



Provider Manual

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I. Introduction

This manual applies to providers in the State Managed Care Network administered by Colorado Access. Unless otherwise noted, policies in this manual apply to both CHP+ and the CHP+ Prenatal Care Program.

NOTE: Colorado Access maintains a separate provider manual for the CHP+ HMO product.

Important Telephone Numbers

Customer Service (Claims, Eligibility, Authorizations)	Local (303) 751-9051
.....	Toll Free 1-800-414-6198
.....	TTY/TDD (720) 744-5126
.....	Toll Free TTY/TDD 1-888-803-4494
Grievance and Appeals	Local (720) 744-5134
.....	Toll Free 1-877-276-5184
Child Health Plan <i>Plus</i> Administrative Offices	Toll Free 1-800-359-1991
Delta Dental	Toll Free 1-800-610-0201

Important Fax Numbers

Authorization (Physical Health) Fax	Local (303) 755-4135
.....	Toll Free 1-877-232-5976
Authorizations (Behavioral Health) Fax	Local (720) 744-5127
Provider Contracting Fax	Local (303) 755-2368
Quality Management Fax.....	Local (303) 369-5741

Important Websites

www.chpplusproviders.com - The CHP+ Provider site is designed specifically for the State Managed Care Network Providers. Important provider information, as well as member information can be located on the site.

www.aap.org - The American Academy of Pediatrics website provides recommended childhood and adolescent immunization and well child visit schedules.

www.coaccess.com - The Colorado Access website contains important information for members and providers. Provider information available in the *For Our Providers* section includes:

- Important Provider Updates
- Provider Manuals

- The Provider Directory
- HIPAA Information

Secured Information:

- Online Eligibility Verification
- Online Claim Status
- Colorado Access Prior Authorization List

Secured Information on www.coaccess.com

Some of the information available on the site, including online eligibility verification, online claim status, and the Colorado Access Prior Authorization List, requires a username and password. To access the secured information, click the *Provider Logon* link located in the *For Our Providers* section and enter your Colorado Access website username and password.

If you need a Colorado Access website username and password please follow these instructions:

- Download the **Web Based Applications Request Form** located online at: <https://www.coaccess.com/providers/files/WebAccessApplication.pdf>.
- Fax the completed application to (303) 755-2368, or email to pns@coaccess.com.

II. Primary Care Providers & Specialists

Each member of Child Health Plan *Plus* (CHP+) and the CHP+ Prenatal Care Program must choose a participating Primary Care Provider (PCP) that is a:

- family and general practitioner,
- internist, or
- pediatrician.

Primary Care Provider Responsibilities

Primary care providers (PCPs) have the following responsibilities when seeing members of the CHP+ and the CHP+ Prenatal Care Program:

- Providing care and services for all enrolled members.
- Being accessible (or have call-coverage) to members 24 hours a day, 7 days a week.
- Providing services to members according to the CHP+ access standards.
- Coordinating healthcare services for members, including referring members to specialists.
- Providing 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.
- Providing culturally appropriate healthcare.
- Maintaining confidentiality of medical information in compliance with all state and federal regulatory agencies (including HIPAA), as well as National Committee for Quality Assurance NCQA standards.
- Maintaining legible and comprehensive medical records for each encounter with a member that conform to documentation standards.

Administrative Responsibilities include:

- Participating in the CHP+ Quality Management and Utilization Management Programs, which adhere to National Committee for Quality Assurance (NCQA) standards, and the CHP+ contract standards, which includes the provision of medical records copies upon request for study purposes.
- Complying with the State Managed Care Network's credentialing requirements.
- Maintaining a separate medical record for each CHP+ member.
- Reporting encounter and claim data to the State Managed Care Network, so that we may track service utilization.
- Verifying eligibility and enrollment for every office encounter.
- Referring members to 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 open/close your practice, notify the State Managed Care Network in writing. The change will become effective no later than 2

business days from the date we receive the notification.

NOTE: New members are not assigned to providers with closed panels. An individual PCP may not have more than 2,000 CHP+ members without consent from the State Managed Care Network. 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.

PCP Coverage

The PCP must assure that coverage is available seven (7) days a week, 24 hours a day for member services. Access to a qualified healthcare practitioner via telephone coverage either onsite, call sharing, or answering service is appropriate.

- The PCP must notify the State Managed Care Network of the name of the practitioner providing on-call coverage.
- Please notify us by sending us a completed On-Call Coverage Sheet (Appendix A). To ensure appropriate payment, we must have this information on file.
- The call-coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

Specialist Responsibilities

Contracted specialty care providers have the following responsibilities to CHP+ and CHP+ Prenatal Care Program members:

- Verifying member eligibility on the date of service.
- Providing specialty consultation care referred by the member's PCP or the State Managed Care Network as necessary.
- Obtaining appropriate authorization from the State Managed Care Network before treating a member.
- Coordinating the member's care with his or her PCP.
- Providing a written consultation report to the PCP within five (5) days of providing service.
- Maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies, as well as NCQA requirements.
- Maintaining a separate medical record for each CHP+ or CHP+ Prenatal Care Program member.
- Maintaining legible and comprehensive medical records for each encounter.

Specialist Coverage

- The Specialist must assure that coverage is available seven (7) days a week, twenty-four (24) hours a day for member services. Access to a qualified healthcare practitioner via telephone coverage either onsite, call sharing, or answering service is appropriate.
- The Specialist must notify the State Managed Care Network of the name of the practitioner providing on-call coverage. Please notify us by sending a completed On-Call

Coverage Sheet (Appendix A).

- To ensure appropriate payment, we must have this information on file. Contact the State Managed Care Network at (303) 751-9051 or toll free 1-800-414-6198.
- The call-coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

Credentialing and Re-credentialing

When applicable, providers shall participate with the credentialing and recredentialing standards and requirements as set forth in this provider manual and shall submit to the Department, or its designee, the appropriate credentialing application and other required attachments, as modified from time to time in accordance with National Committee for Quality Assurance (NCQA) and Colorado Access standards.

The State Managed Care Network conducts credentialing and re-credentialing of the following contracted healthcare practitioners, who treat members outside the inpatient setting who fall within its scope of authority and action:

- Allopathic Physician (MD)
- Osteopathic Physician (DO)
- Doctor of Dental Science (DDS)*
- Podiatrist (DPM)
- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)**

*Dentists who provide care under the medical benefit program only

**Only Nurse Practitioners serving as PCPs in rural underserved areas

The applicant will complete the Colorado Unified Credentialing Application available on the Colorado Access website at <https://www.coaccess.com/providers/credentialsApp.jsp>. The application includes a current and signed attestation by the applicant. The applicant will bear the burden of proving that he/she is eligible and qualified for participation in the State Managed Care Network and shall have the responsibility of producing adequate information for a proper evaluation of his/her 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 information obtained by the State Managed Care Network to evaluate his/her credentialing application to the extent permitted by law. The State Managed Care Network is not required to allow an applicant to review references, recommendations, or other information that is peer-review protected. The State Managed Care Network is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements if disclosure is prohibited by law. In the event that credentialing information obtained from other sources varies substantially from that provided by the applicant, the 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 their credentialing or re-credentialing

application upon request. These rights apply to any applicant who has completed the Colorado Unified Credentialing Application. For additional information, please contact the Credentialing Department at (720) 744-5100 toll free 1-800-511-5010 or email credentialing@coaccess.com.

CAQH Universal Credentialing DataSource

Colorado Access participates with the CAQH Universal Credentialing DataSource. 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 the service or completing the UCD application, please visit www.caqh.org/cred/. If you already participate with CAQH, please designate Colorado Access as an authorized health plan.

Effective Communication with Limited English Proficient (LEP) Persons & Sensory-Impaired/Speech Impaired Persons

The State Managed Care Network will take such steps as are necessary to ensure that members, potential members, family members and designated client representatives (DCR) 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, the State Managed Care Network will give primary consideration to the request of the individual with disabilities. These aids and services include, but are not limited to, the following:

- Multilingual staff
- TTY/TDD
- AT&T Language Line
- Notices 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

Non-Discrimination Policy

The State Managed Care Network does 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 or age. This includes all programs and activities delivered directly or through a contractor or any other entity with whom the State Managed Care Network administrator, Colorado Access, arranges to carry out its programs and activities.

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 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. Department 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

The State Managed Care Network abides by federal and state regulations pertaining to confidentiality standards including requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a provider, it is important for you to follow the State Managed Care Network's expectations concerning confidentiality of member information and records.

Fraud and Abuse

The State Managed Care Network is dedicated to providing quality healthcare services to members while conducting business in an ethical manner. The State Managed Care Network supports the efforts of federal and state authorities in identifying incidents of fraud and abuse. The State Managed Care Network has mechanisms in place to prevent, detect, 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 applicable Federal or State law.

Abuse/Misuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to the CHP+ program, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Misutilization: The incorrect, improper or excessive utilization of medical care and services which are not medically necessary, at the recipient's insistence or request.

The State Managed Care Network complies with requirements of the Colorado Attorney General, the District Attorney, HCPF and other agencies that conduct investigations.

Colorado Access has a Corporate Compliance Officer who is responsible for reporting suspected fraudulent claims to the Fraud Division of the Colorado Division of Insurance and the Colorado

Office of the Attorney General's Department of Law.

The State Managed Care Network is 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 the State Managed Care Network are responsible for reporting potential and/or suspected incidents of fraud, abuse, misuse, or misutilization, including actual or potential violations of law or regulation, to the Colorado Access Corporate Compliance Officer (CCO) or Staff Attorney.

The following methods may be utilized to report such situations:

- Contact the CCO directly at (720) 744-5465
- Call the Confidential Corporate Compliance Hotline at (877) 363-3065;
- E-mail the CCO at corporate_compliance@coaccess.com;
- Download and print the Suspected Fraudulent Claim Form located on the Colorado Access Web site and forward the completed form to Colorado Access, Corporate Compliance Officer, 10065 E. Harvard Ave., Ste. 600, Denver, CO 80231; or
- Send the information to the dedicated fax line at (303) 751-9048 addressed to the Corporate Compliance Officer.

Rights and Responsibilities for Members with Special Needs

New CHP+ members and members with special needs have some additional rights which include the following.

Rights:

- To keep seeing non-CHP+ doctors up to 60 days after joining CHP+ as long as the doctor works with the State Managed Care Network to transfer care.
- To keep seeing non-CHP+ home health or DME providers up to 75 days as long as the member and provider work with the State Managed Care Network to transfer care.

Responsibilities:

- To tell the State Managed Care Network and medical providers, including doctors, home health, and DME providers, that they have enrolled so we can work together to transfer care.

Rights and Responsibilities for Members Who are More than 3 Months Pregnant

Members who are more than 3 months pregnant have some additional rights, which include the following:

Right:

- To see current providers of prenatal care until after delivery if the provider agrees to accept the State Managed Care Network's rates.

Responsibility:

- To tell CHP+ they are pregnant and let CHP+ know who is providing care when enrolled.

Appointment and Service Standards

Member satisfaction is very important to the State Managed Care Network. Excessive wait time for appointments is a major cause of member dissatisfaction with the healthcare provider and health plan. The State Managed Care Network has established the following appointment standards for all contracted providers.

NOTE: The State Managed Care Network reserves the right to adjust or modify appointment standards, based on member and provider needs.

Appointment Standards	
Type of Care	Standard
Pediatric Routine Care	Scheduled within 2 weeks of request
Adult Routine Care (ages 18-19) (Non-symptomatic, well care physical exam)	Scheduled within 4 weeks of request
Non-urgent care	Scheduled within 1 week of request
Urgent care	Scheduled within 24 hours of request

After Hours and Emergency Care	
Type of Care	Standard
After-hours Care	Available 24 hours a day, 7 days a week, access to a qualified healthcare practitioner via telephone coverage either onsite, through call sharing, or an answering service
Emergency Care	Immediately

Access to Interpretive Services	
Type of Care	Standard
Interpretive Services	Language assistance available in the provider office or the member is directed to Colorado Access Customer Service Department for assistance at (303) 751-9051 or toll free 1-800-414-6198.

For providers with 14 or less employees, the State Managed Care Network 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, the State Managed Care Network 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 the Colorado Access Director of the Office of Consumer and Family Affairs, who will make a determination on a case-by-case basis.

Medical Record Documentation

NOTE: The State Managed Care Network may perform chart reviews to assure compliance with medical record review 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. The State Managed Care Network has established medical record documentation guidelines based on applicable regulatory and accrediting body standards that are approved by the Medical/Behavioral Quality Management Committee (MBQIC). We use these standards to assess practitioners' medical record keeping practices and evaluate compliance with the medical record documentation standards.

Each patient record should 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 included 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 provider's name or initials and credentials** – This can be handwritten, electronic, typed or signature stamped.
- **Each entry dated** - This includes progress notes, problem list, med list, assessment forms, etc.
- **Record is legible.**

- **Record is organized** – The chart should be organized in chronological or reverse chronological order and reports should be in a consistent location.
- **Medical history** - For patients seen 3 or more times, a past patient and family history should be present. This includes a history of accidents, illness, and surgeries. Family includes immediate family members' medical illnesses. For patients seen less than 3 times, past history should be documented for the current condition. Must include OB/GYN history for females as applicable.
- **Medication allergies and adverse reactions displayed** – This should be consistently displayed on the front or inside cover of the record. The can be a completed allergy sticker, or NKA (No Known Allergies).
- **Current medication list or meds listed in progress notes** – This should document the current medications, dosages, dates of initial or refill prescriptions or indicate no meds.
- **Current immunization record** - for pediatric patients less than 18 years old.
- **Completed problem list or summary health maintenance exams** – This should summarize significant illnesses, medical conditions, past surgical procedures, chronic health problems or psychological conditions or "none" or "no problems" should be documented.
- **Physical exam appropriate to patient's condition:** - including preventive care or presenting complaint(s).
- **Working diagnoses are consistent with findings.**
- **Treatment plans are 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 for pediatric patients older than 11 years old.**
- **Inquiry/counseling noted, regarding history of alcohol/substance abuse for pediatric patients older than 11 yrs.**
- **Evidence of age appropriate preventive services and screenings, health education and anticipatory guidance.**

Utilization Management Program

Participation in the State Managed Care Network Utilization Management Program is a contractual obligation of every network practitioner, provider and delegate. This includes 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 the State Managed Care Network.

Alternative Treatments

The State Managed Care Network does not prohibit or restrict providers from advising members about any aspect of his or her health status or medical care, advocating on behalf of a member, or advising about alternative treatments regardless of whether such care is a covered benefit.

Servicing Members with Special Healthcare Needs

The State Managed Care Network 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 health care needs may be allowed to have direct access/standing referral to their specialist as needed for their care. If you have a member that may need a longstanding referral, contact the State Managed Care Network for assistance.

The State Managed Care Network providers and vendors must respond within twenty-four (24) hours to any diminishment of a client's capacity to live independently (e.g., a broken wheelchair). The provider and/or vendor shall deliver medically necessary covered services that will restore the member's ability to live independently as soon as possible.

If a provider is unable to accommodate the special healthcare needs of a member, the provider can call Customer Service Department at Local (303) 751-9051 or toll free 1-800-414-6198 for help in finding a provider capable of delivering these services.

Advance Directives

An Advance Medical Directive is a written instruction of care such as a living will or medical durable power of attorney relating the provision of health care 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.

Types of Advance Medical Directives

Living Will - A Living Will tells medical providers not to use artificial life support if the member becomes terminally ill. Copies of Living Will forms should be available at health care facilities, doctors' offices, office supply stores, on the web, and through the Guardianship Alliance of Colorado for further information call the Guardianship Alliance of Colorado at (303) 423-2898.

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 himself or herself.

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 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 Client Representative).

Quality Management Program

The State Managed Care Network utilizes preventive healthcare and care management programs and promotes quality monitoring using nationally recognized standards.

Continuous monitoring of quality indicators provides both the evaluation of individual outcomes and the development of comparative performance and outcome norms. Health Plan Effectiveness Data Information Set (HEDIS) indicators are used to evaluate performance and health status outcomes.

The State Managed Care Network Quality Management program complies with state and federal regulatory requirements and follows applicable National Committee for Quality Assurance (NCQA) Standards for Managed Care Organizations. Operational components include:

- Quality management and improvement through selection of appropriate clinical, cost and service indicators
- Continuous monitoring, feedback and studies
- Utilization management
- Credentialing and re-credentialing
- Satisfaction surveys
- Monitoring use of available preventive health services and improvement of utilization
- Medical records standards and review
- Grievances and quality of care investigation
- Network adequacy and access monitoring

The operation of a comprehensive, integrated program requires all participating Primary Care Clinics, medical groups/IPAs, and other contracting network ancillary and inpatient 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 CHP+ members.

III. Claims Submission

Please submit claims to:

CHP+ Claims
PO Box 17470
Denver, CO 80217-0470

Provider Carrier Disputes/Claims Appeals

PO Box 17189
Denver, CO 80217-0189

Colorado Access acts as the administrative services organization for the State Managed Care Network. All claims for services rendered to members enrolled in CHP+ are processed by Colorado Access, with the exception of non-accident related dental claims, which are processed by Delta Dental, and pharmacy benefits, which are managed by Caremark. CHP+ participating providers must follow the State Managed Care Network's claims filing procedures. All explanations of benefits (EOBs) and payments will be issued by Colorado Access.

Timely Filing

Unless otherwise stated in contract, CHP+ providers must submit claims within **180 calendar days** from the date on which services were rendered.

Should your claim be denied for timely filing, upon appeal, Colorado Access will accept the following documents as proof of timely filing:

- Another health plan's explanation of benefits (EOB).
- An electronic/EDI claim submission acceptance report.

Provider Responsibilities

Providers rendering services to members of CHP+ and the CHP+ Prenatal Care Program have the following responsibilities in relation to billing for these services:

- Verify the member's eligibility prior to submitting the claim
- Ensure that the appropriate authorization requirements have been met
- Verify that place of service codes are correct
- Verify that diagnosis and/or procedure codes match the service provided
- Complete all required data elements including NPI on electronic claims
- 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 for paper claims
- Do not use highlighters to mark claims or attachments
- Bill original claims within 180 days or as specified by contract (whichever is less)
- Bill a member's primary payer as applicable, prior to submitting claims to the State Managed Care Network
- 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 or “interim bills”
- Submit claims timely to ensure timely payment for services
- Submit paper claims to the appropriate address

Colorado Access Responsibilities

As administrator of the State Managed Care Network, Colorado Access has 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 “clean” paper claims within 45 calendar days of receipt
- Approve, deny or settle “clean” electronic claims within 30 calendar days of receipt
- Approve, deny or settle all other claims within 90 calendar days

Required Formats

Providers are required to submit complete claims for all services rendered to members of CHP+ and the CHP+ Prenatal Care Program. **Electronic submission of claims is preferred.** However, we will accept paper claims in CMS 1500 and CMS 1450 (UB04) formats.

In order to process claims in a timely, accurate manner, we ask providers to observe standard reporting requirements.

Electronic Claims

The State Managed Care Network accepts electronic/EDI claims through direct submission or through the use of a clearinghouse. For more information on direct submissions of electronic/EDI claims, please contact edi_coordinator@coaccess.com.

The use of clearinghouses provides quick and efficient submission of electronic/EDI claims that are compliant with current guidelines. Colorado Access accepts electronic/EDI claims from the clearinghouses listed below. If you use one of the clearinghouses noted below, please advise the clearinghouse to direct your claims to the appropriate payer ID for each clearinghouse listed.

- **ENS:** www.enshealth.com (Payer ID: coacc)
- **Emdeon** (formally known as WebMD): www.emdeon.com (Payer ID: 84129)
- **HealthFusion** (formally known as Quadramed): www.healthfusion.com (Payer ID: coacc)
- **Sage Software Healthcare** (formally known as Scinet): www.sagehealth.com

(Payer ID: coacc)

- **Relay Health** (formally known as NDC): www.relayhealth.com (Payer ID: coacc)
- **SSI Group**: www.thessigroup.com (Payer ID: coacc)
- **S&S Datalink**: www.sasdatalink.com (Payer ID: coacc)
- **PNC Bank** (formerly known as Healthcare Admin Tech): www.pnc.com (Payer ID: coacc)

If you would like information on direct EDI claim submission, or for additional information about EDI claims visit the Colorado Access website at www.coaccess.com, or email edi_coordinator@coaccess.com.

CMS 1500

Providers must file all claims for professional/non-facility services, including laboratory services performed by an independent laboratory on the CMS 1500 claim form. Please see Appendix B for CMS 1500 field requirements. Providers must, at the very least, include the information marked "yes" in the required field of Appendix B.

CMS 1450

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital to CHP+ members on the CMS 1450 (UB04) claim form. Please see Appendix C for CMS 1450 field requirements. Provider must at the very least include the information marked "yes" in the required field of Appendix C.

Procedure Coding

We use the Health Care Financing Administration Common Procedure Codes (HCPCS) to identify services provided to eligible recipients. HCPCS codes include CPT™ codes. In order to ensure that claims are processed promptly and accurately please follow these guidelines:

- Use the most current CPT™ (“Current Procedural Terminology”) revision.
- Be aware that not all codes are covered benefits under the State Managed Care Network.
- When we receive billed codes that are considered obsolete, the claim will be denied and written notification will be sent on an Explanation of Benefits (EOB).

POA Indicator & Serious Reportable Events

Effective July 1, 2009, the CHP+ State Managed Care Network began reviewing inpatient claims with a discharge date of July 1, 2009 or after to ensure proper recording of the Present on Admission (POA) indicator.

NOTE: Inpatient claims will be denied if the POA indicator is not submitted on the claim for discharges on or after October 1, 2009.

According to State and Federal guidelines, all inpatient facility claims should include POA indicators. The Center 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. The CHP+ State Managed Care Network reserves the right to collect any overpayments that are the result of the retrospective review.

Serious Reportable Events

In order to protect patient safety and ensure high quality care, the CHP+ State Managed Care Network will adjust reimbursement for hospital claims that include serious reportable events. Effective October 1, 2009, reimbursement will not be increased for additional costs resulting from the following serious reportable events:

1. Foreign object inadvertently left in patient after surgery;
2. Death/disability associated with intravascular embolism;
3. Death/disability associated with incompatible blood;
4. Stage 3 or 4 pressure ulcers after admission;
5. Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes;
6. Catheter-associated urinary tract infection;
7. Vascular catheter-associated infection;
8. Mediastinitis after coronary artery bypass graft surgery;
9. Manifestations of poor glycemic control;
10. Surgical site infection following certain orthopedic procedures;
11. Surgical site infection following bariatric surgery for obesity; and
12. Deep vein thrombosis & pulmonary embolism following certain orthopedic procedures;

In addition, no reimbursement will be made for:

13. Surgery performed on the wrong body part
14. Surgery performed on the wrong patient
15. Wrong surgical procedure on a patient

Members should not be billed or balance-billed for services related to serious reportable events. The CHP+ State Managed Care Network will collaborate with hospitals to assure appropriate reimbursement for cases in which a patient receives subsequent care for a serious reportable event in a hospital other than the original site in which the event occurred.

Diagnosis Coding

We require providers to enter the appropriate diagnosis code on each claim submitted. We will 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.

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 CHP+ 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 member.

Non-Clean Claims

In accordance with Colorado State Senate bill SB02-013, effective July 1, 2002, 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 identify the claim as non-clean and include written explanation of payment (EOP) codes and follow-up instructions to the provider on the voucher as to how to resolve the claim.
- If, within 30 calendar days of our request, a provider fails to submit requested additional information, we may deny the claim.
- Where 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 (absent fraud) within 90 calendar days after the date that the claim was first received.
- According to law, the State Managed Care Network and the CHP+ Prenatal Care Program are exempt from paying interest and penalties on claims.

Resubmissions

Providers may resubmit denied claims for reprocessing within 180 days of the date of service or 90 days from the date of the last denial recorded on a voucher.

Resubmission Process

- Send a photocopy of the original claim, clearly marked “Resubmission” on the face of the claim or 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 photocopy of the original claim may be used to resubmit denied lines.
- Correct the appropriate information clearly and accurately.
- Adjust total charges to reflect the amount being resubmitted.
- Mail all resubmitted claims the claims address listed in this manual.

We will research the resubmission and adjudicate the claim according to the newly resubmitted information. Once adjudicated, the claim will appear on your voucher with a corresponding EOP code outlining the reason for payment or denial.

Late or Additional Charges

When billing late or additional charges for previously submitted claims, please 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.

ClaimCheck[®]

To assist in processing physician payments, we use ClaimCheck[®] software. The following EOP codes will appear on vouchers to alert you of ClaimCheck[®] edits:

QA—Procedure code denied as incidental to anesthesia
 QB1—50% reduced reimbursement for multiple surgeries
 QD1—ClaimCheck[®] duplicate procedure
 QE1—Procedure code denied as exclusive procedure
 QG1—Claim check age edit
 QI1—Procedure code denied as incidental
 QO1—ClaimCheck[®] obsolete code edit
 QR1—ClaimCheck[®] bundled code
 QS1—ClaimCheck[®] gender code edit
 QT1—ClaimCheck[®] assistant surgery edit
 QU1—ClaimCheck[®] unbundled code
 QV1—ClaimCheck[®] visit edit

IV. Provider-Carrier Disputes (Claim Appeals)

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.

Submission Process

In accordance with DOI regulations, we require provider-carrier disputes to be submitted in writing. Information may be submitted in a brief letter or on our Non-clinical Adjustment Request form (Appendix D).

All necessary information should be submitted within 90 calendar days from the date of the voucher on which the disputed claim appears to the following address:

Provider-Carrier Disputes
PO Box 17189
Denver, CO 80217-0189

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

1. Each applicable date of service;
 2. Member/patient name
 4. Member identification number;
 5. Provider name;
 6. Provider tax identification number;
 7. Dollar amount in dispute, if applicable;
 8. 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).

After we receive a dispute in writing, providers or their representatives may present the rationale for a dispute in person, upon request. 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 provider-carrier disputes and issue written notification of the outcome within 60 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 e-mail or facsimile. Both parties may agree to an extension beyond the 60 calendar days from receipt of all necessary

information time frames established by this policy in order to resolve a dispute.
Should a provider be dissatisfied with the State Managed Care Network resolution regarding a provider-carrier dispute, providers can direct written correspondence to:

Health Plan Manager
Child Health Plan *Plus*
Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

V. Coordination of Benefits & Subrogation

Children or expectant woman with other insurance are, by law, not eligible for CHP+ or the CHP+ Prenatal Care Program. Exceptions to this rule include, school accident insurance, dental insurance and Medicare.

The following guidelines apply concerning other insurance coverage:

- A child or expectant woman cannot be covered by a creditable health insurance policy including individual non-group policies.
- If a child or expectant woman is currently covered by an employer-based group health insurance policy where the employer pays more than 50% of the cost, he/she must be uninsured for 90 days prior to his/her enrollment in CHP+ or the CHP+ Prenatal Care Program.
- If a parent or guardian of an applicant child has access to the State of Colorado health benefits plan, the child is not eligible for CHP+.
- A child or expectant woman cannot be eligible for or enrolled in Medicaid.

It is important that providers make their best effort to identify and notify the State Managed Care Network whenever they have reason to believe a member may be entitled to or known to have coverage under any other insurance plan. This includes a commercial insurance policy, Medicaid or Medicare. Providers can find the Notification of Other Insurance Form at <http://www.chpplusproviders.com/materials.asp>. Please download and complete this form and fax to (303) 893-1780.

Filing a Claim for Members with Secondary Coverage

The following steps apply when submitting claims for members with primary coverage such as accident related insurance.

- Providers must submit a hard copy of the CMS 1500/CMS 1500 or UB04/CMS 1450 along with a copy of the Explanation of Benefits (EOB), 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)
 - The State Managed Care Network does not consider refusals of payment due to claim preparation errors or failure to provide sufficient processing information as proof of denial.
 - If an EOB applies to more than one claim, a copy of the EOB must be attached to each claim submission.
- Complete the appropriate TPR data fields/form locators on the claim form submitted to the State Managed Care Network. Claim TPR data fields/form locators are specific to third party insurance or Medicare; they cannot be used interchangeably.
- Submit the claim within 180 calendar days from the TPR's denial date or processing date.

Secondary Benefit Calculation “Lower of Logic”

The State Managed Care Network calculates secondary benefits in the following manner:

- The CHP+ benefit allowance is compared to the primary payment.
- If the primary payment is equal to or greater than the CHP+ benefit allowance, the State Managed Care Network will not make payment.
- If the primary payment is less than the CHP+ benefit allowance, the State Managed Care Network will pay the difference between the two amounts. However, payment will not exceed the other insurance’s (including Medicare) co-insurance, deductible and/or co-pay.
- The State Managed Care Network does not automatically pay the other insurance’s (including Medicare) copayments, coinsurance and/or deductibles.

NOTE: Providers cannot bill members for the difference between the primary payer’s payments and their billed charges when the State Managed Care Network does not make additional payment.

Authorizations and Coordination of Benefits

The State Managed Care Network authorization rules apply only when the plan is considered the primary payer. If the State Managed Care Network is considered the secondary payer, benefits will be coordinated without need for prior authorization by the State Managed Care Network. A provider should request authorization for services anytime he/she believes the State Managed Care Network will be primarily responsible for payment of these services. 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.

VI. Provider's Reimbursement

Fee Schedule

The CHP+ fee schedule is based on the Colorado Adjusted Centers for Medicare and Medicaid Service's (CMS) Resource Based Relative Value Scale (RBRVS). CHP+ uses two (2) separate conversion factors to calculate reimbursement:

- Medical/Surgical/Laboratory
- Anesthesia

Payment of 35% percent of billed charges will be made for those services or procedures which are by report, unlisted or have not been assigned a unit value by RBRVS.

Primary Care Providers

All Primary Care Providers (PCPs) will be reimbursed at the fee-for-service rate for services provided to members of CHP+ and the CHP+ Prenatal Care Program.

Some CHP+ members must pay a co-payment when they receive services. The patient's card shows what his/her co-payment is according to the type of service. PCP offices should collect these co-payments for all office visits that the office would ordinarily generate a charge **except for**:

- Emergency transport/ambulance services
- Inpatient hospitalization and services
- Skilled nursing
- Outpatient/ambulatory surgery
- Laboratory/X-ray services
- Preventive care services (e.g. immunizations, well-child check-ups, and health maintenance visits)
- Durable medical equipment
- Audiology services
- Maternity care

Ancillary Services Performed by the PCP

Ancillary services such as lab tests or X-rays, which are performed by the member's PCP or billed through the PCP office, will be reimbursed on a fee-for-service basis at the rates set forth in the CHP+ fee schedule.

Specialty Care Reimbursement

Co-payments for Specialty Care

Some CHP+ members must pay a co-payment when they receive services. The patient's card shows what his/her co-payment is according to the type of service. Specialty care provider offices should collect these co-payments for all office visits that the office would ordinarily generate a charge except for:

- Emergency transport/ambulance services

- Inpatient hospitalization and services
- Skilled nursing
- Outpatient/ambulatory surgery
- Laboratory/X-ray services
- Preventive care services (e.g. immunizations, well-child check-ups, and health maintenance visits)
- Durable medical equipment
- Audiology services
- Maternity care

All services are reimbursed at the current CHP+ fee schedule.

Laboratory Services

Laboratory services are reimbursed at the rates set forth in the CHP+ fee schedule. Claims for lab services should be billed on a CMS 1500 or a UB04.

Hospital-based Charges

Radiology Services and Hospital Facility Charges for Emergency Room, Surgery, and other Hospital-based Charges

Hospital-based services covered by CHP+ are reimbursed as established by the individual provider's contract with CHP+. Hospital services should be billed on a UB04.

Physical, Occupational, and Speech Therapies

If services such as physical therapy, occupational therapy or speech therapy are hospital based and billed on a UB04, CHP+ will reimburse those services using the same formula that is applied for other hospital-based services. If professionals in freestanding facilities provide these services and bill on a CMS 1500, they will be reimbursed at the rates set forth in the CHP+ fee schedule.

Chiropractic Care

Care provided by a Chiropractor is not a covered benefit under the CHP+ State Managed Care plan.

Reproductive Health Services

The State Managed Care Network will reimburse providers of reproductive health care services at the rates set forth in the CHP+ fee schedule. Reproductive health care services include, but are not limited to:

- Annual gynecological exams;
- Family planning services; and
- Other specialty care related to reproductive health care.
- Most reproductive health care services can be provided without parental consent according to Colorado Statute 13-22-105 and are considered confidential.

Emergency/Urgent Care Services

Valid procedure codes must be used when medical services are rendered in the office or consult room of a hospital where no facility fee is charged, rather than sending the member to an emergency room in an urgent or emergent situation outside normal office hours. After-hours care/office services is care requested outside a provider's normal or published office hours, such as between 10 p.m. and 8 a.m., or services requested when a provider's office is closed on weekends and holidays.

These procedure codes should not be used for routine care that can wait until regular office hours. These codes only apply to emergency and urgent care. Benefits for routine or preventive services provided in the emergency department are not within the meaning of emergency services.

The applicable copay requirements for emergency services remain in place, and CHP+ members are responsible for paying the copay.

Anesthesia Billing

When billing for anesthesia services, please use Anesthesia Service Codes (procedure codes 00100-01999) in field 24-D. Time units must be entered in field 24-G -- one unit equals 15 minutes. When calculating reimbursement on anesthesia claims, the State Managed Care Network does pay for time and units. However, the State Managed Care Network pays for the actual time administered. One unit is equal to 15 minutes. 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 (conversion factor) is multiplied by Y. This total is the payment amount.

Immunizations

Primary Care Providers (PCPs) are required to provide immunizations to CHP+ members who have chosen their practice as their PCP.

- Immunizations administered to CHP+ members are reimbursed on a fee-for-service basis at 100% AWP.
- Payment on Immunization claims for CHP+ members will reflect reimbursement for both the vaccine and administration.
- Please bill administration fees using CPT™ codes 90471 (Immunization administration) or 90472 (Immunization administration; each additional dose).
- Immunizations for work and travel are not a covered benefit of CHP+.
- Flu shots given to members of the State Managed Care Network are covered.
- NOTE: CHP+ members are not eligible for the Vaccines for Children Program.

Dental Services

Delta Dental provides coverage to CHP+ members for non accident-related dental services. Please call Delta Dental at (800) 610-0201 with questions or concerns regarding non-accident related dental benefits.

The State Managed Care Network provides coverage for certain accident related dental services, dental anesthesia, inpatient admission for dental care (including room and board, coverage does not include charges for the dental services), and treatment of cleft palate and cleft lip conditions. All dental services and supplies are subject to pre-authorization guidelines and plan provisions.

Hold Harmless

Providers contracted with the State Managed Care Network agree that in no event, including, but not limited to, non-payment by the State Managed Care Network and the CHP+ Prenatal Program, insolvency or breach of the provider contract, will the provider bill, charge, collect a deposit from, seek compensation remuneration, or reimbursement from, or have any recourse against CHP+ members or persons other than CHP+, acting on its own behalf, for services provided pursuant to the provider contract. This provision will not prohibit collection of copayments in accordance with the terms of the member's Evidence of Coverage or collection of payment for non-covered services, except as otherwise expressly prohibited by the provider contract.

Providers contracted with the State Managed Care Network agree that:

This provision will survive the termination of the provider contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of the member. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between a provider and any member or person acting on his or her own behalf.

VII. Member Grievances & Clinical Appeals

A member or the member's designated client representative (DCR), may file a grievance or appeal for reasons including, but not limited to:

A Grievance example may be:

- When the office staff at a provider's office is rude;
- The inability to schedule an appointment.

- An Appeal example may be:
- Adverse Service determinations

Definitions

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 part, of payment for a service (except payment denials issued by a mental health prepaid inpatient health plan) which makes the Member liable for payment;
- The failure to authorize services in a timely manner;
- The failure to act within the time frames provided in this policy; or
- The denial of a Member's request to exercise the right to obtain services outside the network.

Adverse Determination – a determination by the State Managed Care Network or its designee that request for a benefit has been reviewed and, based upon the information provided, does not meet requirements for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination also includes a denial for a benefit excluded by the State Managed Care Network for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

Appeal - A request for a review of an action by a Member or a DCR.

Designated Client Representative (DCR) - Any person, including a treating health care professional, authorized in writing by the Member or the Member's legal guardian to represent his or her interests related to grievances or appeals about health care benefits and services.

Grievance - An oral or written expression of dissatisfaction communicated by a Member or a DCR 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.

Inquiry - A routine request for information, by a Member or DCR that is resolved through an informal existing process.

Quality of Care Grievance - Any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health or welfare of a Member.

Utilization Review - A set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and retrospective review.

For purposes of the Grievance and Appeals policy, utilization review shall also include reviews for determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given.

Grievance Process

We have established a grievance and appeal process for Members or Designated Client Representatives of the State Managed Care Network. A member may designate an individual as a DCR in writing using a Designated Client Representative Form. A copy of the form is provided in Appendix E.

- We will accept a grievance from a Member or DCR that is submitted within twenty (20) calendar days of the incident.
- Upon receipt of a grievance, we will send a written acknowledgement of each grievance to the member or DCR within two (2) business days of receipt.
- 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 fifteen (15) business days from receipt 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.
- We may extend the resolution time frame of a grievance up to fourteen (14) calendar days if the member requests the extension, or we show a need for additional information and the delay is in the member's best interest. We will provide the Member with prior written notice of the reason for the delay.

Should a member be dissatisfied with the State Managed Care Network resolution regarding a Grievance, members can direct written correspondence to:

Health Plan Manager
Child Health Plan *Plus*
Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

Clinical Appeals

We have established an appeal process and access to a State Fair Hearing for members or Designated Client Representatives (DCRs) of CHP+.

A CHP+ member or DCR may request a review of an adverse determination, not involving an urgent care request, through the appeal process either verbally or in writing. A member may designate an individual as a DCR in writing using a Designated Client Representative Form. A copy of the form is provided in Appendix E. We will allow the member to identify providers to whom the notice of the appeal decision should be sent. An appeal from any other person(s) will not be accepted without a signed DCR form.

For any service denied as “not a covered benefit,” a member, DCR, or legal representative may provide evidence from the provider to indicate what reasonable medical basis there is for the service to be considered a covered benefit. The review standard here is not whether the service is medically necessary. The review standard is whether the evidence supports how the requested service falls within the current schedule of covered benefits. If we determine that there is a reasonable medical basis to consider the service a covered benefit, the denial shall be eligible for appeal. If no reasonable medical basis exists for the service to be considered a covered benefit, the service shall be considered denied and no further internal appeal will be available.

First Level Appeal

1. The State Managed Care Network will provide a written notice of action to members or DCRs.
2. We will make a reasonable effort to provide assistance to a member or DCR in navigating the appeal process including but not limited to, completing necessary appeal forms, and providing interpretive services and toll free numbers that have TTY/TTD capability.
3. We will accept an appeal from a member or DCR that is submitted within 180 calendar days from the date of the notice of action.
4. We will not impose punitive action against a member or DCR for filing an appeal.
5. If the State Managed Care Network or the treating provider determines that taking the 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.
6. For notification purposes, parties to the appeal include the member and/or the DCR or the legal representative of a deceased member estate.
7. Upon receipt of an appeal, a written acknowledgement of the appeal is provided to the member and/or the DCR within two (2) business days of receipt, unless the member or DCR requests an expedited resolution. Expedited resolutions are addressed later in this section.

8. If the original action was made to deny a service, and substantive new clinical information is received; the appeal request may be returned to the original medical reviewer to evaluate the new information and to see if they are able to overturn their original action and approve the service. If the medical reviewer is unable to overturn their action with the new information, the request will be forwarded to a licensed physician who was not involved in the original decision.
9. 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:
 - a) An appeal based on lack of medical necessity; or
 - b) An appeal that involves a clinical decision.
10. We will provide a process for standard and expedited appeals. Standard and expedited appeals will be resolved and a notice provided to the member or DCR as expeditiously as the member's health condition requires, not to exceed the following:
 - a) A standard appeal is resolved and a written notice of the resolution is provided to the member or DCR within 30 calendar days of receipt.
 - b) An expedited appeal is resolved and a written notice of the resolution is provided to the member or DCR within three (3) business days of receipt. We will make a reasonable effort to provide verbal notice to the member and/or DCR. If a request for an expedited appeal resolution is denied, we will make a reasonable effort to give the member prompt verbal notice of the denial with a written notice provided to the member within two (2) calendar days. The appeal will then follow the process for a standard resolution.
 - c) Expedited appeals for non-formulary medication requests resulting in an adverse determination may be requested by the member or provider via phone or fax to the Pharmacy Services, and will be completed within twelve (12) business hours. The member and provider will be notified of the appeal review determination by telephone, fax or by letter within one (1) business day of making the determination. Members and providers have a right to appeal an expedited appeal.
11. We may extend the time frame in order to resolve a standard or expedited appeal up to fourteen (14) calendar days if the member requests the extension or the State Managed Care Network shows a need for additional information and the delay is in the member's best interest. We will provide the member with prior written notice of the reason for the delay.
12. We will make a reasonable effort to provide an opportunity for the member or DCR 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.
13. We will provide resolution notices to all parties regarding the appeal which include the results of the appeal process and the date the resolution was completed. For appeals not resolved wholly in favor of the member, the notice will include the right to request a state fair hearing, the right to request and to receive benefits while the hearing is pending and that the member may be held liable for the cost of those benefits if the hearing decision upholds the State Managed Care Network's initial action.

Second Level Appeal

We have a second-level appeal process for CHP+ .

1. In cases where a CHP+ member is dissatisfied with the first level appeal decision, the member or DCR may request a final internal review by submitting a request for a second level appeal.
2. Members or DCRs may submit a request for a second level appeal within thirty (30) calendar days after the date of receipt of the written decision on the first level appeal.
3. If the first level appeal resulted in the denial of the requested service being upheld, and where substantive new clinical information has been received, the second level appeal request may be returned to the physician who reviewed the first level appeal. The physician will evaluate the new clinical information to see if his or her own decision should be overturned and the original request for service approved. If the physician is unable to overturn the denial with the new information, the appeal will be forwarded to the second level reviewer.
4. For second-level appeals, we will appoint up to three health care professionals to conduct the second-level review. The reviewer(s) will have appropriate expertise in treating the member's condition; will not have been involved in any previous level of review or decision-making or care related to the case; and not have a direct financial interest in the case or in the outcome of the review.
5. We will schedule the second level appeal within sixty (60) calendar days of receiving a request for a second level appeal from a member. If a member requests the opportunity to appear in person before the reviewer(s), We will schedule the appeal during regular business hours at a location reasonably accessible to the member, including accommodations for disabilities.
6. We will notify the member in writing at least twenty (20) calendar days in advance of the date of the second level appeal. The notice will contain the member's rights pertaining to a second level appeal as required by Colorado Division of Insurance regulations. Requests by the member to reschedule the second level appeal will not be unreasonably denied.
7. We will not discourage a member from attending the appeal and meeting with the reviewer(s) face-to-face. In cases where a face-to-face meeting is not practical, we will offer the member (at our expense) the opportunity to communicate with the reviewer(s) by conference call, video conferencing, or other appropriate technology, at no cost to the member.
8. During the second level appeal, the reviewer(s) shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the member without regard to whether the information was submitted or considered in the decision on the original request for service or the first level appeal.
9. If the second level appeal is regarding the applicability of a covered benefit, the determination shall be made on the basis of whether the requested service is a covered benefit, and not solely on the basis of whether the requested service is medically necessary.

10. The reviewer(s) will issue a written decision to the member within seven (7) calendar days of completing the review of a second level appeal.
11. Notice of the decision on the second level appeal will include the following elements:
 - a. The name, title and qualifying credentials of the reviewer(s);
 - b. A statement of the reviewer's understanding of the covered person's request for review of the original adverse determination;
 - c. The reviewer's decision in clear terms;
 - d. A reference to the evidence or documentation used as a basis for the reviewer's decision, including:
 - i) the specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;
 - ii) a statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the request for service;
 - iii) if the reviewer(s) relied on an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
 - iv) if the adverse determination is based on a medical necessity or experimental or investigational treatment, the written statement of the scientific or clinical rationale for the determination; and
 - v) if applicable, instructions for requesting:
 - a. copy of the rule guideline, protocol or other criterion relied on in making the adverse determination;
 - b. the written statement of the scientific or clinical rationale for the determination.
 - vi) a statement describing the procedure for obtaining an independent external review of an adverse determination pursuant to Division of Insurance regulation 4-2-21 and/or a state fair hearing
12. For purposes of calculating time periods within which a decision is required to be made and notice provided, the time period begins on the date of the request for a second level appeal is filed with the State Managed Care Network, according to established procedures, without regard to whether all of the information necessary to make the determination accompanies the request.

Should a member be dissatisfied with the State Managed Care Network resolution regarding an appeal, members can direct written correspondence to:

Health Plan Manager
Child Health Plan *Plus*
Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

VIII. Authorizations & Referrals

The State Managed Care Network's prior authorization policy helps ensure that CHP+ members receive the most appropriate and cost effective care. We appreciate your cooperation. If you have questions or concerns about prior authorizations, please call our Customer Service Department at (303) 751-9051 or toll free 1-800-414-6198, or you may refer to the Prior Authorization List located on our website. Directions for accessing the list are located below.

Providers are contractually obligated to cooperate with the State Managed Care Network administered by Colorado Access in conducting medical management reviews and shall respond to inquiries made by Colorado Access on behalf of the State Managed Care Network and the CHP+ Prenatal Care Program. Failure to respond within a reasonable time frame may result in termination of your contract.

Prior Authorization List

A comprehensive list of procedure codes and corresponding authorization requirements is located on the Colorado Access website at www.coaccess.com. To access the list, click on *For Our Providers*. Then, click on *Provider Logon* and enter your Colorado Access Username and Password. From the Provider Welcome page, click on *Authorization List* to access the list in PDF format.

If you do not have a Colorado Access Username and Password, please complete the Web Based Applications Request Form located on the Colorado Access website at <https://www.coaccess.com/providers/files/WebAccessApplication.pdf>. Fax or email the completed form to (303) 755-2368 or PNS@coaccess.com.

Submitting an Authorization request

Certain services require authorization in order to obtain coverage (payment). In most instances, **prior authorization** is required. It is best to plan ahead and submit an authorization request well in advance of the service being rendered. It takes a minimum of two (2) full working days to process an authorization request, and longer if additional information or reconsideration is required.

The State Managed Care Network cannot retrospectively deny benefits for treatments that have been pre-authorized except in cases of fraud, abuse, or if the member loses eligibility.

Please verify the member's eligibility before submitting an authorization request. Once you have determined that the member is eligible, you may either fax the Service Authorization Form to our Coordinated Clinical Services Department or ask to speak with a Coordinated Clinical Services Representative.

A copy of the Service Authorization Form is provided in Appendix F. Required fields are indicated by bold face type. The form will be returned to sender if the required fields are not

completed. You will be notified if additional information is needed, if the service is authorized, or of an adverse service determination (denial).

As part of utilization review to authorize a service, the State Managed Care Network determines medical necessity. A Covered Service shall be deemed Medically Necessary if, in a manner consistent with accepted standards of medical practice, it is:

- Consistent with the symptom, diagnosis and treatment of a member's medical condition;
- Widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence;
- Not Experimental or Investigational;
- Not solely for cosmetic purposes;
- Not solely for the convenience of the member, physician or other provider;
- The most appropriate level of care that can be safely provided to the member, and;
- Failure to provide the Covered Service would adversely affect the member's health.

Medical necessity determinations are based on the following:

- Standardized national criteria, such as InterQual® criteria.
- Internally developed criteria approved by the Medical/Behavioral Quality Improvement Committee (MBQIC).
- Review by the health plan 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 by calling (303) 751-9051 or toll free 1-800-414-6198.

Authorization Categories

The State Managed Care Network Utilization Management Program has four (4) authorization categories:

No Authorization— Certain services can be provided under specified circumstances (e.g., 911-ambulance calls, emergency department visits, and the following services when rendered by a contracted provider or the assigned PCP; well woman OB/GYN services, family planning services, routine vision care, specialty office visit services) with no notification to or authorization by the State Managed Care Network.

Clinical Referrals— We encourage Primary Care Providers to direct care for specialty office-based services through clinical referrals. We consider a referral to be a clinical 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 the State Managed Care Network for payment purposes. Certain therapies, DME items, and office visits for participating specialists require prior authorization.

Procedure Authorization

Elective Procedures: For procedures requiring authorization, the provider **MUST** request authorization at least two (2) working days in advance of the scheduled service. A review will be done to ensure the following: participating provider, eligible member, covered benefit, and medical necessity.

Emergent Procedures: the provider must notify the State Managed Care Network administered by Colorado Access within 72 hours of the service being rendered or the next business day. A review is done to ensure the following: eligible member, timeliness of notification, and medical necessity.

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

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 two (2) working days in advance of the scheduled service. 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.

Types of Utilization Review Determinations

The State Managed Care Network will make one of the following determinations after reviewing an authorization request.

Authorized—The requested services meets all utilization review criteria. The claim for this service will be paid.

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, reduction and discontinuation of services, or failure to submit necessary information. A claim for this service will not be paid. Only the health plan Associate Medical Director or the designated physician reviewer can deny an authorization request. 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, and/or authorization request has not met timeliness requirements) may result in an Administrative Denial.

All denials/Adverse Service Determinations may be appealed. Please see the Clinical Appeals section of this manual for additional information regarding the appeal process.

General Authorization Rules

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.

CHP+ members have out-of-network benefits for urgent and emergent care or if specifically pre-authorized by the State Managed Care Network administered by Colorado Access. Authorization is needed for a member to see a non-participating specialist. Colorado Access’ Coordinated Clinical Services Department must authorize (approve) referrals to non-participating providers before services are rendered. Referrals to non-participating providers are appropriate only under the following circumstances:

- There is no provider in the CHP+ network, based on access, specialty, distance, appointment wait times, etc., who can reasonably provide the service; or
- Emergency care makes using a non-participating provider necessary.

Primary Care:

Services provided by participating PCPs do not require prior authorization.

Specialists Referrals:

Specialty office visits for participating specialty providers do not require a prior authorization. We encourage Primary Care Providers to direct care for specialty office-based care through clinical referrals. We consider a referral to be a clinical 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 and will be considered on a case-by-case basis for particular clinical needs.

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 3. *Procedure Authorization* in the *Authorization Categories* section. Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria.

Failure to request authorization within timeliness guidelines will result in a denial unless there is documentation of extraordinary circumstances.

Elective Services, Procedures, or Admissions

The facility must request authorization at least two (2) working days in advance of the scheduled service. 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 72 hours of the service being rendered or the next business day. A review is done to ensure the following: eligible member, 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 is not discharged at the same time as the mother, an authorization is required for the infant'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 (1) working day of request.

Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria or 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 the State Managed Care Network on the next working day following discharge from the facility. A review is done to ensure the following: eligible member, 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.

An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, that 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.

The State Managed Care Network and the CHP+ Prenatal Care Program covers all emergency department services necessary to screen and stabilize members if: A prudent lay person would have reasonably believed that use of a contracting 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.

Prior authorization is not required for urgent care services billed with place of service 20. 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 72 hours of the service being rendered or the next business day. A review is done to ensure the following: eligible member, 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 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.

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. 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.

Women's Health / OB/GYN Services:

OB/GYN office-based services do not require referral or prior authorization if the services are obtained from participating providers. Certain facility-based procedures may require prior authorization. Refer to the Prior Authorization List to determine whether a procedure requires authorization. Please logon to the Colorado Access website at <https://www.coaccess.com/providers/Global.jsp> to locate the Prior Authorization List.

Family planning services do not require prior authorization or referral for any participating provider.

Some surgeries and supplies may require authorization. Please refer to the Prior Authorization List for authorization requirements.

Gynecological services that require procedure authorization must be submitted to the State Managed Care Network for review at least two (2) working days in advance of the scheduled service in order to ensure payment of professional fees. For emergent procedures, the provider must notify the State Managed Care Network within 72 hours of the service being rendered or the next business day. Services performed in an outpatient setting (place of service 22 or 24) do not require a facility authorization.

All requests for 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 evaluation, diagnosis and treatments are not covered benefits.

Failure to request authorization within timeliness guidelines will result in an administrative denial.

Maternity Care:

Per the Colorado Women's Healthcare Act, CHP+ and CHP+ Prenatal Care Program 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 Prior Authorization List 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 the State Managed Care Network when a member is admitted for inpatient obstetrical care, or delivery within one (1) 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.

Prenatal Ultrasounds

Two (2) antenatal ultrasounds are covered without prior authorization. After the 2nd ultrasound,

prior authorization is needed. This is to ensure that case management will review the case for pending high risk pregnancy.

Inpatient Maternity Care

All admissions for complications of pregnancy and for delivery require facility authorization and are based on medical necessity review.

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 facility fails to obtain authorization for lengths of stay longer than 48 hours for a vaginal delivery or 96 hours for a Cesarean, additional professional and facility fees for the unauthorized days will be denied.

Newborns are covered under the mother's delivery authorization. For sick newborns who remain in the hospital after the mother's discharge, the State Managed Care Network must be notified and a separate case will be started for the newborn stay. The State Managed Care Network is responsible for any newborn who remains in the hospital from date of birth through discharge.

Postpartum Ambulatory Maternity Care

Office-based postpartum care should occur within 6 weeks of delivery and does not require a referral authorization if provided by the same participating provider or group that provided prenatal care.

Sub-Specialty Maternity Care

The State Managed Care Network encourages Primary Care Providers and Obstetricians/Gynecologist to direct members to contracted specialty/sub-specialist 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 physician 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 subspecialty care).

Genetic Testing/Counseling

This coverage does not cover services including, but not limited to, preconception testing, paternity testing, court-ordered genetic counseling and testing, or testing for inherited disorders, and discussion of family history or testing to determine the sex or physical characteristics of an unborn child. Genetic tests to evaluate risks of disorders for certain conditions may be covered based on medical policy, review and criteria and after appropriate pre-authorization has been obtained.

Continuity of Care for pregnant women joining the State Managed Care Network

Women who become members of the State Managed Care Network in the 1st trimester of their pregnancy will be referred to a participating provider for their maternity care. Women who become members of the State Managed Care Network in the 2nd or 3rd 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 CHP+ effective date. If the patient-provider relationship predates the effective date AND the provider is not a participating provider with the State Managed Care Network, the provider must agree to accept the CHP+ fee schedule as payment in full and agree to follow CHP+ Utilization Management and Quality Management policies and procedures.

Non-participating providers need to notify the State Managed Care Network that s/he has a member who needs continuity of prenatal 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-Par Facilities

If a provider uses a non-par facility for the provision of any of the antepartum or subspecialty 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 the Prior Authorization List to determine whether a diagnostic procedure requires authorization.

Diagnostic Interpretation Services:

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

Vision Care:

Routine vision services do not require prior authorization for payment. Certain specialty procedures may require prior authorization. Refer to the Prior Authorization List to determine whether a procedure requires authorization.

Vision screening is covered as age-appropriate care. No referral or authorization is required for routine eye examinations, glasses, or contact lenses. Vision therapy is an excluded benefit. Blepharoplasties, 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) does not require prior authorization for payment for stays

less than 48 hours. After 48 hours, an authorization must be obtained. Observation may be allowed for up to 72 hours as defined by federal rules.

Home Health Care:

All home health care 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 assigned PCP or discharging physician. The physician's orders must be submitted to a participating home health agency. The home health agency must then notify the State Managed Care Network by submitting the physician's orders with the request, within one (1) working day of service initiation.

Authorization will be given for one (1) evaluation per service type without medical necessity review.

Following the evaluation, a request for procedural authorization must be submitted along with the plan of care within five (5) days of the new plan of care for authorization of additional services beyond the evaluation. Any services rendered beyond the initial evaluation without authorization are subject to denial regardless of medical necessity.

Failure to request authorization within timeliness guidelines will result in an administrative denial.

Any time there is a break in service, the home health agency must notify the State Managed Care Network within one (1) 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 service 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 through the State Managed Care Network. 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 a member of the member's immediate family 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 the Prior Authorization List to determine whether a supply item or piece of equipment requires authorization.

Therapy:

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

A prior authorization approved by the State Managed Care Network 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. Failure to request authorization within timeliness guidelines will result in an administrative denial.

Coverage is subject to benefit limits. Please see section *XII. Benefits & Copayments* for information on benefits.

Downstream Providers:

A downstream provider is defined as a group of providers who render services to our members at the direction of other providers. The State Managed Care Network has determined that these providers should be held harmless from the prior authorization and/or referral process. All downstream providers bill utilizing CMS-1500 billing format. Only the “professional” component of the service is considered downstream. All other billing policies apply (i.e. timely filing and eligibility requirements).

Emergency Room – place of service 23 – all services billed by practitioners are considered downstream.

Inpatient – place of service 21 – pathology, radiology, anesthesia and all other physician services not on the Prior Authorization List 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.
- Anesthesia – all professional services billed within the procedure code range of (00100- 01999).
- Facility – all outpatient facility services billed with place of service 22 or 24.
- 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.

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.

Continuity of Care and Transition of Care for New Members

The State Managed Care Network will contact members who have been identified as having potential transition 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 sixty (60) calendar days for primary and specialty care, and seventy-five (75) calendar days for ancillary services.

If the provider is not contracted with the State Managed Care Network and is not willing to do so, and the service is expected to be ongoing, the State Managed Care Network, 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 post-partum care directly related to the delivery.

If the State Managed Care Network does 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 nonparticipating provider.

Continuity of Care and Transition of Care for Existing Members

At the time the State Managed Care Network is notified of a network transition (i.e. provider group termination or vendor contract termination), a transition 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.

- when proper notice has not been provided, the State Managed Care Network shall allow members to continue receiving care for sixty (60) calendar days from the date a participating provider is terminated without cause, unless it is determined by the health plan Associate Medical Director or designee that continued care with the terminated provider would present undue risk to the member or to the State Managed Care Network.

Primary Care Provider

The process of reassignment of members to a participating primary care provider will be completed within five (5) business days prior to the effective date of the contract termination. Affected members will be issued a new identification card once reassignment has been completed.

IX. Pharmacy Services

Caremark is the pharmacy benefit management company for prescriptions for members of the State Managed Care Network and the CHP+ Prenatal Care Program. Claims filed with Caremark will be reimbursed at the rate of reimbursement defined in the contract each pharmacy has with Caremark.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. For a list of current drugs requiring prior authorization, visit www.coaccess.com or call Customer Service at (303) 751-9051 or toll free 1-800-414-6198. If prior authorization is denied, the member may appeal the decision.

Prescription Copays

The following are the CHP+

	100% or less of FPL	101% - 150% of FPL	151%-205% of FPL
Pharmacy/Rx Generic	\$0	\$1	\$3
Pharmacy/Rx Brand	\$0	\$1	\$5

Mail Order Service

Mail-order service offers a convenient option for obtaining maintenance prescription drugs if the member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail-order service that has entered into a reimbursement agreement with the State Managed Care Network, and the drugs are sent directly to the member's home.

The member must complete the Caremark Mail Order Form, which is available at www.coaccess.com or by calling Customer Service at (303) 751-9051 or toll free 1-800-414-6198. The member must complete the patient profile information only once. The member may mail written prescriptions from the physician or have the physician fax the prescription to the mail-order service. The member's physician may also phone in the prescription to the mail-order service. The member is required to submit the applicable copay amounts to the mail-order service when the member requests a prescription or refill.

NOTE: Class II prescription drugs (e.g., narcotics) will only be dispensed in a 34-day supply.

X. Behavioral Health

Outpatient Treatment

The State Managed Care Network covers outpatient mental health services. Covered outpatient treatments require pre-authorization. Covered services include, but are not limited to:

- Individual counseling.
- Family counseling.
- Group counseling.
- Case management services.

Medication Management

The State Managed Care Network covers medication management of mental health conditions by the member's medical provider, psychiatrist or prescriptive nurse.

Day Treatment

Day treatment services are for children who have specific mental health and educational needs and are sometimes part of the child's Individual Education Plan (IEP). Covered day treatment services require pre-authorization. Day treatment services can include, but are not limited to:

- Individual counseling.
- Family counseling.
- Group counseling.
- Educational support services.

Case Management

State Managed Care Network Case Managers can help members:

- Coordinate care among multiple service providers.
- Help members find resources (such as food, clothing, and housing).
- For information about case management, please call the State Managed Care Network at 303-751-9051 or 1-800-414-6198.

Inpatient Services

The State Managed Care Network covers medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays require pre-authorization. Covered services include:

- Provider visits received during a covered admission.
- Inpatient semi-private room or ancillary services.
- Group psychotherapy.
- Psychological testing.
- Family counseling with family members to help in your diagnosis and treatment.
- Medication management.

Residential treatment service

The same services covered as inpatient services are also covered for residential treatment services. Residential treatment services are services in a licensed residential treatment facility that can provide day services and 24-hour supervision after day program. Residential treatment is approved only if the charges are equal to or less than partial hospitalization.

Home-Based Services (Wrap Around Services)

This is specialized mental health care that members receive in the home when traditional mental health services have not been effective. Covered services require pre-authorization. The goal of home-based services is to help families stay together.

Evaluation/Assessments

More Services

If you have questions about other mental health services that are not listed, please call the State Managed Care Network at (303) 751-9051 or 1-800-414-6198.

Substance Abuse

The State Managed Care Network covers medically necessary outpatient and in-patient substance abuse treatments. Covered outpatient substance abuse treatments require pre-authorization.

Behavioral Health Services that are not Covered

The following services, supplies and care are not covered:

- Private room expenses.
- Vocational Services (includes but is not limited to resume writing, interview skills, work skills training, and career development).
- Psychosocial Treatment (includes but is not limited to home and budget skills).
- Biofeedback.
- Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering the member's education.
- Hypnotherapy.
- Religious, marital and social counseling.
- The cost of any damages to a treatment facility caused by the member.
- Recreational, sex, primal scream, sleep and Z therapies.
- Self-help and weight-loss programs.
- Transactional analysis, encounter groups and transcendental meditation.
- Sensitivity training and assertiveness training.
- Rebirthing therapy.
- Custodial care.
- Domiciliary care.

- Court or police-ordered treatment that would not otherwise be covered.
- Services not authorized by the State Managed Care Network.

XI. Enrollment Procedures & Membership

CHP+ Administration determines eligibility for CHP+ based upon the income and family size reported by the applicant. CHP+ defines a family as a group of people who are related by blood, marriage or other legally recognized domestic relationship; who live in the same household; and who receive at least 50% of their support from the household.

The plan cannot accept a child or pregnant woman who is eligible for Medicaid. If the child or pregnant woman appears to be eligible for Medicaid, the family's application will be referred for Medicaid determination. If the family is denied Medicaid coverage, CHP+ coverage will be retroactive to either the date of the postmark on the envelope containing the original, complete CHP+ application or the date the complete application is delivered to CHP+ or one of its satellite eligibility determination sites.

Some CHP+ families, depending on income level at the time of application, will be required to pay an annual enrollment fee of either \$25 for a single child or \$35 for multiple children. There is not an enrollment fee for pregnant women who enroll in the CHP+ Prenatal Care Program.

Income Test

CHP+ uses an income test to determine eligibility for the program.

The family must report an adjusted gross income of less than 205% of the Federal Poverty Level, determined by family size, to qualify for CHP+. Current income is tested using the most recent thirty days income for all family members. Families who are self-employed can document income with copies of ledgers, checks and bank statements. Gross family income includes all income received by adult members of the family, as defined above, living in the same household, including work income (salary or income from self employment) and non-work income, such as rental income, social security and others.

Presumptive Eligibility (PE)

The CHP+ and CHP+ Prenatal Care Programs offers temporary comprehensive benefits to children or pregnant women while their application for enrollment is reviewed. Member's with PE coverage will receive a temporary ID card. The PE coverage is good for a maximum of 60 days. The temporary ID card will reflect the PE coverage termination date. If the applicant is determined eligible, s/he will receive a new ID card and will be eligible for:

- CHP+: 1 Year from the date the application is approved.
- CHP+ Prenatal Care Program: For the duration of the pregnancy and 60 days following the end of the pregnancy.
- If the applicant is determined ineligible, PE coverage will end 60 days from the application date. CHP+ is not responsible for services rendered to the patient after the termination date indicated on the temporary ID card, unless s/he is determined eligible.

Terms of Eligibility

If a member is accepted onto CHP+, coverage will begin either on the date of the postmark on the envelope containing the original, complete, CHP+ application or the date the complete application is delivered to CHP+ or one of its satellite eligibility sites. If the application or its documentation is not complete when received by CHP+, CHP+ will notify the member and allow them 10 business days to provide the complete information. Coverage will begin on the date the complete information is received by CHP+.

CHP+ only requires documentation as required by Federal Minimum Verification Rules. The applicant must acknowledge every question, documentation of the last 30 days income must accompany the application, and the application must be signed and dated.

No medical bills incurred prior to the date of a complete application as defined above will be covered by CHP+. In an urgent situation, CHP+ will accept an application submitted by fax to the CHP+ Offices. Please note: the original application must be sent to CHP+ within five (5) days of the faxed application or coverage will be terminated.

Enrollment in CHP+ is good for one (1) year (children applying during their 18th year will only be covered until the last day of the month of their 19th birthday). During that time, the members are not asked to provide any additional financial documentation. However, if the member is accepted by Medicaid or obtains other insurance during their enrollment year, both the member and the provider are obligated to inform CHP+.

CHP+ enrollment is contingent upon absence of other insurance coverage excluding Indigent Care, Medicare or the Health Care Program for Children with Special Needs (HCP). If the subscriber is covered by any other valid coverage, including Medicaid and individual non-group coverage, she or he is not eligible for CHP+. Each eligible child will receive an ID card:

Member copays

Preventive Care	\$ 0
Office Visit	\$ 5
Vision	\$ 0
Lab and X-Ray	\$ 0
ER/Urgent/After Hours Care	\$ 15
Hospital Inpatient	\$ 0
Outpatient Surgery	\$ 0
Outpatient Mental Health	\$ 0
Pharmacy/Rx Generic	\$ 3
Pharmacy/Rx Brand	\$ 5

FOR MEMBERS

- You must show this ID card every time you see a healthcare provider.
- Your Primary Care Provider (PCP) will coordinate your medical care (except in emergencies).
- Referrals to specialists or hospitals must be obtained from your PCP before services are performed.

Emergency Care

- If possible, call your PCP before going to the emergency room.
- In a true emergency, call 911 or go to the emergency room.
- If you are not sure what to do, call your PCP.

FOR PROVIDERS

Send claims to: Colorado Access Claims Department, P.O. Box 17470, Denver, CO 80217-0940

To check eligibility, go to: www.coaccess.com or call: 303-751-9021 or 1-888-214-1101

The effective dates for enrollment in the CHP+ Managed Care Network

Pharmacy information

This is a unique ID number and group code issued by Colorado Access. This is the member's ID number while enrolled in the State Managed Care Network.

Members Enrolled in the CHP+ Prenatal Care Program are eligible until 60 days following the end of the member's pregnancy. While eligible, the member is not asked to provide any additional financial documentation. However, if the member is accepted by Medicaid, obtains other insurance during the time she is enrolled in the CHP+ Prenatal Care Program, or moves out of Colorado, both the member and the provider are obligated to inform CHP+.

Pre-HMO Enrollment Period

The following information does not apply to the CHP+ Prenatal Care Program.

CHP+ members who reside in a county where one or more HMOs participate with CHP+ must choose from the participating HMOs to access CHP+ covered services. Membership information is transferred to CHP+ participating HMOs by the 23rd of each month. Because CHP+ provides immediate access to care for eligible families based upon the receipt of a complete application, there is a period of time where members in HMO participating counties are not enrolled with their chosen HMO, this is referred to as the Pre-HMO Enrollment Period. In order to be able to offer services to these members, CHP+ enrolls members in the State Managed Care Network until they become effective with the HMO of their choice.

NOTE: The Pre-HMO Enrollment Period is usually 45 days or less.

The membership identification cards from the State Managed Care Network indicates where claims, referrals and authorizations are processed. Claims incurred during the pre-HMO enrollment period should be sent to the State Managed Care Network. Claims incurred after the effective date of the member's enrollment with an HMO should be sent to the HMO the member selected. The member's HMO, in accordance with the terms set forth in their own provider agreements, makes reimbursement for covered services from that point forward.

All CHP+ members receive an initial card from the State Managed Care Network for their pre-HMO enrollment period. See the previous page for an example of the ID card. This card is valid from their CHP+ enrollment date through the day before they transfer to their chosen HMO. The effective dates of the member's coverage in the State Managed Care Network are printed on the card. HMO members will receive new cards from their HMO when they enroll with the HMO. To avoid rejected claims, we suggest that you check the member's card every time he/she comes to your office for services, and verify eligibility using the Colorado Access website.

HMO Enrollment

The following information does not apply to the CHP+ Prenatal Care Program.

In many counties in Colorado, a member's PCP is contracted with one or more CHP+ Health Maintenance Organizations (HMOs) to provide care for CHP+ members. In the counties where HMOs are available, CHP+ applicants are required to choose a PCP and an HMO that the PCP is affiliated with to access CHP+ benefits. Once a CHP+ member is enrolled with their designated HMO, that HMO is responsible for managing the member's care. For more information regarding HMO availability by county, please contact the CHP+ Administrative Offices at 1-800-359-1991 or visit <http://chplus.org/>.

Members may change their HMO only 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).

Membership Identification

Membership ID cards – All CHP+ members receive a member identification card when they are enrolled in the State Managed Care Network. An example of the ID card can be found on page 49. Members will also receive a separate ID card from Delta Dental for all covered dental services. For information regarding dental membership ID cards or benefits, contact Delta Dental at 1-800-610-0201.

Verifying Eligibility and PCP Assignment

The provider is responsible for verifying eligibility when rendering services. A member's enrollment with the State Managed Care Network may be verified by any of the following means:

- Logging on to the Colorado Access Web site and utilizing the Eligibility Search (please see the Introduction to this manual for more information on the Colorado Access website).
- Logging on to the State Web Portal at <https://sp0.hcpf.state.co.us/Mercury/login.aspx>.
- Verifying member enrollment on the monthly Colorado Access Membership report. Lists of members assigned to specific PCPs are generated during the first five (5) working days of the month and are available on the Colorado Access Web site (www.coaccess.com). New members are designated with an asterisk (*).
- Calling Customer Service at (303) 751-9051 or toll free 1-800-414-6198.

Cancellation of Member's Coverage

If a member of CHP+, including the CHP+ Prenatal Care Program, has lost eligibility, the payments for that member will be adjusted back to the date of disenrollment from CHP+. The sole exception to this occurs when a child becomes covered by Medicaid or has other primary insurance that was not reported to CHP+. In these cases, CHP+ will retract all payments back to the date of the child's effective date in Medicaid or with other insurance.

The State's Child Health Plan Plus Managed Care Network

Prior to enrollment with an HMO, CHP+ members receive care through the State Managed Care Network. Additionally, CHP+ Prenatal Care Program members and CHP+ members that reside in counties that do not currently offer HMO coverage are enrolled in the State Managed Care Network administered by Colorado Access.

XII. Benefits & Copayments

Out of Pocket Limit

The CHP+ out of pocket limit is 5% of the annual family income, adjusted for family size and determined by CHP+. It is the family's responsibility to notify CHP+ when they reach the out of pocket limit.

Eligible expenses that count toward the out of pocket limit include the annual enrollment fee for CHP+ and co-payments for covered medical and dental services.

Once a family has reached the out of pocket limit and has notified CHP+, CHP+ will verify that the out of pocket limit has been met. The family will then receive a sticker for each family member's ID card. The sticker indicates that the family is no longer responsible for copayments for the remainder of their benefit year.

This limit is only for the remainder of the benefit year the member is enrolled. It does not add to payments in the next benefit year or any that follow.

Copayments

Providers are encouraged to collect the applicable copayment from CHP+ members on the date of service. Member copayments are listed on the member's ID card. The following copays apply to covered services.

	100% or less of FPL	101% - 150% of FPL	151%-205% of FPL
Preventive Care	\$0	\$0	\$0
Office Visit	\$0	\$2	\$5
Vision	\$0	\$2	\$5
Lab and X-Ray	\$0	\$0	\$0
ER/Urgent/After Hours Care	\$3	\$3	\$15
Hospital Inpatient	\$0	\$0	\$0
Outpatient Surgery	\$0	\$0	\$0
Outpatient Mental Health	\$0	\$2	\$5
Pharmacy/Rx Generic	\$0	\$1	\$3
Pharmacy/Rx Brand	\$0	\$1	\$5

Covered Services/Benefits

The following pages contain a summary of covered services and the associated benefit. Please refer to the member's ID card for the exact copay amount. If you have a question about a specific service, please call our Customer Service Department at (303) 751-9051 or toll free 1-800-414-6198.

Summary of State Managed Care Network Benefits	
Service	Available Benefits
Preventive Care	Covered in full when provided by your Primary Care Provider (PCP). Includes immunizations, well-child, well-teen and routine exams.
Reproductive Health Care Services	Covered in full when provided by an in-network provider. Includes well-woman check-ups.
Medical Office visit	Primary Care Provider (PCP) visits and specialty visits covered.
Inpatient Hospital Stay	Covered in full.
Lab, X-ray & Diagnostic Services	Covered in full.
Outpatient Prescription Drugs	Covered in full if included on the formulary. Standard CHP+ copays are \$0 to \$5.
Skilled Nursing Facility	Covered in full.
Outpatient / Ambulatory Surgery	Covered in full.
Emergency Room and Urgent/ After-hours Care	Covered in full for a life or limb emergency. Standard CHP+ copays are \$0 to \$15.
Emergency Transport / Ambulance Services	Covered in full for a life or limb emergency.
Vision Services	Coverage for age-appropriate preventive care and specialty care. \$50 benefit for the purchase of lenses, frames or contacts per calendar year.
Audiological Services	<ul style="list-style-type: none"> • Age appropriate hearing screenings for preventive care. • Newborn hearing screening and follow-up for a failed screen. • 1 Hearing aid once every five years. Additional hearing aids can be provided if medically necessary, including: A new hearing aid when alterations to the existing hearing aid cannot adequately meet your needs. • Services and supplies including, but not limited to the initial assessment fitting, adjustments, and auditory training that is provided according to accepted professional standards. • The CHP+ Prenatal Care Program covers hearing aides for congenital and traumatic injuries up to a maximum of \$800 per calendar year.
Physical, Occupational and Speech Therapy	For outpatient physical rehabilitation (physical, occupational, and/or speech therapy) the standard CHP+ coverage is limited to 30 visits per calendar year. For children aged 0-3 the benefit of physical, occupational and speech therapy is unlimited.
Durable Medical Equipment	Maximum of \$2,000 per calendar year, excluding eyeglasses, contacts or hearing aids.
Home Health Care	Skilled services covered with prior authorization
Maternity Care	All prenatal and delivery visits covered in full.
Behavioral or Mental Health	Coverage for medically necessary services and may require a prior authorization.
Alcohol and Substance Abuse	Coverage for medically necessary outpatient services and may require an authorization.
Transplant Services	Coverage for limited transplants with prior authorization.
Dental Care provided by Delta Dental	Periodic cleanings, exams, x-rays, fillings and root canals. A maximum benefit of \$600 per person per calendar year. Note: Prenatal members receive emergency dental care only.
Exclusions: Services not shown above may not be covered. Call State Managed Care Network at 303-751-9051 or 1-800-414-6198 for more information. This is for summary purposes only and does not guarantee coverage.	