Provider Manual

Child Health Plan *Plus* (CHP+)

State Managed Care Network & Prenatal Care Program

CHP+ Child Health Plan *Plus*

Have questions? Call us at 303-751-9051 or 800-414-6198 (toll free)

Visit us on the web at chpplusproviders.com

Provider Manual - Contents

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: 800-414-6198
TTY/TDD: 720-744-5126
Toll Free TTY/TDD: 888-803-4494

Grievances and Appeals -

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

Child Health Plan *Plus* Administrative Offices -

Toll Free: 800-359-1991

DentaQuest -

Toll Free: 888-307-6561

IMPORTANT FAX NUMBERS

Authorization (Physical Health) Fax -

Local: 303-755-4135
Toll Free: 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

PROVIDER PORTAL

We maintain a provider portal that gives you access to member eligibility, member roster, claim status, and remittance advice information. To register for the portal, you'll need a provider ID number. Please send an email to ProviderRelations@coaccess.com for assistance. Portal usernames and passwords are confidential and may not be shared. In the event that your username or password has been compromised, contact Colorado Access immediately. The provider portal is located at https://secure.healthx.com/v3app/publicservice/loginv1/login.aspx?bc=7be2e49e-b678-4291-9a17-

699997acb06f&serviceid=3c53cf41-7238-4737-b4f1-c2c1f640ef57

IMPORTANT WEBSITES

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

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

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

- Important provider updates
- Provider manuals
- The provider directory
- Online eligibility verification
- Online claim status
- Colorado Access prior authorization list

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) who 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
- Hours of operation must not be less than those offered to commercial members
- 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 and 42 CFR Part 2) Maintain legible and comprehensive medical records for each encounter with a member that conform to documentation standards

Administrative Responsibilities include:

- Participating in our quality management and utilization management programs
- Complying with our 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 have track service utilization
- Authenticate patient's identity at every office encounter to prevent card sharing and patient identity theft
- Verifying eligibility and enrollment for every office encounter
- Referring members to participating providers
- Adhering to the professional code of conduct

PRACTICE CAPACITY AND ACCEPTANCE OF NEW PATIENTS

A PCP may determine how many members the practice will accept and at what point the panel is open or closed. To request a change in member capacity or an open/closed panel status change, please contact our provider network services department. To close the panel to new members, the Provider must give a 60-day advance written notice to our provider relations department by emailing ProviderRelations@coaccess.com or calling 800-511-5010. Opening a panel to new members will become effective on the date the notification is received. Upon receipt of the notice, provider network services staff members will provide written notice to the Provider, indicating the effective date for the requested panel status change.

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.

NOTE: New members are not assigned to providers with closed panels.

PCP COVERAGE

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

- The PCP must ensure that coverage is available 24 hours a day, 7 days a week, for member services. Access to a qualified health care Provider by phone either onsite, call sharing, or answering service is appropriate. Please note, a recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage Provider must know and follow the requirements 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 days of providing service
- Maintaining confidentiality of medical information in compliance with all state and federal requirements.
- Maintaining a separate medical record for each CHP+ or CHP+ Prenatal Care Program member.

- Maintaining legible and comprehensive medical records for each encounter.Hours of operation must not be less than those offered to members with commercial health plans.

SPECIALIST COVERAGE

- The specialist must assure that coverage is available 24 hours a day, 7 days a week for member services. Access to a qualified health care Provider by phone either onsite, call sharing, or answering service is appropriate.
- Please note: A recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care. If you have questions or concerns regarding the provider responsibilities, please email ProviderRelations@coaccess.com.

SECOND OPINION

Members have a right to a second opinion. If members need assistance to arrange a second opinion or set an appointment, please call 303-751-9021 or 888-214-1101 and ask to speak to a care manager.

CREDENTIALING AND CREDENTIALING SCOPE

We credential our contracted Providers and follow National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing and recredentialing. We also credential and recredential hospital-based Providers who provide care in an outpatient setting (such as an anesthesiologist offering pain management or university faculty who have private practices that are, or will be, contracted with us to provide health care services). We perform credentialing of hospitals, home health agencies, skilled nursing facilities, nursing homes and freestanding surgical centers prior to contracting and re-credentialing occurs at least every three years thereafter. Providers that are exempt from the credentialing process are listed below:

- Covering providers and locum tenens;
- Providers who practice exclusively within the inpatient setting or are hospital-based and who provide care to our members only as a result of the member being directed to the hospital or another inpatient setting (i.e., anesthesiologists, pathologists, radiologists, emergency medicine, neonatologists, telemedicine consultants, and hospitalists);
- Providers who practice exclusively within freestanding facilities and who provide care to members only as a result of members being directed to the facility (mammography centers, urgent care, surgery centers, and ambulatory behavioral health facilities);
- Dentists who provide primary dental care only under a dental plan or rider;
- Pharmacists who are contracted with a pharmacy benefit management organization (PBM) who is contracted with Colorado Access; and
- Unlicensed doctoral or master level Providers only when necessary to meet member linguistic/cultural needs, or for service provision in a rural or underserved area.

Provider shall participate with the Colorado Access credentialing standards and requirements as set forth in the Colorado Access policies and procedures and shall submit to Colorado Access, or its designee, the Colorado Health Care Professional Credentials Application or the Colorado Access Organizational Provider Application and other required attachments, as modified from time to time in accordance with NCQA and Colorado Access standards. Provider agrees to voluntarily provide and disclose, as part of the credentialing process, all such documents or materials requested by Colorado Access and recognizes a continuing duty to disclose such information that is relevant to the credentialing process. Provider and its Provider Representatives shall not begin to perform contract services until such application has been approved by Colorado Access. Provider further warrants and represents that it shall timely supplement the Provider's application for credentials and provide any further information requested by Colorado Access and shall further notify Colorado Access of any and all actions or events that materially affect the application and/or approval for credentials.

Credentialing Applications

We participate in the CAQH ProView. 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 health care organizations. If you would like more information about registering for this service or completing the CAQH application, please visit proview.caqh.org. If you already participate with CAQH, please designate Colorado Access as an authorized health plan.

For additional information, please contact our credentialing department at 720-744-5100 or 800-511-5010, or by email at credentialing@coaccess.com.

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
- Interpreter services (over the phone and in person)
- Information and materials translated into the member's primary language
- Notices prepared in large print
- Reading the contents of notices aloud for members who are unable to ready large print or who have

low literacy levels.

- Audio tape
- Braille
- Relay Colorado

NON-DISCRIMINATION POLICY

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, age, socioeconomic level, health status, participation in any government program (including Medicaid and Medicare), source of payment, participation in a health plan, marital status, or physical or mental disability. This includes all State Managed Care Network programs and activities or through a contractor or any other entity with whom State Managed Care Network arranges to carry out its programs and activities.

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

State Managed Care Network will not discriminate in its selection process against providers that serve high-risk populations or who specialize in conditions that require costly treatment. In addition, State Managed Care Network will not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable Colorado State law, solely on the basis of that license or certification.

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 US 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. As a provider, it is important for you to follow the State Managed Care Network's expectations concerning confidentiality of member information and records. We expect you to abide by applicable state and federal rules to protect members' personal information, including name, address, Social Security number, Medicaid/plan number, and any other information considered to be protected health information by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law requires health care organizations to keep certain sensitive information confidential, such as AIDS or substance use disorder-related information. The laws are not intended to prevent our Providers from accurately and appropriately submitting claims. Disclosure of clinical record information must be made in accordance with all state and federal laws. You can find more information at coaccess.com/privacy-security-of-member-information.

Substance Use Information Protected by 42 CFR Part 2

We are required to submit claims data to the Colorado Department of Health Care Policy and Financing regarding payment of substance use disorder services. If you submit claims that are protected by 42 CFR Part 2, we expect you to obtain the necessary consent authorizing this disclosure and to keep the original signed copy in the member's records. If you have questions about our privacy policies, please contact our privacy official at 855-879-8286, or by email at compliance@coaccess.com

FRAUD, WASTE, 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, waste and abuse. The State Managed Care Network has mechanisms in place to prevent, detect, report, and correct incidents of fraud, waste 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 himself/herself or some other person. This includes any act that constitutes fraud under applicable federal or state law.

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to 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.

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

The State Managed Care Network complies with requirements of the Colorado Attorney General, the District Attorney, The Department of Health Care Policy & Financing, 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 mis-utilization, including actual or potential violations of law or regulation.

The following methods may be utilized to report such situations:

- Call the anonymous and confidential compliance hotline at 877-363-3065; or
- Email compliance@coaccess.com.

Overpayments

You are required by federal law to report and return any Medicaid overpayment within 60 days. Failure to return overpayments creates the possibility of legal liability and penalties for committing fraud, waste, and abuse. Overpayments can be returned by filing a corrected or voided claim, or by submitting a written request to our claims department. Please review the Claims section of this manual for further instruction on how to return an overpayment.

MEMBER RIGHTS AND RESPONSIBILITIES

Members have the right to:

- Receive information regarding terms and conditions of your health care benefits.
- Use your rights without any adverse effects on the way you are treated.
- Be treated respectfully and with consideration. Be free from any form of restraint or seclusion used as a means of convincing you to do something you may not want to do.
- Receive all the benefits to which you are entitled under this Booklet.
- Obtain complete information from a provider regarding your health care in terms you can reasonably understand. This includes diagnosis, treatment, and prognosis. Get copies of your treatment records and service plans and ask us to change your records if you believe they are incorrect or incomplete.
- Receive quality health care through providers in a timely manner and in a medically-appropriate setting.

- Have an upfront (candid) discussion with providers about appropriate or medically necessary treatment options for you condition, regardless of the cost or benefit coverage including any alternative treatments that may be self-administered.
- Participate with your provider(s) in decision-making about health care treatment.
- Get a second opinion.
- Refuse treatment and be informed by a provider(s) of what will happen if you do so.
- Receive wellness information to help you stay healthy and maintain a healthy lifestyle.
- Express any concerns and complaints about care and services provided so that we can investigate and take appropriate action.
- File a complaint or appeal a decision with us as outlined in the Complaints, Appeals & Grievances section without fear of retaliation.
- Expect that your personal health information will be kept in a confidential manner.
- Make recommendations about the Member Rights and Responsibilities policies.
- Receive information about the administrative services organization (Colorado Access), the CHP+ managed care organizations (health plans), services, the practitioners and providers delivering care, and the rights and responsibilities of the members.
- Request information on participating provider compensation arrangements.
- Ask anything about physician incentive plans.
- Get family planning services. You must get services directly from any provider who is licensed or certified to provide such services. This does not depend on enrollment and a referral is not necessary.
- To make decisions regarding medical care and to create an advance directive that, under state law, must be respected by your provider and Colorado Access.
- Ask for information about how to Get Involved at Colorado Access by going to our website https://www.coaccess.com/partnering/getinvolved/ or contact our Member Outreach and Inclusion team at 720-744-5610.

MEMBERS HAVE THE RESPONSIBILITY TO:

- Use in-network providers and remember to show you CHP+ State Managed Care Network ID card.
- Maintain ongoing patient-provider relationships with the providers who give you care or coordinate your total health care needs.
- Give your providers complete and honest information about your health care status and history.
- Follow the treatment plan recommended by providers.
- Understand how to access care in non-emergency and emergency situations, and to know your out-of-network health care benefits, including coverage and copayments.
- Notify the provider or CHP+ State Managed Care Network about your concerns regarding the

services or medical care you receive.

- Be considerate of the rights of other members, providers, and CHP+ State Managed Care Network staff.
- Read and understand your CHP+ Member Benefits Booklet.
- Pay all member payment requirements in a timely manner.
- Provide us with complete and accurate information about other health care coverage and/or benefits you may have or obtain.
- Work with your provider to understand your health care concerns and to develop treatment goals.
- Provide Colorado Access with written notice after filing a claim or an action against a third-party responsible for your illness or injury.

RIGHTS AND RESPONSIBILITIES FOR MEMBERS WITH SPECIAL NEEDS

All members have the rights and responsibilities listed above. Members with special health care needs also have some additional rights and responsibilities which include the following:

Rights:

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

Responsibility:

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

RIGHTS AND RESPONSIBILITIES FOR MEMBERS WHO ARE MORE THAN THREE MONTHS PREGNANT

Members who are more than three months pregnant have all of the rights and responsibilities listed above, but also have an additional right and responsibility as follows:

Right:

- To see their current prenatal care provider until after delivery.

Responsibility:

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

APPOINTMENTS 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 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**
Routine care (non-symptomatic, well care physical	Scheduled within 30 calendar days of request
Non-urgent care (symptomatic)	Scheduled within 7 calendar days of request
Urgent care	Scheduled within 24 hours of request

Appointment Standards (Behavioral Health)	
Type of Care	**Standard**
Routine care (non-urgent, symptomatic behavioral health services)	Within 7 calendar days of member's request
Urgent care	Within 24 hours of initial contact by member
Emergency services (face-to-face)	Urban/suburban: within 1 hour of contact Rural/frontier: within 2 hours of contact

Appointment Standards (Behavioral Health)	
Emergency services (phone)	Within 15 minutes of initial contact
Outpatient follow-up appointments after hospital (behavioral health & physical	Within 7 calendar days after discharge from a hospitalization

After Hours and Emergency Care	
Type of Care	**Standard**
After-hours care	Available 24 hours a day, seven 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 is available in the provider office or the member is directed to the Colorado Access customer service department for assistance at 303-751-9051 or 800-414-6198 (toll free)

Missed Appointments

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

MEDICAL RECORD DOCUMENTATION

Providers are responsible for maintaining a medical record system that promotes 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 standards based on applicable regulatory and accrediting body standards. These standards are reviewed periodically and are utilized to assess medical recordkeeping practices of our network practitioners.

The State Managed Care Network may perform chart reviews to assure compliance with medical record review standards.

- Patient's date of birth
- Home address of patient
- Home or work phone number
- All pages contain patient identification
- Each entry has provider's name or initials either handwritten, electronic, typed, or signature stamp
- Current medication list or medication note
- Allergies and adverse reactions prominently displayed
- Visit exam coincides with the chief complaint
- Each return visit or follow-up plan noted
- Each encounter with a physician has documentation of any unresolved problems from a previous visit or if all problems are resolved
- Pediatric patients birth to 19 years; preventive care visits include anticipatory guidance such as injury prevention, violence prevention, sleep positioning, and nutrition counseling
- Each entry is dated
- Legible documentation
- Individual medical record for each patient or individual sheet or section for each family member
- Medical record organized in chronological or reverse chronological order with reports in a consistent location within the chart
- Lab and other diagnostic studies reviewed with results signed or initialed by physician
- Documentation or inquiry regarding smoking habits and history of alcohol/substance abuse

- If a consult is ordered, the consultant report or note is received and reviewed
- Past medical history including past patient and family history including a history of accidents, illness, and surgeries
- Advance directive
- Completed problem list or summary of health maintenance exams listing summarizes significant illnesses, medical conditions, past surgical procedures or chronic health problems and is updated as new problems are encountered

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 who may need a longstanding referral, contact the State Managed Care Network for

The State Managed Care Network providers and vendors must respond within 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 the customer service department at 303-751-9051 or 800-414-6198 (toll free) for help to find a provider capable of delivering these services.

ADVANCE DIRECTIVES

An advance directive is a written instruction of care such as a living will or medical durable power of attorney relating to 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 of the facility with a copy.

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.

You shall document prominently 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 provider (on behalf of a member) can file a grievance. If you cannot execute or implement an advance medical directive on the basis of conscience, you are to issue a written or other appropriate form of statement of limitation to the member (or the member's representative). To learn more about advance medical directives, please visit our website at coaccess.com/advance-directives.

QUALITY MANAGEMENT

The philosophy of the Colorado Access Quality Assessment and Performance Improvement (QAPI) program is to ensure that members receive access to high quality care and services in an appropriate, comprehensive, and coordinated manner that meets or exceeds community standards. Emphasis is placed on community-based, individualized, culturally sensitive services designed to enhance self-management and shared decision making between members, their families, and Providers. The Colorado Access QAPI program promotes objectives and systematic measurement, monitoring, and evaluation of services and work processes and implements quality improvement activities based upon the outcomes. The QAPI program uses a continuous measurement and feedback paradigm with equal emphasis on internal and external services affecting the access, appropriateness, and outcomes of care. Performance is measured against specific standards and analyzed to detect trends or patterns that indicate both successes and areas that may need improvement.

Activities associated with the QAPI program focus on the following:

- Accessibility and availability of services
- Overutilization and underutilization of services
- Member experience of care
- Quality, safety, and appropriateness of care
- Clinical outcomes and performance measurement
- Service monitoring
- Clinical practice guidelines and evidence-based practices
- Care management

The operation of a comprehensive, integrated program requires all participating primary care Providers, medical groups, specialty Providers, and other contracted ancillary Providers to actively monitor quality

of care. The results of program initiatives and studies are used in planning improvements in operational systems and clinical services. Information about the QAPI program and summaries of activities and results are available to Providers and members upon request. Information is also published in provider and member bulletins/newsletters.

ESSENTIAL COMMUNITY PROVIDERS (ECP)

We encourage all of our contracted Providers to become designated as Essential Community Providers (ECP) with the Colorado Department of Health Care Policy and Financing (HCPF). Essential Community Providers are providers that historically serve medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent populations who comprise a significant portion of our patient population. The ECP designation will apply to providers participating in Health First Colorado (Colorado's Medicaid Program, hereto referred to as Medicaid), Child Health Plan Plus (CHP+), and Connect for Health Colorado.

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

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

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

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 DentaQuest, and pharmacy benefits, which are managed by Navitus. 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 your 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:

- Except in the case of emergencies, verify the member's eligibility and PCP assignment prior to rendering services
- Ensure that the appropriate authorization requirements have been met
- Bill in compliance with any/all applicable HCPF billing/coding manuals
- 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
- Provider shall comply with fraud and abuse regulations and shall bill in compliance therewith

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 (except fraudulent, abusive, and/or wasteful claims) within 90 calendar days
- Apply interest and/or penalties to clean claims paid outside of these guidelines in accordance with Division of Insurance regulations

Note: we will not interpret claim information from provider statements or superbills.

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

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 batch file submission in the HIPAA5010 version of the 837 file format 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**: enshealth.com (Payer ID: coacc)
- **Emdeon** (formerly known as WebMD): emdeon.com (Payer ID: 84129)
- **HealthFusion** (formerly known as Quadramed): healthfusion.com (Payer ID: coacc)
- **Safe Software Healthcare** (formerly known as Scinet): sagehealth.com (Payer ID: coacc)
- **Relay Health** (formerly known as NDC): relayhealth.com (Payer ID: coacc)
- **SSI Group**: thessigroup.com (Payer ID: coacc)
- **S&S Datalink**: sasdatalink.com (Payer ID: coacc)
- **PNC Bank** (formerly known as Healthcare Admin Tech): 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 coaccess.com, or email edi_coordinator@coaccess.com.

EDI Front-End Validation Process

We have an EDI Front-End Validation Process to ensure that inbound claims are meeting the standard HIPAA validation rules and to increase auto-adjudications rates. The process will be validating WEDI SNIP Level 1-7. Claims that fail the SNIP levels will be rejected and the provider will be notified via the 277.

CLAIM STATUS

Providers can check the status of a claim in two ways; by using our provider portal or calling our customer service department.

Online Provider Portal

To check the status of your claim on our website, you must register for the provider portal and receive your username and password. If you do not have a provider portal account, you can request one by

submitting the form located at coaccess.com/frequently-used-forms.

Customer Service

303-751-9051 (Denver metro area) 800-414-6198 (toll free)

Our customer service team can answer questions regarding benefits, claims, claim appeals, claim status, and general questions about our policies. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m., Mountain Time.

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.

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.

PRESENT ON ADMISSION (POA) INDICATOR

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

Note: inpatient claims will be denied if the POA indicator is not submitted on the claim.

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

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

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

- Y – Yes
- N – No
- U – Unknown
- W – Clinically undetermined unreported/not used (exempt from POA reporting)

In the event of improper reporting, DRG assignment and reimbursement will be adjusted accordingly. In some cases, retrospective claim review may occur. We reserve the right to collect any overpayments that are the result of the retrospective review.

PROCEDURE CODING

We use the Health Care Financing Administration Common Procedures 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 CPTTM ("Current Procedural Terminology")/HCPCS code revision, based on date of service
- 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)
- Our claims transaction system utilizes the CMS-mandated Correct Coding Initiative (CCI) edits and American Medical Association's (AMA) CPT guidelines to evaluate coding accuracy

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, 10th Revision, Clinical Modification (ICD-10 codes). The provider must enter ICD-10 codes clearly on the claim form and include all digits and characters.

Some procedures are appropriate only when specific conditions are present. 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.

OUT-OF-AREA SERVICES

The State Managed Care Network is financially responsible for emergency services and certain urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a State Managed Care Network member to Colorado Access at 800-414-6198 (toll free). Out-of-area providers should submit claims to our claims address for processing.

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.

CORRECTED CLAIMS

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.

Corrected Claim Process

- Corrected electronic claims should be submitted following the guidelines in the HIPAA standard TR3 Implementation Guide, using the frequency code of "7" in Loop 2300, Segment CLM05-3 and the original claim number in Loop 2300, Ref*F8.
- Corrected paper claims should be clearly marked "Corrected" on the face of the newly completed claim form.
- The resubmission must be newly dated and signed with an authorized signature.
- Correct the appropriate information clearly and accurately.
- Adjust total charges to reflect the amount being resubmitted.
- For a UB04 claim form, change the fourth digit of the bill type to a "7," the original claim number in Box 64. For example, an initial inpatient claim would be submitted with a bill type of 0111 and a corrected claim would be submitted with a bill type of 0117.
- For a CMS 1500 claim form, enter a "7" in Box 22 with the original claim number of the corrected claim.
- Mail all resubmitted claims to our claims address (see our addresses located in this section).

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

Late or Additional Charges

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

AND the original claim lines.

Circumstances in Which a Member can be Billed for Services

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

OVERPAYMENTS

You should routinely review claims and payments in an effort to determine if you have received any overpayments. Overpayments requiring recoupment from a provider routinely occur in a number of ways, including, but not limited to:

- Claims paid in error;
- Claims allowed/paid greater than billed;
- Duplicate payments;
- Payments made for individuals who are not eligible;
- Payments made for services in excess of applicable benefit limitations; or
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

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

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

Repayments for non-participating Providers will be made by check.

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

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

All necessary information 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
3. Member identification number
4. Provider name
5. Provider tax identification number
6. Dollar amount in dispute, if applicable
7. Provider position statement explaining the nature of the dispute, and
8. 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 email or fax. Both parties may agree to an extension beyond the 60 calendar days from receipt of all necessary information timeframe 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 women 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 online at chpplusproviders.com/materials.asp. Please download and complete this form and fax to 303-893-1780.

FILING A CLAIM FOR MEMBERS WITH SECONDARY COVERAGE

- 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.

FILING A CLAIM FOR MEMBERS WITH THIRD PARTY LIABILITY

- 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:

Coordination of Benefits & Subrogation

- 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 a 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) coinsurance, deductible, and/or copay.
- 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 payments.

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.
- If a claim is submitted under the above circumstances and an authorization has not been obtained, the claim may deny for no authorization. We will perform a retrospective review for medical necessity if the claim is resubmitted on appeal.

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 separate conversion factors to calculate reimbursement:

- Medical/Surgical/Laboratory
- Anesthesia

Payment of 35% 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 copayment when they receive services. The patient's card shows what his/her copayment is according to the type of service. PCP offices should collect these copayments for all office visits that the office would ordinary 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 checkups, 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

Copayments for Specialty Care

Some CHP+ members must pay a copayment when they receive services. The patient's card shows

what his/her copayment is according to the type of service. Specialty care provider offices should collect these copayments 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 checkups, 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 Network 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
- 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 and 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 10:00 p.m. and 8:00 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 the CHP+ members are responsible for paying the copay.

ANESTHESIA BILLING

When billing for anesthesia services, please use Anesthesia Services 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 does).
- 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

DentaQuest provides coverage to CHP+ Prenatal members for non-accident-related dental services. Please call DentaQuest at 888-307-6561 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 preauthorization guidelines and plan provisions.

HOLD HARMLESS

Providers contracted with the State Managed Care Network agree that in no event, including, but not limited to, nonpayment 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 shall not prohibit collection of copayments on Colorado Access' or Payer's behalf in accordance with the terms of the applicable Benefit Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of members; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and members or persons acting on their behalf. This includes charging members for missed appointment and for failing to follow appointment cancellation policies.

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/her own behalf.

VII. Member Grievances & Clinical Appeals

Member Grievances and Appeals

Members and their families have the right to the highest quality care. We notify members regarding their rights and how to file a grievance. Providers should also inform members of their right to file a grievance or appeal. The term "member" refers to the member, the member's parent or legal guardian, authorized representative, or designated grievance and appeal representative. Members may designate an individual, including the provider, to submit a grievance or appeal on behalf of a member. A member's grievance or appeal will be completed without adverse consequences or retaliation. A Provider designated as the member's appeal representative may also request a State Fair Hearing according to the appeals process.

Detailed instructions for filing a member grievance or an appeal are located in the member handbooks and on our website at coaccess.com/general-forms-information.

Clinical Appeals Process

A clinical appeal may be filed by a member (or authorized representative) or a treating provider. The clinical appeal must be received within 60 calendar days from the date of the notice of the adverse benefit determination.

- *Standard Appeals*: A standard appeal is resolved within 10 business days of receipt (this excludes Colorado state holidays) and the appeal requestor is provided an acknowledgement letter within two business days of receipt.
- *Expedited Appeals*: An expedited appeal is resolved within 72 hours of receipt and can be initiated if we determine or the requestor indicates that the time for a standard resolution would seriously jeopardize the member's life, health, or the ability to maintain or regain maximum function. An acknowledgement letter is not required for an expedited appeal request.

If you have any questions on the clinical appeal process, please call us at 844-683-1072. More information about the clinical appeal process can be found in policy ADM219 Member Appeal Process here.

Alternative Treatment Options

We do not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the Provider's patient for the following:

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

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 800-414-6198 (toll free), or you may refer to the General Authorization List located on our website and the Master Authorization listed on the Colorado Access 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 timeframe may result in termination of your contract.

We authorize some behavioral health services. Our utilization management service coordinators are available 24 hours a day, 7 days a week to take authorization requests.

We authorize some physical health services. Our utilization management service coordinators are available Monday through Friday from 8:00 am to 5:00 pm to receive physical health authorization requests.

The Master Authorization List, a comprehensive list of procedure codes and corresponding prior authorization requirements, is on the Colorado Access website at coaccess.com/providers/forms/.

We don't perform prior authorization review on services that have already been rendered. If you provide services without an authorization, your claim may be denied. This summary of our authorization rules does not guarantee coverage.

Contact the utilization management department for more information.

PRIOR AUTHORIZATION LIST

A comprehensive list of procedure codes and corresponding authorization requirements is located on the Colorado Access website at coaccess.com/providers/forms/.

SUBMITTING AN AUTHORIZATION REQUEST

Prior authorization request process

It is best to plan ahead and submit an authorization request well in advance of the service being rendered. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function). We cannot retrospectively deny benefits for treatments that have been preauthorized except in cases of fraud, abuse, or if the member loses eligibility.

In order to submit a request for prior authorization:

1. Prior to submitting an authorization, please verify the member's eligibility through the Colorado Access website or the Department of Health Care Policy and Financing eligibility portal.
2. Complete a Prior Authorization Form below and fax, with appropriate clinical information, to the number listed on the form. Please complete all required fields – incomplete forms will not be accepted and will be returned to sender. You can find the following forms on our website at coaccess.com/providers/forms/:
    a. Physical Health Prior Authorization Request Form
    b. Home Health or Outpatient Therapy Prior Authorization Request Form
    c. Durable Medical Equipment (DME) Prior Authorization Request Form
    d. Behavioral Health Prior Authorization Request Form
    e. Psychological Testing Authorization Request Form
    f. Pharmacy Injectable Medication (J-Code) Authorization Request Form
3. You will be notified if additional information is needed, if the service is authorized, or if the service will not be authorized.
4. If you have questions, please call us at 800-511-5010.

As part of utilization review to authorize a service, the State Managed Care Network determines medical necessity.

Medical Necessity

Colorado Access makes utilization review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner.

For more information about the criteria utilized, please reference the CCS302 Medical Criteria for Utilization Review policy on the Colorado Access website.

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 800-414-6198 (toll free).

PEER REVIEW PROCESS

When a Colorado Access medical director has issued a denial, the Colorado Access utilization management reviewer will hold off on processing the formal denial letter until after the facility/provider has been verbally notified of the decision. During this verbal notification, the facility will be informed of the process by which to request a peer review. Prior to the issuance of a formal denial, facilities have the ability to request a peer review with a Colorado Access medical director. During a peer review, a facility physician/prescriber has the ability to discuss the case with a Colorado Access medical director (this may not always be the same medical director who rendered the denial), and present any information that may not have been clear in the initial request. The Colorado Access medical director conducting the peer review will issue a decision at the close of the peer review call. This decision will either uphold the initial denial or overturn the initial denial. If upheld, the denial will be formally issued via the required denial

letters. If overturned, the reviewer will proceed with issuing the authorization per the peer review agreement.

AUTHORIZATION CATEGORIES

The State Managed Care Network Utilization Management Program has four 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 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 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 timelines 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.

Providers who object to providing services on moral and/or religious grounds must furnish information about the services you do not provider to the State Managed Care Network.

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. Please reference the CCS307 Utilization Review Determinations policy on the COA website.

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 Grievance and 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 preauthorized by the State Managed Care Network administered by Colorado Access. Authorization is needed for a member to see a non-participating specialist. The coordinated clinical services department at Colorado Access 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.

Specialist 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 *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 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 section. 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 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 of whether or not the services are rendered by a participating or non-participating provider.

An emergency medical condition is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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 layperson 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 a 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, a 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 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.

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 a 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 coaccess.com/prior-authorization-2015 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 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 provider for pregnancy or well-woman care. Please be advised that certain procedures performed by OB/GYNs may require an authorization. Please refer to the 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 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 antenatal ultrasounds are covered without prior authorization. After the second 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 six 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/gynecologists 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 requires 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 sub-specialty 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 test to evaluate risks of disorders for certain conditions may be covered based on medical policy, review, and criteria and after appropriate preauthorization 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 first 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 second or third trimester of their pregnancy may continue to receive their maternity care with their existing provider if the patient-provider relationship or the current pregnancy predates the 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 he or she 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 sub-specialty care services above, an authorization for the services will be required.

Diagnostic Services – Routine laboratory and imaging services do not require prior authorization. Specialized diagnostic procedures may require prior authorization. Refer to 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 (place of service 22) does not require prior authorization for payment. 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 working day of service initiation.

Authorization will be given for one 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 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 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 administrative denial.

Coverage is subject to benefit limits. Please see the 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 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 60 calendar days for primary and specialty care, and 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 the routine authorization to ensure that they continue to be appropriate at the current level of care.

Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of postpartum care directly related to the delivery.

If 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 provider 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 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 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

Navitus 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 Navitus will be reimbursed at the rate of reimbursement defined in the contract each pharmacy has with Navitus.

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 coaccess.com or call Customer Service at 303-751-9051 or 800-414-6198 (toll free). If prior authorization is denied, the member may appeal the decision.

X. Behavioral Health

OUTPATIENT TREATMENT

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

- Individual counseling
- Family counseling
- Group counseling
- Care 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 preauthorization. Day treatment services can include, but are not limited to:

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

CARE MANAGEMENT

State Managed Care Network care managers help members:

- Coordinate care among multiple service providers
- Help members find resources (such as food, clothing, and housing)

For more information about care management, please call the State Managed Care Network at 303-751- 9051 or 800-414-6198 (toll free).

INPATIENT SERVICES

The State Managed Care Network covers medically necessary inpatient stays to treat mental health conditions. Covered inpatient stays require preauthorization. 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 preauthorization. The goal of home-based services is to help families stay together.

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 800-414-6198 (toll free).

SUBSTANCE ABUSE

The State Managed Care Network covers medically necessary outpatient and inpatient substance abuse treatments. Covered outpatient substance abuse treatments require preauthorization.

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 260% 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 offer temporary comprehensive benefits to children or pregnant women while their application for enrollment is reviewed. Members 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, he or she will receive a new ID card and will be eligible for:

- CHP+: One 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 he or she is determined eligible

TERMS OF ELIGIBILITY

Benefits & Copayments

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 days of the faxed application or coverage will be terminated.

Enrollment in CHP+ is good for one 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, he or she is not eligible for CHP+. Each eligible child will receive an ID card:

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

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

The membership identification cards from the State Managed Care Network indicate 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 or 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 800-359-1991 or visit colorado.gov/hcpf/child- health-plan-plus.

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.

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 website 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 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 working days of the month at are available on the Colorado Access website (coaccess.com). New members are designated with an asterisk (*)
- Calling customer service at 303-751-9051 or 800-414-6198 (toll free)

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 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 copayments 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 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.

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 800-414-6198 (toll free).

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 checkups.
Medical Office Visit	Primary care provider (PCP) visits and specialty visits covered.
Inpatient Hospital Stay	Covered in full.
Lab, X-ray, and Diagnostic Services	Covered in full.
Outpatient Prescription Drugs	Covered in full if included in the formulary. Standard CHP+ copays are $0 to $15.
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. There is a $50 benefit for the purchase of lenses, frames, or contacts per calendar year.
Audiological Services	• Age appropriate hearing screenings for preventive care • Newborn hearing screening and follow-up for a failed screen • One 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 aids 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 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.

SUMMARY OF STATE MANAGED CARE NETWORK BENEFITS	
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.
Exclusions: Services not shown above may not be covered. Call State Managed Care Network at 303-751-9051 or 800-414-6198 (toll free) for more information. This is for summary purposes only and does not guarantee coverage.	