifications	\$14,000.00 Lifetime Maximum	Per Modification	EBD, BI, CMHS

The Department will perform mass adjustments on all claims with these procedure codes to ensure correct payment.

Please note: Mass adjustments made by the Department can only be performed if the originally submitted charge on a claim is greater than the newly revised rate. Any claim on or after the date that new rates become effective, with a submitted charge lower than the revised rate, must be adjusted by the provider. It is recommended that providers submit charges based on Usual & Customary rates when applicable.

Please refer to the [Provider Rates & Fee Schedule](#) website for the most current fee schedules or the [Billing Manuals](#) website for the appropriate rate and fee schedule.

Please contact Colin Laughlin at Colin.Laughlin@state.co.us with questions.

March and April 2016 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 Training](#) 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.

March 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
13	14	15 CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m. *WebEx* PT/OT/ST 1:00 p.m.-3:00 p.m.	16 UB-04 9:00 a.m.-11:30 a.m. Web Portal 837I 11:45 a.m.-12:30 p.m. IP/OP 1:00 p.m.-3:00 p.m.	17 *WebEx* Waiver 9:00 a.m.-11:30 a.m. *WebEx* Web Portal 837P 11:45 a.m.-12:30 p.m. *WebEx* Personal Care 1:00 p.m.-3:30 p.m. *WebEx* Web Portal 837I 3:45 p.m.-4:30 p.m.	18 *WebEx* CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m.	19

April 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
10	11	12 *WebEx* CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m.	13 *WebEx* UB-04 9:00 a.m.-11:30 a.m. Web Portal 837I 11:45 a.m.-12:30 p.m. *WebEx* NHVP 1:00 p.m.-3:00 p.m.	14 *WebEx* Pharmacy 9:00 a.m.-11:00 a.m. Practitioner 1:00 p.m.-3:00 p.m.	15 Hospice 9:00 a.m.-11:00 a.m. Transportation 1:00 p.m.-3:00 p.m.	16

Reservations are required for all workshops:

Email reservations to: workshop.reservations@xerox.com

Or Call the Reservation hotline to make reservations:
800-237-0757, extension 6, option 4.

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 email 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 a Provider Relations Representative at 800-237-0757.

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:

[Light Rail](#)

[Free MallRide](#)

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

Xerox State Healthcare Provider Services at 800-237-0757.

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

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