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I. Colorado Access General Information

MISSION STATEMENT
Partner with communities and empower people with access to quality, affordable care.

Our employees will work together in an environment that promotes mutual respect and partnering in support of the following commitments:

- We will eliminate barriers to access to high quality healthcare for each of our members
- We will facilitate services to support coordinated care for all our members
- We will develop programs that support continuity of care for the medically underserved
- We will work closely with providers to develop and administer streamlined managed care principles
- We will support our partner providers in an effort to improve the safety-net system
- We will work with our regulators to ensure the effective movement of the medically underserved population into managed care programs
- We will strive to exceed expectations

PROVIDER NETWORK SERVICES
We are committed to managing a network that is accessible and attentive to providers’ concerns and needs. We continuously monitor and endeavor to improve our performance in this regard. Regular publications, including updates to this provider manual and periodic provider bulletins, facilitate a better understanding of the requirements for network providers. Providers can also contact our customer service department for general information and policy clarification at 800-511-5010, or your provider and community liaison as noted below in the next section.

This manual is made a part of the provider contract, is updated frequently and replaces in its entirety all previous versions. Please refer to the online version as it is the most current version, available at coaccess.com/provider-resources. We will notify you of updates through the provider bulletin and/or the Colorado Access website. Provider bulletins are distributed by email only, so please be sure we have your current email address for our distribution list. You can submit your email information to pns@coaccess.com.

PROVIDER RELATIONS
We have provider and community liaisons that can assist you with issues related to contracts. If you have general questions, please email pns@coaccess.com.

PROVIDER AND COMMUNITY LIAISONS BY REGION

Central Region, including Denver, Jefferson, and Park counties –
Local: 720-744-5202
Toll Free: 800-511-5010 ext. 5202
Central Region, including Broomfield, Boulder, Gilpin, Clear Creek and Adams counties –
Local: 720-744-5467
Toll Free: 800-511-5010 ext. 5467

Central Region, including Arapahoe, Douglas, El Paso and Elbert counties –
Local: 720-744-5208
Toll Free: 800-511-5010 ext. 5208

Northeastern Region, including Cheyenne, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma counties –
Local: 720-744-5213
Toll Free: 800-511-5010 ext. 5213

Southern Region, including Alamosa, Baca, Bent, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo, Rio Grande, Saguache, and Teller counties –
Local: 720-744-5239
Toll Free: 800-511-5010 ext. 5239

Western Slope, including Archuleta, Chaffee, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, Lake, La Plata, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanca, Routt, San Juan, San Miguel, and Summit counties –
Local: 720-744-5218
Toll Free: 800-511-5010 ext. 5218

A provider liaison map can be located on our website at coaccess.com/for-providers

MEMBER RIGHTS AND RESPONSIBILITIES
Detailed information on member rights and responsibilities, and procedures for grievances and appeals, can be found on the Colorado Access website at coaccess.com/plans-services. Each line of business provides a Member Handbook/Benefits Booklet/Evidence of Coverage. We encourage you to direct our members to our website or to call Customer Service at toll free 800-511-5010 if they have questions or want to request a copy of their member benefits information.
II. Colorado Access Policies

The following is a summary of important policies:

COLORADO ACCESS DIVERSITY COMMITMENT
We are committed to maintaining an environment that respects the perspectives, beliefs, and differences of our providers, members, and staff. To this end, we will promote cultural diversity and competency to increase access to care and quality of service.

CULTURAL COMPETENCY TRAINING PROGRAM
Cultural competency goes beyond racial bounds to include color, national origin, sex, gender, religion, creed, sexual orientation, mental or physical disability, socioeconomic level, age, and more. It celebrates the numerous strengths that people with different backgrounds bring to an organization.

We live in a world filled with people who come from different places and cultural backgrounds. We believe these differences should be recognized in order for organizations to be more effective. We offer a free cultural competency training program for providers to help achieve this end. Understanding your patients and coworkers will enhance the services you provide and improve the effectiveness of your workplace.

We assist network providers in providing culturally sensitive care and services by offering cultural competency training. Cultural competency training is designed to provide a basic understanding of cultural competence in the context of delivering healthcare services. It serves as a means of strengthening the member-provider relationship through an increased awareness of cultural and linguistic barriers that exist in accessing needed healthcare services. Ultimately, the training is intended to equip network providers with a set of skills, attitudes and guidelines to draw from while providing care and services to members with cultural differences.

At Colorado Access, the Cultural Competency Training Program goals are high. Achieving such high standards is not only worth the effort; we believe it is a necessity. For more information, please contact Customer Service at 800-511-5010.

CULTURALLY SENSITIVE SERVICES
We recognize that a critical aspect of providing quality healthcare services is to promote culturally sensitive services through our providers and our staff. To promote this, we have developed training and communications regarding healthcare attitudes, beliefs, and practices for our contracted providers. This policy is a commitment to quality services for all of our members. For questions on how to receive training, please refer to the above section regarding the Cultural Competency Training Program.

EFFECTIVE COMMUNICATION WITH LIMITED ENGLISH PROFICIENT PERSONS & SENSORY-IMPAIRED/SPEECH-IMPAIRED PERSONS
We will take the steps that are necessary to ensure that members, potential members, family members, and designated personal representatives (DPRs) with limited English proficiency or who are sensory-
impaired/speech-impaired receive information about services, benefits, consent forms, waivers of
rights, financial obligations, consent to treatments, etc., in a language or format that they understand.
Language interpreters and auxiliary aids will be provided without cost to the individuals being assisted.
In determining what type of auxiliary aid is necessary, we will give primary consideration to the request
of the individual. These aids and services include, but are not limited to, the following:

- Multilingual staff
- TTY/TDD
- Language Line
- Information and materials translated into the member’s primary language
- Notices prepared in large print
- Reading the contents of notices aloud for members who are unable to read large print or who
  have low literacy levels
- Audio tape
- Braille
- Relay Colorado
- Interpretation services at provider offices

NON-DISCRIMINATION
We do not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of
race, color, national origin, gender, sex, religion, creed, sexual orientation, disability, marital status, or
age. This includes all of our programs and activities or through a contractor or any other entity with
whom we arrange to carry out our programs and activities.

Providers shall not discriminate against any member on the basis of race, color, national origin, gender,
religion, sex, creed, sexual orientation, age, health status, participation in any government program
(including Medicaid and Medicare), source of payment, participation in a health plan, marital status, or
physical or mental disability. Nor shall providers knowingly contract with any person or entity which
discriminates against any member on such basis.

This statement is in accordance with the provisions of:

- Title VI of the Civil Rights Act of 1964
- Title VII of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- The Americans with Disabilities Act of 1990 (ADA)
- The ADA Amendments Act of 2008 (ADAAA)
- The Age Discrimination Act of 1975
- The Age Discrimination in Employment Act of 1976
- Title IX of the Education Amendment of 1972
- Regulations of the U.S. Dept. of Health and Human Services issued pursuant to the Acts
NOTE: Other federal laws and regulations provide similar protection against discrimination on grounds of sex and creed.

CONFIDENTIALITY OF PROPRIETARY INFORMATION
Providers shall hold all confidential or proprietary information or trade secrets received under the provider agreement in trust and confidence and shall use such information only for the purposes necessary to fulfill the terms of the providers’ agreement, and not for any other purpose. Specifically, providers shall keep strictly confidential all terms of the provider agreement, including but not limited to, compensation rates, except for the method of compensation (e.g., fee-for-service, capitation, shared risk pool, DRG, per diem, etc.), unless otherwise required by state or federal laws.

CONFIDENTIALITY OF MEMBER INFORMATION

Privacy of Member Information
We abide by federal and state regulations pertaining to privacy standards including requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 42 CFR Part 2, as updated from time to time. As a provider, it is important for you to understand our expectations and your obligations concerning privacy of member information and records.

For privacy related questions or complaints, please contact our privacy official at 800-511-5010 or by email at privacy@coaccess.com.

Regulatory Requirements
Providers are required to understand and comply with all applicable state and federal laws, rules and/or regulations, including but not limited to those related to the provision and billing of covered services, HIPAA, HITECH, 42 CFR Part 2, the Affordable Care Act, the False Claims Act, the Deficit Reduction Act, physician self-referral (Stark laws), and fraud, waste and abuse.

Designating a Personal Representative
We are required by HIPAA to treat a member’s personal representative as the member with respect to uses and disclosures of personal health information as well as decisions related to the member’s healthcare and rights. Please contact our privacy official at 800-511-5010 or by email at privacy@coaccess.com for questions on designating a personal representative.

Requests from Members to Access Information
The HIPAA privacy rule requires us to provide access to or a copy of member health information to the member, the member’s legal guardian, or the member’s designated personal representative. Our members have the right to inspect and/or request a copy of their health information upon providing of a valid written and signed authorization.

- We may impose a nominal charge to members for providing copies of their health information.
• Our members have the right to request that an amendment be made to their health information.
• Our members have the right to receive their health information in a confidential manner.
• Our members have the right to request a restriction on disclosures of their health information under certain circumstances.

For questions on member access to information, please contact our privacy official at 720-744-5100 or by email at privacy@coaccess.com.

Member Medical Information
We tell members and prospective members the following:

• As an insurance plan, we have a right to get medical information about the member from the provider without consent.
• We use this information to help manage the member’s healthcare and for administrative purposes.
• We have policies and procedures in place about how we will get, use and release member information.
• We will not disclose this information to anyone else without member written authorization, unless disclosure is otherwise required or permitted by applicable laws, rules and/or regulations.
• Members have a right to get copies of their medical records from their providers. We do not keep these medical records at Colorado Access. Members can call their provider’s office to find out how to get the records and how to get a copy of them made.

Information Used to Submit and Process Claims
Federal and state laws provide stringent penalties for failure to keep certain sensitive information confidential, such as AIDS-related information. The legislation is not intended to prevent our providers from accurately and appropriately submitting claims to Colorado Access.

We are required to submit claims data to certain entities, such as the Department of Health Care Policy and Financing, for payment of substance use disorder services. In order for us to submit this claims data, providers must sign a Qualified Service Organization Agreement as an attachment to the provider agreement, or have the member sign a consent authorizing this disclosure and to keep the original signed copy in the member’s chart records. The provider must notify us if the member refuses to sign or revokes their consent. Providers who disclose Part 2 data to us must include the written prohibition on re-disclosure required by 42 CFR Part 2. Our claims may also contain information about application for and receipt of public assistance. This information is required for the administration of our programs. Information is used to process claims, calculate costs and project future funding and does not jeopardize the privacy of the member information.
For more information about privacy, please visit our website at coaccess.com/privacy-security-of-member-information or contact our privacy official at 800-511-5010 or by email at privacy@coaccess.com.

FRAUD, WASTE AND ABUSE

We are dedicated to providing quality healthcare services to members while conducting business in an ethical manner. We support the efforts of federal and state authorities in identifying incidents of fraud and abuse and have mechanisms in place to prevent, detect, investigate, report, and correct incidents of fraud and abuse in accordance with contractual, regulatory, and statutory requirements.

The following definitions are taken from state and federal guidelines:

Fraud: An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. This includes any act that constitutes fraud under Medicare and Medicaid, or other applicable federal or state law.

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to Colorado Access or federal healthcare programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Waste: Incurring unnecessary costs as a result of deficient management, practices, systems or controls; the over-utilization of services not caused by criminally negligent actions, and the misuse of resources.

We comply with the reporting requirements of the Centers for Medicare and Medicaid Services (CMS), the Colorado Attorney General, the Department of Health and Human Services, the Colorado Department of Health Care Policy and Financing, the Colorado Division of Insurance, and other agencies that conduct investigations. We have a corporate compliance officer (CCO) who is responsible for reporting credible allegations of fraud to the applicable state and federal agencies and authorities.

We are required to take appropriate disciplinary and enforcement action against employees, providers, subcontractors, consultants, members, and agents found to have committed fraud. We are also required to take appropriate corrective actions to prevent further offenses through systems and process changes.

All employees, providers, subcontractors, consultants, members, and agents of Colorado Access are responsible for reporting potential and/or suspected incidents of fraud, waste or abuse, including actual or potential violations of law or regulation, to our corporate compliance officer.

The following methods may be utilized to report such situations:

- Call the anonymous and confidential Compliance Hotline at 877-363-3065;
- Email directly to the CCO at compliance@coaccess.com;
- Send the information to the dedicated fax line at 303-649-8930 addressed to the CCO.
We receive reports from those sources identified above, as well as from internal review and monitoring of claims, billing practices and trends. We may perform independent investigations of provider billing practices, at our discretion, based upon these reports or on our own initiative. These investigations may include certain audit activities which may be performed by us under the policies and procedures of Colorado Access or by external auditors. Audit participation is part of the contractual obligation of every provider. Audits may be conducted on site or through a desktop review process. Providers are required to provide access to or copies of records for audits at no charge, as requested by Colorado Access. Failure to provide requested records or inadequate audit findings could include a variety of outcomes, including but not limited to: required provider education, corrective action plans, ongoing monitoring, termination of provider contract, reporting by Colorado Access to state and federal agencies and authorities, and/or repayment of claims.

*Our fraud and abuse policy can be located on our website at coaccess.com/compliance*

**APPOINTMENT AND SERVICES STANDARDS**

Member satisfaction is very important to us. Excessive wait time for appointments is a major cause of member dissatisfaction with the healthcare provider and health plan; therefore, we have established the following appointment standards for all contracted providers.

**NOTE:** We reserve the right to adjust or modify appointment standards, based on member and provider needs.

### APPOINTMENT STANDARDS

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Care</strong>&lt;br&gt;(Non-symptomatic, well care physical exam, preventive care)</td>
<td>Scheduled within 4 weeks of request</td>
</tr>
<tr>
<td><strong>Non-urgent care</strong>&lt;br&gt;(symptomatic)</td>
<td>Scheduled within 1 week of request</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Scheduled within 24 hours of request</td>
</tr>
</tbody>
</table>

### APPOINTMENT STANDARDS

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Care</strong>&lt;br&gt;(new requests for service)</td>
<td>Available within 7 business days of initial contact by the member</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Scheduled within 24 hours of initial contact by the member</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Phone contact within 15 minutes of the initial contact, and face-to-face clinical evaluation within 1 hour of contact in urban/suburban areas or within 2 hours in rural areas</td>
</tr>
</tbody>
</table>
APPOINTMENT STANDARDS
(Behavioral Health)

| Follow-Up Care after Discharge from a Hospital or ATU | Scheduled within 7 calendar days after an inpatient discharge |
| Substance Use Disorder (non-emergent, non-urgent) | Scheduled within 2 weeks of request |

AFTER-HOURS AND EMERGENCY CARE

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-hours Care</td>
<td>Available 24 hours a day, 7 days a week, access to a qualified healthcare provider via telephone coverage either onsite, through call sharing, or an answering service</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediately</td>
</tr>
</tbody>
</table>

ACCESS TO INTERPRETIVE SERVICES

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretive Services</td>
<td>Language assistance available in the provider office or the member is directed to Colorado Access Customer Service Department for assistance at 303-751-2657 or toll free 877-441-6032.</td>
</tr>
</tbody>
</table>

For providers with 14 or less employees, we will pay for oral or other interpretive services in compliance with federal and state rules and regulations and line of business contracts.

For providers with 15 or more employees, we may pay for oral or other interpretive service only where the cost to the provider is deemed an undue burden. If such services are requested by a provider, justification must be provided to our director of the Office of Member and Family Affairs, who will make a determination on a case-by-case basis. Please call Customer Service at 303-751-2657 or toll free 877-441-6032 with questions or concerns.

MEDICAL RECORD DOCUMENTATION
We may perform chart reviews to assure compliance with medical record documentation standards.

Providers are responsible for maintaining confidential medical records that are current, detailed and organized and that promote continuity of care for each patient. Well documented medical records facilitate communication, coordination and continuity of care and effective treatment. We have established medical record documentation guidelines based on applicable regulatory and accrediting body standards that are approved by the Colorado Access Quality Performance Advisory Committee (QPAC). These standards are used to assess providers’ medical record keeping practices and to evaluate compliance with the medical record documentation standards.
Each patient record should be legible, organized in chronological or reverse chronological order with reports in a consistent location within the record and contain the following information:

- **Patient identification on each page** – Name, social security number, or other unique patient identifier. This must appear on both sides of double sided pages.
- **Personal biographical information** – This includes the patient’s date of birth, address, and telephone number. If the records are kept in a computerized system, this data must be easily accessible.
- **Each entry has the provider’s name or initials and credentials** – This can be handwritten, electronic, typed or signature stamped.
- **Each entry should be dated** – Dates should be included on progress notes, problem list, med list, assessment forms, etc.
- **Medical history** – For patients seen three or more times, a past patient and family history should be present. This includes a history of accidents, illness, and surgeries. Family members include immediate family and their medical illnesses. For patients seen less than three times, past history of the current condition should be documented. This must include OB/GYN history for females as applicable.
- **Medication allergies and adverse reactions should be displayed** – This should be consistently displayed on the front or inside cover of record. May be a completed allergy sticker, or NKA (No known allergies).
- **Current medication list should be included in progress notes** – This should document current medications, dosages, dates of initial or refill prescriptions or no meds.
- **Completed problem list or summary health maintenance exams** – This should summarize significant illnesses, medical conditions, past surgical procedures, chronic health problems or psychological conditions. "None" or "no problems" can also be documented.
- **Physical exam appropriate to patient’s condition** – preventive care or presenting complaint(s).
- **Working diagnoses are consistent with findings**.
- **Treatment plans are current and consistent with diagnoses**.
- **Return visit or follow-up plan noted**.
- **Each visit prior problem addressed**.
- **Consultation, lab or imaging reports or notes received, reviewed and initialed (if ordered)**.
- **Inquiry/counseling noted, regarding smoking habits**.
- **Inquiry/counseling noted, regarding history of alcohol/substance abuse**.
- **Evidence of age appropriate preventive services and screenings, health education and anticipatory guidance**.
- **Advance directives documented (patients over age 21)** - This documentation should indicate whether or not the member has executed an advance directive.

**UTILIZATION MANAGEMENT PROGRAM**

Participation in the Colorado Access Utilization Management Program is a contractual obligation of every network provider. This includes:
PROVIDER MANUAL

- Adhering to policies, procedures, and standards;
- Identifying and addressing barriers to the provision of quality care;
- Reporting grievances and/or quality of care concerns;
- Participating in auditing processes; and
- Providing access to or copies of clinical records or other documents, as requested by Colorado Access.

PROVIDER SUBCONTRACTING
Every subcontract regarding the provision of health care services and supplies between the provider and a subcontractor, including an independent contractor provider representative, shall comply with URAC Health Plan Standards as well as with state and federal law and have terms and conditions that are consistent with the provider’s contract.

ALTERNATIVE TREATMENT OPTIONS
We do not prohibit, or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider’s patient for the following:

- The member’s health status, medical care or treatment options, including any alternative treatments that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment
- The member’s right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

MORAL OR RELIGIOUS OBJECTIONS
If a provider objects to providing a service on moral or religious grounds, you must notify us about the services you do not provide.

ADVANCE DIRECTIVES
An advance directive is a written instruction of care such as a living will or medical durable power of attorney relating the provision of healthcare when or if the individual is incapacitated. Medical providers have the responsibility to provide information about advance medical directives, and to assist members with completing advance medical directive forms, as appropriate. If the member has an advance medical directive, it is the responsibility of the member to provide medical providers or the facility with a copy.

There are three kinds of advance medical directives. They are:

- **Living Will** – A living will tells medical providers not to use artificial life support if the member becomes terminally ill.
- **Medical Durable Power of Attorney (also called a Health Care Proxy)** – A Medical Durable Power of Attorney is a person the member chooses to make healthcare choices for the member if the member cannot speak for her/himself.
• **Cardiopulmonary Resuscitation (CPR) Directive** – A CPR directive directs paramedics, doctors, medical staff or others to not try to resuscitate a member if his/her heart or breathing stops.

Hospitals, skilled nursing facilities, and home health agencies must maintain written policies and procedures concerning advance medical directives. These policies must specify how and when a directive can be changed, as well as procedures for providers to give information to the client regarding implementation of the advance medical directive.

Providers shall document in the member’s medical record in a prominent place if the individual has executed an advance medical directive. The presence or absence of an advance medical directive is not a provision of care and providers cannot discriminate against an individual based on advance medical directive status. If possible discrimination or coercion is suspected, a member or a provider (on behalf of a member) can file a grievance. If the provider cannot execute or implement an advance medical directive on the basis of conscience, the provider is to issue a written or other appropriate form of statement of limitation to the member (or designated personal representative).

*To learn more about advance medical directives, visit our website at:* [coaccess.com/advance-directives](http://coaccess.com/advance-directives)

**QUALITY MANAGEMENT**

The Colorado Access Quality Management Program complies with state and federal regulatory requirements, and follows applicable URAC Standards for Health Plans and National Committee on Quality Assurance (NCQA) Standards for Managed Care Organizations. These standards serve as guidelines for measuring and improving the quality of clinical care and service delivery. Quality improvement is defined as an ongoing assessment, feedback, and intervention loop designed to examine internal and external structures, processes, and outcomes, to identify opportunities for development and improvement in the quality, appropriateness, effectiveness and efficiency of care and services. Performance is measured on specific standards and analyzed to detect trends or patterns that indicate both successes and areas that may need improvement.

The scope of the program includes but is not limited to the following elements of care and service:

- Access to services
- Provider availability
- Utilization monitoring and trending clinical outcomes reporting and trending performance improvement projects
- Care management
- Clinical practice guidelines
- Member and provider satisfaction
- Grievances and appeals
- Monitoring quality of care investigations
- Medical record standards review
- Claims validation
- Credentialing and recredentialing of practitioners
Organizational provider assessment

The operation of a comprehensive, integrated program requires all participating primary care providers, medical groups/IPAs, and other contracted network ancillary and facility providers to actively monitor quality of care. Equally important is the active monitoring of appropriate service utilization. Our mutual goal is to improve the health status of our members.

The results of program initiatives and studies are used in planning improvements in operational systems and clinical services. Information about the Quality Assessment and Performance Improvement Program and summaries of activities and results are available to providers and members upon request. Information is also published in provider and member bulletins/newsletters.

QUALITY OF CARE CONCERNS

A quality of care concern is any concern or grievance regarding the professional competence and/or conduct of a provider, which could adversely affect the health or welfare of a member. Any potential quality of care concerns that a provider identifies during a course of treatment of a member must be reported to us. The identity of any provider reporting a potential quality of care concern is confidential. Providers identifying potential quality of care concerns may report such situations by contacting Customer Service at 800-511-5010 and providing the necessary information. Please note that the reporting of any potential quality of care concerns is in addition to any mandatory reporting of critical incidents or child abuse as required by law or applicable rules and regulations.

MENTAL HEALTH PARITY

When applicable, we will comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all applicable associated federal and/or state laws, regulations and binding regulatory guidance. When required under MHPAEA, we will ensure that the financial requirements (such as, copays and deductibles) and treatment limitations (such as, visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits we offer under our health benefit plans.

CLINICAL RECORD DOCUMENTATION STANDARDS

Providers are responsible for maintaining a clinical record for each member. This helps to promote quality and continuity of care. We follow NCQA standards and guidelines for clinical record documentation.

Chart reviews are routinely performed to ensure compliance with clinical record standards. Records must be provided or made available at no charge to Colorado Access upon request for utilization management or quality management purposes, in accordance with provider contracts. Failure to provide requested records may result in sanctions, up to and including contract termination.
Provider Responsibilities
Participation in the Colorado Access Quality Management Program is part of the contractual obligation of every provider. This involves adhering to quality management policies, submitting accurate encounter claims, and participating in quality management studies. The auditing process may include member record review by our staff members or outside auditors. Audits may be conducted on site. Contracted providers are required to provide access to or copies of member medical records in a timely manner, as requested by Colorado Access.

Measurement of Outcomes
We primarily utilize the Healthcare Effectiveness Data Information Set (HEDIS), Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure outcomes. Topics for monitoring are chosen based on federal requirements and relevant demographic and epidemiologic characteristics of plan membership. Records must be provided or made available at no charge to Colorado Access upon request for outcomes measurement purposes.

CREDENTIALING AND CREDENTIALING SCOPE
- We conduct credentialing and recredentialing for all participating providers who are contracted to provide health care services.
- Providers that are exempt from the credentialing process are listed below. However, we do credential and recredential hospital-based providers who provide care in an outpatient setting (such as an anesthesiologist offering pain management or university faculty who have private practices that will be contracted or are contracted with Colorado Access to provide healthcare services):
  - Covering providers and locum tenens
  - Providers who practice exclusively within the inpatient setting or are hospital-based and who provide care to Colorado Access members only as a result of the member being directed to the hospital or another inpatient setting (i.e., anesthesiologists, pathologists, radiologists, emergency medicine, neonatologists, telemedicine consultants, and hospitalists);
  - Providers who practice exclusively within free-standing facilities and who provide care to Colorado Access members only as result of members being directed to the facility (mammography centers, urgent care, surgery centers, and ambulatory behavioral health facilities);
  - Dentists who provide primary dental care only under a dental plan or rider.
  - Pharmacists who are contracted with a pharmacy benefit management organization (PBM) who is contracted with Colorado Access; and
  - Unlicensed doctoral or master level providers only when necessary to meet member linguistic/cultural needs, or for service provision in a rural under-served area.

The credentialing applicant (the applicant) should complete the state mandated Colorado Health Care Professional Credentials Application available through the Council for Affordable Quality Healthcare (CAQH) or on our website at coaccess.com/credentialing. The application includes a current and signed
attestation by the applicant. The applicant will bear the burden of proving that he or she is eligible and qualified for participation with Colorado Access and shall have the responsibility of producing adequate information for a proper evaluation of her/his current competence, relevant training, and experience. The applicant is also responsible for resolving any questions about such qualifications.

The applicant has the right to review the information we obtained to evaluate his or her credentialing application to the extent permitted by law. We are not required to allow an applicant to review references, recommendations, or other information that is peer-review protected. We are not required to reveal the source of information if the information is obtained to meet credentialing verification requirements or if disclosure is prohibited by law. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, our credentialing department will notify the applicant of the process to correct erroneous information submitted by another party.

The applicant has the right to be informed of the status of his or her credentialing or recredentialing application upon request. These rights apply to any applicant who has completed the Colorado Health Care Professional Credentials Application. For additional information, please contact the Colorado Access Credentialing Department at 720-744-5100, toll free 800-511-5010, or email credentialing@coaccess.com.

Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource
We participate with the CAQH Universal Credentialing DataSource (UCD). CAQH is a web-based tool that enables providers to enter credentialing information online and avoid the hassles of completing the same paperwork for multiple healthcare organizations. If you would like more information about registering with this service or completing the UCD application, please visit upd.caqh.org/oas/. If you already participate with CAQH, please designate Colorado Access as an authorized health plan.

Recredentialing Requirements
Recredentialing takes place at least every three years. The decision-making process will include the information listed above and incorporate information from the following sources:

- Member grievances and quality of care concerns
- Information from quality improvement activities as applicable

Practice Site Review Guidelines
We have a formal process to evaluate the physical environment and medical/treatment recordkeeping practices for all contracted providers who fall within the scope of credentialing. A site review will be conducted for any provider who exceeds established thresholds for complaints related to physical environment.
Facility Requirements
We perform credentialing of hospitals, home health agencies, skilled nursing facilities, nursing homes and free-standing surgical centers prior to contracting and re-credential occurs at least every three years thereafter to review the following:

- Current licensure by the State of Colorado, Department of Health (does not apply to home health agencies);
- Current accreditation by the appropriate accrediting body or if not accredited, satisfactory completion of CMS DMH or ADAD site review or Colorado Access site visit with a copy of the entity’s credentialing policies;
- Current certification for Medicare/Medicaid participation;
- Professional liability coverage for the organization; and
- No suspension or exclusion from Medicare and Medicaid during last three years.

Delegated Credentialing
We may delegate responsibility for performing credentialing activities, to provider organizations if a provider organization demonstrates the ability to perform in a manner which meets or exceeds our and URAC delegation standards.

MEMBER’S DISCHARGE FROM CARE
The provider may request a member’s discharge from the practice for reasons including, but not limited to:

- Abusive behavior by the member
- Non-compliance
- Failure to keep or cancel scheduled appointments

If a provider is considering discharging a member from the panel, the provider must notify the member both verbally and in writing. In the written notification, the provider must:

- Document the inappropriate behavior.
- Explain the impact on provider’s ability to provide adequate care to the member.
- Warn the member of possible discharge from service, if the behavior is not corrected.

The provider should send a copy of the written notification to the Colorado Access Grievance and Appeals Team at:

P.O. Box 17950
Denver, CO 80217-0950

After receipt of the written notification, our Grievance and Appeals Team will contact the member. We maintain a copy of the documentation. If the disruptive behavior continues, we may disenroll a member after following requirements in the Medicare Managed Care Manual, Chapter 2, Section 50.2.

More information for providers can be found on our website at: coaccess.com/for-providers
III. Provider Responsibilities

PRIMARY CARE PROVIDERS (PCPs)
Each of our members may select, or be assigned to, a participating primary care provider (PCP). The PCP is responsible for managing the member’s total healthcare services. These responsibilities include the following:

- Providing care and services for all eligible members
- Being accessible (or have call coverage) to members 24 hours a day, 7 days a week
- Hours of operation must not be less than those offered to commercial members
- Provide services to members according to the plan’s access standards
- Coordinating healthcare services for members, including referring members to specialists
- Provide preventive health services and offering provision for special needs
- Educating members about healthy lifestyles and prevention of serious illness
- Counseling members about appropriate emergency department utilization
- Provide culturally appropriate healthcare
- Maintaining confidentiality of medical information in compliance with all state and federal regulatory agencies (including HIPAA and CFR Part 2), as well as URAC and National Committee for Quality Assurance (NCQA) standards
- Maintain legible and comprehensive medical records for each encounter with a member that conform to documentation standards.

Administrative Responsibilities include:

- Participating in the Colorado Access quality management and utilization management programs which adhere to URAC and NCQA standards
- Complying with our credentialing requirements
- Maintaining a separate medical record for each of our members
- Reporting encounter and claim data to Colorado Access, so that we may track service utilization
- Authenticate patient’s identity at every office encounter to prevent card sharing and patient identity theft
- Verifying eligibility and enrollment for every office encounter
- Referring members to Colorado Access participating providers
- Adhering to the professional code of conduct.

Practice Capacity and Acceptance of New Patients
A PCP may determine how many members the practice will accept and at what point the panel is open or closed. To request a change in member capacity or an open/closed panel status change, please contact our provider network services department. To close the panel to new members, the provider must give 60 day advance written notice to our provider network services department. Opening a panel to new members will become effective on the date notification is received. Upon receipt of notice,
provider network services staff members will provide written notice to the provider, indicating the effective date for the requested panel status change.

Notice to Colorado Access Provider Network Services shall be sent to:

    Colorado Access  
    ATTN: Provider Network Services  
    P.O. Box 17580  
    Denver, CO 80217-0580

    OR by email:

    pns@coaccess.com

The PCP is responsible for the care of members assigned to the PCP from the date of assignment, whether or not the PCP has previously provided care to the patient.

**Coverage**

- The PCP must ensure that coverage is available 24 hours a day, 7 days a week, for member services. Access to a qualified healthcare provider by telephone either onsite, call sharing, or answering service is appropriate. NOTE: a recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

**SPECIALTY CARE PROVIDERS**

Contracted specialty care providers have the following responsibilities to our members:

- Verify member eligibility on the date of service
- Provide specialty consultation care approved by the member’s PCP or by Colorado Access, as necessary
- Obtain appropriate authorization from Colorado Access before treating a member
- Coordinate the member’s care with his or her PCP
- Provide a written consultation report to the PCP within five days of providing service
- Maintain confidentiality of medical information in compliance with all state and federal regulatory bodies, as well as HIPAA, URAC and NCQA requirements
- Maintain a separate medical record for each of our members
- Maintain legible and comprehensive medical records for each encounter
- Hours of operation must not be less than those offered to commercial members

**Second Opinion**

Members have a right to a second opinion. If members need assistance arranging a second opinion, or setting an appointment, please call 800-511-5010 and ask to speak to a care manager.
Coverage

- The specialist must assure that coverage is available 24 hours a day, 7 days a week for member services. Access to a qualified healthcare provider by telephone either onsite, call sharing, or answering service is appropriate.

NOTE: a recorded message advising a member to seek emergency care does not constitute after hours coverage.

- The call coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

If you have questions or concerns regarding the provider responsibilities, please email pns@coaccess.com.
IV. Eligibility Verification & PCP Assignment

VERIFYING ELIGIBILITY
We will not pay claims for members who are not eligible on the date of service. The provider is responsible for verifying eligibility before rendering services. We strongly recommend that providers continue to verify eligibility on an ongoing basis, as eligibility status is subject to change. Determination of a member’s enrollment with Colorado Access may be verified by the following means:

- Use the state’s eligibility web portal system at [https://sp0.hcpf.state.co.us/Mercury/login.aspx](https://sp0.hcpf.state.co.us/Mercury/login.aspx). Obtain a screen print of the eligibility screen on the date of service and keep in the member’s record for documentation.
- Log on to the Colorado Access website (coaccess.com/for-providers) and utilize the online eligibility verification tool. See the overview below.
- Call our customer service team at 800-511-5010.
- In addition to verifying eligibility, providers should verify the identity of each member every time services are provided, even if the member is an established patient. Each patient setting must have measures for identification, detection, prevention and mitigation of identity theft in accordance with federal and state laws and regulations. We will not pay claims for services provided to anyone who is not a Colorado Access member.

PRIMARY CARE PROVIDER (PCP) ASSIGNMENT

Initial PCP Assignment
New members select a participating PCP when they first become a member of Colorado Access. Initial PCP assignments are made effective on the first date of enrollment. If the member does not contact us, the member will be assigned to a PCP located near his or her listed home address.

Requesting a PCP Change
The member or designated personal representative (DPR) may request a PCP change, either verbally or in writing. We will issue the member a new ID card with the name of the new PCP, within approximately 7 – 10 business days.

The provider or provider’s office staff may submit a PCP change request by logging on to the Colorado Access eligibility verification tool online (see the directions in the overview below). In most cases, the change will be made within four business days. Providers must print the PCP change form from the website and have the member or member’s parent, guardian or DPR sign the request. Providers must keep copies of the signed request. We may audit the provider to assure the member’s involvement with the request.
PCP changes will be made effective on the date of the request except when the member is inpatient on the date of the request, and then the change will become effective the day after the member is discharged from the hospital.

ELIGIBILITY ONLINE VERIFICATION OVERVIEW
Our online eligibility verification tool can be used by providers to verify enrollment in one of our health plans, verify primary care provider (PCP) assignment and PCPs can use this tool to update a member’s PCP choice.

Eligibility verification requires a username and password. If you do not have a username and password, you can request one by submitting the form located at coaccess.com/frequently-used-forms.

The following provides a brief overview for using this tool. If you need additional assistance, please contact your provider and community liaison (in Section I above), email pns@coaccess.com, or call Customer Service at 720-744-5100 or 800-511-5010.

1. Go to the For Our Providers Page

From the Colorado Access homepage (coaccess.com), click on For Our Providers.

This will bring you to the provider page (coaccess.com/for-providers).
2. Login to Eligibility
From the provider page, locate the heading, **Colorado Access Provider Tool Kit**. Below this heading is a series of buttons. Click on the button labeled **Eligibility**.

A **Colorado Access Network Login** screen will open in a new window.

Enter your Colorado Access Username and Password and then click **Login**.
3. Search for a Member

After you login, you will be brought to the search screen. On this page is a list of available search criteria (Colorado Access ID, State ID, etc.). Click on the circle next to the search criteria you would like to use.

After you choose the search criteria, enter the text you would like to search for in the blank field. The correct format is indicated in an example below the blank field.

Click Search. You will notice that the circle below the search button will turn blue. This means that the tool is working.

*Sometimes, when searching by name, you may receive multiple results. Search through the list until you locate your member. Then double click on the line in which their information appears.
4. Verify Member Coverage

Once the search tool finds the member you are searching for, you will be brought to the Member Eligibility page.

Member eligibility is located below the member’s demographic information.

Verify the member demographic information to make sure the tool has found the correct member.

Active (current) coverage is below the green line.

Click this button to expand or collapse certain elements of the page.

Inactive (past) spans of coverage will be located below the red line.
**Change PCP (For PCPs Only)**

If a member would like to choose your office as their Primary Care Provider (PCP), you may request it for them by using this tool. NOTE: This is only enabled for providers who are designated as PCPs by Colorado Access. The member can also call customer service to request a PCP change.

From the **Member Eligibility** page, click on the **Change PCP** button.

Verify that your office/practice name is in the **Request Change to PCP Name** drop down box.

Have the member or member representative sign the printed copy of the PCP change and retain a copy in the member’s medical record.

The provider should sign the printed copy of the PCP change.

Click the **Commit Change** button in order to make the PCP change. After you click on **Commit Change** the date and time of the request will appear below the **Provider Signature** line. Then, a printer window will open.

Remember to print the PCP change after you click on **Commit Change**.
V. Claims & Provider Reimbursement

CLAIMS MAILING ADDRESSES

**Colorado Access Initial or Corrected Claims:**
PO Box 17470
Denver, CO 80217-0470

**Access Health Colorado Initial or Corrected Claims:**
P.O. Box 5846
Denver CO 80217

**Provider Carrier Disputes (Appeals):**
P.O. Box 17189
Denver, CO 80217-0189

CUSTOMER SERVICE/CLAIM STATUS

**Customer Service**

- Denver Metro Area ............................................................. 720-744-5100
- Toll Free ................................................................................. 800-511-5010

Customer Service can answer questions regarding benefits, claims, claim appeals, claim status and general questions about our policies. Customer Service representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. (Monday through Sunday, 8:00 a.m. to 8:00 p.m. for Access Advantage only; and Monday through Friday, 8:00 a.m. to 6:00 p.m. for CHP+ State Managed Care Network only), Mountain Time.

Providers can also check claim status on our website. To do so, you must have a Colorado Access username and password. If you do not have a Colorado Access username and password, you can request one by submitting the form located at [coaccess.com/frequently-used-forms](http://coaccess.com/frequently-used-forms).

To check claim status from the Colorado Access website, follow these simple steps.

1. From the Colorado Access homepage, click on the *For Our Providers* tab
2. Then proceed to click on the *Claim Status* tab. The login screen will open in a new window
3. Enter your Colorado Access username and password and click on *Login*
4. From the claim and search screen, make sure your provider TIN appears at the top of the screen. Then either enter your internal account number (as submitted on the claim), enter a date range, or leave blank for a list of all accounts that have been recently submitted and click on *Search*
TIMELY FILING

- Initial claims must be submitted within 120 calendar days from the date of service or the contractual time limit; whichever is shorter.
- Provider carrier disputes (claim appeals) or corrected claims must be submitted within 120 days from the date of service or 60 calendar days from the date of the provider Explanation of Payment (EOP) on which the claim appears.
- Claims that involve a third party resource (TPR), such as auto insurance, must be submitted within 120 calendar days from the TPR’s denial date or processing date.

COLORADO ACCESS RESPONSIBILITIES

We have the following responsibilities with respect to the provider:

- Provide information about requirements for filing claims
- Notify new providers of standard forms, instructions or requirements upon acceptance into the plan
- Notify providers of changes in standard forms, instructions or requirements within 15 calendar days
- Determine whether sufficient information has been submitted to allow proper consideration of the claim
- Provide appropriate explanations for denied claims
- Approve, deny or settle all “clean” paper claims within 45 calendar days of receipt, or the time period specified in the provider’s contract
- Approve, deny or settle all “clean” electronic claims within 30 calendar days of receipt, or the time period specified in the provider’s contract
• Approve, deny or settle all other claims (except fraudulent claims) within 90 calendar days
• Apply interest and/or penalties to clean claims paid outside of these guidelines in accordance with Division of Insurance regulations

NOTE: We will not interpret claim information from provider statements or superbills.

NOTE: In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond our control, we may be unable to process claims on a timely basis. No legal action or lawsuit may be taken against Colorado Access due to a delay caused by any of these events.

PROVIDER RESPONSIBILITIES
Providers rendering services to our members have the following responsibilities in relation to billing for these services:

• Except in the case of emergencies, verify the member’s eligibility and PCP assignment prior to rendering services
• Ensure that the appropriate authorization requirements have been met
• Verify place of service codes are correct
• Verify that diagnosis and/or procedure codes match the service provided
• Complete all required data elements (see Appendix B for a complete list)
• Leave non-required data fields blank (do not enter N/A)
• Use only black or dark red ink on any handwritten paper claims
• Use only good quality toner, typewriter or printer ribbons/cartridges for paper claims
• Do not use highlighters to mark claims or attachments
• Bill original claims within 120 days or as specified by contract
• Bill third party prior to submitting claims to Colorado Access
• Attach all required documentation to the claim
• If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim
• Do not submit “continuation” claims
• We will allow interim billing only if the claim pays a per diem rate per contract. If the claim will pay a DRG rate we cannot accept an interim claim.
• Submit paper claims to the appropriate address

Providers are required to submit complete claims for all services rendered to our members, whether the services are rendered under capitation or fee-for-service. Electronic submission of claims is preferred. However, we will accept paper claims in current CMS HCFA1500 or UB04/CMS 1450 formats. In order to process claims in a timely, accurate manner, we ask providers to observe standard billing requirements.

Providers may also reference the following resources when completing claims submissions:

• CMS 1500 Physician’s Manual
• UB04 Billing Manual
• ICD-9-CM Code Book
• Health Care Financing Administration Common Procedure Coding System (HCPCS)

ELECTRONIC CLAIMS
We accept claims electronically through clearinghouses or through direct batch file submissions in the HIPAA5010 version of the 837 file format. We currently do not accept electronic claims through a web-based application/web portal. If you have questions about electronic claim submissions please email edi_coordinator@coaccess.com.

EDI Clearinghouses
The use of clearinghouses is preferred as they provide quick and efficient submission of electronic/EDI claims that are compliant with current guidelines. We accept electronic/EDI claims from the clearinghouses listed at coaccess.com/electronic-claims. If you use one of these clearinghouses please advise the clearinghouse to direct your claims to the appropriate payer ID.
Providers must file all claims for professional services, including laboratory services performed by an independent laboratory, on the current CMS HCFA1500 form. Please see below for a sample form and a list of required fields. Colorado Access providers must, at the very least, include the information marked “yes” in the “Required” column.

![Sample CMS HCFA 1500 Claim Form](image-url)
<table>
<thead>
<tr>
<th>CMS 1500 BOX NUMBER</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Insurance</td>
<td>The type of health insurance coverage carried by the patient</td>
<td>Yes</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID Number</td>
<td>Patient’s ID Number</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td>Patient’s last name, first name and middle initial exactly as they appear on the MAC</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date/Sex</td>
<td>Patient’s DOB using MMDDYY format and Patient’s Sex (M = Male, F = Female)</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>Last name, first name, middle initial</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td>Relationship between the patient and the policyholder (insured) of the third party insurance</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s Relationship to Insured</td>
<td>Address and telephone number of the policyholder (insured) of the insurance. Thirty party claims refer to subscriber not 3rd party</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td>Policyholder’s last name, first name and middle initial</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>8</td>
<td>Patient Status</td>
<td>Married, single, other and employed, full-time student, part-time student</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td>Policyholder’s last name, first name and middle initial</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Policy Number</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>9b</td>
<td>Other Insured’s Birth Date and Sex</td>
<td>Date of birth, sex of policyholder</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>9c</td>
<td>Employer’s Name or School Name</td>
<td>Employer’s Name or School Name</td>
<td>No</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Name of insurance company or program providing 3rd party coverage</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>10</td>
<td>Is Patient’s Condition Related to</td>
<td>Indicate whether patient’s condition is related to employment, auto accident or other accident</td>
<td>No</td>
</tr>
<tr>
<td>10d</td>
<td>Reserved for Local Use</td>
<td>Enter the accident date in MMDDYY format</td>
<td>No</td>
</tr>
<tr>
<td>CMS 1500 BOX NUMBER</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group of FECA Number</td>
<td>Enter the Colorado Access group number. Refer to the patient’s Colorado Access ID Card for appropriate group numbers</td>
<td>Optional. Including the Group Name may assist in adjudicating the claim more quickly</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth and Sex</td>
<td>Insured’s Date of Birth and Sex</td>
<td>No</td>
</tr>
<tr>
<td>11b</td>
<td>Employer’s Name or School Name</td>
<td>Employer’s Name or School Name</td>
<td>No</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Insurance Plan Name or Program Name</td>
<td>No</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan</td>
<td>Indicate whether or not patient has 3rd party coverage. If yes, complete boxes 9 a-d</td>
<td>Required if patient has 3rd party coverage</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td>Patient’s signature or notation that signature is “on file.”</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s or Authorized Person’s Signature</td>
<td>Insured’s signature or notation that signature is “on file.”</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness, Injury or Pregnancy</td>
<td>Date of First Symptoms, accident or last menstrual period using MMDDYY format</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>If Patient Has Had Same or Similar Illness Give First Date</td>
<td>If Patient Has Had Same or Similar Illness Give First Date</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in current Occupation</td>
<td>Dates Patient Unable to Work in current Occupation</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Name of Physician</td>
<td>No</td>
</tr>
<tr>
<td>CMS 1500 BOX NUMBER</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>17a</td>
<td>ID Number of Referring Physician</td>
<td>Provider Tax ID Number of the referring physician</td>
<td>No</td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>NPI number of the referring physician</td>
<td>No</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for Local Use</td>
<td>Reserved for Local Use</td>
<td>No</td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab/$ Charges</td>
<td>Indicate whether ALL laboratory work was performed outside of the physician’s office by an independent lab. If yes, no payment will be made to the physician for laboratory fees. Do not check yes if ANY laboratory work was performed within the physician’s office.</td>
<td>No</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Enter up to four ICD-9-CM diagnosis codes. Decimal points should not be entered. A written description is optional. Note: Up to four additional diagnoses may be reported by attaching a second claim form.</td>
<td>Yes</td>
</tr>
<tr>
<td>22</td>
<td>Medicaid Resubmission Code – Original ref. No.</td>
<td>Code and the original reference number</td>
<td>No</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Prior Authorization number received from Colorado Access or from the Primary Care Provider (PCP).</td>
<td>No</td>
</tr>
<tr>
<td>24 A</td>
<td>Dates of Service</td>
<td>Dates that service began and ended using MMDDYY format</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 24 B                | Place of Service | Colorado Access requires providers to use the correct CPT code that is appropriate for the place of service listed on the claim form. The following is a list of place of service codes used by Colorado Access. In order for claims to be processed, these codes must be used. Single digit or alpha place of service codes will be considered invalid codes. **Code:** **Description:**
  - 11 Office
  - 12 Patient’s home
  - 20 Urgent Care effective 06/01/03
  - 21 Inpatient hospital
  - 22 Outpatient hospital | Yes |
<table>
<thead>
<tr>
<th>CMS 1500 BOX NUMBER</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td></td>
<td>Emergency room-hospital</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>Ambulatory surgical center</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>Birthing center</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>Military treatment facility</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
<td>Skilled nursing facility</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td></td>
<td>Nursing facility</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>Custodial care facility</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td></td>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td></td>
<td>Ambulance – land</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td></td>
<td>Air ambulance</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>Inpatient psychiatric</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td></td>
<td>Psychiatric facility partial hospital</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td></td>
<td>Community mental health center</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td></td>
<td>Interim care facility (ICF)</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td></td>
<td>Residential substance abuse facility</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td></td>
<td>Comp IP rehabilitation facility</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td></td>
<td>Comp OP rehabilitation facility</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
<td>End stage renal treatment facility</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td></td>
<td>ST/Local disease treatment facility</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td></td>
<td>Rural health clinic</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td></td>
<td>Independent laboratory</td>
<td></td>
</tr>
<tr>
<td>24 D</td>
<td>Procedures, Services or Supplies</td>
<td>CPT-4 or HCPCS code (including any valid modifier codes for the service code).</td>
<td>Yes</td>
</tr>
<tr>
<td>24 E</td>
<td>Diagnosis Pointer</td>
<td>Number 1, 2, 3, or 4 from field 21 to indicate which diagnosis is related to the procedure on each billing line. Do not enter the ICD-9-CM code.</td>
<td>Yes</td>
</tr>
<tr>
<td>24 F</td>
<td>$ Charges</td>
<td>Usual and customary charge for each service</td>
<td>Yes</td>
</tr>
<tr>
<td>24 G</td>
<td>Days of Units</td>
<td>Number of service units for each procedure. Days or units must be whole numbers</td>
<td>Yes</td>
</tr>
<tr>
<td>24 H</td>
<td>EPSDT Family Plan</td>
<td>EPSDT Family Plan</td>
<td>No</td>
</tr>
<tr>
<td>24 I</td>
<td>ID Qual/NPI</td>
<td>ID Qual/NPI</td>
<td>No</td>
</tr>
<tr>
<td>24 J</td>
<td>Rendering Provider ID Number</td>
<td>Rendering Provider ID Number</td>
<td>No</td>
</tr>
<tr>
<td>24 J</td>
<td>NPI</td>
<td>Enter the NPI number of the provider that rendered the service</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Claims & Provider Reimbursement

<table>
<thead>
<tr>
<th>CMS 1500 BOX NUMBER</th>
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<th>DESCRIPTION</th>
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</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Federal Tax ID Number (SSN/EIN)</td>
<td>Enter the nine-digit Provider Tax ID number of the provider or agency that will receive payment for these services (Check the box that applies – SSN or EIN)</td>
<td>Yes</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number</td>
<td>The account number assigned by the provider’s office. If entered, the account number will appear on the Colorado Access voucher for the claim</td>
<td>Yes</td>
</tr>
<tr>
<td>27</td>
<td>Accepts Assignment</td>
<td>All Colorado Access claims are reimbursed to the provider</td>
<td>No</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Sum of all charges listed in field 24 F</td>
<td>Yes</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>All amounts paid by a third party. If not applicable, input $0. Required if Applicable</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td>The net amounts of line 28 and line 29</td>
<td>Yes</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician</td>
<td>Authorized signature or printed name and date of the physician. Note: including a legible (printed) name assists Colorado Access in more quickly adjudicating the claim</td>
<td>Yes</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility</td>
<td>Name and address of the facility where services were rendered – if other than home or office</td>
<td>Yes</td>
</tr>
<tr>
<td>32 A</td>
<td>NPI</td>
<td>The NPI number of the facility where services were rendered</td>
<td>Yes</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Phone Number</td>
<td>The provider’s billing name, payment address and telephone number</td>
<td>Yes</td>
</tr>
<tr>
<td>33 A</td>
<td>NPI</td>
<td>The NPI number of the billing provider</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB04/CMS 1450. Please see below for a sample form and a list of required fields. Colorado Access providers must, at the very least, include the information marked “yes” in the “Required” column.
### UB04/CMS 1450 Box Number

<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Data Provider name, address and telephone number</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3a</td>
<td>Pat CNTL Number Patient Control Number – Account or bill control number assigned by the provider</td>
<td>Yes</td>
</tr>
<tr>
<td>3b</td>
<td>Med Rec Number Medical Record Number is assigned by the provider</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill Type of facility (1st digit), bill classification (2nd digit), and frequency (3rd digit). Refer to the AHA UB04 Uniform Billing Manual for a list of codes</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Fed Tax Number The Federal Tax ID Number</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period Beginning and ending service dates of the period included on the bill</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>8a</td>
<td>Patient Identifier The patient’s ID number</td>
<td>Yes</td>
</tr>
<tr>
<td>8b</td>
<td>Patient’s Name The patient’s Last, First and Middle Initial</td>
<td>Yes</td>
</tr>
<tr>
<td>9a</td>
<td>Patient’s Address The patient’s street address</td>
<td>Optional</td>
</tr>
<tr>
<td>9b</td>
<td>Patient’s City – not labeled The city in which the patient resides</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Patient’s Birth Date The patient’s date of birth</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>Patient’s Sex The patient’s gender, enter M (male) or F(female)</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date The date care began (the date of admission or the date care was initiated)</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Admission HR The hour in which the patient was admitted for care. The hour should be entered in military time (00 – 24).</td>
<td>No</td>
</tr>
<tr>
<td>UB04/CMS 1450 BOX NUMBER</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 14                       | Admission Type | The single digit code that describes the reason for admission:  
1. **Emergency** – Patient requires medical intervention for severe, life-threatening or potentially disabling conditions. Documentation **must** be attached.  
2. **Urgent** – Patient requires immediate attention  
3. **Elective** – Patient’s condition permits time to schedule services  
**Newborn** – Patient is a newborn. The newborn source of admission code must be entered in field 15 (see below) | No |
| 15                       | Admission SRC | The code that best describes the source of admissions:  
1. Physician Referral  
2. Clinical Referral  
3. HMO Plan Referral  
4. Transfer from Hospital  
5. Transfer from Skilled Nursing Home  
6. Transfer from other Health Care Facility  
7. Emergency Room  
8. Court/Law Enforcement  
9. Information not available  
**Newborns (Refer to Field 19)**  
1. Normal Birth  
2. Premature Birth  
3. Sick Newborn  
Extramural Birth | No |
<table>
<thead>
<tr>
<th>UB04/CMS 1450 BOX NUMBER</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
</table>
| 16                       | DHR          | The code that best describes the patient’s status for this billing period.  
1. Discharged to home or self-care  
2. Transferred to another short-term hospital  
3. Transferred to a skilled nursing facility  
4. Transferred to an intermediate care facility  
5. Transferred to another type of institution  
Discharged to home under the care of an organized home health services | Yes |
| 17                       | STAT         | The code that best describes the patient’s status for this billing period.  
1. Discharged to home or self-care  
2. Transferred to another short-term hospital  
3. Transferred to a skilled nursing facility  
4. Transferred to an intermediate care facility  
5. Transferred to another type of institution  
6. Discharged to home under the care of an organized home health services organization  
7. Left against medical advice  
8. Discharged/Transferred to home under care of home IV provider  
9. Expired  
10. Still a patient  
11. Expired at home  
12. Expired in hospital, SNF, ICF or Hospice  
13. Expired, place unknown | Yes |
<p>| 18-28                    | Condition Codes | Codes used to identify conditions related to the claim that may affect processing. | No |
| 29                       | ACDT State | Accident State – if the claim is related to an accident, enter the abbreviation of the state in which the accident occurred. | No |
| 30                       | N/A | N/A | N/A |
| 31-34                    | Occurrence Code and Date | The code and associated date defining a significant event relating to the claim that may affect processing | No |</p>
<table>
<thead>
<tr>
<th>UB04/CMS 1450 BOX NUMBER</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-36</td>
<td>Occurrence Span Code, from Through</td>
<td>The beginning and end dates of the event relating to the claim</td>
<td>No</td>
</tr>
<tr>
<td>37</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>38</td>
<td>Name and Address of Responsible Party</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>39 – 41</td>
<td>Value Code and Amount</td>
<td>Codes used to identify payment variation</td>
<td>No</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td>Codes that identify a specific accommodation, ancillary service, or billing calculation. Accommodation days should not be billed on outpatient bill types. Revenue codes are to be billed in the following sequence: chronologically for accommodation dates; in descending order for non-accommodation revenue codes</td>
<td>Yes</td>
</tr>
<tr>
<td>43</td>
<td>Description</td>
<td>Description of the related revenue code</td>
<td>No</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rate/HIPPS Code</td>
<td>Accommodation rate for inpatient bills and the HCPCS code for all ancillary services and outpatient bills. HCPCS codes and rates should be submitted on lab claims that fall under the Colorado Access Lab Contract.</td>
<td>Yes</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>Date of outpatient service in MMDDYY format</td>
<td>Yes</td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td>Services units provided. If accommodation days are billed, the number of units billed must be consistent with the Statement Covers Period (box 6). Service units should be billed in whole numbers. Round any fractions to the nearest whole number.</td>
<td>Yes</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Total charges for Field 47 are obtained by multiplying the units of service (box 46) by the value of the revenue code (box 42).</td>
<td>Yes</td>
</tr>
<tr>
<td>48</td>
<td>Non-Covered Charges</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>49</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>UB04/CMS</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>1450 BOX NUMBER</td>
<td>Payer Name</td>
<td>Name of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement. Colorado Access should be the last entry.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Health Plan ID</td>
<td>Identification number (if available) of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>REL Info</td>
<td>Release of Information – Enter “Y” if the provider has signed written consent from the patient to release medical/billing information. Otherwise, enter “R” for restricted or modified release or “N” for no release.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>ASG BEN</td>
<td>Assignment of Benefits – A code showing whether the provider has a signed form authorizing the party payer to pay the provider.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Prior Payments</td>
<td>Amount received toward the payment from any payer, including the patient. If no payment was received as a result of billing, enter “0.” The “0” indicates that a reasonable attempt was made to determine available coverage for the services provided.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Estimated Amount Due</td>
<td>Estimated Amount Due</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>NPI</td>
<td>National Provider Identifier – The NPI number of the billing provider</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Other Prv ID</td>
<td>Other Provider Identification – Number assigned to the provider by the payer indicated in box 50 A, B, C</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Insured’s Name</td>
<td>Name of the insured who is covered by the payer listed in box 50.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>P. Rel</td>
<td>Patient’s Relationship to the Insured – Code indicating relationship of the insured to the patient. For Medicaid, code will be 01.</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Insured’s Unique ID</td>
<td>The patient’s member ID Number</td>
<td>Yes</td>
</tr>
<tr>
<td>UB04/CMS 1450 BOX NUMBER</td>
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<td>DESCRIPTION</td>
<td>REQUIRED</td>
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<tr>
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<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>61</td>
<td>Group Name</td>
<td>Insured’s group name. Refer to Colorado Access ID card.</td>
<td>No</td>
</tr>
<tr>
<td>62</td>
<td>Insurance Group Number</td>
<td>The Insurance Group Number – Refer to the Colorado Access ID</td>
<td>Yes</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>If applicable, enter the Colorado Access authorization number for the services rendered.</td>
<td>Yes – if applicable</td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
<td>Employer Name</td>
<td>No</td>
</tr>
<tr>
<td>66</td>
<td>Dx</td>
<td>Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – Enter “9”</td>
<td>Yes</td>
</tr>
<tr>
<td>67</td>
<td>Principal Diagnosis</td>
<td>Principal diagnosis, determined after study, using ICD-9-CM codes. The codes should match those on the Colorado Access prior authorization letter if an authorization has been obtained.</td>
<td>Yes</td>
</tr>
<tr>
<td>68</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>69</td>
<td>Admit Dx</td>
<td>Admitting Diagnosis – ICD-9-CM diagnosis code that represents the significant admitting diagnosis</td>
<td>Yes – if inpatient</td>
</tr>
<tr>
<td>70 A,B,C</td>
<td>Patient Reason Dx</td>
<td>The diagnosis that represents the reason for the patient’s outpatients visit</td>
<td>Yes – if outpatient</td>
</tr>
<tr>
<td>71</td>
<td>PPS Code</td>
<td>Prospective Payment System Code – The code that identifies the DRG.</td>
<td>Yes – if applicable</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>External Cause of Injury – the E-Code (ICD-9-CM code) that represents the cause of injury, poisoning or adverse effects.</td>
<td>No</td>
</tr>
<tr>
<td>73</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code and Date</td>
<td>Principal procedure code and date the principal procedure was performed during this hospital stay. ICD-9-CM procedure codes are required. If more than one procedure is performed, the principal procedure should be the one related to the principal diagnosis, which was performed for definitive treatment of that condition and requires the highest skill level.</td>
<td>No</td>
</tr>
<tr>
<td>74 A − E</td>
<td>Other Procedure Date</td>
<td>Other procedure codes performed during the hospital stay. Enter the codes in descending order</td>
<td>No</td>
</tr>
</tbody>
</table>
**Claims & Provider Reimbursement**

**PROVIDER MANUAL**

<table>
<thead>
<tr>
<th>UB04/CMS 1450 BOX NUMBER</th>
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<th>DESCRIPTION</th>
<th>REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>N/A</td>
<td>of importance.</td>
<td>N/A</td>
</tr>
<tr>
<td>76</td>
<td>Attending/NPI</td>
<td>Attending provider’s National Provider Identifier (NPI) number, and the provider’s Last and First Name</td>
<td>Yes</td>
</tr>
<tr>
<td>77</td>
<td>Operating/NPI</td>
<td>Operating physician’s National Provider Identifier (NPI) number, and the physician’s Last and First name</td>
<td>Yes – if applicable</td>
</tr>
<tr>
<td>78 – 79</td>
<td>Other/NPI</td>
<td>Other providers’ National Provider Identifier (NPI) number, and the provider’s Last and First name</td>
<td>Yes – if applicable</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Information when applicable</td>
<td>No</td>
</tr>
<tr>
<td>81 a – d</td>
<td>CC</td>
<td>Codes that do not fit in the other code fields of the form, and externally maintained codes approved by NUBC for the institutional data set.</td>
<td>No</td>
</tr>
</tbody>
</table>

**NOTE:** We require providers to bill professional and/or technical components of hospital-based physicians and certified registered nurse anesthetists separately on a CMS 1500 claim form.

**PRESENT ON ADMISSION (POA) INDICATOR**

We require a Present on Admission (POA) Indicator on all inpatient claims.

**NOTE:** Inpatient claims will be denied if the POA indicator is not submitted on the claim.

According to state and federal guidelines, all inpatient facility claims should include POA indicators. The Centers for Medicare and Medicaid Services (CMS) defines present on admission as:

“... present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.”

A POA indicator should be assigned to the principal and secondary diagnoses. According to coding guidelines, the correct POA indicators are:

- **Y** – Yes
- **N** – No
- **U** – Unknown
- **W** - Clinically undetermined unreported/Not used – (Exempt from POA reporting)

In the event of improper reporting, DRG assignment and reimbursement will be adjusted accordingly.

In some cases, retrospective claim review may occur. We reserve the right to collect any overpayments that are the result of the retrospective review.
DIAGNOSIS CODING
We require providers to enter the appropriate diagnosis code on each claim submitted. We only accept those codes published in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 codes). The provider must enter ICD-9 codes clearly on the claim form and include all digits and characters.

- Some procedures are appropriate only when specific conditions are present (i.e., 99381-99387 is valid only with Diagnosis Code V20.2).
- We require providers to ensure the diagnosis entered is appropriate for the services provided and is supported by the patient’s medical record.
- We require providers to submit ICD-9 codes to the highest specificity with all of the required digits (three, four, or five) to completely and accurately describe the disorder or illness, including behavioral health services.

Confidential Diagnosis Coding
Please enter AIDS or AIDS-related diagnosis codes on the claim form as with any other diagnosis or condition. While federal and state statutes provide stringent penalties for failure to keep AIDS related information confidential, these statutes are not intended to prevent accurate and appropriate submission of claims.

Federal and state statutes prohibit disclosure of information regarding application for or receipt of public assistance. However, this information may be disclosed for purposes of administering a public assistance program. Claims submitted for services rendered to our members include information necessary to process claims, calculate costs and project future funding. In sharing information for these purposes, we do not jeopardize the privacy of the recipient.

PROCEDURE CODING
We use the Centers for Medicare and Medicaid Services’ Healthcare Common Procedure Coding System (HCPCS) to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. In order to ensure that claims are processed promptly and accurately please follow these guidelines:

- Use the most current CPT/HCPCS code revision, based on date of service.
- Be aware that not all codes are covered benefits under Colorado Access member benefits.
- When we receive billed codes that are considered obsolete, the claim line(s) will be denied and written notification will be sent on a claim voucher.

ANESTHESIA BILLING
Anesthesia service codes (procedure codes 00100-01999) must appear in field 24-D. Time units must be entered in field 24-G (1 unit equals 15 minutes). When calculating reimbursement on anesthesia claims,
we do pay for time and units. However, we pay for the actual time administered. Please see the example below:

Step 1: Actual time divided by 15 equals X.
Step 2: The Base Factor is added to X. This total equals Y.
Step 3: The Relative Value is multiplied by Y. This total is the payment amount.

IMMUNIZATIONS
- Please report all immunizations given to Colorado Access members on the CMS 1500 claim form with the vaccine procedure code.
- A separate vaccine code should be listed for each vaccine administered. For example:
  - CPT code 90708 for measles, mumps, and rubella (MMRV)
  - CPT code 90659 for adult influenza injection
- Providers should bill the appropriate vaccine administration code(s) per CPT guidelines. When billing immunization administration fees submit on a single claim line with the appropriate number of units. This will avoid denials for duplicate charges.
- Immunization information may be used for tracking and reporting purposes.

MULTIPLE OCCURRENCES
Report multiple occurrences of the same procedure on the same date on one billing line, using multiple units of service. The charges reported should equal the unit procedure price multiplied by the number of units provided.

- Providers may refer to the CPT or HCPCS Bulletin for more information about unit definitions.
- DME providers should use the units outlined in the CPT coding manual.

NON CLEAN CLAIMS PROCESS
In accordance with CRS 10-16-106.5, if a submitted claim requires additional information in order to be paid, denied, or settled, the claim will not be considered a clean claim. Such claims will be paid, denied, or settled according to the following schedule:

- Within 30 calendar days of receiving the claim, we will pend/hold the claim in its processing system and include Explanation of Payment (EOP) codes and follow-up instructions on the voucher as to how to resolve the claim.
- If, within 30 calendar days of our request, a provider fails to submit the additional information, we may deny the claim.
- When all additional information necessary to resolve the outstanding claim has been provided, during the 30 calendar day period, the claim will be paid, denied or settled by Colorado Access, absent fraud, within 90 calendar days after the date that we first received the claim.
LOCUM TENENS

A member’s regular provider may submit a claim and receive payment for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician if:

- the regular physician is unable to provide the visit services;
- the member has arranged or seeks to receive the services from the regular physician;
- the regular physician pays the locum tenens for his or her services on a per diem or similar fee-for-time basis;
- the substitute physician does not provide the visit services to members over a continuous period of longer than 14 days for a reciprocal billing arrangement, or a continuous period of longer than 90 days for a locum tenens arrangement; and
- the regular physician identifies the patient visit as services provided by a substitute physician meeting the requirements of this section by entering modifier Q5 (service furnished by a substitute physician under a reciprocal billing arrangement) or Q6 modifier (service furnished by a locum tenens physician) in box 24d of CMS 1500, after the procedure code. Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician’s UPIN, and make this record available to Colorado Access upon request.

A continuous period of covered visit services begins with the first day on which the substitute physician provides covered services to the patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Example: The regular physician goes on vacation on June 30, 2009 and returns to work on September 4, 2009. A substitute physician provides services to patients of the regular physician on July 2, 2009 and at various times thereafter, including August 30, 2009 and September 2, 2009. The continuous period of covered visit services begins on July 2nd and runs through September 2nd, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive payment for them. The regular physician may, however, bill and receive the payment for the services that the substitute physician provides on his/her behalf in the period July 2nd through August 30th.

NOTE: A physician who has left a group, and for whom the group has engaged a locum tenens physician as a temporary replacement, may still be considered a member of the group until a permanent replacement is obtained.
OUT-OF-AREA SERVICES
We are financially responsible for all emergency services and urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a Colorado Access member to Customer Service at 800-511-5010.

• Out-of-area providers should submit claims to the Colorado Access claims address (see our addresses located at the beginning of this section) for processing.

CORRECTED CLAIM
Providers may resubmit denied claims for reprocessing within 120 days of the date of service or the time frames outlined in the provider’s contract or 60 days from the date of the last denial recorded on a voucher.

CORRECTED CLAIM PROCESS
• Send a copy of the original claim, clearly marked “Resubmission” on the face of the claim or a newly completed claim form.
• The resubmission must be newly dated and signed with an authorized signature.
• Attach a copy of the voucher listing the originally submitted claim as denied.
• If one or more items on an original claim have been paid and other items denied, a legible copy of the original claim may be used to resubmit the denied lines.
• Correct the appropriate information clearly and accurately.
• Adjust total charges to reflect the amount being resubmitted.
• For a UB04 claim form change the fourth (4th) digit of the bill type to a “7”. For example, an initial inpatient claim would be submitted with a bill type of 0111 and a corrected claim would be submitted with a bill type of 0117.
• For a CMS 1500 claim form enter a “7” in box 22.
• Mail all resubmitted claims to the Colorado Access claims address (see our addresses located in this section).

We will research the resubmission and adjudicate the claim according to the newly resubmitted information. Once adjudicated, the claim will appear on the provider’s voucher with a corresponding Explanation of Payment (EOP) code outlining the reason for payment or denial.

LATE OR ADDITIONAL CHARGES
Providers billing late or additional charges for previously submitted claims must resubmit the entire claim. Do not submit the missing lines or additional lines separately. For example, if an inpatient claim was submitted without the laboratory fees, the new/corrected claim must include the laboratory fees AND the original claim lines.

MEMBER BILLING OR BALANCE BILLING

Hold Harmless Clause for covered services
According to your contract with Colorado Access and CRS § 25.5-4.301(1)(a)(l),
Provider agrees that, in no event, including nonpayment by Colorado Access, the insolvency of Colorado Access, or breach of this Agreement by any party, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against members or persons other than Colorado Access. This provision shall not prohibit collection of copayments on Colorado Access’ or a Payer’s behalf in accordance with the terms of the applicable Benefit Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of members; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and members or persons acting on their behalf.

This includes charging members for missed appointments and for failing to follow appointment cancellation policies.

**Circumstances in Which a Member can be Billed for Services**

- Any deductible, copayment or coinsurance that is the member’s cost share
- A member sees a non-participating provider in a non-emergent, non-urgent, outpatient setting without prior authorization (applies to in-state and out-of-state providers).
- A member does not follow the pharmacy rules (member may have to pay for the medication).
- A member receives non-emergent healthcare services outside of the United States of America.

**Third Party Insurance**

Under third party insurance situations, a member may have to pay if he or she does not follow the rules of a third party payer – he or she will have to pay what the other insurance would have paid.

**Overpayments**

Providers should routinely review claims and payments in an effort to determine if the provider has received any overpayments. Overpayments requiring recoupment from a provider routinely occur in a number of ways including, but not limited to: (a) claims paid in error; (b) claims allowed/paid greater than billed; (c) duplicate payments; (d) payments made for individuals who are not eligible; (e) payments made for services in excess of applicable benefit limitations; or (f) payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

These types of errors are typically discovered through self-disclosure by the provider or through our claims review and/or audit processes. These are considered overpayments discovered during the normal course of business, and do not include auditing performed or repayments required specific to fraud, waste and abuse efforts.

When an overpayment is discovered during the normal course, the provider may be directed to either submit a revised claim on a Non-Clinical Adjustment/Appeal Process Request form available at coaccess.com/frequently-used-forms, or submit a check for the overpayment, at our discretion. Any revised claim adjustments will be reflected as a credit balance and are set off against future claims submitted by the provider.
Repayments for non-participating providers will be made by check.

In the event that there is an outstanding negative balance as a result of claims adjustments or nonpayment after a reasonable period of time, we may issue a demand for repayment to the provider, subject to applicable laws and regulations. If a provider fails to respond and/or provide the amounts demanded within a reasonable period of time, such failure to respond is deemed approval and agreement with the demand for repayment, and we may pursue all available remedies. If the provider disagrees with demand for repayment of an overpayment, the provider may request in writing that such demand for repayment be reviewed, provided that such review is submitted prior to the due date of the repayment.
VI. Provider-Carrier Disputes (Claim Appeals)

CLAIM APPEALS ADDRESS

Provider-Carrier Disputes (Appeals):
P.O. Box 17189
Denver, CO 80217-0189

SUBMISSION PROCESS

A provider or a provider representative may access the provider-carrier dispute process to submit a written request for a resolution of a dispute regarding an administrative, payment or other issue not related to an action.

In accordance with Division of Insurance regulations, we require provider-carrier disputes (claims appeals) to be submitted in writing. Information may be submitted in a brief letter or on the Colorado Access Claim Appeal Request form located on our website at coaccess.com/frequently-used-forms.

All necessary information must be submitted within 60 calendar days from the date of the voucher on which the disputed claim appears, to the address noted above.

Necessary information for purposes of a provider-carrier dispute includes the following:

- Each applicable date of service;
- Member name;
- Member identification number;
- Provider name;
- Provider tax identification number (TIN);
- Dollar amount in dispute, if applicable;
- Provider position statement explaining the nature of the dispute; and
- Supporting documentation where necessary (e.g., medical records, proof of timely filing, State Web Portal eligibility screen prints verifying reasonable attempts to capture member eligibility on date of service).
- Access Advantage only: Colorado Access cannot process claim appeals from non-participating providers without a Waiver of Liability (available at coaccess.com/updates-and-forms)

After we receive a dispute in writing, providers or their representatives may present the rationale for a dispute in person. When a face-to-face meeting is not practical, we will provide alternative methods of communication such as teleconference.

PROCESSING TIMEFRAMES

Upon receipt of a provider-carrier dispute, we will review, record, investigate, resolve and provide appropriate and timely notifications in accordance with applicable state and federal rules and regulations.
• We will issue a written confirmation to the provider or the provider’s representative within 30 calendar days of receiving a complete dispute resolution request.
• We will resolve claims appeals and issue written notification of the outcome within 45 calendar days of receipt of the initial request for resolution and upon receiving all necessary information.
• We may choose to use electronic means to send required notification to providers including email or facsimile.
• Both parties may agree, in writing, to an extension beyond the 45 calendar days from receipt of all necessary information time frames established by this policy in order to resolve a dispute.
VII. Coordination of Benefits

FILING A CLAIM FOR A PATIENT WITH THIRD PARTY RESOURCES

- Providers must submit a hard copy of the CMS 1500 or UB04/CMS 1450 along with a copy of the Explanation of Payment (EOP), denial notice (including all denial reason wording), benefits exhausted statement or a copy of the check/voucher used for claim payment from the other insurance/third party resource (TPR).
- We do not consider refusals of payment due to claim preparation errors or failure to provide sufficient processing information as proof of denial.
- If an EOP applies to more than one claim, a copy of the EOP must be attached to each claim submission.
- Complete the appropriate TPR data fields/form locators on the claim form submitted to Colorado Access. Claim TPR data fields/form locators are specific to third party insurance or Medicare; they cannot be used interchangeably.
- Submit the claim within 120 calendar days from the TPR’s denial date or processing date.

SECONDARY BENEFIT CALCULATION “LOWER OF LOGIC”

We calculate secondary benefits in the following manner:

- The Colorado Access benefit allowance is compared to the primary payment.
- If the primary payment is equal to or greater than the Colorado Access benefit allowance, we will not make a payment.
- If the primary payment is less than the Colorado Access benefit allowance, we will pay the difference between the two amounts. However, payment will not exceed the other insurance’s (including Medicare) coinsurance, deductible and/or copay.
- We do not automatically pay the other insurance’s (including Medicare) copayments, coinsurance and/or deductibles.

NOTE: Providers cannot bill clients for the difference between the primary carrier’s health insurance payments and their billed charges when we do not make additional payments.

AUTHORIZATIONS AND COORDINATION OF BENEFITS

If Colorado Access is the secondary payer, no authorization is required to coordinate benefits with the primary payer. Colorado Access authorization rules apply when we are the primary payer or are anticipated to become the primary payer. You should request authorization for services anytime you believe Colorado Access will be responsible for primary payment of services that require prior authorization. This includes:

- when services are not a covered benefit of the primary payer.
- when benefits are exhausted by the primary payer.
- when the primary payer does not have an adequate network to provide the covered service.
If a claim is submitted under the above circumstances and an authorization has not been obtained, the claim may deny for no authorization. We will perform a retrospective review for medical necessity if the claim is resubmitted on appeal.
VIII. Authorizations and Referrals

SUBMITTING AN AUTHORIZATION

Certain services require prior authorization in order to obtain coverage (payment). A comprehensive list of procedure codes and corresponding prior authorization requirements is located on our website at coaccess.com/our-providers. To access the list, click on For Our Providers. Then, click on Authorization List located in the Provider Tool Kit. The login screen will open in a new window and you will need to enter your Colorado Access username and password. If you do not have a Colorado Access username and password, you can request one by submitting the Provider Logon ID Request Form located at coaccess.com/frequently-used-forms.

It is best to plan ahead and submit an authorization request well in advance of the service being rendered. Authorization requests are processed as expeditiously as the enrollee’s health condition requires and within the specific line of business requirements, which are:

- AA – within 14 calendar days
- ABC and CHP+ – within 10 calendar days
- AHC – within 15 calendar days

We don’t perform prior authorization review on services that have already been rendered. If you provide services without an authorization your claim may be denied.

We cannot retrospectively deny benefits for treatments that have been preauthorized except in cases of fraud, abuse, or if the member loses eligibility.

Prior to submitting an authorization, verify the member’s eligibility either through our website (coaccess.com/our-providers) or by calling Customer Service 800-511-5010. Once you have determined that the member is eligible, complete the applicable service authorization form (located on our website at coaccess.com/frequently-used-forms) and fax to our coordinated clinical services department at:

- 303-755-4135 or 877-232-5976 for physical health, DME, home health, or outpatient therapy authorization requests
- 720-744-5127 for pharmacy authorization requests
- 720-744-5130 for behavioral health authorization requests

You will be notified if additional information is needed, if the service is authorized, or of an adverse service determination (services will not be authorized).

COLORADO ACCESS AUTHORIZATION LIST

A comprehensive list of procedure codes and corresponding authorization requirements, by line of business, is located on our website at coaccess.com/for-providers. To access the list, click on For Our Providers. Then, click on Authorization List. The login screen will open in a new window; enter your Colorado Access username and password to access the list. If you do not have a Colorado Access
username and password, you can request one by submitting the form located at coaccess.com/frequently-used-forms.

**MEDICAL NECESSITY**

As part of utilization review to authorize a service, we determine medical necessity. A service is medically necessary if it is:

- Appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and
- Within standards of good medical practice within the organized medical community of the treating provider; and
- Not primarily for the convenience of the member or the treating provider; and
- Consistent with the medical policy, the utilization management program, quality management program, and benefit program requirements applicable to the benefit program under which the covered services are rendered; and
- The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member’s condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

**Medical necessity determinations are based on the following:**

- Standardized national criteria, such as InterQual® criteria.
- Internally developed criteria approved by the Colorado Access Medical/Behavioral Quality Performance Advisory Committee (QPAC).
- Review by the Colorado Access medical director (or an associate medical director). This may include discussing treatment alternatives and approaches with the provider requesting the service.

We consider individual needs as well as the capacity of the local delivery system when applying medical review criteria. A provider may request the criteria used to make a determination from our coordinated clinical services department at 303-751-2657 or toll free 877-441-6032.

**AUTHORIZATION CATEGORIES**

The Colorado Access Utilization Management Program has four authorization categories:

- **No Authorization** - Certain services can be provided under specified circumstances with no notification to or authorization by Colorado Access. These include:
  - 911 ambulance call
  - emergency department visit
  - urgent care
and the following services when a covered benefit and rendered by a contracted provider or the assigned PCP:

- Well woman OB/GYN services
- Family planning services
- Routine outpatient care
- Routine vision care
- Specialty office visit services

**Clinical Referrals** - We encourage primary care providers (PCPs) to direct care for specialty office-based service through clinical referrals. We consider a clinical referral to be a communication between the PCP and the specialty provider for the purposes of care continuity and treatment planning. Specialty office visits for contracted specialty providers do not require prior authorization from Colorado Access for payment purposes. Certain therapies, DME items, and office visits for non-participating specialists require prior authorization from Colorado Access.

**Procedure Authorization:**

- **Elective Procedures:** For procedures requiring authorization, the provider MUST request authorization at least five working days in advance of the scheduled service. Authorization requests are processed as expeditiously as the enrollee’s health condition requires and within the specific line of business requirements which are:
  - AA – within 14 calendar days,
  - ABC and CHP+ – within 10 calendar days
  - AHC – within 15 calendar days

  A review will be done to ensure the following: participating provider, eligible member, covered benefit, and medical necessity.

- **Emergent Procedures:** The provider must notify Colorado Access within one working day of the service being rendered. A review is done to ensure the following: eligible member, covered benefit, timeliness of notification, and medical necessity.

- **For After Hours Discharge Planning Needs:** The provider (vendor), in order to initiate home health, DME, and/or oxygen supplies, (on holidays or weekends) must notify Colorado Access on the next working day following discharge from the facility. A review is done to ensure the following: eligible member, covered benefit, medical necessity, and timeliness of notification. For continuing needs, the provider (vendor) must initiate a procedure authorization. Failure to request authorization within timeliness guidelines will result in an administrative denial.

**Transportation Authorization:**

- **Emergency Transport Base Rate and Mileage Reimbursement:** The provider must submit the claim with the trip sheet attached. Air ambulance services are covered only if ground transport is inaccessible or the member’s condition requires expedited transport. Air ambulance and interstate transportation services are subject to retrospective review.
Non-emergent, Scheduled Ambulance Transportation: The provider must request prior authorization at least five working days in advance of the scheduled service. Authorization requests are processed as expeditiously as the enrollee’s health condition requires and within the specific line of business requirements which are:

- AA – within 14 calendar days
- ABC and CHP+ – within 10 calendar days
- AHC – within 15 calendar days

Services are covered for members who are bed confined and if no other means of transportation can be used without endangering the individual’s health. A review will be done to ensure the following: eligible member, covered benefit, and medical necessity. Failure to request authorization within timeliness guidelines will result in an administrative denial.

POST-STABILIZATION CARE SERVICES:
Covered services, related to an emergency medical condition, which are furnished by a qualified provider after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member’s condition.

Emergency services and urgently needed services do not require prior authorization. We cover, without prior authorization, regardless of whether the services are obtained within or outside the Colorado Access provider network and in accordance with the prudent layperson’s definition of emergency medical condition:

“A person having average knowledge of health services and medicine and acting reasonably, would have believed that an emergency medical condition or life-or-limb threatening emergency existed.”

We may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms that are otherwise covered under its contracts. We may not refuse to cover emergency services based on the emergency room provider, hospital, or agent not notifying the member’s primary care provider, Colorado Access, or the applicable state entity of the member’s screening and treatment. The physician treating the member must decide when the member may be considered stabilized for transfer or discharge, and that decision is binding on Colorado Access.

TYPES OF COLORADO ACCESS UTILIZATION REVIEW DETERMINATIONS
We will make one of the following determinations after reviewing an authorization request. Our utilization review determinations comply with state and federal guidelines.

- Authorized - The requested service meets all utilization review criteria including, but not limited to, member eligibility, medical necessity and if the service is a covered benefit. Authorization is not a guarantee of payment.
- Pended - A determination cannot be made with current information. The case is pending receipt of additional information and/or documentation.
• Adverse Service Determination ("Denied") - The requested service is not covered by the benefit plan, is not medically necessary, is a reduction and/or has been discontinued, and/or the authorization request has not met timeliness requirements. A claim for this service will not be paid.
  o Only the Colorado Access medical director or the designated physician reviewer can deny an authorization request.
  o For prospective or concurrent determinations, the treating physician may request a reconsideration of the denial.
• Administrative Denial - A provider’s failure to follow contractual requirements and/or established procedures regarding authorization requirements (i.e., out of timely notification, failure to submit necessary information, etc.) may result in an administrative denial.

All denials may be appealed.

GENERAL AUTHORIZATION RULES
The following is a summary of our authorization rules and does not guarantee coverage. Please refer to the member benefits information located on our website at coaccess.com/plans-services. From the Plans & Services page, click on the specific line of business the member has coverage under and locate the Evidence of Coverage/Member handbook/Member booklet.

Participating vs. Non-Participating Providers
In general, all services rendered by non-participating providers require prior authorization for payment except where specifically noted in the rules below.

Primary Care
Services provided by participating primary care providers (PCPs) do not require prior authorization.

Specialists Referrals
Office visits for participating specialty providers do not require a referral to be submitted to Colorado Access from the member’s PCP. We encourage PCPs to direct care for specialty office-based care through clinical referrals. We consider a clinical referral to be communication between the PCP and the specialty provider for the purposes of care continuity and treatment planning.

Office visits for non-participating specialists do require a prior authorization from Colorado Access and will be considered on a case-by-case basis for particular clinical needs.

NOTE: Certain services, such as visits with physical, occupational and speech therapists may require authorization.

Inpatient Care

• All inpatient care (place of service 21) requires prior authorization at a facility level
• Professional services and ancillary services rendered during an inpatient stay are considered
downstream and do not require separate authorization for both participating and non-
participating providers except as described in the Authorization Categories section under
Procedure Authorization. Initial authorization and concurrent review determinations are based
on medical necessity as determined by InterQual® criteria and national coverage guidelines.

Elective Services, Procedures, or Admissions
The facility must request authorization at least five working days in advance of the scheduled service.
Authorization requests are processed as expeditiously as the enrollee’s health condition requires, but no
later than 10 calendar days after the date the request was received at Colorado Access. A review is done
to ensure the following: participating provider, eligible member, covered benefit, medical necessity, and
allowed length of stay.

Emergent Admissions
The facility must request authorization within one working day of the service being rendered. A review is
done to ensure the following: eligible member, covered benefit, timeliness of notification, and medical
necessity.

Childbirth
The facility must obtain authorization as per the above-mentioned guidelines. Additional authorization is
required for lengths of stay longer than 48 hours after vaginal delivery or 96 hours for a Cesarean. If a
newborn baby is not discharged at the same time as the mother, an authorization is required for the
baby’s continued stay.

Concurrent Review
The facility must phone or fax clinical information supporting the medical necessity of admission and/or
continued stay within one working day of the request for information by Colorado Access. Initial
authorization and concurrent review determinations are based on medical necessity as determined by
InterQual® criteria and national coverage guidelines or a health plan associate medical director review.

After Hours Discharge Planning Needs
For after-hours discharge planning needs (to initiate home health, DME, oxygen supplies), such as on
holidays or weekends, the provider (vendor) must notify Colorado Access on the next working day
following discharge from the facility. A review is done to ensure the following: eligible member, covered
benefit, medical necessity, and timeliness of notification. For continuing needs, the provider (vendor)
must initiate a procedure authorization.

Emergency and Urgent Care
Emergency services (place of service 23) and urgent care services (place of service 20) do not require
prior authorization regardless if the services are rendered by a participating or non-participating
provider.
**Definition of an Emergency Medical Condition**

An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, which a prudent layperson could reasonably expect to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part if immediate medical attention is not obtained.

We cover all emergency department services necessary to screen and stabilize members if:

- A prudent layperson would have reasonably believed that use of a [contracted] provider would result in a delay that would worsen the emergency; or a provision of federal, state or local law requires the use of specific provider (DOI Regulation 4-2-17).

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge from the emergency department.

**Urgent Care**

Prior authorization is not required for urgent care services billed with place of service 20.

**Definition of Urgent Care**

Urgent care is defined as provision of medically necessary covered services to treat an injury or illness of a less serious nature than those requiring emergency care but required in order to prevent serious deterioration in the member’s health, or to maintain a member’s activities of daily living.

**EMERGENT OPERATING ROOM & EMERGENT ADMISSION**

- The facility must request authorization within one working day of the service being rendered.
- A review is done to ensure the following: eligible member, covered benefit, timeliness of notification, and medical necessity.
- Services performed in an outpatient setting (place of service 22 or 24) do not require a facility authorization.

**Ambulance**

- Emergency ground or air ambulance transport does not require prior authorization.
- Scheduled ambulance transport from facility to facility is covered, but does require prior authorization.
- Non-emergent scheduled ambulance transportation is covered with prior authorization for member’s who are confined to a bed and if no other means of transportation can be used without endangering the individual’s health.
- A review will be done to ensure the following: eligible member, covered benefit, and medical necessity.
Outpatient Hospital / Ambulatory Surgery

- Procedures that are performed in an outpatient hospital (place of service 22) or ambulatory surgery center (place of service 24) may require prior authorization for the professional services.
- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) for authorization requirements. Facility and ancillary services are considered downstream to the procedure and do not require separate authorization for payment. Authorization for procedures is based on medical necessity as determined by InterQual© criteria and national coverage guidelines.

Women’s Health - OB/GYN Services

- OB/GYN office-based services do not require referral or prior authorization if the services are obtained from a participating provider.
- Certain facility-based procedures may require prior authorization.
- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) for authorization requirements.

Family Planning Services

- Family planning services do not require prior authorization or referral for any provider, both participating and non-participating.
- Some surgeries and supplies may require authorization.
- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) for authorization requirements.

Gynecological Services that Require Procedure Authorization

- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) for authorization requirements.
- Gynecological services that require a procedure authorization must be submitted to Colorado Access for review at least five working days in advance of the scheduled service in order to ensure payment of professional fees. Authorization requests are processed as expeditiously as the enrollee’s health condition requires, but no later than 10 calendar days after the date the request was received at Colorado Access.
- For emergent procedures, the provider must notify Colorado Access within one working day of the service being rendered.
- Services performed in an outpatient setting (place of service 22 or 24) do not require a facility authorization.

Gynecological Services from Non-participating Specialists

- All requests for a referral authorization for gynecologic care through a non-participating specialist are redirected to a similar participating specialist.
• The exception would be if there is a medical necessity review to support the need for services outside the scope of practice for all available participating specialists.

Infertility

• Infertility evaluation, diagnosis and treatments are not covered benefits.

Abortion

• Abortion is a covered benefit when the life of the mother would be endangered if the fetus were carried to term, or if the pregnancy is the result of rape or incest.
• All abortion procedures require procedure authorization for medical necessity determination.

Multi-fetal pregnancy reduction is considered an abortion procedure and is subject to the same benefit restrictions and procedure authorization requirements.

Maternity Care

Per the Colorado Women’s Healthcare Act, our members do not need a referral to see a participating provider for pregnancy or well-woman care. Please be advised that certain procedures performed by OB/GYNs may require an authorization. Please refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) for authorization requirements.

Basic Maternity Care

• Basic maternity care includes professional services and facility charges for antepartum, intrapartum, and postpartum management of pregnancy and obstetrical conditions.
• Antepartum care generally includes monthly visits up to 28 weeks gestation, biweekly visits up to 36 weeks gestation, and weekly visits until delivery. More visits may be needed for women with pregnancy risk factors. Frequency of visits is a provider decision.
• Routine maternity care can be provided by qualified participating PCPs, participating OB/GYN specialists, or participating certified nurse midwives.

Facilities are responsible for notifying Colorado Access when a member is admitted for inpatient obstetrical care or delivery within one working day of admission.

Antepartum Ambulatory Care

• Authorization is not required to a participating obstetrician, gynecologist and/or certified nurse midwife for routine services or participating specialist or sub-specialist.
• Diagnostic obstetrical ultrasound and fetal monitoring services provided by the participating, treating prenatal care provider (PCP or specialist) and provided in either the office or a par
facility do not require authorization or notification.

Inpatient Maternity Care

• All admissions for delivery and/or complications of pregnancy require facility notification to Colorado Access and may require authorization under certain circumstances.
• Professional services for vaginal delivery, Cesarean delivery, or vaginal delivery after previous Cesarean (VBAC) do not require a procedure authorization by the provider
• If the inpatient stay goes past five days, the facility must notify Colorado Access and obtain authorization for additional days
• If newborn remains in the hospital after mother is discharged, the facility must obtain authorization for the newborn stay

Newborns
Coverage of services to a newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother’s eligibility alone.

Postpartum Ambulatory Maternity Care
Office-based postpartum care should occur within six weeks of delivery and does not require a referral authorization if provided by the same participating provider or group that provided antepartum care.

Sub-Specialty Maternity Care
We encourage PCPs and OB/GYNs to direct members to contracted specialty/sub-specialty providers for office-based care through clinical referrals.

• Office visits with contracted specialty/sub-specialty providers do not require prior authorization for payment purposes.
• All care provided by non-participating providers require authorization. The sub-specialty provider will be expected to follow the same requirements for medical necessity authorization as detailed above.

Amniocentesis and Chorionic Villus Sampling

• Diagnostic amniocentesis and chorionic villus sampling are covered benefits except for instances where the sole purpose is for determination of fetal sex.
• Amniocentesis and chorionic villus sampling do not require a procedure authorization for medical necessity, but do require a referral authorization if being performed in an outpatient setting by a perinatologist, reproductive geneticist or maternal-fetal medicine specialist (see Sub-Specialty Maternity Care).

Genetic Testing/Counseling
• Preconception testing, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders and discussion of family history, or testing to determine the sex or physical characteristics of an unborn child are not a covered benefit.
• Genetic tests to evaluate risks of disorders for certain conditions may be covered based on medical policy, review, and criteria and after appropriate prior authorization has been obtained.
Continuity of Care for Pregnant Women

- Women who become Colorado Access members in the first trimester of their pregnancy will be referred to a participating provider for their maternity care.
- Women who become Colorado Access members in the second or third trimester of their pregnancy may continue to receive their maternity care with their existing provider if the patient-provider relationship or the current pregnancy predates the Colorado Access effective date. If the patient-provider relationship predates the effective date and the provider is not a participating provider with Colorado Access, the provider must agree to accept the Colorado Access fee schedule as payment in full and agree to follow the Colorado Access Utilization Management and Quality Management policies and procedures.

Non-participating providers need to notify Colorado Access that they are seeing a member who needs continuity of antepartum care. A single case agreement will be processed to provide payment for services for this member.

All services rendered by a non-participating prenatal care provider must be authorized prior to the service being performed. If a non-participating provider declines to accept the policy regarding transition of care and authorization requirements, the plan will work with the member to assure appropriate care with a participating provider.

Use of Non-Participating Facilities

If a provider uses a non-participating facility for the provision of any of the antepartum or sub-specialty care services above, an authorization for the services will be required.

Diagnostic Services

- Routine laboratory and imaging services do not require prior authorization.
- Specialized diagnostic procedures may require prior authorization.
- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) to determine authorization requirements.

Diagnostic Interpretation Services

Interpretation of diagnostic services, usually indicated by modifier 26, does not require prior authorization for participating providers.

Vision Care

Routine Vision Care

- Please refer to the member benefits information for the specific line of business to confirm if routine vision care is a covered benefit.
- Vision screening may be covered as age-appropriate care.
- No referral or authorization is required for routine eye examinations, glasses, or contact lenses.
Specialty Vision Care

- Please refer to the member benefits information for the specific line of business to confirm if routine vision care is a covered benefit.
- Certain specialty procedures may require prior authorization. Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) to determine authorization requirements.
- Blepharoplasty, eyelid revisions and other ophthalmologic surgeries require prior authorization.
- Radial keratotomy and other surgical refractive corrections are not covered benefits.

Observation Services

- Observation stays (place of service 22) of 48 hours or less, do not require prior authorization for payment.
- If the observation stay converts to an inpatient stay, the facility will need to contact our coordinated clinical services department within one business day of conversion to notify of the inpatient stay and initiate the review process. You can contact our coordinated clinical services department at 720-744-5100, toll free 800-511-5010 or by fax at 877-232-5976.

NOTE: The inpatient stay admission date will be the date the patient presented in the facility emergency room.

Home Healthcare

- All home health services require prior authorization for payment. Home health services shall mean skilled nursing, home health aide, occupational therapy, physical therapy, speech therapy, and infusion therapy services rendered by a Medicare-certified home health agency or organization.
- Covered home health services must be initiated with physician’s orders by the PCP or discharging physician. The physician’s orders must be submitted to a participating home health agency. The home health agency must then notify Colorado Access by submitting the physician’s orders with the request, within one working day of service initiation.
- Authorization will be given for two skilled nursing, two physical therapy, and one occupational therapy evaluation without medical necessity review.
- Following the evaluation, a request for procedural authorization must be submitted along with the plan of care within five calendar days of the new plan of care for authorization of additional services beyond the evaluation visits.
- Any services rendered beyond the initial evaluation without authorization are subject to denial regardless of medical necessity.
- Any time there is a break in service, the home health agency must notify Colorado Access within one working day of the usually scheduled visit.
- All requests for home health authorization are reviewed for the medical necessity of each specific service in the plan of care, as well as necessity for services to be rendered in the home as opposed to an outpatient setting.
Services must be provided in the member’s place of residence.

Home health aide services strictly for the purpose of providing unskilled personal care, to assist with activities of daily living and/or homemaker services are not covered by Colorado Access.

Nursing visits for the purpose of providing home health aide supervision are not authorized or reimbursed as separate nursing visits.

Home health nursing services provided by an individual who ordinarily resides in the member’s home, or is an immediate family member are not a covered benefit.

Private duty nursing is not a covered benefit.

Durable Medical Equipment (DME)

Durable medical equipment may require prior authorization.

In general, basic equipment and supplies or equipment that is ancillary to other procedures do not require prior authorization.

Enhanced or specialty equipment or supplies generally require prior authorization.

Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) to determine whether a supply item or piece of equipment requires authorization.

Therapy

All physical, occupational, and speech therapy services require prior authorization.

A prior authorization approved by Colorado Access is required for the initial evaluation.

Ongoing services may be requested and approved based on medical necessity.

For ongoing services, a procedure authorization is required.

NOTE: Coverage may be subject to benefit limits. Please refer to the plan’s member benefits information located on our website coaccess.com/plans-services, click on the plan name to locate plan specific documents.

Downstream Providers

A downstream provider is defined as any provider who renders services at the direction of other providers.

We have determined that these providers are not subject to the prior authorization and/or referral process.

Emergency Room (place of service 23) services billed by providers are considered downstream.

Inpatient (place of service 21) pathology, radiology, anesthesia and all other physician services not on our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) are considered downstream.

Outpatient (place of service 22) the following services should be considered downstream:

- Pathology – all professional laboratory procedures.
- Radiology – all professional radiology procedures.
Authorizations and Referrals

PROVIDER MANUAL

- Anesthesia – all professional services billed within the procedure code range of (00100-01999).
- Facility – all outpatient contracted facility services billed with place of service 22 or 24. The use of a non-contracted facility requires prior authorization.

- Skilled nursing facility (place of service 31 or 32) physician services for care rendered in a skilled nursing facility. However, podiatrists (DPM) are required to obtain prior authorization.
- Interpretive Services – all services using modifier 26.

Pharmacy and Injectable Medications

- Certain injectable medications require prior authorization.
- Refer to our authorization list (located in the For Our Providers section of our website at coaccess.com/for-providers) to determine authorization requirements.
- Retail pharmacy drugs are managed by formulary.
- The formulary is located online at coaccess.com/pharmacy-services.
- Certain formulary drugs may be preferred agents or may require prior authorization. Refer to the Colorado Access formulary for more information.

Mental Health

For authorizations or questions regarding mental health services, please call customer service at 800-511-5010. Refer to the member benefits information for each specific line of business to confirm covered benefits.

Members can access mental health services, either by PCP referral or by directly accessing care from a contracted provider. Most routine outpatient care, including therapy provided in an office, does not require prior authorization.

CONTINUITY OF CARE

We will contact new members who have been identified as having potential continuity of care needs so that a needs assessment may be completed. If the member is in an ongoing course of treatment with a provider, and the provider agrees to continue the service, the member may continue to receive medically necessary covered services at the level of care received prior to enrollment, for a transition period of up to 60 calendar days for primary and specialty care, and 75 calendar days for ancillary services.

If the provider is not contracted with Colorado Access and is not willing to do so, and the service is expected to be ongoing, Colorado Access, as appropriate, will work with the member and provider to have the appropriate services transitioned into the network by the completion of the transition period. Services will be reassessed at the end of the transition period as part of routine authorization to ensure that they continue to be appropriate at the current level of care.
Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of postpartum care directly related to the delivery.

If we do not have the direct capacity to provide a medically necessary covered service within the network, arrangements will be made for the continued service to be provided through a single case agreement with an approved non-participating provider.

CONTINUITY OF CARE FOR EXISTING MEMBERS
At the time we are notified of a network transition (i.e., provider group termination or vendor contract termination), a plan will be prepared to provide a coordinated approach to the transition. A good-faith effort will be made to provide written notice of a provider termination (with or without cause) within 15 calendar days to members who are patients of that provider. We shall allow members to continue receiving care for 60 calendar days from the date a participating provider is terminated without cause, unless it is determined by an associate medical director or designee that continued care with the terminated provider would present undue risk to the member or to Colorado Access.

TELEMEDICINE
Telemedicine is the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.

Telemedicine is a way of providing access to healthcare services to members where distance separates the patient and the provider. Telemedicine typically involves two providers: an “originating site” and a “distant site.” The place where the patient is located is the originating site and the provider in another location is the distant site.

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient). Telemedicine services require “live interactive” two-way audio-video communications and adequate technology to allow the provider to render a medical decision. Sometimes the distant site is the only provider involved in the visit, such as with mental health services. Telemedicine does not include visits by phone, fax or email.

The audio and visual telemedicine system used shall, at a minimum, have the capability to meet the procedural definition of the most recent edition of the State of Colorado Uniform Service Coding Standards Manual procedure code modifiers that represents the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology codes that are billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decision-making.

The telemedicine provider assumes all responsibility for:
• Technical support, including that all telemedicine systems are working properly
• Transmission and equipment costs
• Patient authorization for telemedicine services and or waiver of face-to-face contact
• Patient informed consent
• The confidentiality and security of telemedicine services required to examine, diagnose, treat and educate patients at a distance, including but not limited to, secure email, back up, telephone lines, encryption, video cameras, and other computer technology
• Maintenance of all images and information from the telemedicine services as part of the patient’s medical record
• Appropriate billing of telemedicine services
IX. Care Management

Our care management program aims to improve the health of our members. In order to reach this objective, the program focuses on enhancing the communication and coordination among multiple providers, incorporating physical, behavioral and psychosocial issues into the care management process and encouraging member self-management.

Inadequate communication and coordination among multiple providers is a common barrier to optimizing healthcare for beneficiaries. As a result, a primary goal of the care management team is to assist our members in establishing a relationship with a primary care provider (PCP) who acts as a “medical home.” The care management team is available to support this relationship and to assist in communication and coordination as needed.

In addition to its emphasis on communication and coordination, the care management program has been developed with the basic philosophy that in order for care plans to be sustained; the care management process must incorporate physical, behavioral and psychosocial issues. Patients with multiple medical co-morbidities, psychiatric disorders and psychosocial issues are frequently unable to meet their basic healthcare needs. Unfortunately, this often leads to avoidable emergency department visits or hospitalizations as well as a continuous decline in quality of life. Care managers assist in educating and advocating for the special needs of our members.

Another core principle of our care management program is member self-management of medical, emotional and personal issues. This is accomplished by improving self-confidence and motivation, not only through education about specific medical or behavioral conditions, but by teaching skills in goal setting and planning. The objective is for our members to learn these skills to ultimately improve communication with their physicians, pharmacists and other caregivers.

The emphasis on communication and coordination is also present in the coordination of members Medicare, CHP+ and Medicaid benefits. Care managers and the customer service team assist members with locating, identifying and getting connected to providers that accept both Medicaid, CHP+ and Medicare, and or providers that accept only Medicaid. In addition, the customer service and care management teams regularly assists both providers, and members with the nuances associated with Medicare, CHP+ and Medicaid benefits, billing, as well as eligible and non-eligible services. Care managers work with members, providers and the larger community to help members obtain necessary services seamlessly without bias of the member’s status as Medicare and or Medicaid benefit status.

MEASURABLE GOALS OF CARE MANAGEMENT

We identify specific, measurable care management goals which include:

- Improving access to essential services such as medical, mental health, and social services.
- Improving access to quality affordable care.
- Improving beneficiary health outcomes.
- Improving coordination of care through an identified point of contact (e.g., a gatekeeper).
• Improving seamless transitions of care across healthcare settings, providers, and health services.
• Improving access to preventive health services.
• Assuring appropriate utilization of services.

TRANSITION ACCESS PROGRAM
We assist our members with planned and unplanned transitions between care settings. Our Transition Access Program (TAP) care managers notify the primary care provider (PCP) of record within one business day of notification of admission. By providing this notification to the PCP we strive to facilitate comprehensive care transitions, encourage follow-up with PCPs, and to ensure that providers are aware when their patients are hospitalized. All Colorado Access providers are asked to assist with seamless care transitions for our members by ensuring that care plans are sent within one business day for planned and unplanned transitions from the usual setting of care to the hospital and from the hospital to the next care setting.

ABOUT THE COLORADO ACCESS CARE MANAGEMENT TEAM
In addition to the duties noted above, our care management team works with members with a variety of complex medical and/or psychiatric conditions. Members of the care management team include licensed physicians and licensed healthcare professionals with appropriate expertise who are available for regularly scheduled clinical review and consultation as needed.

Furthermore, care managers have a working knowledge of how healthcare needs and member interaction with the healthcare system might vary as a result of the following circumstances:

• Age specific needs and abilities
• Literacy level
• Hearing and /or visual impairment
• Cultural diversity and associated expectations of the healthcare system
• Developmental disability
• Cognitive ability
• Primary language and ability to communicate efficiently with providers
• Motivation to commit to lifestyle changes

Core members of the care management team include medical directors. The medical directors are accountable for clinical components of the care management program. This includes conducting regular clinical supervision meetings to review cases with the care management team and providing day to day clinical guidance.

INTERDISCIPLINARY CARE TEAM
In order to optimize the member’s health status, enhance coordination of services, decrease overutilization, and improve outcomes, our care management team works alongside an interdisciplinary care team (ICT). As the member’s advocate, the care manager brings the member’s issues and concerns to the ICT and assists in the development of the individualized care plan. Additional members of the ICT
include the member (when possible), their family members or caregivers (when requested by the member), the providers working with the member, and other community supports and resources.

Each member of the ICT is involved in the development of the member’s individualized care plan. Active member participation increases the probability that medical services will reach a successful conclusion and the overall health status of the member will be maintained or improved.

Goals of the individualized care plan focus on increasing a member’s ability to manage their own illnesses and increase independence. Primary goals include:

- Self-management
- Member empowerment
- Early identification of problems or worsening symptoms
- Appropriate responses to member problems and/or worsening symptoms
- Disease focused education
- Coordination of needed healthcare services
- Reduction or elimination of barriers to achieving satisfactory health status and functioning
- Regularly reviewed care plans that are kept up-to-date and modified as member needs change

Members may request copies of their care plans at any time and have the option to participate in care conferences as they wish.

In addition to the development of the individualized care plan, the ICT provides the following:

- Coordination of short and long-term goals
- Facilitation of needed care and services
- Assistance in achieving self-management of chronic conditions

**CLINICAL PRACTICE GUIDELINES**

We require that all services be delivered according to published practice guidelines, as they are available. We have identified specific mental health diagnoses where clinical practice guidelines may be of benefit and we will continue to provide resources regarding the availability of guidelines. These resources will be updated on an ongoing basis and can be found on our website at [coaccess.com/practice-guidelines](http://coaccess.com/practice-guidelines).

Guidelines and tools adopted by us are designed to provide information and resources for clinicians, members, family members and other interested parties. The Quality Performance Advisory Committee reviews and recommends adoption of guidelines from recognized sources such as the HealthTeamWorks, professional healthcare and medical associations, and nationally recognized clinical research protocols.
Appendix A: Colorado Access Advantage

BACKGROUND

Colorado Access Advantage Summit Plan is a Dual Eligible Special Needs Plan for members who are enrolled in Medicare Parts A & B and who receive medical assistance from the state (Medicaid).


Colorado Access Advantage Peak Plan is a low premium Medicare Advantage plan that offers additional benefits such as extra vision, and dental care.

Colorado Access Advantage Peak Plan is available in the Denver Metro Area (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson counties), El Paso County, Pueblo County the San Luis Valley (Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache counties), Larimer County, Logan County and Weld County.

Colorado Access Advantage Vista Prescription Drug Plan (PDP) is a prescription only plan that can be added to Traditional Medicare benefits or to a Medicare Advantage Plan.

For more information about Colorado Access Advantage, visit our website at coaccess.com/providers

HOW TO CONTACT COLORADO ACCESS ADVANTAGE
Customer Service

Denver Metro Area ................................................................. 303-751-2657
Toll Free ................................................................................... 877-441-6032
TTY users ................................................................................ 888-803-4494

Customer Service can answer questions regarding provider network issues including benefits, claims, claim appeals, claim status, eligibility and general questions about Colorado Access policies. Customer Service representatives are available Monday through Friday 8:00 am to 5:00 pm Mountain Time (during open enrollment Monday through Sunday 8:00 am to 8:00 pm).

A complete list of our contact information can be located on our website at coaccess.com/contact-information
COLORADO ACCESS ADVANTAGE MEMBER ID CARDS

Once enrolled, we send each Colorado Access Advantage member an ID card. The following is a sample of the ID card:

COLORADO ACCESS ADVANTAGE PLAN ENROLLMENT

Colorado Access Advantage plans are available to individuals with Medicare Parts A&B, who live in the plan service area, and who meet any of the additional criteria listed below:

- Summit Plan – Individuals who receive medical assistance from the State.
- Peak Plan - Medicare individuals who live in the plan service area.

Eligible beneficiaries may enroll directly through Colorado Access or through the Centers for Medicare & Medicaid Services’ (CMS) Online Enrollment Center, located at medicare.gov.
Medicare beneficiaries may be enrolled in only one Medicare health plan at a time. Enrolling in Colorado Access Advantage automatically disenrolls the member from any other Medicare health plan and/or Medicare prescription drug plan.

To remain a member of Colorado Access Advantage, the member must continue to keep Medicare Part A and Part B.

If it is found that the member is not entitled to Medicare Part A and Part B at the time coverage begins and the member has used the plan’s services after the effective date, then the member may be financially liable for those services.

Individuals with end-stage renal disease (ESRD) may not join Colorado Access Advantage unless they have had a successful kidney transplant and no longer need dialysis. However, individuals with ESRD are eligible for coverage under standard Medicare fee for service.

Colorado Access Advantage renews its contract with the federal government annually. Coverage beyond the end of the contract year is not guaranteed.

To learn more about enrollment, visit our website at coaccess.com/access-advantage.

COLORADO ACCESS ADVANTAGE PLAN DISENROLLMENT

Voluntary Disenrollment

A member may disenroll from Colorado Access Advantage by utilizing one of the following methods:

1. Giving or faxing a signed written notice to Colorado Access at 720-744-5115;
2. Giving a signed written notice to any Social Security Administration (SSA) or Railroad Retirement Board (RRB) office; or
4. Enrolling in another Medicare health plan during one of the enrollment periods will end a member’s enrollment in Colorado Access Advantage.

Member Cost Share - Deductibles, Copayments & Coinsurance

Members who do not have full Medicaid as secondary coverage are responsible for certain cost share amounts and may be billed for these amounts. Cost share information will be indicated on the provider voucher. Please see each plan’s Evidence of Coverage on our website at coaccess.com/summary-of-benefits-2015 for cost share details.

Members with Medicaid as Secondary (Summit Plan)

According to CRS § 26-4-403, a Medicaid recipient is not liable for the cost of medical care received during the time the recipient is Medicaid eligible, provided the care is a benefit of Medicaid. In addition, a provider may not bill the Medicaid recipient for the difference between provider’s charges and payment by Medicaid, Medicare, or private insurance. These constraints apply regardless of whether or not Medicaid paid the claim.
Circumstances in Which a Member can be Billed for Services

- A member sees a non-participating provider in a non-emergent, non-urgent, outpatient setting without prior authorization (applies to in-state and out-of-state providers).
- A member does not follow the pharmacy rules (member may have to pay for the medication).
- A member signs a consent form that says he/she will pay the doctor/provider or hospital.
- A member receives non-emergent healthcare services outside of the United States of America.

Health Risk Assessment & Measurement

We use multiple assessment tools that screen for physical/functional, psycho-social and emotional health problems. All Colorado Access Advantage members can receive an initial and annual Health Risk Assessment (HRA). HRA results are analyzed by the care management team and stratified depending on the needs identified. Scoring and stratification methodology is proprietary. The results of the HRA are communicated by the care management team to the ICT and/or licensed healthcare professionals on the care management team. Members with high intensity physical and/or emotional needs receive priority in assistance with accessing resources and/or needed care.

In addition to the HRA, information is collected from other sources and agencies as appropriate and supplemental assessment tools are used by the care management team to assist in development of an individualized care plan.

We measure our Special Needs Plan (SNP) model of care using standardized performance and health outcomes measures. Examples of both service and clinical data that are collected, analyzed, reported, and acted upon, to evaluate the dual eligible model of care include, but are not limited to:

- Utilization monitors such as admissions and readmissions
- Inpatient days per 1,000 members
- Average length of stay (Inpatient)
- ER visits per 1,000 members
- Office visits per 1,000 members
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Complaints and grievance trending
- Secret shopper calls for appointment access
- After-hours access monitoring
- Member satisfaction survey
- Claims monitoring
- Denial and appeal monitoring
- Disenrollment trends
PROVIDER TRAINING REQUIREMENTS UNDER ACCESS ADVANTAGE

The Medicare Managed Care Manual, Chapter 21, Section 50.3.1 requires all providers supplying services to Colorado Access Advantage members to receive general compliance training annually. Fulfillment of this training requirement must be documented. Proof of training may include copies of sign-in sheets, employee attestations or electronic certifications from the providers taking and completing the training. Providers must complete the CMS approved training program titled “Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training” which may be downloaded from the Medicare Learning Network® (MLN) Provider Compliance page located at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

Providers who are enrolled in Medicare Parts A or B must complete Part 2 (“Medicare Parts C and D General Compliance Training”) of the MLN training program on an annual basis. Providers who are enrolled in Medicare Parts A or B are not required to complete Part 1 (“Medicare Parts C and D Fraud, Waste, and Abuse Training”) of the MLN training program on an annual basis.

IMMEDIATE REVIEW PROCESS FOR HOSPITAL INPATIENTS

Required notice to Medicare members

Hospitals must notify Medicare members who are inpatient about their inpatient hospital discharge appeal rights. Hospitals use “An Important Message from Medicare About Your Rights” (IM) which is a statutorily-required notice, to explain the enrollee’s rights as a hospital inpatient, including discharge appeal rights. Hospitals must issue the IM up to seven days before admission, or within two calendar days of admission, must obtain the signature on the form and provide the member with a copy of the signed notice. Hospitals may also need to deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two calendar days before discharge.

The IM must be signed and dated by the member to indicate that he or she received the notice and understands its contents. If a member refuses to sign the notice, hospitals may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

A member who is a hospital inpatient has a right to request an immediate review by the Quality Improvement Organization (QIO) when the Medicare health plan and the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

Members may utilize the Colorado Access Advantage member appeal and grievance process to request the review of an adverse organization determination. Instructions are in the Evidence of Coverage (member handbook).

NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

The NOMNC is a written notice that informs the member that their covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) authorization is
ending. All members receiving covered SNF, HHA, or CORF services must receive a NOMNC upon termination of services, even if they agree that services should end.

We use the Office of Management and Budget (OMB) approved standardized notice which meets the regulated contents requirements:

- The date the coverage of services ends
- The date that the member’s financial liability for continued services begins
- A description of the member’s right to a fast-track appeal
- Including how to contact the independent review entity (IRE)
- The right to submit evidence showing that services should continue
- The availability of other managed access appeal procedures if the member fails to meet the deadline for a fast-track IRE appeal
- The member’s right to receive detailed information why services are either no longer reasonable, necessary or are no longer covered.

We will issue the NOMNC to the SNF, HHA or CORF provider no later than three days prior to the proposed termination of services. The provider is responsible for delivering the notice to the member. The notice to the member may be delivered earlier, but no later than two days prior to the proposed termination of services.

**HOSPICE**

When a Colorado Access member elects a hospice benefit, providers are required to bill the Fee-For-Service (FFS) Fiscal Intermediary (FI) for services rendered unrelated to the member’s terminal illness and/or the provider did not know the member had elected a hospice benefit. Colorado Access enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by the FFS FI as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Covered hospice services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and for services that are covered by Medicare Part A or B related to a terminal condition: Traditional Medicare (rather than our plan) will pay for hospice services and any Part A and Part B services related to the terminal condition.

For services that are covered by Medicare Part A or B and are not related to a terminal condition: Non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to a terminal condition reimbursement is dependent on whether the provider is participating or not:
If services are provided from a network provider, the member pays the plan cost-sharing amount for in-network services.

If services are provided from an out-of-network provider, the member pays the cost-sharing under Fee-for-Service Medicare (Traditional Medicare).

For services that are covered by Colorado Access Advantage but are not covered by Medicare Part A or B: Colorado Access Advantage will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to a terminal condition.

Prevention Perks Programs

Our members are encouraged to participate in various programs aimed at prevention. These programs are at no cost to members and are meant to encourage healthy behaviors. For example some members are eligible to receive a $10 gift card for each of the following services completed during each calendar year:

- Annual wellness exam
- Flu vaccine
- Breast cancer screening/mammograms
- Colorectal cancer screening
- Glaucoma eye exam
- Bone mass measurement
- Cardiovascular screening
- Diabetes self-management training
- Diabetes screening

Members will be required to show proof of receiving the recommended preventive services by submitting a coupon signed by their provider.

To learn more about the Prevention Perks program, visit our website at: coaccess.com/prevention-perks
Appendix B: Access Behavioral Care

Access Behavioral Care operates under the Colorado Access HMO Certificate of Authority and license. As a Behavioral Healthcare Organization (BHO) we are responsible for assuring access to medically necessary behavioral health services to Medicaid recipients in the counties of Denver, Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne. Our key providers consist of the region’s premier safety-net providers for mental health services, including Centennial Mental Health Center, North Range Behavioral Health, Touchstone Health Partners, The Mental Health Center of Denver, and hundreds of individual and organizational providers.

ACCESS BEHAVIORAL CARE IS GUIDED BY THE COLORADO ACCESS CORE VALUES:

**Compassion** – We act with great care and attention for the people we serve. We are driven by the desire to improve lives and communities. We treat each other with respect and kindness.

**Trust** – Nothing is more important than the trust of our members, providers, partners and employees. We operate with integrity at all times and we follow rules and regulations as a matter of principle, not obligation.

**Excellence** – We are driven by helping those we serve achieve positive results. We strive to exceed expectations and create a positive experience for our customers and employees. We demonstrate accountability for delivering high performance, strong results, value-added operations and quality service.

**Collaboration** – We work as a team with our partners in the community. We build on the success and innovation of mission-aligned partners to the benefit of those we serve. We achieve better results when we work together.

**Innovation** – We find new ways to add value with technology, ideas, programs, services, and tools. We are forward-thinking, seeking ways to transform healthcare with innovative approaches and proven solutions. We share and apply lessons we learn to continuously improve and grow.

These core values guide the ongoing development of the Access Behavioral Care provider network. This network represents a comprehensive care delivery system designed specifically for Medicaid and other public sector consumers. Access Behavioral Care serves as a vehicle for coordinating behavioral healthcare services among the providers and provider organizations that serve members enrolled in the plan.
ACCESS BEHAVIORAL CARE CONTACT INFORMATION

Initial Authorization and Reauthorization for Continued Services

Completed forms may be faxed to Access Behavioral Care at 720-744-5130 or mailed to:

Access Behavioral Care
Coordinated Clinical Services
P.O. Box 17580
Denver, CO 80217-0580

ACCESS BEHAVIORAL CARE GENERAL PHONE NUMBERS

Access Behavioral Care Denver 303-751-9030 or 800-984-9133
Access Behavioral Care Northeast 970-221-8508 or 844-880-8508

Use this phone number for:

- Access Behavioral Care service coordinators
- Access Behavioral Care care managers
- Access Behavioral Care help line
- Customer service
- Interpretation services
- Office of Member and Family Affairs
- To obtain materials in languages other than English or copies of the Access Behavioral Care Member Handbook

ACCESS BEHAVIORAL CARE TTY/TDD NUMBER

720-744-5126 or 888-803-4494

CCAR (COLORADO CLIENT ASSESSMENT RECORD) TRAINING

Contact your provider and community liaison for CCAR training.

CCAR Submission

CCARs must be completed and submitted via the website at coaccess.com/our-providers. Providers that are electronically submitting the CCAR directly to DBH should continue to do so. A hard copy of the electronically submitted CCAR must be printed at the provider site to remain in the member’s chart. CCAR instructions can be found at coaccess.com/for-providers.

Psychological Testing Request

Complete the form found at coaccess.com/access-behavioral-care-provider-information and fax to Access Behavioral Care at 720-744-5130.
Quality of Care Concerns

Contact Customer Service at:

Access Behavioral Care Denver: 303-751-9030 or 800-984-9133
Access Behavioral Care Northeast: 970-221-8508 or 844-880-8508

You may also find a form for your use to report a Quality of Care Concern at coaccess.com/access-behavioral-care-provider-information.

Emergency Care

Access Behavioral Care Denver: 303-751-9030 or 800-984-9133
Access Behavioral Care Northeast: 970-221-8508 or 844-880-8508

If the emergency is life-threatening call 911

Access Behavioral Care Crisis Line

877-560-4250

Members in crisis can use this number 24/7 to speak with a licensed clinician

Mobile Crisis Service

Access Behavioral Care Denver: 303-751-9030 or 800-984-9133
Access Behavioral Care Northeast: 970-221-8508 or 844-880-8508
Website: http://coloradocrisisservices.org/

WAITING ROOM GUIDELINES

Our expectation of all providers is that members are seen promptly for outpatient appointments. Members should not be made to wait for long periods of time past their scheduled appointment. We understand that unexpected circumstances arise that may delay appointments or force schedule changes; however, these should be communicated as soon as is reasonable to members to avoid long waits.

Our guidelines for waiting room time are as follows:

- Members will wait no longer than 10 minutes past their scheduled appointment.
- If there is a known situation that occurs prior to a member’s appointment that will force an anticipated wait longer than 10 minutes, the provider should attempt to contact the member by phone or other means to reschedule.
- If the provider is unable to contact the member, the situation should be communicated to the member at check-in.
- The member should be given the option of rescheduling their appointment.
• If the member cannot or does not wish to reschedule, the provider will attempt to reach a compromise solution for the member’s appointment.
• If a compromise cannot be reached, the member will be given the opportunity to contact Access Behavioral Care concerning the situation.
• If a situation arises during the member’s wait that will force a longer wait time, the member must be notified of this as soon as possible and the steps described above must be followed.

We will monitor providers from time to time regarding their adherence to these guidelines. All providers must develop a mechanism to document appointment time and actual time seen.

NOTE: Waiting time guidelines apply only to the scheduled appointment time. If a member arrives early for their appointment, the time spent between their arrival and the appointment time does not count as excessive wait time.

ARRANGING TRANSPORTATION SERVICES
Members who need transportation to mental health services should be directed to Access Behavioral Care so we may facilitate obtaining such services. A care manager or service coordinator can help members access transportation benefits so that arrangements can be made for transportation to appointments.

Total Transit website: http://tticolorado.com/ or call 855-264-6368

MISSED APPOINTMENTS
Access Behavioral Care providers are responsible for actively promoting the continuation of services for those members who unexpectedly miss appointments or discontinue services. In all cases, providers should contact the member at the time of the missed appointment, assess the reason for the missed appointment and the member’s clinical condition, and attempt to reschedule the appointment. An outreach letter or telephone call from the provider is necessary when a member has unexpectedly dropped out of treatment. Clinically appropriate intervention is required in urgent or emergent situations.

Attempts to re-engage members who unexpectedly miss appointments will include provider efforts to determine if there are concerns or barriers that contribute to the missed appointments. When specific problems are identified, providers should attempt to find a solution. Our care managers and peer specialists are available resources for clinicians and members, to assist in promoting continuation of services.

Providers are required to document evidence of their outreach efforts to determine clinical status and presence of barriers that might be remedied, actions taken to promote continuation of needed services, and the member’s response, which may include refusal to continue treatment. In cases involving imminent risk associated with 27-650 criteria, providers must document efforts to initiate crisis services, including inpatient care, if indicated.
MEMBER COPAY
There are no fees for medically necessary, covered services to our members.

Providers may not require a copay for covered services rendered to members enrolled with Access Behavioral Care.

MEMBER AND FAMILY AFFAIRS

- Peer specialists are members or family members who help members get the mental health services they need. They help members arrange transportation to mental health appointments, understand the service delivery system and advocate for their rights and treatment needs. For more information or to refer a member for peer specialist services, call 303-751-9030 or toll free at 800-984-9133.

- The Member and Family Advisory Board meets quarterly to advise Access Behavioral Care staff about member concerns. Members and their families are invited to be active participants of this board. For more information call 303-751-9030 or toll free at 800-984-9133.

- The Partnership Newsletter is sent to all Access Behavioral Care members on a quarterly basis. The newsletter has useful information about member and family activities, health education materials, the Member and Family Advisory Board meeting schedule and agenda, and other helpful program information.

- Training and education on member and family issues, such as cultural or linguistic matters, is a resource available free of charge to Access Behavioral Care providers. For more information, please contact the Director of Member and Family Affairs at 303-751-9030 or toll free at 800-984-9133.

MEMBER MATERIALS
The Access Behavioral Care Office of Member and Family Affairs can provide member handbooks to provider sites for distribution. An Access Behavioral Care peer specialist is available to provide a presentation about rights and responsibilities to members and family members. Please call 303-751-9030 or 800-984-9133.

To obtain materials in languages other than English, or an alternative format such as audiotape or large print, contact Access Behavioral Care at 303-751-9030 or 800-984-9133.

MEMBER RIGHTS AND RESPONSIBILITIES
As an Access Behavioral Care provider, you are required to give members information on rights, responsibilities, grievances and appeals. The form that will need to be placed in the member chart can be found under Access Behavioral Care Provider forms at coaccess.com/access-behavioral-care-provider-information.

The Ombudsman for Medicaid Managed Care
Access Behavioral Care will work with the Ombudsman for Medicaid Managed Care, and will inform members about its services and how to access them. Please contact the Access
Behavioral Care Office of Member and Family Affairs at 303-751-9030 or toll free at 800-984-9133 for more information.

To contact the Ombudsman directly, call 303-830-3560 or toll free 877-435-7123, or for the deaf or hard of hearing TTY 888-876-8864.

**MEMBER GRIEVANCES AND APPEALS**
Members and their families have the right to the highest quality care. Access Behavioral Care provides education to members regarding their rights, and how to file a grievance. Access Behavioral Care providers should inform members of their right to file a grievance or appeal. A provider must be a member’s DCR in order to submit a grievance or appeal on behalf of a member. A member’s grievance or appeal will be completed without adverse consequences or retaliation. A provider, acting on behalf of a member, may request a State Fair Hearing.

The instructions for members filing a grievance or an appeal are located in the member handbook and on our website at coaccess.com/general-forms-information. Providers should have copies available during Access Behavioral Care member intake.

Access Behavioral Care’s member grievance and appeals process will provide a consistent approach to collecting, tracking and trending information. Resolution will be timely and appropriate to the members concerns.

**INDIVIDUALIZED SERVICE PLAN (ISP)**
An Individualized Service Plan (ISP) must be developed and annually updated for each member. ISP treatment goals and services should be developed collaboratively with the member and member’s family (if appropriate).

**Member and Family Member Participation in Treatment Planning**
Members should be actively involved at all stages in the development of their Individual Service Plan (ISP).

The member should be an active participant with the clinician in the assessment of needs, and in the development of goals and objectives. Their preferences regarding services and type of clinician(s) (age, gender, cultural awareness, language, etc.) should be identified at all points: at intake, assessment, during the development of the ISP, and during review of the ISP.

While the involvement of the member’s family or legal guardian(s) is mandatory for children and adolescents, we expect this level of involvement for adults and older (geriatric) adults, as well. Specific requirements to assure this involvement include:

An assessment (initial and ongoing) will be conducted at sites that are convenient to the
member and family. This may include conducting assessments when indicated at school, home, the place of residence (for members in alternative care or nursing home settings), detention centers, hospitals, clinics and other outpatient settings during times that are convenient for the member/family in settings that are comfortable and accessible.

**Individualized Service Plan Standards**

1. Service plans are consistent with the assessment and diagnoses and contain individualized goals related to needs identified in the assessment. Whenever possible, service plan goals reflect member self-determination and choice. If all identified needs are not addressed, a rationale is documented.

2. Service plans are written with strength-based language, i.e., positive, nonjudgmental, skill- and growth-oriented terms. Service plans are written in clear, easily comprehensible language that takes into account the age, cultural considerations, and cognitive ability of the member, and whenever possible, uses the member’s own words in defining goals.

3. Service plan goals or objectives are specific and measurable, and include types and frequencies of services, and estimated time frames for goal attainment or problem resolution.

4. All services provided by the mental health center, clinic, and other service provider(s) are integrated into the service plan (e.g. individual, group, family, case management, residential, vocational, medication management, substance abuse treatment, psychosocial rehabilitation, non-traditional services).

5. The person primarily responsible for overseeing and coordinating services will be prominently identified on the service plan as the care coordinator.

6. There is a crisis plan for any member prone to crises due to mental illness.

7. For children and adolescents, the service plan includes family/guardian involvement and coordination with appropriate school personnel when mental health issues affect the member’s performance in school.

8. Evidence of member and/or member DPR participation in the development of the service plan and any revisions or updates is documented by means of member or DPR signature. If the member or DPR does not agree with all or part of the service plan, the reason is documented. If there is no member or DPR signature, a valid reason for missing signature is documented.

9. The service plan is reviewed and signed by the clinician and the clinician’s supervisor (if the clinician is not licensed). The service plan is not valid until the last required signature is obtained, or documentation explaining why a signature was not obtained is present.

10. The service plan and assessment is reviewed and updated as necessary with the member at least every 12 months, or when a change in the member’s condition or service needs occurs, or monthly for members receiving involuntary treatment pursuant to CRS 27-65-101. Reviews include evidence of progress made toward service plan goals and/or changes in service needs, and evidence of member participation in the review and update (signature) and involvement of other stakeholders.
Documentation of Active Treatment

1. The focus of treatment interventions is consistent with the service plan goals and objectives. Progress notes clearly reflect interventions related to service plan goals, and member response to treatment interventions.

2. Treatment interventions reflect the cultural perspectives, practices and/or beliefs of the member and/or family. All services are provided or coordinated in a culturally sensitive manner. Services are provided in a language or format that is easily understood by the member.

3. The CCAR is updated annually at a minimum, showing evidence of review and changes in status (Exceptions: meds-only or inactive status). The updated CCAR is consistent with other clinical information in the record at the time of the update.

4. A progress note is written for each billable service, and reflects progress toward goals and objectives from the ISP. Progress notes include the date and type of service, the time and duration of discrete services, the level of the member’s participation in therapy, and the member’s strengths and limitations in achieving goals/objectives.

5. Each record indicates medications that have been prescribed, the dosages of each, the dates of initial prescriptions or refills, and member education on the medication name, its prescribed use, and reason for prescribing the medication, and description of expected benefits, common side effects, major risks, and probable consequence of not taking the medication.

6. Medication reviews occur at a minimum of every 3 months for voluntary clients, unless otherwise indicated on the service plan and justified by the physician. For medications with frequent and/or potentially serious side effects, there is evidence that lab and other tests are ordered and reviewed by the physician as indicated by accepted standards of medical care.

7. The treatment record reflects continuity and coordination of care efforts between the primary clinician, PCP, ancillary providers and institutions, and consultants. Case management documentation may include phone calls to other involved professionals or systems, linkage to community supports and resources, follow-up, or advocacy. Continuity of care functions between persons, agencies, or institutions is evidenced by documentation that referral information has been provided, appointments have been secured for the member, and barriers to accessing services have been addressed. Progress notes reflect the person, agency, or institution contacted and the content of contacts.

8. Members who become homicidal, suicidal, or unable to conduct activities of daily living during the course of treatment are promptly referred to the appropriate level of care. There is clear documentation of crisis management interventions and responses, including description of transportation method in case of imminent risk, disposition, and follow-up.

9. The clinical record documents preventive services as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources). Evidence of referral to preventive programs or services may be included in the progress notes, service plan, or discharge summary.

10. There is evidence of attempts to re-engage members when appointments are missed.
11. For members that have unexpectedly missed appointments, the clinical record documents that the provider or their designee has made an outreach telephone call at the time of the missed appointment. For unplanned discontinuation of services, there is evidence of an outreach letter or telephone call. Documentation in either case includes evidence of efforts to determine clinical status, if there is a problem that can be remedied, actions taken to promote continuation of needed services, and the member’s response.

Discharge Planning Standards

1. The clinical record contains a discharge summary to ensure continuity of care, that includes a summary of the services provided, the reason for transfer or discharge, member status, progress toward achieving treatment goals, follow-up appointments or referrals, and who and where the member/family may call for additional services if necessary.

2. A discharge CCAR is completed. The CCAR information is congruent with the information in the clinical record at the time of discharge.

Special Population Standards

1. Medication-Only Status:
   a. There is documentation of a medication-only approval by the physician, which includes:
      i. An assessment that determines that medication-only is the appropriate service,
      ii. The reasons that a medication-only level of care is adequate and sufficient (e.g., the individual has supports and/or ancillary care providers in the community and/or has reached maximum benefits from other treatment modalities), and
      iii. The physician’s signature on an assessment, chart note, and/or service plan.
   b. For transfers to medication-only status, there is documentation that the clinician/case manager:
      i. Concurs with medication-only status, and
      ii. Has reviewed the meds-only treatment option with the member.
   c. There is documentation initially and annually thereafter that the member concurs with medication-only status.
   d. A service plan placing the voluntary member on medication-only status is completed, which includes:
      i. The rationale for medication-only status,
      ii. The frequency of medication-only physician reviews of the medication(s), and
      iii. Justification by the physician if the frequency of medication reviews differs from the three month review requirement.
   e. The CCAR is completed when an individual has been placed on medication-only status, and upon reactivation of regular status or discharge from meds-only status. Medication-only status is indicated on the CCAR. Annual CCAR updates are not required.
   f. The physician’s signed progress notes serve in lieu of medical necessity and/or service plan updates. The physician’s notes must:
i. Be completed per the time frame indicated on the service plan,
ii. Include documentation of the services provided,
iii. Include documentation of ongoing assessment and plan, and
iv. Include documentation of any medical issues.
g. There is no evidence that the member has received services other than an isolated case management contact, including clinical case management more than once monthly or emergency services that would indicate need for return to regular status.

2. OBRA/PASARR (for members residing in a long-term care/nursing facility)
a. There is a Pre-Admission Screen and Annual Resident Review (PASARR)

   a. There is evidence that Level II recommendations were addressed and/or appropriate referral(s) made.
   b. The service plan is current, addresses Level II recommendations, and includes case management with the nursing facility.
   c. There is evidence of coordinated service planning with the nursing facility.
   d. There is documentation of consideration of a less restrictive placement.

4. Outpatient Certification:
   a. There is documentation that the member was advised of his/her rights and received a written copy of the rights.
   b. There is evidence that the member was given the name and telephone number of the patient representative.
   c. All required paperwork is complete and contained in the record, including the court order for court-ordered medications.
   d. The form to petition the court and supporting letter is complete and timely.
   e. The court order upholding the certification is contained in the record.
   f. The Imposition of Legal Disability is noted in the service plan.
   g. The service plan includes accessing medical and emergency services, as well as other needed goods and services.
   h. The necessary level of functioning to terminate certification is indicated in the plan
   i. The member has been offered a copy of the service plan.
   j. There is evidence that need for certification is reviewed monthly by a professional person.
   k. The service plan is reviewed and revised monthly as needed, by a professional person.

5. Conditional Release:
   a. All conditional release conditions are included in the service plan.
   b. Approval of any changes to conditional release conditions are documented in the chart.
   c. There is evidence of ongoing coordination and annual review of the service plan between the Colorado Mental Health Institute at Pueblo and mental health center.
   d. There are lab tests for medication compliance for persons with a history of violence.
   e. Quarterly reports are submitted in a timely manner to the District Attorney.
Satisfaction surveys will be administered on an ongoing basis to assess whether members feel they have been adequately included in the process.

IN VolVEMENT OF FAMiLy MEMBERS AND ThEraPISTS IN ONGoING TREATMENT
It is important to involve family members and other supportive individuals in the treatment process, at the member’s request. This allows the family and others to be informed about the member’s needs so that they can better understand how to support the member in his or her recovery process.

COLORADO ClIENT ASSESSMENT Record (CCAR)
The Colorado Client Assessment Record (CCAR) is a multi-page state-mandated form for assessing a member’s clinical status, level of functioning, and available strengths and resources. The CCAR is required for all members, and must be completed for each member and submitted to Access Behavioral Care, according to state guidelines. The CCAR manual is also available on our website at coaccess.com/access-behavioral-care-provider-information.

Training on CCAR completion may be obtained from your Provider and Community Liaison or through the Division of Behavioral Health (DBH). Access Behavioral Care will send notification of the periodic CCAR training offered by DBH.

Disclosure of clinical record information must be made in accordance with all applicable State and federal laws, including HIPAA and HITECH. You can find more information regarding HIPAA at coaccess.com/privacy-security-of-member-information.

An authorization to release information must be signed and dated by the member, legal guardian, or (individual legally authorized to act on behalf of the member), if applicable, and specify the type of information to be released, the person or agency to whom information is being released, the reason for release of information, the period for which the release is valid (no longer than one year) and the right to revoke the release of information in writing by the member, legal guardian, or DPR if applicable, at any time. A link to a release of information form that you can print coaccess.com/access-behavioral-care-provider-information. In an emergent clinical situation and in the absence of consent, the basis for release of information and to whom information was released must be documented.

EVIDENCE BASED PRACTICES
We have processes for seeking resources for measuring performance in evidence-based and promising practices (EB/PPs). Evidence-based practices include those that show results as demonstrated through rigorous research, which is published and available to clinicians for review and adoption in their work with members. Promising practices are those that appear to be leading to demonstrable efficacy and are followed by the research community.

Our primary goal is to increase service quality and to work with our providers to promote continuing improvement and accountability. Collaboration between Access Behavioral Care and providers is
ongoing and we work to engage providers in efforts to adopt and utilize evidence-based and promising practices.

Please refer to the information provided by the United States Department of Health and Human Services on the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Mental Health Information Center webpage: nrepp.samhsa.gov/Index.aspx.

Clinical practice guidelines and evidence-based practice resources are available from the following sources:

- National Guideline Clearinghouse (guideline.gov/)
- Substance Abuse & Mental Health Services Administration (SAMHSA) Guide To Evidence-Based Practices (EBP) on the Web samhsa.gov/ebpwebguide/index.asp
- Substance Abuse & Mental Health Services Administration (SAMHSA) Evidenced Based Practices Toolkit (nrepp.samhsa.gov/Index.aspx)

From time to time, we provide guidance regarding particular therapies and treatment methodologies. You can find these documents on our website at coaccess.com/practice-guidelines. Although we do not generally prohibit or restrict providers from advising members about any aspect of his or her health status or care, we do require that treatment fall within the guidelines of the clinical opinions that are published on our website and according to generally accepted treatment standards as indicated in published clinical guidelines. We encourage providers to advocate on behalf of a member, or advising about alternative treatments regardless of whether such care is a covered service under the Medicaid contract, as appropriate. If you have questions regarding this information, please do not hesitate to contact us.

EPSDT SERVICES
For children and adolescents through age 20, providers are expected to contact the PCP for results of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exams.

EPSDT is a healthcare program for Medicaid recipients, up to and through 20 years of age. The EPSDT program detects and treats health problems early by providing regular medical, dental, vision, and hearing check-ups, diagnosis, and treatment. Under federal Medicaid requirements, any service necessary to treat healthcare needs identified through an EPSDT screening must be provided through the Medicaid program even if the identified service is not included in the State’s Medicaid plan.

The mental health provider should determine if the EPSDT screening has been conducted by the PCP. With the member’s or guardian’s permission the mental health provider can obtain and review the results of the screening, especially those findings that indicate a need for mental health services. If an EPSDT screening has not been done, the mental health provider should refer the family to their PCP with a recommendation that an EPSDT screening be done. If the youth does not have a PCP, the family may be referred to their Medicaid health plan, if they are enrolled in one, or to HealthColorado, the Enrollment Broker for the Medicaid program, at 303-839-2120 or toll free 888-367-6557. Families should request a PCP to conduct screening under the EPSDT program.
Access Behavioral Care providers, with written consent from the member, are expected to communicate with the member’s PCP to coordinate any significant physical and behavioral healthcare needs, or attempt to link members to a PCP through referral to their health plan or HealthColorado (as stated above). This is particularly important for members who may be taking prescription psychiatric medication.

We ask that providers inquire about medical issues with members and follow the procedures described below:

1. As soon as it is therapeutically appropriate, the mental health provider should obtain (a) release(s) from the member in order to communicate with the member’s PCP and other medical providers. This should be done as early in the intake evaluation or treatment episode as possible, preferably at the first face-to-face contact. The attempt to obtain release(s) of information should be documented in the member’s clinical record if the member or guardian declines to give authorization. Levels of disclosure that the member may select are:
   a. Release of any applicable information to and from the mental health provider including:
      i. Diagnosis
      ii. Treatment plan
      iii. Medication
      iv. Results of lab tests and consultations
   b. Information on how the mental health provider and PCP/physical health provider may contact one another
   c. Release of EPSDT screening findings only (for youth)
   d. Release of medication information only to and from the physician or
   e. Not to release information to or from the provider

A sample of the PCP Communication form is available on our website at coaccess.com/access-behavioral-care-provider-information.

2. To facilitate continuity of care, the provider should communicate with the PCP when any of the following occur:
   a. Initiation of treatment
   b. Initial prescription of psychiatric medications
   c. Significant changes in prescribed medications
   d. Changes in the member’s clinical condition that could potentially impact his/her overall medical care

3. The provider should also request the member’s permission to obtain from the PCP any pertinent medical information that might be a factor in mental health treatment and diagnosis.

In general, when coordinating care with other service providers, providers may only release the information authorized by the member or his/her guardian. Any communication by telephone must be documented in the clinical record and any written communications should be contained in or copied for
the clinical record. Coordination of care efforts should be documented on the service plan as a case management function.

As part of the Access Behavioral Care Quality Assessment and Performance Improvement Program (PIP), documentation of provider care coordination activities may be reviewed, including:

- Presence in the clinical record of a signed Authorization(s) to Request/Release
- Information form to the PCP and other physicians or service providers
- Presence in the clinical record of a letter or other treatment notification form to the PCP If authorized, inclusion of documentation in the member’s clinical record of communication with the PCP including when the communication took place, a general description of information shared, and method of communication
- If the member or guardian refuses to sign a release form, documentation of this within the member’s clinical record
- Documentation of coordination of care functions in the member’s individualized service plan

SERVICES PROVIDED BY ABC
We have many kinds of behavioral health care services for individuals and families and will help clients find what works best for them. Services include:

- Outpatient treatment
- Day treatment
- Psychosocial rehabilitation
- Case management:
- Medication management:
- Emergency services
- Inpatient services
- Residential services
- Home-based services for children and adolescents
- Evaluations/assessments
- Deaf and hard of hearing services
- Vocational services
- Senior services
- Peer support

For more information on services that are provided by ABC please visit coaccess.com/services-offered.

EMERGENT AND URGENT SERVICES
Access to emergency services must be made available to Access Behavioral Care members 24 hours a day, 365 days a year at multiple points of entry across a continuum of providers.
We require emergency services to be available by telephone within 15 minutes of the initial contact, and if clinically indicated, in person within one hour of initial contact in urban and suburban areas, or within two hours within rural areas.

**COVERED EMERGENCY SERVICES**

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Provider Locations</th>
<th>Time to Service</th>
<th>Benefit Limit</th>
<th>Authorization Necessary?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Evaluation</td>
<td>Any hospital emergency room or other member location</td>
<td>• Within 15 minutes by phone</td>
<td>No limit if service is determined by Access Behavioral Care to be necessary to treat a mental illness</td>
<td>No</td>
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<td></td>
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<td>• In person within 1 hour (urban or suburban areas)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In person within 2 hours (rural areas)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>Hospitals serving Medicaid patients</td>
<td>Immediately following determination of need for hospital treatment</td>
<td>No limit if service is determined by Access Behavioral Care to be necessary to treat a mental illness</td>
<td>Yes, to be obtained by provider</td>
</tr>
<tr>
<td>Acute Treatment Unit (ATU)</td>
<td>See provider directory on our website</td>
<td>Immediately following identification of need for ATU treatment</td>
<td>No limit if ATU treatment is determined by Access Behavioral Care to be necessary to treat a mental illness</td>
<td>Yes, to be obtained by provider</td>
</tr>
<tr>
<td>Post- Stabilization Services</td>
<td>Hospitals serving Medicaid patients</td>
<td>Immediately following crisis stabilization</td>
<td>No limit if service is determined by Access Behavioral Care to be necessary to treat a mental illness</td>
<td>Yes, to be obtained by provider</td>
</tr>
</tbody>
</table>

Access Behavioral Care members have access to the following emergency services:
Access Behavioral Care

PROVIDER MANUAL

Access Behavioral Care:

Access Behavioral Care Denver: 303-751-9030 or 800-984-9133
Access Behavioral Care Northeast: 970-221-8508 or 844-880-8508

Members in need of emergency services can access this telephone line 24 hours a day. The line is staffed by qualified clinicians. Depending on the type and severity of the situation, the clinician may direct the caller to the nearest hospital emergency department, dispatch the Mobile Crisis Team to further assess the situation, or access law enforcement assistance.

Provider Sites: During normal business hours, we expect members to be able to receive urgent and emergent access by calling their established provider. We encourage all providers to offer walk-in emergency services whenever this service is feasible. All providers must have the ability to accept or re-direct emergency member calls after hours.

Emergency Departments: Members may also call or go to the nearest hospital emergency department to obtain emergency services. The Access Behavioral Care provider network includes all area hospital systems. Contracts are in place for these hospitals to provide emergency evaluation and treatment at all times. Members may receive emergency services from any emergency room provider, in or out of the geographic service area, without the need to pre-authorize services.

AUTHORIZATION FOR EMERGENCY ROOM AND OBSERVATION SERVICES
Members identified as needing emergency services should be referred directly to the nearest hospital emergency department. The hospitals with whom we work most closely are:

- University of Colorado Hospital ........................................ 720-848-9111
- Children’s Hospital Colorado ........................................... 720-777-6888
- Denver Health Medical Center ........................................... 303-602-8100
- Medical Center of the Rockies Trauma Center .................. 970-624-2500
- Platte Valley Medical Center ........................................... 303-498-1999
- North Colorado Medical Center Emergency Room ............. 970-350-6244
- Banner North Colorado Emergency Care ....................... 970-395-2636
- University of Colorado Health Greeley Emergency Center ...... 970-392-4360

While prior authorization for emergency room and observation services is not required, Access Behavioral Care must be notified of all emergency care rendered. An Access Behavioral Care Contact and Triage form and Application for Authorization of Services form (located online at coaccess.com/access-behavioral-care-provider-information) must be forwarded to Access Behavioral Care, preferably at the time of service, but no later than 24 hours after delivery of the service. Forms may be faxed to Access Behavioral Care at 720-744-5130.
In situations where members access emergency services directly, emergency care providers are required to contact Access Behavioral Care to communicate post-emergency plans and authorization of post-emergency care. Requests for authorization can be submitted 24 hours a day, seven days a week.

**URGENT CARE SERVICES**

An urgent situation is one that is likely to become an emergency in the absence of prompt treatment. We require urgent services to be provided within 24 hours of the initial contact by the member, family member, or DPR.

Urgent care services can be provided at any provider site based on appointment availability. Members can directly contact any of our provider service sites or call us at:

- **Access Behavioral Care Denver**: 303-751-9030 or 800-984-9133
- **Access Behavioral Care Northeast**: 970-221-8508 or 844-880-8508

If a provider is unable to meet the 24 hour timeframe for urgent services, it is expected that the member, family member, or DPR be referred to Access Behavioral Care for assistance in accessing urgent services. Access Behavioral Care service coordinators can be reached by calling:

- **Access Behavioral Care Denver**: 303-751-9030 or 800-984-9133
- **Access Behavioral Care Northeast**: 970-221-8508 or 844-880-8508

**Initial Triage Assessment**

Members can access mental health services by calling Access Behavioral Care for assistance with finding and scheduling an appointment with a provider, or by contacting an Access Behavioral Care provider directly. Calls requesting specific needs will be referred to a care manager, most of who are licensed and experienced clinicians. Care managers may conduct a brief triage assessment by telephone to assist a member, family member, or DPR with referrals to the most appropriate provider.

All assessments performed by providers will identify service needs by evaluating the member’s current clinical status.

**Special Populations**

If a member accessing services at a provider site is identified as belonging to a special treatment population, the member may be referred back to a care manager to ensure an appropriate member/provider match. Special treatment populations would include members with dual diagnoses or co-morbidities such as mental illness and substance abuse, developmental disability, and/or active medical problems. Service coordinators are also able to assist members with special language needs, those who are deaf or hard of hearing and members with specific cultural, linguistic or other identified needs.
AUTHORIZATION OF HIGHER LEVELS OF CARE, INCLUDING INPATIENT SERVICES

Initial Authorization

All new treatment episodes for higher levels of care, including but not limited to residential treatment, day treatment, in-home services, and inpatient psychiatric care require prior authorization by Access Behavioral Care. Both the Initial Contact and Triage form and the Application for Authorization/Reauthorization of Services form are required to be completed in full.

The completed forms may be faxed to Access Behavioral Care at 720-744-5130, or mailed to:

Access Behavioral Care
Coordinated Clinical Services
10065 E. Harvard Avenue - Suite 600
Denver, CO 80231

Reauthorization for Continued Services

All requests for ongoing non-routine services beyond the initial authorization require reauthorization. The Application for Authorization/Reauthorization of Services form is the only form required. It must be completed and submitted to Access Behavioral Care prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility.

Concurrent Reviews

Authorizations for higher levels of care such as residential treatment, day treatment, are reviewed by Service Coordinators on a regular and ongoing basis throughout the episode of care. The Service Coordinator will normally contact the provider early in the episode of care for initial review of the episode of care, and then will establish a schedule for follow-up reviews. The subsequent reviews are normally conducted telephonically or onsite.

Access Behavioral Care service coordinators conduct inpatient reviews within one business day of notification to verify that the admission meets inpatient criteria, establish continued stay review requirements and timetable, and initiate discharge planning. Subsequent concurrent review assessments are performed to assure continued stay criteria are met. The medical director reviews all admissions and stays that do not meet medical necessity criteria. If a request for an extended length of stay is denied by the medical director, the provider and attending practitioner will be notified and may request a peer-to-peer review within one business day. Payment will be made only for the authorized length of stay. We will provide written notice of a denial to the attending provider, the member, and, if appropriate, guardian or individual representing the member. All clinical denials are subject to our appeals procedures. Requests for peer-to-peer conversations are not considered complaints or appeals.
REDUCTION IN OR DISCONTINUATION OF SERVICES
Through the care coordination process, we will work in conjunction with the treating provider to determine the most appropriate medically necessary services at the least restrictive level. Treatment plan review may show that a discontinuation or a reduction of service is indicated. The treating provider will discuss the proposed treatment plan with the member. If the member agrees with the proposed treatment plan, the treatment plan will be implemented.

The member’s agreement with the changes in the treatment plan should be documented in the member’s clinical record.

REMEMBER: Members should be full participants in service planning and treatment decisions. The member has the right to not accept a proposed treatment plan that would result in reduction or discontinuance of services. In a situation where the member disagrees with an Access Behavioral Care decision to reduce or discontinue services, he/she can request an appeal, following receipt of the notice of action. We will mail the notice at least 10 days before the effective date of reduced or discontinued services. The notification will contain information regarding the member’s right to appeal and an explanation of the process to request a review.

DISCHARGING FROM MENTAL HEALTH SERVICES
Upon completion of the treatment plan, or when Access Behavioral Care, the provider, and member agree to discontinue treatment, a discharge from services will occur.

The steps in the discharge process are as follows:

1. The provider will complete a discharge summary and discharge CCAR
2. The service coordinator closes the case for this episode of care
1. Each page in the clinical record contains the member’s name or ID number.
2. All entries in the clinical record and service plan are signed, with the responsible clinician’s name and professional degree.
3. All entries are dated, including all member visits, telephone calls, and provider notes or initials on laboratory reports.
4. The record is legible to someone other than the writer.
5. Personal/ biographical data includes the following: name, address, date of birth, home telephone, employer or school, work telephone if applicable, marital status, legal status (voluntary or court-ordered treatment), and emergency contact (name, address, and telephone number of guardian, significant other, or next of kin).
6. Consent for psychiatric services, or authorization for treatment of a minor, is documented. (Exception: Minors age 15 or older may enroll in mental health treatment without parental consent.) When custody is shared, signature of both parents is recommended.
7. A professional disclosure statement is reviewed and signed by the member. Where services will be provided by multiple providers, the primary clinician makes the disclosure. (Exception: This does not apply to MDs or nurses.) The disclosure statement is clear and explanatory of the
practitioner’s names, highest degree and state license if applicable, supervisor if applicable, and the provider agency or institution.

8. Member is notified of specific rights and responsibilities including the right to file a grievance, grievance and appeal procedures including where to call or write, the right to confidentiality, and the right to review the clinical record. Member rights are available in this manual, on the website, or upon request.

9. Authorization to release information, signed and dated by the client or DPR, is present for every instance in which information has been requested or shared with external sources. Release of information forms specify that the release is valid for no longer than one year and may be revoked in writing by the member, parent, or DPR at any time. In an emergent situation and in the absence of consent, the basis for release of information is documented. There is also documentation that the member has been informed about what information is being released and to whom.

10. Completed Access Behavioral Care Contact and Triage Form (if applicable)

11. AMDs or evidence of provider advisement on advance directives.

Assessment Standards

1. The chief complaint, referral source, the presenting problem(s) or family’s understanding of the problem, history and duration of the problem are clearly documented, including the member’s perception of why services are needed, circumstances leading to treatment at this time, precipitating events, current symptoms, changes in functioning, and impact on family.

2. Psychosocial history and conditions affecting the client’s medical and psychiatric status includes at a minimum assessment of the following areas:
   a. Current living arrangements and conditions
   b. Custody/guardianship status (children and adolescents)
   c. Strengths and resources of the member and the family/support system
   d. Peer and interpersonal relationships
   e. Educational and employment history
   f. Academic performance and behavior (children/adolescents)
   g. Past or present legal problems
   h. Military history if applicable
   i. History of neglect, physical or sexual abuse or perpetration, and current risk
   j. Current and past involvement with human service agencies and/or correctional system

3. Cultural factors and considerations impacting the members beliefs and healthcare seeking behavior includes at a minimum discussion of the following areas:
   a. Race
   b. Color
   c. National origin
   d. Sex
   e. Religion, religious/spiritual beliefs
   f. Creed
g. Ethnicity
h. Language, effective communication needs
i. Age
j. Sexual orientation
k. Beliefs
l. Cultural perspectives
m. Individual values
n. Customs
o. Norms
p. Family

4. For children and adolescents, a complete developmental history and assessment is documented, including the following elements:
   a. Significant prenatal and perinatal events
   b. Physical growth and development
   c. Emotional growth and development
   d. Social development, peer relationships, and family dynamics
   e. Cognitive/intellectual growth and development
   f. Academic/school adjustment
   g. Daily activities and interests

5. Psychiatric history is easily identified, including co-occurring conditions, previous treatment dates, locations, provider identification, therapeutic interventions/responses, results of laboratory tests and/or consultation reports as applicable, and family history of medical, psychiatric, and/or substance abuse conditions. Records from previous treatment facilities or providers are obtained when indicated, with the required consent. Assessment includes need for medications and/or need for evaluation performed by a psychiatrist.

6. Medical history and conditions are listed, prominently identified and revised as needed. Assessment of physical health status includes evaluation of medical conditions producing psychiatric symptoms, and attention to medical issues specific to older adults.

7. There is a signed release of information to the PCP to facilitate communication with the PCP either by telephone or in writing. Any communications with the PCP, if authorized, are documented, including when communication took place, method of communication, and general description of the information exchanged or requested. Member refusal to sign a release of information to the PCP is documented. A referral is documented when a physical health problem is identified or suspected, and the member does not have a PCP.

8. For youth ages 0-21, there is documentation that Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam results were requested from the Primary Care Provider (PCP), and reviewed if obtained. A referral is documented when EPSDT screening has not been done or the child does not have a PCP.

9. Allergies and adverse reactions to pharmaceuticals and other substances, or lack thereof, are prominently listed in assessments, medication tracking sheets, and/or self-reported medical history, and identified on the chart cover.
10. For all members age 12 and older, past and present substance use of cigarettes, alcohol, and any past or present use of illicit, prescribed, and/or over-the-counter drugs is documented.

11. A mental status evaluation including the following elements is documented:
   a. Presentation/appearance
   b. Speech
   c. Mood and affect
   d. Intellectual functioning
   e. Thought process
   f. Thought content
   g. Attention
   h. Concentration
   i. Memory
   j. Impulse control
   k. Judgment
   l. Insight

12. Safety and risk assessment of special status situations, such as risk of harm to self or others, suicidal ideation, or elopement potential, is prominently noted, and includes documentation of the clinician’s course of action/intervention and member response to safety plan.

13. DSM-V diagnoses on all five Axes are noted and are consistent with the presenting problems, history, mental status examination, and other assessment data. Documentation contains sufficient DSM criteria to support a working diagnosis or any changes in diagnosis.

14. An admission Colorado Client Assessment Record (CCAR) is present and the information contained in the CCAR is congruent with information in assessment data, e.g., mental status, psychosocial history, and clinical interview.

FORMS
The Initial Contact and Triage form must be completed in full for all Access Behavioral Care members receiving services other than routine outpatient services and submitted to Access Behavioral Care. The form and instructions for its completion can be found at coaccess.com/access-behavioral-care-provider-information and may be faxed to us at 720-744-5130.

The Application for Authorization/Reauthorization of Services is required for authorization of all levels of care other than routine outpatient care. This form may also be used to request an extension or reauthorization of services. The form can be found at coaccess.com/access-behavioral-care-provider-information, and may be faxed to us at 720-744-5130.

The CCAR is a State-mandated form to be filled out according to the rules promulgated by the Office of Behavioral Health. These rules, as well as the specific instructions for completion of the CCAR and its submission can be found at coaccess.com/access-behavioral-care-provider-information.

Training for the CCAR may be obtained by contacting your Provider and Community Liaison. CCARs must be completed and submitted via the website at coaccess.com/our-providers.
Providers that are electronically submitting the CCAR directly to OH should continue to do so. A hard copy of the electronically submitted CCAR must be printed at the provider site to remain in the member’s chart.

**Psychological Testing Request Form**

A request for psychological testing requires submission of a specialized form, which can be found at coaccess.com/access-behavioral-care-provider-information and faxed to us at 720-744-5130. Information must include the reason(s) for the request and should include copies of other consultations or assessments performed.

**Primary Care Provider (PCP) Communication Form**

Providers should routinely notify the member’s PCP of mental health services, using the form found at coaccess.com/access-behavioral-care-provider-information:

- At the outset of care
- When changes in the member’s status occur that may impact medical condition(s)
- When medications are prescribed or changed

Information about clinical documentation and forms can also be found on our website at coaccess.com/access-behavioral-care-provider-information. Please contact us if you have any questions about required clinical documentation.

**Auditing**

We are required by the Department of Health Care Policy and Financing (HCPF) to perform a data validation audit annually to ensure that providers maintain complete and accurate chart records for ABC members. Each year, HCPF defines the scope of the audit to include 411 chart records from providers selected randomly, audited against certain data fields determined by HCPF and the coding requirements of the USCS Manual.
Appendix C: Child Health Plan Plus (CHP+) offered by Colorado Access

BACKGROUND
Starting in 1998, Colorado Access began serving low-income children through Child Health Plan Plus (CHP+) offered by Colorado Access. As the State’s largest CHP+ Managed Care Organization (MCO), the plan currently serves children in 44 counties up and down the Front Range and in the Eastern Plains. Members of CHP+ offered by Colorado Access receive benefits beyond the standard CHP+ benefit package, including additional vision benefits, reduced prescription copayments, coverage of over-the-counter medication with a doctor’s prescription, additional hearing aid benefits, additional PT/OT/ST visits and special healthcare programs for diseases such as diabetes, depression and asthma.

Child Health Plan Plus (CHP+) is a part of Colorado Access, a nonprofit health plan. Colorado Access is dedicated to the operation of a competitive health plan designed to improve access to needed healthcare directly for enrolled members, and indirectly through its partners, to all underserved Coloradans with an emphasis upon primary care and the maintenance of the continuum of care.

ENROLLMENT
In order to enroll in CHP+ offered by Colorado Access, children must be eligible for CHP+. The State CHP+ program or the County Department of Human/Social Services determines eligibility through the Colorado Public Health Insurance for Families Application. A copy of this application is located online at colorado.gov/hcpf/how-to-apply. Children on CHP+ will be passively enrolled into a Health Maintenance Organization (HMO) if there is more than one HMO option in their county. Choosing an HMO will no longer occur when the family fills out the application; the HMO selection question will be removed from both the online and the paper applications. After a child has been determined eligible for CHP+, the parent or guardian will have 90 days to choose the HMO by calling CHP+ customer service at 800-359-1991 prompt #5, if they were not placed into their HMO of choice.

MEDICAL APPLICATION ASSISTANCE
Colorado Access is certified to provide Presumptive Eligibility and can assist with the application process for potential members.

Services Provided:

- Determine Presumptive Eligibility for individuals who qualify for CHP+ and Medicaid.
- Assistance in completing the Medical Assistance Application for CHP+ and Medicaid, both in person, telephonically, and through the utilization of the PEAK online resource.
- Verification of income, citizenship and identification.
- Assist families to ensure all necessary documentation is submitted along with the application.
- Full processing of the Medical Assistance application into the State’s system to determine Medicaid or CHP+ eligibility.
Contact Information

- Phone: 303-755-4138; Toll Free 855-221-4138
- Website: coaccess.com/presumptive-eligibility-and-certified-application-assistance
- Email: appassist@coaccess.com
- Address: 3033 S. Parker Rd., Suite 800, Aurora, CO 80014
- Hours of Operation: 8:00 a.m. to 5:00 p.m., Mountain Time, Monday through Friday.

CHP+ ELIGIBILITY

In order to qualify for CHP+ children must:

- Be 18 or under,
- Be a U.S. citizen or legal permanent resident for at least 5 years,
- Not have any other health insurance (except those specifically listed below in section X. Coordination of Benefits), and
- Meet the most current income guidelines for enrollment into CHP+. Please reference the following website colorado.gov/cs/Satellite/HCPF/HCPF/1198141245169.

COLORADO ACCESS SERVICE AREA

CHP+ offered by Colorado Access is available to eligible children who live in the following Colorado counties:


PRE-HMO ENROLLMENT PERIOD

There is a period of time when members, determined eligible for CHP+, are not yet enrolled with their chosen HMO; this is referred to as the Pre-HMO Enrollment Period. So that members may receive services during this time, the State CHP+ Department enrolls them in the CHP+ State Managed Care Network (CHP+ SMCN) until they become effective with the HMO of their choice. The Pre-HMO Enrollment Period is usually 45 days or less.

Beginning January 1, 2013 the State enacted passive enrollment for all new SMCN members. Each member who is new to the CHP+ SMCN plan will be auto assigned to a CHP+ HMO health plan that is available in the county of residence. Members can change this HMO assignment by calling the state enrollment broker at 888-367-6557 within the first 90 days of enrollment into the HMO plan. If you are seeing a patient on SMCN who gets auto assigned to a HMO health plan that you do not accept there could be issues with claim payments or your patient may need to find a new doctor.
**Child Health Plan Plus (CHP+) offered by Colorado Access**

**PROVIDER MANUAL**

**CHP+ NEWBORN ENROLLMENT**
Children born to CHP+ members are covered for the first 30 days of life or until the end of the following month. To ensure continued coverage, members need to call the State CHP+ Program at 800-359-1991 to enroll their newborn.

**ENROLLMENT POSTPONEMENT DUE TO INPATIENT STAY**
If a member is an inpatient of a hospital at 11:59 p.m. the day before his or her enrollment into CHP+ offered by Colorado Access is scheduled to take effect, enrollment shall be postponed. Within 60 calendar days of discovering the member’s hospital admission, Colorado Access will notify the Department of Health Care Policy and Financing (HCPF) that the enrollment shall be delayed.

**MEMBER ID CARDS**
Once enrolled, Colorado Access sends each CHP+ offered by Colorado Access member an ID card. The following is a sample of the ID card:

![ID Card Sample]

**DISENROLLMENT**
The State CHP+ Department may disenroll a member from Colorado Access for the following reasons:

- The child becomes 19 years of age
- Administrative error on the part of CHP+, including but not limited to enrollment of a person who does not reside in Colorado Access’ service area;
- A change in the enrollee’s residence to an area not in Colorado Access’ service area;
- The child becomes eligible for the Medicaid program or gains other health insurance coverage;
- The child becomes an inmate of a public institution or a patient in an institution for mental diseases;
- Fraud or intentional misconduct, including but not limited to, non-payment of applicable fees by the member, knowing misuse of covered services by a member, knowing misrepresentation of membership status by member; or
- An egregious, ongoing pattern of behavior by the member that is abusive to a provider, staff or other patients or disruptive to the extent that Colorado Access' ability to furnish covered services to the member or other patients is impaired.
Members may only change their HMO for good cause reasons or at the time of renewal. Good cause reasons include, but are not limited to:

- Member moved out of service area
- Data entry error
- Other (must be approved by the Department of Health Care Policy and Financing)

**Effective Dates of Disenrollment**

When a member disenrolls from Colorado Access, the effective date of the disenrollment shall be no later than the first day of the second month following the month in which the member requested the disenrollment. If a member requests disenrollment and a decision is not made by the Department of Health Care Policy and Financing, or its designee, by the first day of the second month following the month in which the member requested the disenrollment, the disenrollment shall be considered approved.

**Disenrollment Postponed Due to Inpatient Hospital Stay**

If a current member of CHP+ offered by Colorado Access is an inpatient of a hospital at 11:59 p.m. the day before his/her disenrollment is scheduled to take effect, disenrollment shall be postponed until discharged from the hospital. When the member is discharged from the hospital the new disenrollment date shall be the last day of the month following discharge.

**Member Moves Outside of Service Area**

Members must notify their county Department of Human/Social Services that they have moved. This information will be communicated to the State, which will then disenroll the member effective the first day of the month following confirmation of the move outside of the service area.

**Material Incentives Prohibition**

Colorado Access and its participating providers are prohibited from providing material incentives unrelated to the provision of service as an inducement to members to enroll or disenroll in the health plan or to use the services of a particular subcontractor.

**Missed Appointments**

Per state requirements, members are not subject to missed appointment fees, even if cancellation occurred within 24 hours of the scheduled appointment time.

**BENEFITS AND COPAYS**

The following services are benefits of CHP+ offered by Colorado Access. This information is for summary purposes only and does not guarantee coverage. See the CHP+ offered by Colorado Access Member Benefits Booklet for covered services and exclusions. The booklet is located on our website at coaccess.com/chp-forms-and-documents.
Additional Colorado Access Benefits

- $150 toward eyeglasses or contact lenses per calendar year.
- More than 200 over-the-counter medications like vitamins and Tylenol®, when prescribed by a provider.
- 40 outpatient visits per calendar year (combined) for physical, occupational, and speech therapy.
- Unlimited physical, occupational, and speech therapy for children ages 0-3.
- Reduced co-payments for prescriptions.
- Elimination of copays for prescription birth control.
- Elimination of $2,000 benefit limit for oxygen and oxygen supplies.
- Smoking Cessation benefits through the Quit Line 800-QUIT-NOW (800-784-8669). Members over the age of 15 can self-refer, identify themselves as a Colorado Access member and provider their ID number in order to receive services.

Health Risk Assessment & Care Management

All Colorado Access CHP+ members receive an initial Health Risk Assessment (HRA) within 30 days of enrollment to screen for special health care needs such as physical, functional and behavioral health problems. HRA results are analyzed by the care management team and stratified depending on identified needs. Based on the results of the HRA, the care management team will contact the member to discuss individual needs and link the member to the appropriate licensed healthcare professionals and community resources. Members with high intensity physical and/or emotional needs receive priority in assistance with accessing resources and/or needed care.

Care managers contact the member and discuss special health care needs. The care manager’s first priority is to ensure that the member is connected with an ongoing source of primary care, whether that is a PCP or specialist who can best monitor the needs of the member. Care managers coordinate with the necessary providers (PCP, specialists, subspecialists) and community resources (facilities and agencies, ancillary or nonmedical services) to help the member access the health care and other services that they need and to prevent duplication of those activities.

If necessary, an individualized care plan is created that addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. The care manager will engage the member by asking them to establish goals in their care plan that contributes to effective management of the special healthcare need(s). The goal-setting process shall include steps that the member will take toward reaching goals and what interventions the care manager will take to help the member successfully reach their goals. Our medical director may confer with the treating physician(s) as necessary and make suggestions for revisions to the care plan.

Care managers work to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Care managers are also asked to document any
cultural or linguistic needs that might impact a member’s ability to access necessary health care services and community resources.

**SERVICING MEMBERS WITH SPECIAL HEALTHCARE NEEDS**

CHP+ has an obligation to ensure appropriate services and accommodations are made available to members with special healthcare needs. Services must be provided in a manner that promotes independent living and facilitates member participation in the community.

Members with special healthcare needs may be allowed to have direct access/standing referral to their specialist as needed for their care. If you have a member who may need a longstanding referral, contact Colorado Access for assistance.

**Fluoride Varnish provided in a Primary Care Setting:**

Fluoride varnish services can be provided by participating PCPs. Fluoride varnish may also be provided by an in-network dentist. When provided by a dentist these services are covered by Delta Dental under the routine dental benefit.

**Note:** This service is not covered for the CHP+ Prenatal Care Program.

- Covered services must be provided by the member’s assigned, in-network, PCP and does not require prior authorization.
- Benefit covers up to 2 fluoride varnish treatments in a calendar year for children ages 0 - 4.
- Risk assessments must be performed prior to providing varnish treatment.
- All PCPs providing this service must receive the appropriate training. For information regarding training, visit the following website [cavityfreeatthree.org](http://cavityfreeatthree.org) or call 303-724-4750.

CHP+ offered by Colorado Access will no longer reimburse claims for oral hygiene instruction (D1330), effective July 1, 2011.

Below are the complete billing procedure instructions:

**For children ages 0-2** (until the day before their third birthday):

Private practices: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with primary caregiver) must be billed on a CMS1500 paper claim form or electronically as an 837P (Professional) transaction.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): D1206 and D0145 must be itemized on the claim with a well-child visit, but reimbursement will be at the current encounter rate.

The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I (Institutional) transaction.
For children ages 3 and 4 (from their first birthday until the day before their fifth birthday):

Private practices: D1206 (topical fluoride varnish) and D0190 (dental screening) must be billed on a CMS1500 paper claim form or electronically as an 837P transaction.

What Dental Related Services are not Covered (exclusions)?

- Routine dental services are not covered by the CHP+ Prenatal Care Program.
- The following services, supplies, and care are not covered:
  - Restoring the mouth, teeth, or jaws due to injuries from biting or chewing.
  - Restorations, supplies or appliances, including, but are not limited to, cosmetic restorations, cosmetic replacement of serviceable restorations and materials (such as precious metal) that are not medically necessary to stabilize damaged teeth.
  - Inpatient or outpatient services due to the age of the member, the medical condition of the member and/or the nature of the dental services, except as described above.
  - Upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital or acquired characteristic.
  - Artificial implanted devices and bone graft for denture wear.
  - Temporomandibular (TMJ) joint therapy or surgery is not covered unless it has a medical basis.
  - Administration of anesthesia for dental services, operating, and recovery room charges, and surgeon services except as allowed above.

Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of post-partum care directly related to the delivery. The provider must agree to accept the Colorado Access fee schedule as payment in full and agree to follow Colorado Access Utilization Management and Quality Management policies and procedures.

ACCESS FOOD FOR SHOTS

Our members receive a $10 food gift certificate and a chance to win a $250 gift certificate when children are up-to-date on immunizations before the age of two. For more information visit our website at coaccess.com/access-food-for-shots.

CHP+ BENEFITS AND COPAYMENTS

<table>
<thead>
<tr>
<th>CHP+ offered by Colorado Access Benefit</th>
<th>Income Level 1</th>
<th>Income Level 2</th>
<th>Income Level 3</th>
<th>Income Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care and Urgent/After-Hours Care</td>
<td>$3</td>
<td>$3</td>
<td>$15</td>
<td>$20</td>
</tr>
<tr>
<td>Emergency Transport/Ambulance Services</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital/Other Facility Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$0</td>
<td>$0</td>
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### CHP+ offered by Colorado Access Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Income Level 1</th>
<th>Income Level 2</th>
<th>Income Level 3</th>
<th>Income Level 4</th>
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<tbody>
<tr>
<td>Physician</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient/Ambulatory</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Routine Medical Office Visit</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Laboratory and X-ray</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive, Covered Childhood Immunizations, and Family Planning Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>Prenatal</td>
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<td>$0</td>
</tr>
<tr>
<td>Delivery &amp; Inpatient Well Baby Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Prescription Birth Control</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Mental Illness Care &amp; Substance Abuse</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Residential/Day Treatment</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
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<tr>
<td>Non-Office Based Mental Health and Substance Abuse:</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(there is no copay for drop in-centers, school based, club house, or home based services.)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Outpatient and Office Based Mental Health and Substance Abuse</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Physical Therapy, Speech Therapy, and Occupational Therapy</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$0</td>
<td>$0</td>
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</tr>
<tr>
<td>Transplants</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>Hospice Care</td>
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</tr>
<tr>
<td>Prescription Medications (including covered over-the-counter medications, please see the Member Benefits – Covered Services – Prescription Medications section in the Member Benefits Handbook for details)</td>
<td>$0</td>
<td>$1</td>
<td>$3 – generic</td>
<td>$5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>$3 – brand name</td>
<td>$10</td>
</tr>
<tr>
<td>Kidney Dialysis</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Skilled Nursing Facility Care</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Routine Vision Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialty Vision Services – A specialty vision service is when you see a vision provider for something other than a routine exam.</td>
<td>$0</td>
<td>$2</td>
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<td>$10</td>
</tr>
<tr>
<td>Audiology Services</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Intractable Pain</td>
<td>$0</td>
<td>$2/office</td>
<td>$5</td>
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</tr>
</tbody>
</table>
**Child Health Plan Plus (CHP+) offered by Colorado Access**

**PROVIDER MANUAL**

<table>
<thead>
<tr>
<th>CHP+ offered by Colorado Access Benefit</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Income Level 1</td>
</tr>
<tr>
<td></td>
<td>visit</td>
</tr>
<tr>
<td>Autism Coverage</td>
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<tr>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Dietary Counseling /Nutritional Services</td>
<td>$0</td>
</tr>
<tr>
<td>Therapies: Chemotherapy and Radiation</td>
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</tr>
</tbody>
</table>

**MEMBER RIGHTS AND RESPONSIBILITIES**

**Member Rights**

Members have the right to:

- Get information about their healthcare benefits.
- Be treated fairly and with respect to their dignity and privacy.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Get all of the correct benefits from CHP+ HMO.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.
- Get copies of their treatment records and service plans.
- Ask for their medical records to be changed if they believe they are incorrect or incomplete.
- Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.
- Get a second opinion.
- Participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- Obtain family planning services from any duly licensed provider in or out of network without a referral.
- Get information on how to stay well and how to help them stay and live healthy.
- Tell us about any concerns and complaints they have about the care and services they got. CHP+ HMO will look into it and will take the right action.
- File a complaint or appeal a decision with CHP+ HMO without fear of it being used against them (retaliation) (See the Grievances and Appeals section).
Expect that their personal health information will be kept in a confidential manner.

Have input about the Member Rights and Responsibilities policies.

Get information about CHP+ HMO, Colorado Access, other CHP+ health plans, services, providers and doctors, and the rights and responsibilities of members.

Ask how we pay the providers and doctors that work with us. They can also ask about any incentive plans we may pay them.

To make decisions regarding medical care and to create an advance directive that, under state law, must be respected by their provider and Colorado Access.

Ask for information on how to be a part of the Member Advisory Board at Colorado Access by contacting the Office of Member and Family Affairs at 720-744-5610.

To request information about the Contractor’s Quality Assessment and Performance and Population Health Outcomes Plan program and member satisfaction survey results contact Customer Service at 303-751-9021, toll free 888-214-1101 or TTY at 888-803-4494.

Request information on participating provider compensation arrangements.

As a member, they have the responsibility to:

- Use in-network providers and remember to show their Colorado Access member ID card.
- Maintain ongoing patient-provider relationships with the providers who give them care or coordinate their total healthcare needs.
- Give their providers complete and honest information about their healthcare status and history.
- Understand how to access care in non-emergency and emergency situations, and to know their out-of-network healthcare benefits, including coverage and copayments.
- Notify the provider or Colorado Access about their concerns regarding the services or medical care they receive.
- Be considerate of the rights of other members, providers, and Colorado Access staff.
- Read and understand their CHP+ offered by Colorado Access Member Benefits Booklet.
- Pay all member payment requirements in a timely manner.
- Provide Colorado Access with complete and accurate information about other healthcare coverage and/or benefits they may have or obtain.
- Work with their provider to understand their healthcare concerns and to develop treatment goals.

RIGHTS AND RESPONSIBILITY FOR MEMBERS WITH SPECIAL HEALTHCARE NEEDS

All members have the rights and responsibilities listed above. Members with special healthcare needs also have some additional rights and responsibility, which include the following.

Rights:

- To keep seeing their non-Colorado Access providers up to 60 days after they join Colorado Access as long as the provider works with us to transfer care.
• To keep seeing their non-Colorado Access home health or DME provider up to 75 days as long as they, or the provider, works with us to transfer care.

Responsibility:

• To tell their medical providers, including doctors, home health, and DME providers, that they have enrolled with Colorado Access so we can work together to transfer care.

RIGHT AND RESPONSIBILITY FOR MEMBERS WHO ARE MORE THAN THREE MONTHS PREGNANT
Members who are more than three months pregnant have all of the rights and responsibilities listed above, but also have an additional right and responsibility as follows:

Right:

• To see their current prenatal care provider until after delivery, if the provider agrees to accept our reimbursement rates and work with us.

Responsibility:

• To tell us they are pregnant and let us know who is providing their care upon enrollment.

SERVICE CHANGE
We will notify members in writing if:

• Benefits change.
• Their PCP or specialist leaves the plan.
• Services are denied.

CHILD HEALTH PLAN PLUS (CHP+) CLAIMS SPECIFIC INFORMATION
Effective Immediately: When rendering services please check the State web portal to confirm eligibility. If the state web portal is showing a child is eligible for CHP+ on the date of service a copy of that printout can be used as proof of eligibility regardless of future retro-enrollment activities. Please utilize the State web portal at https://sp0.hcpf.state.co.us/Mercury/login.aspx.

REMINDER:
If you have administered any covered services, including immunization vaccines to a member who was eligible for CHP+ on the date of service, please submit your claim with a copy of the State web portal printout for payment. The County Department of Human/Social Services letter stating the member’s eligibility span can also be used as proof of eligibility.

ESSENTIAL COMMUNITY PROVIDER
We encourage all of our contracted providers to become designated as an Essential Community Providers (ECP) with the Department of Health Care Policy and Financing (HCPF). Essential Community
Providers are providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of our patient population. The ECP designation will apply to providers participating in Medicaid/CHP+, and the Colorado Health Benefit Exchange (COHBE).

ECPs are currently defined in Colorado state statute 25.5-5-403 (2) as a health care provider that:

- has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and
- Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client’s financial limitations.

In order to become designated, please visit the following website: colorado.gov/hcpf and complete the Application Form. If your application is approved you will be included in the current list of Essential Community Providers, which can be accessed from the same website. The above website offers supplemental information regarding this designation as well as other resources such as FAQs.

CLINICAL APPEALS & GRIEVANCES

NOTE: The term “member” refers to the member, his or her parent or legal guardian, authorized representative, or designated personal representative (DPR).

CHP+ has established an appeal process, which includes information about how to access a State Fair Hearing. This process complies with the requirements of the Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8 - Medical Assistance §8.209 - Medicaid Managed Care Grievance and Appeal Processes. The appeal process is available to members, their Designated Personal Representatives (DPRs), and legal representatives to request the review of an action, as defined below. CHP+ will inform members or DPRs of the availability of assistance with the appeal process through the CHP+ Member Benefits Booklet.

Definition of Terms:

Action – Any of the following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure to act within the timeframes provided for the resolution of grievances and appeals;
- The denial of a member’s request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network for members in rural areas with only one managed care organization.
**Appeal** – a request for review of an action.

**Designated Personal Representative (DPR)** – any person, including a treating healthcare professional, authorized in writing by the member or the member’s legal guardian to represent his or her interests related to complaints or appeals about healthcare benefits and services. A DPR can also be the legal representative of a deceased member’s estate.

**State Fair Hearing** – The formal adjudication process for appeals described in the Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8 - Medical Assistance §8.057-Recipient Appeals. Any member or their DPR can apply for a State Fair Hearing.

**CHP+ Appeal Process**

- CHP+ will provide a written notice of action to members or DPRs as described in policy and procedure CCS307 Utilization Review Determinations and in accordance with State Rules, including information on member rights to request an appeal or State Fair Hearing and procedures for doing so.
- CHP+ will make reasonable effort to provide assistance to a member, DPR, or legal representative in navigating the appeal process including but not limited to, completing any necessary appeal forms, putting oral requests for a State Fair Hearing into writing, and providing interpretive services and toll free numbers that have TTY/TTD capability when necessary.
- A member, DPR, or legal representative must submit an appeal within 30 calendar days from the date of the notice of action.
- CHP+ will not take any punitive action against a member, provider, DPR, or legal representative for filing a standard or expedited appeal, or supporting a request for a standard or expedited appeal.
- If CHP+, the member, DPR, or legal representative has determined that taking time for a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function, an expedited appeal may be requested.
- Upon receipt of an appeal, a written acknowledgement of the appeal is provided to the member, DPR, or legal representative within two business days of receipt, unless an expedited resolution has been requested. A notification will be sent explaining how to receive a copy of the case file related to the appeal and how to submit additional information whether in writing or in person.
- If the original action was made to deny, limit, suspend or terminate a service, and substantive new clinical information is received, the request may be returned to the original medical reviewer to evaluate the new information to see if the original reviewer is able to overturn the original action and approve the service. If the medical reviewer is unable to overturn the original action with the new information, the request will be forwarded to a licensed physician who was not involved in the original decision.
• Appeal decisions are made by a licensed physician who was not involved in any previous level of review or decision-making regarding the appeal, and who has appropriate clinical expertise in treating the member’s condition or disease if deciding any of the following:
  o An appeal of a denial based on lack of medical necessity; or
  o Any appeal that involves a clinical issue.
• A grievance regarding the denial of expedited resolution of an appeal. Standard and expedited appeals will be resolved and a notice provided to the member, DPR, or legal representative as expeditiously as the member’s health condition requires, or within the following time frames if an extension is not required:
  o A standard appeal is resolved and written notice of the resolution and the date it was completed is provided to the member, DPR, or legal representative within 10 business days of receipt.
  o An expedited appeal is resolved and written notice of the resolution and the date it was completed is provided to the member, DPR, or legal representative within three business days of receipt. If the member, DPR, or legal representative wishes to present additional evidence to support allegations of fact or law for an expedited appeal, this may be done in person or in writing. This evidence must either accompany the request for an expedited appeal or be received with the three business days of the receipt of the request for an expedited appeal in order to be considered part of the request for an expedited appeal. CHP+ will make a reasonable effort to provide verbal notice to the member, DPR, or legal representative within three business days of receipt of the request for an expedited appeal.
• If a request for an expedited appeal resolution is denied, CHP+ will make a reasonable effort to give the member, DPR, or legal representative prompt verbal notice of the denial and provide written notice to the member, DPR, or legal representative within two calendar days. The appeal will then follow the process for a standard resolution.
• For appeals not resolved wholly in favor of the member, the written notice to the member, DPR, or legal representative will include:
  o The right to request a State Fair Hearing and how to do so;
  o The right to request and to receive benefits while the hearing is pending and how to make the request; and
  o That the member may be held liable for the cost of those benefits if the hearing decision upholds CHP+’s action.
• CHP+ may extend the time frame in order to resolve a standard or expedited appeal up to 14 calendar days if the member, DPR, or legal representative requests the extension or CHP+ shows a need for additional information and the delay is in the member’s best interest. CHP+ will provide the member, DPR, or legal representative with prior written notice of the reason for the delay.
• CHP+ will make a reasonable effort to provide an opportunity for the member, DPR, or legal representative to examine the records and documents associated with their appeal and to present evidence and allegations of fact or law in person or in writing.

request, CHP+ will inform the member, DPR or legal representative, using the notice of action/appeal information and the Member Benefits Booklet, of the limited time available to present this information. This evidence must either accompany the request for an expedited appeal or be received within the three business days of the receipt of the request for an expedited appeal in order to be considered part of the request for an expedited appeal.

- CHP+ will provide for the continuation of benefits of a previously authorized service while an appeal is pending when all of the following criteria are present:
  - The member/provider files the appeal before the service ends, or within 10 calendar days of the date the Notice of Action was received;
  - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - The services were ordered by an authorized provider; and
  - The period covered by the original authorization has not expired; and the member requests an extension of benefits.

- Duration of continued or reinstated benefits. If at the member’s request, CHP+ continues or reinstates the member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  - The member withdraws the appeal.
  - Ten days pass after CHP+ mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10 day timeframe, has requested a State Fair Hearing decision with continuation of benefits.
  - A State Fair Hearing Office issues a decision adverse to the member.
  - The time period or service limits of the previously authorized service has been met.

- For inpatient stays or residential treatment stays where an existing authorization has expired, no extension of the original authorization will be given and no additional services provided under the original authorization are required. This applies when CHP+ has denied a member or provider's request for additional services contiguous to the original authorization for services.

- Where CHP+ grants an extension of benefits under #15 above, and the denial is upheld on appeal, CHP+ may recover the cost of the services furnished to the member while the appeal or State Fair Hearing was pending.

- If the appeal determination upholds CHP+' action, CHP+ may recover the cost of the services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8 - Medical Assistance §8.209.

- If the appeal determination overturns CHP+' action, reversing a decision to deny, limit or delay services that were not provided while the appeal was pending, CHP+ shall authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires.

- If the appeal determination overturns CHP+'s action to deny authorization of services and the member received the services while the appeal was pending, CHP+ must pay for those services.
APPEAL CONTACT INFORMATION
For a standard or expedited clinical appeal, the provider, member, or DPR may call or write to:

Grievance and Appeals Department
P.O. Box 17950
Denver, Colorado 80217

Phone: 720-744-5134
Toll Free: 877-276-5184

For a State Fair Hearing, the member or DPR may call or write to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Phone: 303-866-2000
Fax: 303-866-5909

State Fair Hearing

CHP+ members or their DPR’s may request a State Fair Hearing at any time during the appeal process but no later than 30 calendar days from the date of the notice of action that lead to the appeal. The member does not need to exhaust CHP+’s appeal process.

CHP+ informs CHP+ members of their right to a State Fair Hearing and how to request one primarily through the member’s notice of action and the accompanying letter CHP+ Member Appeal Information. Members are encouraged to file with the Office of Administrative Courts at the same time that they file an appeal to preserve their right to the State Fair Hearing within the allotted timeframe. CHP+ also includes information about this avenue for resolving an appeal in other written member materials such as the Member Benefits Booklet.

CHP+ will provide reasonable assistance to a member, DPR, or legal representative in requesting a State Fair Hearing including, but not limited to, putting oral requests for a State Fair Hearing into writing, and providing access to interpretive services and toll free numbers with TTY/TDD capability.

CHP+ will provide for the continuation of benefits of a previously authorized service while a State Fair Hearing is pending when all of the following criteria are present:

- The member/provider files the appeal or State Fair Hearing within 10 calendar days of the date the Notice of Action was received;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
• The services were ordered by an authorized provider;
• the original period covered by the original authorization has not expired; and
• The member requests an extension of benefits.
• Duration of continued or reinstated benefits. If at the member’s request, CHP+ continues or
reinstates the member’s benefits while the appeal is pending, the benefits must be continued
until one of the following occurs:
  o The member withdraws the appeal.
  o Ten calendar days pass after CHP+ mails the notice, providing the resolution of the
    appeal against the enrollee, unless the enrollee, within the 10 calendar day timeframe,
    has requested a State Fair Hearing decision with continuation of benefits until a State
    Fair Hearing decision is reached.
  o State Fair Hearing issues a decision adverse to the member.
  o The time period or service limits of the previously authorized service has been met.

Where CHP+ grants an extension of benefits under #4 above, and the denial is upheld on appeal or an
Administrative Law Judge issues an opinion in favor of CHP+, CHP+ may recover the cost of the services
furnished to the member while the State Fair Hearing was pending.

If the final resolution of the appeal upholds CHP+’s action, CHP+ may recover the cost of the services
furnished to the member while the appeal is pending to the extent that the services were furnished
solely because of the requirements of Colorado Health Care Policy and Financing Medicaid Staff Manual
Volume 8 - Medical Assistance §8.209.

If the State Fair Hearing officer reverses CHP+’s decision to deny, limit or delay services that were not
provided while the appeal was pending, CHP+ shall authorize or provide the disputed services promptly
and as expeditiously as the member’s health condition requires.

If the State Fair Hearing reverses CHP+’s decision to deny authorization of services and the member
received the services while the appeal was pending, CHP+ must pay for those services.

GRIEVANCES
A grievance is an oral or written expression of dissatisfaction communicated by a member to CHP+ and
its participating providers about any matter other than an action, including but not limited to, quality of
care or services provided, aspects of interpersonal relationships such as rudeness of provider or
employee, or the failure to respect the member’s rights.

As a partner in serving our members, CHP+ is reliant upon providers to pass along the concerns of our
members. In order to give our members/patients a voice, CHP+ requests that participating providers
relay member concerns to our grievance number at 720-744-5134 or toll free 877-276-5184. Providers
can call directly on behalf of the member or can refer the member to this phone number. CHP+ will
implement its grievance process (identified below) accordingly.
CHP+ requests that participating providers cooperate with the investigation and make themselves reasonably available to answer any questions pertaining to that grievance.

In order to provide support to members who believe that they may have reported concerns to the appropriate person or entity, CHP+ may contact participating providers to determine whether any members have expressed dissatisfaction or grievances.

**Grievance Process**

CHP+ has established a grievance and appeal process for members or DPRs of the CHP+ plan. This process complies with the requirements of the Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8 - Medical Assistance §8.209 - Medicaid Managed Care Grievance and Appeal Processes.

CHP+ will accept a grievance from a member that is expressed within 30 calendar days of the incident. Quality of care concerns are addressed in accordance with the CHP+ Quality of Care Concerns policy.

- Upon notification of a grievance, CHP+ will send a written acknowledgement of each grievance to the member within two business days of knowing that the member expressed dissatisfaction.
- Grievance decisions are made by a designated employee who was not involved in any previous level of review or decision-making regarding the grievance.
- Grievances are resolved as expeditiously as the member’s health condition requires, not exceeding 15 business days from notification of the grievance. A written resolution notice that explains the results of the grievance and the date it was completed is sent to the member.

CHP+ may extend the resolution time frame of a grievance up to 14 calendar days if the member requests the extension, or CHP+ shows a need for additional information and the delay is in the member’s best interest. CHP+ will provide the member with prior written notice of the reason for the delay.
Appendix D: Access Health Colorado

New Health Ventures, Inc. (NHV) is a subsidiary of Colorado Access. In 2014, we launched our Access Health Colorado line of business (a product of NHV), which is a Qualified Health Plan (QHP) in the Connect for Health Colorado Marketplace. Access Health Colorado offers a variety of different plans, both on and off the Marketplace, with in and out-of-network benefits. We have both PPO (Preferred Provider Organization) and EPO (Exclusive Provider Organization) networks. Our Value plans are offered through our EPO network and DO NOT have out of network benefits except for emergent/urgent care. We have partnered with Delta Dental for the pediatric dental benefit. We work exclusively with Qwest Diagnostics for lab services. If you utilize LabCorp under our EPO plans, the member will be held responsible for those charges. If you utilize LabCorp under our PPO plans, the member will be held responsible for those charges under their out of network benefits.

<table>
<thead>
<tr>
<th>Networks - PPO vs. EPO</th>
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<tbody>
<tr>
<td><strong>PPO Network:</strong></td>
<td>EPO Network:</td>
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<tr>
<td>Able to get healthcare services in all counties</td>
<td>Provider partners are: Centura, Children’s Hospital Colorado, and affiliated physician groups</td>
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<tr>
<td>Out-of-network benefits are available</td>
<td>There are no out of network benefits, except for emergent/urgent care</td>
</tr>
<tr>
<td>Need a PCP referral to see a specialist</td>
<td>A PCP assignment is required</td>
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Networks - PPO vs. EPO

Exclusive Provider Network
For more information about Access Health Colorado, visit our website at coaccess.com/providers or accesshealthco.com.

HOW TO CONTACT ACCESS HEALTH COLORADO

Customer Service

Denver Metro Area ................................................................. 303-368-8548
Toll Free ................................................................. 855-325-9426
TTY/TTD users ................................................................. 888-803-4494
Customer Service can answer questions regarding provider network issues including benefits, claims, claim appeals, claim status, eligibility and general questions about Access Health Colorado policies. Customer Service representatives are available Monday through Friday 8:00 am to 5:00 pm Mountain Time (during open enrollment Monday through Saturday 8:00 am to 8:00 pm).

A complete list of contact information can be located on our website at coaccess.com/contact-information or accesshealthco.com.

ACCESS HEALTH COLORADO MEMBER ID CARDS
Once enrolled, we send each Access Health Colorado member a member ID card. The following is a sample of the ID card:
ACCESS HEALTH COLORADO PLAN ENROLLMENT

Our plans are available to individuals and families within the state of Colorado. Eligible members may enroll for on-Marketplace plans through Connect for Health Colorado at connectforhealthco.com or for off-Marketplace plans through our online member portal, Access Health Colorado sales representatives, or through participating brokers. Annual Open Enrollment periods are dictated by Connect for Health Colorado and CMS. Members may enroll in the plan outside the annual open enrollment period for a qualifying life change event (e.g. marriage, divorce, adoption, birth of a child).

ACCESS HEALTH COLORADO PLAN DISENROLLMENT

Voluntary Disenrollment

A member may disenroll from Access Health Colorado by utilizing one of the following methods:

- Giving or faxing a signed written notice to AHC at 720-744-5115;
- Giving a signed written notice to Connect for Health Colorado for on-Marketplace plans;
- Enrolling in another QHP during one of the enrollment periods.
In-Voluntary Disenrollment

We may cancel a member’s policy for the following reasons:

- When the required monthly premium has not been paid and exceeds the grace period: 31 day grace period for a member NOT receiving a Marketplace advance premium tax credit (APTC) and three months for a member receiving an APTC (note that providers are responsible for collecting payment prior to delivery of services during the second and third months of the grace period for APTC members);
- On the date the benefits described in the policy terminate;
- Fraud or intentional misrepresentation of a material fact;
- Notification is received from Connect for Health Colorado to cancel any member or dependent.

ELIGIBILITY VERIFICATION

We cannot process claims for members who are not eligible on the date of service. The provider is responsible for verifying eligibility prior to rendering services. Determination of a member’s enrollment may be verified by calling Access Health Colorado:

- Denver Metro Area ................................................................. 303-368-8548
- Toll Free ................................................................. 855-325-9426
- TTY/TDD users ................................................................. 888-803-4494

PCP REFERRAL

We do not require that a member select a PCP. However, we do require the member to obtain a referral from a PCP to see a participating specialist. If a member fails to obtain a referral prior to seeing a specialist, the provider will not be adversely affected - claims will not be denied or pended.

PAPER CLAIMS & PROVIDER APPEALS

Claims must be filed within 90 days after the date of service. Failure to file a claim within 90 days will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give notice within 90 days, and that notice was given as soon as reasonably possible. Any claims filed after one year may be refused.

Provider payment disputes must be submitted in writing within sixty (60) calendar days from the date of the provider EOP.

Submit claims and appeals to:

Access Health Colorado
P.O. Box 5846
Denver CO 80217

Fax: 720-755-4143
ACCESS TOTAL WELLNESS
To help your patients achieve their best health, we provide a disease management program entitled Access Total Wellness. Access Total Wellness allows members with health conditions to speak with a registered nurse who will provide health guidance and answer questions regarding ongoing care.

The nurse health coach can help patients understand their condition and set step-by-step goals to maintain a healthy lifestyle in between their regular visits with you. The nurse health coach may reach out to you for additional information on patient’s plan of care. Access Total Wellness is a confidential program and is available at no cost to patients.

Patients can participate in Access Total Wellness if they have:

- Asthma*
- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease
- Chronic pain (from osteoarthritis, rheumatoid arthritis or low back pain)
- Congestive heart failure
- Coronary artery disease
- Diabetes*
- High cholesterol
- High blood pressure
- Pediatric asthma and diabetes programs are available.

To learn more about the Access Total Wellness program, visit our website at accesshealthco.com

MEMBER COST SHARE - DEDUCTIBLES, COPAYMENTS & COINSURANCE
Members are responsible for certain cost share amounts and may be billed for these amounts. Cost share information will be indicated on the member ID card. Please call Access Health Colorado for specific benefit cost share information.

Circumstances in Which a Member can be Billed for Services

- A member sees a non-participating provider in a non-emergent, non-urgent, outpatient setting without prior authorization (applies to in-state and out-of-state providers).
- A member does not follow the pharmacy rules (member may have to pay for the medication).
- A member signs a consent form that says he/she will pay the doctor/provider or hospital.
- A member receives non-emergent/non-urgent healthcare services outside of the United States of America.
- A member who receives an APTC and is actively in the second month, or later, of the three month grace period.
This provider manual was revised in November 2015. Some policies and procedures may have changed since that time. If you have any questions regarding any of the information found in this manual, please call our customer service department toll free at 800-511-5010.