



Colorado Access Health Plan – Enhanced Care Management

Provider Manual

This Provider Manual was updated on October 14, 2009. Some policies and procedures may have changed since that time. If you have any questions regarding any of the information found in this manual, please call our Customer Service Department at (303) 751-5903 or toll free at 1-888-380-3726.

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I. Colorado Access Health Plan—Enhanced Care Management

Colorado Access Health Plan—Enhanced Care Management is a health plan specially designed for individuals with Medicaid who are elderly or disabled. Enhanced care management is intended to support a member's healthcare experience with involvement of care managers. Core activities for enhanced care management include health risk assessments, goal setting, individualized care planning, and interventions.

Colorado Access Health Plan—Enhanced Care Management was created as a result of a partnership between the Center for Health Care Strategies (CHCS), the State of Colorado (Department of Health Care Policy and Financing) and Colorado Access.

The goals of this program are to:

- ♦ Develop a specialized continuum of care management.
- ♦ Develop a program that is economically sustainable.
- ♦ Improve the quality of care.
- ♦ Decrease the cost of care for Medicaid clients.
- ♦ Design a medical home for patients that do not have one.
- ♦ Create a collaborative infrastructure with our provider community.

How to Contact Colorado Access Health Plan

Customer Service

Denver Metro Area (303) 751-5903
Toll Free 1-888-380-3726

Customer Service can answer questions regarding benefits, claims, claim appeals, claim status, eligibility and general questions about Colorado Access policies. Customer Service representatives are available Monday through Friday 8:00 AM to 5:00 PM MT.

Provider Relations

Colorado Access has Provider and Community Relations Liaisons that can assist you with issues related to contracts. If you have general questions for our Provider Relations department, please e-mail provider.relations@coaccess.com.

Provider and Community Relations Liaisons by Region

Denver-Metro Area, including Adams, Arapahoe
Boulder, Broomfield, Clear Creek, Denver, Douglas,
Elbert, Gilpin and Jefferson Counties (720) 744-5202
..... Toll Free: 1-800-511-5010 ext. 5202

Northeast Region, including Cheyenne, Kit Carson,
Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick,



Washington, Weld and Yuma Counties..... (720) 744-5213
..... Toll Free: 1-800-511-5010 ext. 5213

Southern Region, including Alamosa, Baca, Bent, Costilla,
Crawley, Custer, El Paso, Fremont, Huerfano, Kiowa, Las Animas,
Otero, Park, Prowers, Pueblo, Saguache, and Teller Counties (720) 744-5209
..... Toll Free: 1-800-511-5010 ext. 5209

Western Slope, including Archuleta, Chaffee, Conejos, Delta, Dolores,
Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, Lake, La Plata,
Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanca,
Rio Grande, Routt, San Juan, San Miguel, and Summit Counties..... (720) 744-5208
..... Toll Free: 1-800-511-5010 ext. 5208

Colorado Access Health Plan Enrollment

Eligible Members

Colorado Access Health Plan is available to Medicaid members that are 21 years of age and older who live in the following counties:

- ♦ Adams,
- ♦ Arapahoe,
- ♦ Boulder,
- ♦ Broomfield and
- ♦ Denver.

And who qualify for services under the following aid categories:

- ♦ OAP-A and OAP-B (Old Age Pension)
- ♦ AND (Aid to the Needy and Disabled)

Individuals with both Medicare and Medicaid (dual eligibles) are not eligible for enrollment.

Enrollment

Colorado Access is not responsible for services rendered prior to a member’s enrollment in Colorado Access Health Plan.

Eligible Medicaid members that wish to enroll in Colorado Access Health Plan can call HealthColorado, the Medicaid enrollment broker, at (303) 839-2120 to enroll in Colorado Access Health Plan. For more information, visit HealthColorado’s Web site at <http://www.healthcolorado.net/index.shtml>.

If the member chooses Colorado Access Health Plan during their open enrollment period, enrollment will become effective on the first day of the month following the open enrollment period. If the member chooses Colorado Access Health Plan on or before the last day of the month, enrollment will become effective on the first day of the following month.

Passive Enrollment

Some members may be passively enrolled in Colorado Access Health Plan. This means that a subset of

eligible Medicaid members will receive letters from the Medicaid enrollment broker, HealthColorado. The letter will advise members to call HealthColorado if they do not wish to enroll in Colorado Access Health Plan. If they do not call within 30 days, they will be enrolled in Colorado Access Health Plan.

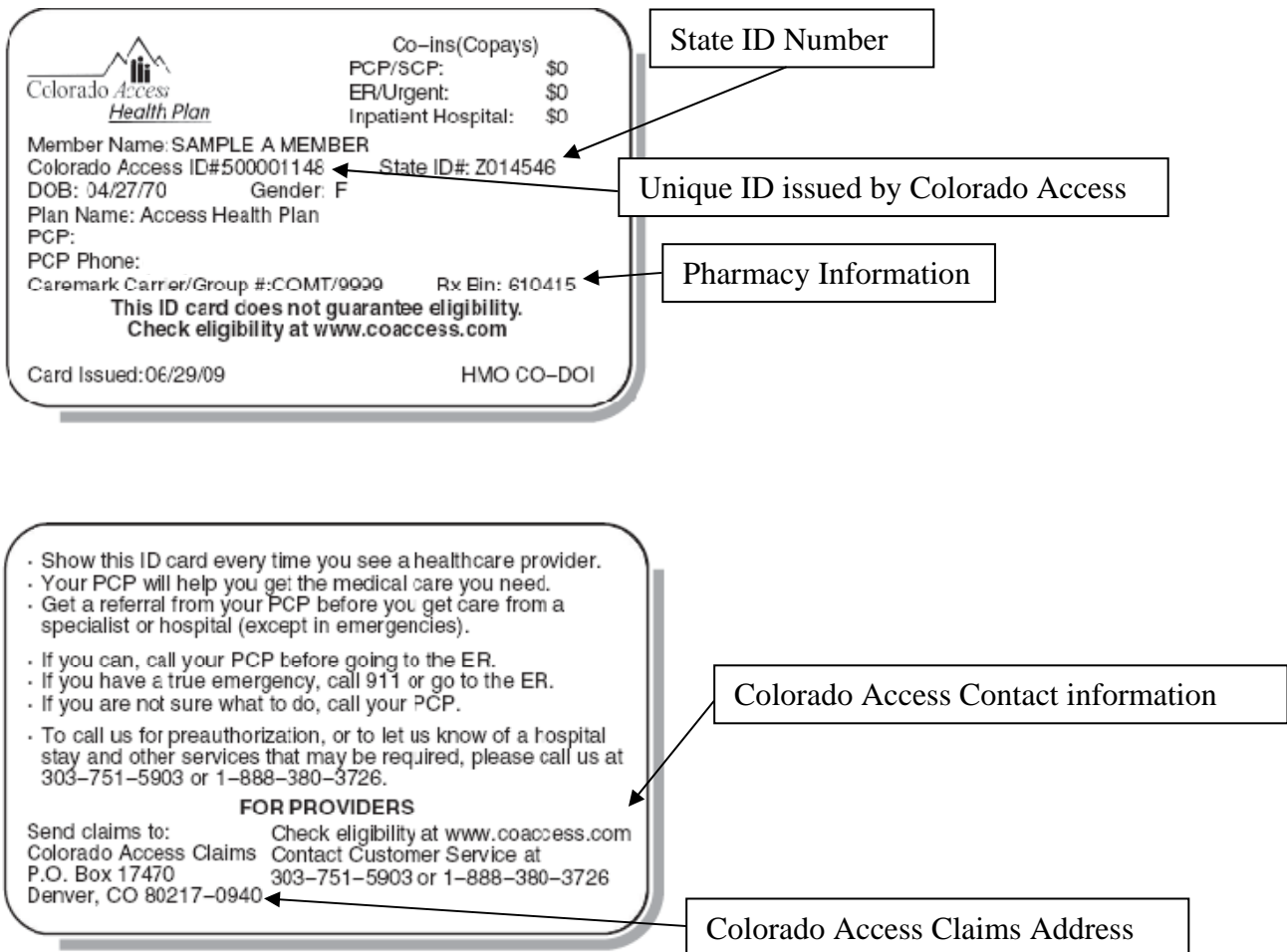
- ♦ **NOTE:** Once enrolled, members have an additional 90 day disenrollment period during which they can leave the plan without cause.

Enrollment Postponement Due to Inpatient Stay

If a member is an inpatient of a hospital at 11:59 p.m. the day before his/her enrollment into Colorado Access Health Plan is scheduled to take effect, enrollment shall be postponed. Within 60 calendar days of discovering the member's hospital admission, Colorado Access will notify the Department of Health Care Policy and Financing that the enrollment shall be delayed.

Colorado Access Health Plan Member ID Cards

Once enrolled, Colorado Access sends each Colorado Access Health Plan member an ID card. The following is a sample of the ID card:



The image shows a sample of a Colorado Access Health Plan Member ID Card. The card is divided into two main sections. The top section contains member information and insurance details, while the bottom section contains instructions for providers and contact information. Callout boxes with arrows point to specific fields on the card:

- State ID Number:** Points to the 'State ID#: Z014546' field.
- Unique ID issued by Colorado Access:** Points to the 'Colorado Access ID#500001148' field.
- Pharmacy Information:** Points to the 'Rx Eln: 610415' field.
- Colorado Access Contact information:** Points to the 'FOR PROVIDERS' section, which includes the phone number '303-751-5903 or 1-888-380-3726'.
- Colorado Access Claims Address:** Points to the 'Send claims to:' section, which includes the address 'Colorado Access Claims, P.O. Box 17470, Denver, CO 80217-0940'.

Card Content:

Colorado Access Health Plan
 Co-ins(Copays)
 PCP/SCP: \$0
 ER/Urgent: \$0
 Inpatient Hospital: \$0
 Member Name: SAMPLE A MEMBER
 Colorado Access ID#500001148 ← State ID#: Z014546
 DOB: 04/27/70 Gender: F
 Plan Name: Access Health Plan
 PCP:
 PCP Phone:
 Caremark Carrier/Group #:COMT/9999 Rx Eln: 610415
 This ID card does not guarantee eligibility.
 Check eligibility at www.coaccess.com
 Card Issued:06/29/09 HMO CO-DOI

FOR PROVIDERS
 Send claims to: Colorado Access Claims, P.O. Box 17470, Denver, CO 80217-0940
 Check eligibility at www.coaccess.com
 Contact Customer Service at 303-751-5903 or 1-888-380-3726

Instructions:

- Show this ID card every time you see a healthcare provider.
- Your PCP will help you get the medical care you need.
- Get a referral from your PCP before you get care from a specialist or hospital (except in emergencies).
- If you can, call your PCP before going to the ER.
- If you have a true emergency, call 911 or go to the ER.
- If you are not sure what to do, call your PCP.
- To call us for preauthorization, or to let us know of a hospital stay and other services that may be required, please call us at 303-751-5903 or 1-888-380-3726.

Colorado Access Health Plan Disenrollment

Members of Colorado Access Health Plan may request disenrollment without cause:

- ♦ During the first 90 days of enrollment.
- ♦ During the member's open enrollment period.
- ♦ Upon automatic re-enrollment after a temporary loss of Medicaid eligibility if the temporary loss caused the member to miss their open enrollment period.
- ♦ When institutionalized in a skilled nursing facility.
- ♦ If the Department of Health Care Policy and Financing imposes intermediate sanction on Colorado Access.

Members of Colorado Access Health Plan may request disenrollment with cause at any time. The following are cause for disenrollment:

- ♦ The member moves out of Colorado Access Health Plan's service area
- ♦ Colorado Access does not, because of moral or religious objections, cover the service the member needs.
- ♦ The member needs related services to be performed at the same time, but not all related services are available within the Colorado Access Health Plan network; and the member's Primary Care Provider (PCP) or another physician determines that receiving the services separately would subject the Member to unnecessary risk.
- ♦ Administrative error on the part of the Department of Health Care Policy and Financing or its designee or Colorado Access including, but not limited to, system error.
- ♦ Poor quality of care, as documented by the Department of Health Care Policy and Financing.
- ♦ Lack of access to Covered Services, as documented by the Department of Health Care Policy and Financing.
- ♦ Lack of access to providers experienced in dealing with the member's healthcare needs, as documented by the Department of Health Care Policy and Financing.
- ♦ The member enrolled in Colorado Access Health Plan with his/her physician and the physician leaves the Colorado Access Health Plan Network.
- ♦ Other reasons satisfactory to the Department of Health Care Policy and Financing.

Colorado Access can request disenrollment of a member with cause. The following are acceptable reason for disenrollment:

- ♦ Admission to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.
- ♦ Receipt of comprehensive health coverage other than Medicaid.
- ♦ Enrollment in a Medicare MCO or capitated health plan other than such a plan offered by Colorado Access.
- ♦ Abuse or intentional misconduct.
- ♦ Fraud or knowingly furnishing incomplete/ incorrect information.
- ♦ Any other reason, as determined by the Department of Health Care Policy and Financing.

Effective Dates of Disenrollment

When a Member voluntarily disenrolls from Colorado Access Health Plan, the effective date of the disenrollment shall be no later than the first day of the second month following the month in which the Member requested the disenrollment. If a decision regarding the Member's disenrollment is not made by

the Department of Health Care Policy and Financing, or its designee, by the first day of the second month following the month in which the Member requested the disenrollment, the disenrollment shall be considered approved.

Disenrollment Postponed Due to Inpatient Hospital Stay

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

Member Moves Outside of Service Area

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

II. Colorado Access Health Plan Benefits

The following services are benefits of Colorado Access Health Plan. Claims for these services should be submitted to Colorado Access.

This list is for summary purposes only and does not guarantee coverage. See the Member Handbook for covered services and exclusions.

Service	Description	Covered
Ambulance Service	Use of an ambulance for an emergency when the member cannot be safely transported by a car or van.	Yes
Dental Care for Adults	Covered by Colorado Access Health Plan only when it is an oral surgical service. Coverage is limited to treat certain conditions such as accidental injury or treatment for tumors.	Yes
Doctor Appointments	Appointments with primary care providers or specialists	Yes
Durable Medical Equipment	Only equipment and supplies that are medically necessary for treatment of an illness, injury, or condition are covered by Colorado Access Health Plan.	Yes
Emergency Services	An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, that a prudent layperson could reasonably expect to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part if immediate medical attention is not obtained.	Yes
Flu Shots	Covered by Colorado Access Health Plan.	Yes
Home Healthcare Services (first 60 days)	If medically necessary, they are covered by Colorado Access Health Plan for 60 days.	Yes
Hospital Services	Planned hospital services must be at a Colorado Access Health Plan hospital. Emergency hospital services may be at any hospital.	Yes
Laboratory Services	All medically necessary tests are covered by Colorado Access Health Plan.	Yes
Oral Surgery	Limited to certain conditions. Call Customer Service for details.	Yes
Over-the-Counter Medication	Colorado Access Health Plan pays for some over-the-counter medication with a doctor's prescription. Review the plan formulary for more information.	Yes
Pregnancy (delivery)	Covered by Colorado Access Health Plan.	Yes
Pregnancy (prenatal)	Covered by Colorado Access Health Plan.	Yes
Prenatal Vitamins	Covered by Colorado Access Health Plan.	Yes
Prescription Drugs	Please review the Colorado Access Health Plan Formulary for more information.	Yes

Service	Description	Covered
Prescription or pharmacy “buy-up”	Members may pay extra if they want a medicine that is more expensive than the medicine that is approved by Colorado Access Health Plan. An example is if a member wants a brand name drug and a generic is available. Colorado Access Health Plan pays the basic cost and the member pays the extra cost.	Yes
Primary and Preventive Care	This includes all physicals, health screenings like mammograms, prostate screenings, flu shots, etc. Members do not need a referral to see their participating PCP for these services.	Yes
Shots	Recommend vaccinations such as flu shots and pneumococcal shots are covered for adults. Other shots may be covered if the doctor determines they are necessary.	Yes
Skilled Nursing Facility (first 30 days)	Covered for the first 30 days by Colorado Access Health Plan. Members need a referral from their PCP for these services.	Yes
Specialty Care	Covered by Colorado Access Health Plan.	Yes
Substance Abuse Treatment	Available only for medical detoxification. Members need a referral from their PCP for these services.	Yes
Therapies	This includes speech therapy, occupational therapy, physical therapy and cardiac rehabilitation. Members need a referral from their PCP.	Yes
Vision “buy-ups”	Members can pay extra for frames or glasses that cost more than the basic frames that Colorado Access Health Plan pays for. Colorado Access Health Plan pays the basic frame cost and the member pays the difference for more expensive frames.	Yes
Vision Therapy	Members need a referral from their PCP for these services.	Yes
Vision (Adults ages 21-47)	Includes routine exams and eyeglasses once every 2 years.	Yes
Vision (Adults ages 48 and older)	Includes routine exams and eyeglasses once a year.	Yes
Well-Women Healthcare	Covered by Colorado Access Health Plan.	Yes
X-ray Services	All medically necessary x-ray services are covered.	Yes
Family Planning (In-Network)	Members may go to any Colorado Access Health Plan doctor or clinic for these services. No referral is needed. For sterilization, members must be 21 years old or over and must sign a consent form at least 30 days before.	Yes

Benefits of the State Medicaid Program

The following services are benefits of the State Medicaid Program. Claims for these services should be submitted to the State’s Fiscal Agent.

Please call State Medicaid with questions or concerns regarding these services at (303) 866-3513.

This list is for summary purposes only and does not guarantee coverage. See the Member Handbook for covered services and exclusions.

Service	Description	Covered
Drug and Alcohol treatment for pregnant women	Covered by the State Medicaid Program.	Yes
Home and Community Based Services (HCBS)	Covered by the State Medicaid Program.	Yes
Home Healthcare Services (after 60-days)	Home Healthcare Services after 60-days, are covered by the State Medicaid Program and require prior authorization from the State Medicaid Program.	Yes
Hospice Care	Covered by the State Medicaid Program.	Yes
Intestinal Transplants	Covered by the State Medicaid Program.	Yes
Private Nursing Duty	Covered by the State Medicaid Program.	Yes
Skilled Nursing Facility (after 30 days)	The State Medicaid Program pays for this care after 30 days. Members may need a referral from their PCP.	Yes
Skilled Nursing Services	After 30 days it is covered by the State Medicaid Program.	Yes
Family Planning (Out-of-Network)	Covered by the State Medicaid Program when seen by a non-Colorado Access Health Plan provider (such as Planned Parenthood). No referral is needed. Counseling care, treatment, and follow-up is available. This includes birth control pills, the putting in and taking out of birth control devices, diaphragm measurement, and surgical sterilization for men and women.	Yes
Mental Health Services	Covered by the Behavioral Health Organization in the member's area.	Yes
Transportation	Non-emergency transportation may be covered through the member's local County Department of Human/Social Services.	Yes

Plan Exclusions (Non-Covered Services)

The following services are plan exclusions and are not covered.

This list is for summary purposes only and does not guarantee coverage. See the Member Handbook for covered services and exclusions.

Service	Description	Covered
Auditory Services	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No

Service	Description	Covered
Cosmetic Surgery	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Custodial Care	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Exercise Programs	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Health Club Memberships	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Home Modification	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Infertility Services	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Personal Hygiene	Items such as toothpaste, deodorant, shampoo are not covered by Colorado Access Health Plan or the State Medicaid Program.	No
Vocational Rehab	Not covered by Colorado Access Health Plan or the State Medicaid Program.	No

III. Member Rights and Responsibilities

Member Rights

Members of Colorado Access Health Plan have the following rights:

- ♦ To be treated with respect. Colorado Access Health Plan will respect a member's dignity and privacy.
- ♦ To receive information on available treatments and choices. Members will be informed of treatments in a way that considers medical needs and in a way they can understand.
- ♦ To participate in decisions about their healthcare, the right to accept or refuse medical treatment, and the right to ask for a second opinion.
- ♦ To be free to tell Colorado Access anything about their healthcare needs, and the right to discuss their healthcare with their Colorado Access Health Plan provider.
- ♦ To get family planning services from any Colorado Access Health Plan or Medicaid provider who provides these services without a referral.
- ♦ To ask for and get a copy of medical records and to ask for corrections as allowed by law.
- ♦ To exercise their rights and know that Colorado Access Health Plan will not treat them differently if they do.
- ♦ To be free from any form of restraint or seclusion to force cooperation, or for punishment, because it is easier for the caregiver, or as retaliation.
- ♦ To receive information about any Colorado Access Health Plan doctor, hospital, healthcare provider, or services.
- ♦ To expect that all healthcare communications be kept private.

Member Responsibilities

Members of Colorado Access Health Plan have the following responsibilities:

- ♦ To choose a Colorado Access Health Plan PCP.
- ♦ To inform Colorado Access Health Plan Customer Service of any changes, such as address, phone number, marriage, birth of a child, or adoption of a child.
- ♦ To learn about the benefits provided by Colorado Access Health Plan and to be cooperative and considerate with their healthcare providers and staff.
- ♦ To follow the Colorado Access Health Plan and Medicaid rules described in the Member Handbook.
- ♦ To ask their PCP for a referral to see a specialist or get special services or equipment.
- ♦ To follow the Colorado Access Health Plan steps in the Member Handbook for grievances and appeals.
- ♦ To talk to Colorado Access Health Plan when he/she would like to change doctors.
- ♦ To pay for healthcare services not covered by Colorado Access Health Plan or Medicaid.
- ♦ To tell Colorado Access Health Plan about any other insurance, including Medicare.
- ♦ To tell Colorado Access and healthcare providers of enrollment in Colorado Access Health Plan so we can work together to transfer care.

Asking for Information

Colorado Access Health Plan members have the right to ask Colorado Access for information about:

- ♦ Names, locations, and phone numbers for Colorado Access Health Plan providers who speak other languages.
- ♦ Member rights and protections.
- ♦ Colorado Access' Notice of Privacy Practices and how to get a copy.
- ♦ Procedures for getting benefits.
- ♦ Cost sharing, if it applies.
- ♦ Access to Care Plan.
- ♦ After-hours and emergency care information.
- ♦ The structure and operations of Colorado Access.
- ♦ Post-stabilization care services.
- ♦ The amount, length, and scope of benefits.
- ♦ How and where to get any benefits that are covered by State Medicaid, but not part of Colorado Access Health Plan.
- ♦ Grievance, appeal and fair hearing procedures.
- ♦ How to get benefits from an out-of-network provider.
- ♦ Advance Medical Directives.
- ♦ Physician Incentive Plans.
- ♦ Standard Practice Preventive Guidelines.
- ♦ Policy on referrals for specialty care.
- ♦ Quality assessment and improvement program analysis and annual report.
- ♦ Any restrictions (limits) on freedom of choice among Colorado Access Health Plan providers.
- ♦ Providers who are not accepting new members.
- ♦ Information on the qualifications of healthcare professionals contracted with Colorado Access Health Plan.

Service Change

Colorado Access will notify members in writing if:

- ♦ Benefits change.
- ♦ Their PCP or specialist (such as bone doctor, heart doctor, cancer doctor) leaves the plan.
- ♦ Services are denied.

The Ombudsman for Medicaid Managed Care

The Ombudsman for Medicaid Managed Care is an independent facilitator contracted by the Department of Health Care Policy and Financing (HCPF) to receive and respond to concerns and issues of members enrolled in Medicaid Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs).

The Ombudsman has a Business Associate agreement with the Department of Health Care Policy and Financing. This agreement permits Medicaid providers to share information needed to research the issue or complaint with the Ombudsman without a signed release of information, making it possible to resolve member's issues quickly and at the lowest level of intervention.

What can the Ombudsman do for members and providers?

- ♦ Research and resolve member grievances about care or service.
- ♦ Help members understand their rights and responsibilities.
- ♦ Assist with navigating the Medicaid managed care process.
- ♦ Act as a fair and impartial go-between to help resolve disputes at the lowest level of intervention.
- ♦ Identify and report trends and systematic problems to HCPCF.

Why would a member call the Ombudsman?

- ♦ Unhappy with care or services provided.
- ♦ Needs assistance accessing covered services.
- ♦ A requested covered service has been denied, reduced or stopped.
- ♦ Assistance with filing a grievance or appeal.
- ♦ As a resource for when members just aren't sure who to call.

To contact the Ombudsman for Medicaid Managed Care call (303) 830-3560 within Metro Denver (Spanish available) 1-877-435-7123 outside Metro Denver (Spanish available) TTY 1-888-876-8864 for hearing impaired, fax: (303) 832-8352, or e-mail help123@maximus.com.

IV. Colorado Access Policies

The following is a summary of important Colorado Access policies. Additional information may be located on our Web site at www.coaccess.com.

Colorado Access Diversity Commitment

Colorado Access is committed to maintaining an environment that respects the perspectives, beliefs and differences of our customers and staff. To this end, we will promote cultural diversity and competency to increase access to care and quality of service.

Cultural Competency Training Program

Cultural competency goes beyond racial bounds to include gender, sexual orientation, abilities and age. It celebrates the many strengths that people with different backgrounds bring to an organization.

We live in a world filled with people who come from different places and cultural backgrounds. Colorado Access believes these differences should be recognized in order for organizations to be more effective. Colorado Access offers a free Cultural Competency Training Program for providers to help achieve this end. Understanding your patients and coworkers will enhance the services you provide and improve the effectiveness of your workplace.

The Colorado Access Cultural Competency Training Program is NOT a seminar on race relations and political correctness. Instead it offers a pragmatic approach to understanding and working with differences in the workplace, stemming from:

- ♦ Age,
- ♦ Gender,
- ♦ Race,
- ♦ Culture,
- ♦ Socioeconomic level,
- ♦ Disability,
- ♦ Corporate culture,
- ♦ Religion, and
- ♦ Sexual orientation.

At Colorado Access, the Cultural Competency Program goals are high. Achieving such high standards is not only worth the effort; we believe it is a necessity. For more information, please contact Colorado Access at (303) 751-5903.

Culturally Sensitive Services

Colorado Access recognizes that a critical aspect of providing quality healthcare services is to promote culturally sensitive services through our providers and our staff. To promote this, Colorado Access has developed training and communication regarding healthcare attitudes, beliefs and practices for our contracted providers. This policy is a commitment to quality services for all of our members. For

questions on how to receive training, please refer to the above section regarding the Cultural Competency Training Program.

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

Colorado Access will take such steps as are necessary to ensure that members, potential members, family members and designated client representatives (DCRs) 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, Colorado Access will give primary consideration to the request of the individual. These aids and services include, but are not limited to, the following:

- ♦ Multilingual staff
- ♦ TTY/TDD
- ♦ AT&T Language Line
- ♦ Notices translated into the member's primary language
- ♦ Notices prepared in large print
- ♦ Reading the contents of notices aloud for members who are unable to read large print or who have low literacy levels.
- ♦ Audio Tape
- ♦ Braille

Non-Discrimination

Colorado Access does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, gender, sex, religion, creed, sexual orientation, disability or age. This includes all Colorado Access programs and activities or through a contractor or any other entity with whom Colorado Access arranges to carry out its programs and activities.

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

This statement is in accordance with the provisions of:

- ♦ Title VI of the Civil Rights Act of 1964
- ♦ Title VII of the Civil Rights Act of 1964
- ♦ Section 504 of the Rehabilitation Act of 1973
- ♦ The Americans with Disabilities Act of 1990 (ADA)
- ♦ The Age Discrimination Act of 1975
- ♦ The Age Discrimination in Employment Act of 1976
- ♦ Title IX of the Education Amendment of 1972
- ♦ Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts

NOTE: Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.

HIPAA, Confidentiality and Privacy of Member Information

Confidentiality of Proprietary Information

Providers shall hold all confidential or proprietary information or trade secrets of each other in trust and confidence and shall use such information only for the purposes necessary to fulfill the terms of the providers' agreement, and not for any other purpose. Specifically, providers shall keep strictly confidential all compensation rates, except for the method of compensation (e.g., fee-for-service, capitation, shared risk pool, DRG, per diem, etc.), unless otherwise required by State or Federal Laws.

Privacy of Member Information

For HIPAA related complaints, please contact the Colorado Access Privacy Official at (720) 744-5100. Colorado Access abides by federal and state regulations pertaining to privacy standards including requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and as updated from time to time. As a provider, it is important for you to understand Colorado Access' expectations concerning confidentiality and privacy of member information and records.

Information for Colorado Access Health Plan Providers

Colorado Access employees, and anyone acting on behalf of the company, will use and/or disclose member information only as permitted by contract, federal and state law. The State of Colorado Department of Health Care Policy and Financing and the HIPAA Privacy Rule directs Colorado Access to provide access to or a copy of member health information to the member, the member's legal guardian, or the designated client representative, as follows:

- ♦ Colorado Access members may have the right to inspect and/or request a copy of their health information upon receipt of a proper written and signed authorization from the member or the member's guardian.
- ♦ Colorado Access may impose a nominal charge to members for providing copies of their health information.
- ♦ Colorado Access members may have the right to request that an amendment be made to their health information.
- ♦ Colorado Access members have a right to receive their health information in a confidential manner.
- ♦ Colorado Access members may have the right to request a restriction on disclosures of their health information.
- ♦ Colorado Access members have the right to revoke an authorization to use and/or disclose their information.

Member Medical Information

We tell members and prospective members the following:

- ♦ As your insurance plan, we have a right to get medical information about you without your consent.
- ♦ We use this information to help arrange your healthcare.

- ♦ We have policies and procedures about how we will get, use and release your information.
- ♦ We will not disclose this information to anyone else without your written authorization, unless disclosure is otherwise required or permitted by other laws, rules or regulations.
- ♦ You have a right to get copies of your medical records from your providers. We do not keep these medical records at Colorado Access. You can call your provider's office to find out how to get your records and to get a copy of them made for you.

Information Used to Submit and Process Claims

Federal and state statutes provide stringent penalties for failure to keep AIDS-related information confidential. The legislation is not intended to prevent Colorado Access providers from accurately and appropriately submitting claims to Colorado Access.

Colorado Access claims may also contain information about application for and receipt of public assistance. This information is required for the administration of our programs. Information is used to process claims, calculate costs and project future funding and does not jeopardize the privacy of the member.

For more information, please visit our Web site at <http://www.coaccess.com/hipaa-information>.

Fraud and Abuse

Colorado Access is dedicated to providing quality healthcare services to members while conducting business in an ethical manner. Colorado Access supports the efforts of federal and state authorities in identifying incidents of fraud and abuse. Colorado Access has mechanisms in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements.

The following definitions are taken from state and federal guidelines:

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

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

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

Colorado Access complies with the reporting requirements of the Colorado Attorney General, the District Attorney, the Department of Health Care Policy and Financing, and other agencies that conduct investigations. Colorado Access has a Corporate Compliance Officer who is responsible for reporting suspected fraudulent claims to the applicable state and federal agencies and authorities.

Colorado Access is required to take appropriate disciplinary and enforcement action against employees, providers, subcontractors (including providers), consultants, members, and agents found to have

committed fraud. We are also required to take appropriate corrective actions to prevent further offenses through systems and process changes.

All employees, providers, subcontractors, consultants, members, and agents, of Colorado Access are responsible for reporting potential and/or suspected incidents of fraud, abuse, misuse, or misutilization, including actual or potential violations of law or regulation, to the Colorado Access Corporate Compliance Officer (CCO) or Staff Attorney.

The following methods may be utilized to report such situations:

- ♦ Call the Confidential Corporate Compliance Hotline at 1-877-363-3065;
- ♦ E-mail directly to the CCO at corporate_compliance@coaccess.com;
- ♦ Download and print the Suspected Fraudulent Claim Form (located at http://www.coaccess.com/sites/default/files/fraud_and_abuse_12309%20_for%20web.pdf) and mail the completed form to Colorado Access, Corporate Compliance Officer, 10065 E. Harvard Ave., Ste. 600, Denver, CO 80231; or
- ♦ Send the information to the dedicated fax line at (303) 751-9048 addressed to the Corporate Compliance Officer.

Colorado Access' Fraud and Abuse policy can be located on our Web site at <http://www.coaccess.com/corporate-compliance>.

Appointment and Services Standards

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

NOTE: Colorado Access 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 exam)	Scheduled within 4 weeks of request
Non-urgent care	Scheduled within 1 week of request
Urgent care	Scheduled within 24 hours of request

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

Access to Interpretive Services	
Type of Care	Standard
Interpretive Services	Language assistance available in the provider office or the member is directed to Colorado Access Customer Service Department for assistance at (303) 751-5903 or toll free 1-888-380-3726.

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

For providers with 15 or more employees, Colorado Access may pay for oral or other interpretive service only where the cost to the provider is deemed an undue burden. If such services are requested by a provider, justification must be provided to the Colorado Access Director of the Office of Member and Family Affairs, who will make a determination on a case-by-case basis. Please call Customer Service at (303) 751-5903 or toll free 1-888-380-3726 with questions or concerns.

Medical Record Documentation

NOTE: Colorado Access may perform chart reviews to assure compliance with medical record documentation standards.

Providers are responsible for maintaining confidential medical records that are current, detailed and organized and that promote continuity of care for each patient. Well documented medical records not only promote continuity of care, they also facilitate communication and effective treatment. Colorado Access has established medical record documentation guidelines based on applicable regulatory and accrediting body standards that are approved by the Medical/Behavioral Quality Improvement Committee (MBQIC). Colorado Access uses these standards to assess practitioners' medical recordkeeping practices and evaluate compliance with the medical record documentation standards.

Each patient record should contain the following information:

- ♦ **Patient identification must be on each page:** All pages with entries should contain patient identification; name, SSN, or other unique patient identifier. This must appear on both sides of double sided pages.
- ♦ **Must contain personal biographical information:** The medical record should contain the patient's date of birth, address, and telephone number. If the records are kept in a computerized system, this data must be easily accessible.
- ♦ **Must include the provider's name or initials and credentials:** Each entry should contain the provider's name or initials and credentials. An entry is any documentation in the progress notes, medication renewals, and telephone orders. A provider can be a physician, LPN, RN, NP, PA, or Medical Assistant. This can be handwritten, electronic, typed or entered with a signature stamp. Where the name or initials are typed or stamped, a counter signature or counter initials must appear. If initials are used, they should be identified once in a signature log within the record or within the provider's office. Minimally, solo practitioners must initial each entry. Physician co-signatures should be present for mid-levels and trainees (PAs, residents, medical student).
- ♦ **Each entry must be dated:** All entries must be dated. This includes progress notes, problem list, med list, assessment forms, etc.
- ♦ **Record must be legible:** All elements that pertain to the current review should be legible to the reviewer.
- ♦ **Record must be organized:** Chart should be in chronological or reverse chronological order. Reports are in respective sections of the record; lab information is in lab section, or lab information is in a consistent location in the progress notes.
- ♦ **Medical history:** For patients seen 3 or more times, a past patient and family history should be present. The patient history includes a history of accidents, illness, and surgeries. Family history includes immediate family members' medical illnesses. It should be easily located in one section of the chart. For patients seen <3 times, there should be past history documented for the current condition. Must include OB/GYN history for females, as applicable.
- ♦ **Medication allergies and adverse reactions:** Documentation of allergies and adverse reactions must be conspicuously and consistently displayed in the record (on front or inside cover of record). This includes a completed allergy sticker, or NKA (No Known Allergies) prominently displayed in record.
- ♦ **Current medication list or medications listed in the progress notes or problem list:** Evidence of a medication list documenting current medications, dosages and dates of initial or refill prescriptions. This can be on a separate medication sheet, or in consistent location within the progress notes or on the problem list. This should include medications prescribed during the visit or renewed over the phone. If the patient is not on medications, this should be documented in the record.
- ♦ **Completed problem list or summary of health maintenance exams:** Record must contain an updated, completed problem list or summary of health maintenance exams. An updated list summarizes significant illnesses, medical conditions, past surgical procedures, chronic health problems or psychological conditions and is updated as new problems are encountered (as evidenced in the progress notes). The list can be a separate section, or be contained within progress notes. If the patient does not have past or present problems, a summary of health maintenance exams should be documented or "none" or "no problems" should be documented.
- ♦ **Physical exam appropriate to patient's condition:** including preventive care or presenting complaint(s), and is documented for each visit.

- ♦ **Working diagnoses are consistent with findings:** Documented working diagnoses are consistent with findings.
- ♦ **Treatment plans are consistent with diagnoses:** Documented treatment plans are consistent with diagnoses and possible risk factors for the patient are relevant to the particular treatment.
- ♦ **Return visit or follow-up plan noted:** Each encounter documents follow-up care, calls, or visit, unless problem is resolved and no follow-up is necessary. Follow-up is noted in days, weeks, months, or as needed.
- ♦ **Each visit, prior problem is addressed:** Each encounter with physician has documentation of any unresolved problems from a previous visit, or if all problems are resolved.
- ♦ **Consultation, lab or imaging reports or notes received, reviewed and initialed:** If consultation, lab or imaging is ordered, a report or note should be received and initialed/signed by the physician, or the record should contain an explicit note regarding the review of the report, or note of verbal communication with consultant. Both indicators must be present in order to score.
- ♦ **Inquiry/counseling regarding smoking habits:** Documentation of inquiry and/or counseling regarding smoking habits noted in history and physical or progress notes.
- ♦ **Inquiry/counseling regarding history of alcohol/substance abuse:** Documentation of inquiry and/or counseling regarding alcohol/substance abuse noted in history and physical or progress notes.
- ♦ **Advance Directive documented:** For patients over 21 years of age, the medical record contains documentation of whether or not the member has executed an advance directive.
- ♦ **Evidence of preventive services & screenings/health education/anticipatory guidance is available:** Preventive care visits include age appropriate preventive services, discussion of appropriate screenings and healthy lifestyle education.

Utilization Management Program

Participation in the Colorado Access 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 Colorado Access.

Alternative Treatments

Colorado Access 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.

Advance Directives

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

There are 3 kinds of Advance Medical Directives. They are:

- ♦ **Living Will**—A Living Will tells medical providers not to use artificial life support if the member becomes terminally ill. Copies of Living Will forms are at healthcare facilities, doctors’ offices, office supply stores, on the web, and through the Guardianship Alliance of Colorado, (303) 228-5382.
- ♦ **Medical Durable Power of Attorney (also called a “Health Care Proxy”)**—A medical durable power of attorney is a person the member chooses to make healthcare choices for the member if the member cannot speak for himself or herself.
- ♦ **Cardiopulmonary Resuscitation (CPR) Directive**—A “CPR Directive” directs paramedics, doctors, medical staff or others to not try to resuscitate a member if his/her heart or breathing stops.

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

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

To learn more about Advance Directives, visit our Web site at:
<http://www.coaccess.com/advance-directives>.

Quality Management

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

The scope of the program encompasses the following aspects of care and service, which are described below:

- ♦ Provider Access
- ♦ Provider Availability
- ♦ Preventive Care & Clinical Practice Guidelines
- ♦ Care Management & Disease Management
- ♦ Health Programs/EPSTD

- ♦ Cultural Diversity Training
- ♦ Clinical Quality Measurement & Outcomes Studies (HEDIS)
- ♦ Performance Improvement Projects (PIPs)
- ♦ Medical Record Review
- ♦ Member Satisfaction
- ♦ Complaint & Appeals Monitoring
- ♦ Credentialing & Recredentialing
- ♦ Organizational Assessment
- ♦ Delegation

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

Provider Responsibilities

Participation in the Colorado Access Quality Management Program is part of the contractual obligation of every provider. This involves adhering to Quality Management policies, submitting encounter claims, submitting EPSDT information, and participating in Quality Management studies. The auditing process may include member record review by Colorado Access staff or outside auditors. Audits may be conducted on site. Contracted providers are required to provide access to or copies of member medical records, as requested by Colorado Access.

Measurement of Outcomes

Colorado Access primarily utilizes HEDIS and CAHPS to measure outcomes. Topics for monitoring are chosen based on relevant demographic and epidemiologic characteristics of plan membership.

Credentialing and Re-credentialing

Colorado Access conducts credentialing and re-credentialing of the following contracted healthcare practitioners, who treat members outside the inpatient setting who fall within its scope of authority and action:

- ♦ Allopathic Physician (MD)
- ♦ Osteopathic Physician (DO)
- ♦ Doctor of Dental Science (DDS)*
- ♦ Doctor of Dental Medicine(DMD)*
- ♦ Podiatrist (DPM)
- ♦ Certified Nurse Midwife (CNM)
- ♦ Nurse Practitioner (NP, APN, and APRN)**

* Dentists who provide care under the physical health medical benefit program only

** Only when providing services through a direct provider agreement

The applicant will complete the state mandated Colorado Unified Credentialing Application available through CAQH (Council for Affordable Quality Healthcare) or on the Colorado Access Web site at <http://www.coaccess.com/credentialing>. The application includes a current and signed attestation by the applicant. The applicant will bear the burden of proving that he/she is eligible and qualified for

participation with Colorado Access and shall have the responsibility of producing adequate information for a proper evaluation of his/her current competence, relevant training, and experience. The applicant is also responsible for resolving any questions about such qualifications.

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

The applicant has the right to be informed of the status of their credentialing or re-credentialing application upon request. These rights apply to any applicant who has completed the Colorado Unified Credentialing Application. For additional information, please contact the Credentialing Department at (720) 744-5100 toll free 1-888-380-3726 or e-mail credentialing@coaccess.com.

CAQH Universal Credentialing DataSource

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

Re-credentialing Requirements

Re-credentialing takes place at least every 3 years. The decision-making process will include the information listed above and incorporate information from the following sources:

- ♦ Member grievances
- ♦ Information from quality improvement activities

Practice Site Review Guidelines

Colorado Access has a formal process to evaluate the physical environment and medical/treatment recordkeeping practices for all practitioners who fall in the scope of credentialing. A site review will be conducted for any practitioner who exceeds established thresholds for complaints related to physical environment.

Facility Requirements

Colorado Access performs an assessment of hospitals, home health agencies, skilled nursing facilities, nursing homes and free-standing surgical centers prior to contracting and at least every 3 years to review the following:

- ♦ Current licensure by the State of Colorado, Department of Health (does not apply to Home Health Agencies);

- ♦ Current accreditation by the appropriate accrediting body or if not accredited, satisfactory completion of CMS DMH or ADAD site review or Colorado Access site visit with a copy of the entity's credentialing policies;
- ♦ Current certification for Medicare/Medicaid participation;
- ♦ Professional liability coverage for the organization; and
- ♦ No suspension or exclusion from Medicare and Medicaid during last 3 years.

Delegation

Colorado Access may delegate responsibility for performing certain activities, to provider or practitioner organizations if a provider or practitioner organization demonstrates the ability to perform in a manner which meets or exceeds Colorado Access standards.

Servicing Members with Special Healthcare Needs

NOTE: A list of resources for members with special needs is available in the Community Resources section (section XIII) of this manual.

Colorado Access has a contractual 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.

Colorado Access 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.

Colorado Access keeps a database of providers that are able to meet special healthcare needs. If a provider is unable to accommodate the special healthcare needs of one of our members, the provider can call Customer Service at (303) 751-5903 or 1-888-380-3726 for help in finding a provider capable of delivering these services.

Member's Discharge from Care

The provider may request a member's discharge from the practice for reasons including, but not limited to:

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

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

- ♦ Document the inappropriate behavior.
- ♦ Explain the impact on practitioner's ability to provide adequate care to the member.
- ♦ Warn the member of possible discharge from service, if the behavior is not corrected.
- ♦ Copy the letter to the Colorado Access Grievance and Appeals Team.

After receipt of the letter, the Colorado Access Grievance and Appeals Team will contact the member. Colorado Access maintains a copy of the documentation. If the inappropriate behavior continues, Colorado Access can notify the Colorado Department of Health Care Policy and Financing to request disenrollment of the member.

V. Provider Responsibilities

Primary Care Providers

Each Colorado Access member may select, or is assigned to, a participating Primary Care Provider (PCP). The PCP is responsible for managing the member's total healthcare services. These responsibilities include the following:

- ♦ Providing care and services for all enrolled members.
- ♦ Being accessible (or have call-coverage) to members 24 hours a day, 7 days a week.
- ♦ Providing services to members according to the Colorado Access plan's access standards.
- ♦ Coordinating healthcare services for members, including referring members to specialists.
- ♦ Providing preventive health services and offering provision for special needs.
- ♦ Educating members about healthy lifestyles and prevention of serious illness.
- ♦ Counseling members about appropriate emergency department utilization.
- ♦ Providing culturally appropriate healthcare.
- ♦ Maintaining confidentiality of medical information in compliance with all state and federal regulatory agencies (including HIPAA), as well as National Committee for Quality Assurance (NCQA) standards.
- ♦ Maintaining legible and comprehensive medical records for each encounter with a member that conform to documentation standards.

Administrative Responsibilities include:

- ♦ Participating in the Colorado Access Quality Management and Utilization Management Programs, which adhere to NCQA standards.
- ♦ Complying with Colorado Access credentialing requirements.
- ♦ Maintaining a separate medical record for each Colorado Access member.
- ♦ Reporting encounter and claim data to Colorado Access, so that we may track service utilization.
- ♦ Verifying eligibility and enrollment for every office encounter.
- ♦ Referring members to Colorado Access participating providers.
- ♦ Adhering to the professional code of conduct.

Practice Capacity and Acceptance of New Patients

A PCP may determine how many members the practice will accept and at what point the panel is open or closed. To request a change in member capacity or to open/close the practice's panel, the provider must notify Colorado Access Provider Contracting in writing. To close the panel to new members, the provider must give sixty (60) day advance written notice to Colorado Access Provider Contracting.

Upon receipt of notice to close a panel, Colorado Access Provider Contracting personnel will send written confirmation to the provider indicating the effective closure date for the panel.

Provider shall send written notice to Colorado Access Provider Contracting in order to open a previously closed panel to new members. The provider will receive written confirmation from Colorado Access Provider Contracting that includes the effective date of the panel being available to new patients.

Notice to Colorado Access Provider Contracting shall be sent to:

Colorado Access
PO Box 17580
Denver, CO 80217-0580
ATTN: Director Provider Contracting

An individual PCP may not have more than 2,000 Colorado Access members without consent from Colorado Access. In addition, we reserve the right to change maximum panel size when appropriate and communicate that change in writing. The PCP is responsible for the care of members assigned to the PCP from the date of assignment, whether or not the PCP has previously provided care to the patient.

Coverage

- ♦ The PCP must assure that coverage is available 24 hours a day, 7 days a week, for member services. Access to a qualified healthcare practitioner via telephone coverage either onsite, call sharing, or answering service is appropriate.
- ♦ The PCP must notify Colorado Access of the name of the practitioner providing on-call coverage. Please notify us by sending us a completed Call Coverage Information form located online at <http://www.coaccess.com/frequently-used-forms>. To ensure appropriate payment, we must have this information on file.
- ♦ The call-coverage provider must know and follow the specifications of the authorization process.
- ♦ Coverage responsibilities include outpatient and inpatient care.

Specialty Care

Contracted specialty care providers have the following responsibilities to Colorado Access members:

- ♦ Verifying member eligibility on the date of service.
- ♦ Providing specialty consultation care approved by the member's PCP or Colorado Access as necessary.
- ♦ Obtaining appropriate authorization from Colorado Access before treating a member.
- ♦ Coordinating the member's care with his or her PCP.
- ♦ Providing a written consultation report to the PCP within 5 days of providing service.
- ♦ Maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies, as well as NCQA requirements.
- ♦ Maintaining a separate medical record for each Colorado Access member.
- ♦ Maintaining legible and comprehensive medical records for each encounter.

Coverage

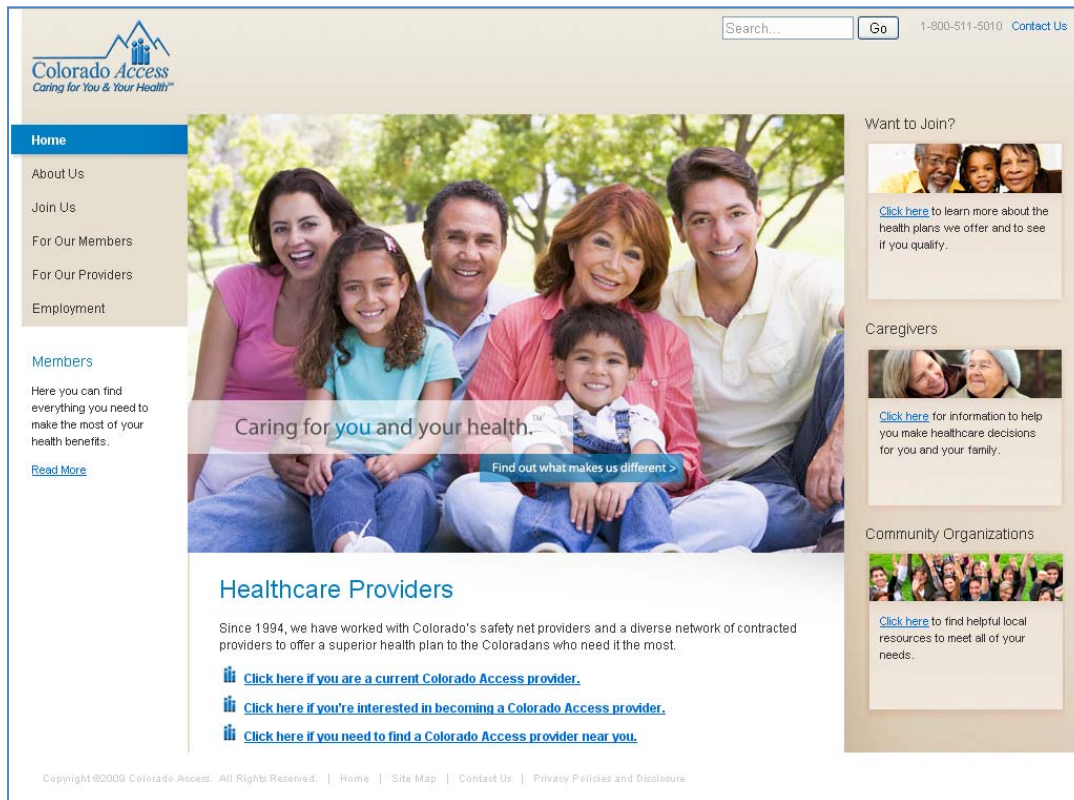
- ♦ The Specialist must assure that coverage is available 24 hours a day, 7 days a week for member services. Access to a qualified healthcare practitioner via telephone coverage either onsite, call sharing, or answering service is appropriate.
- ♦ The Specialist must notify Colorado Access of the name of the practitioner providing on-call coverage. Please notify us by sending a completed Call Coverage Information form located online at <http://www.coaccess.com/frequently-used-forms>. To ensure appropriate payment, we must have this information on file.
- ♦ The call-coverage provider must know and follow the specifications of the authorization process.

- ◆ Coverage responsibilities include outpatient and inpatient care.

If you have questions or concerns regarding the provider responsibilities, please e-mail pns@coaccess.com.

VI. Colorado Access Web Site

The Colorado Access Web site is located at www.coaccess.com.



Provider Information



For Our Providers

To access Colorado Access provider information, click on the *For Our Providers* link located on the homepage.

Provider Tools & Tips

The following information listed under the *Provider Tools & Tips* heading requires a Username and Password. If you do not have a Colorado Access Username and Password, you can request one at http://www.coaccess.com/sites/default/files/logon_id_request.pdf.

- ◆ Claim Status Lookup
- ◆ Colorado Client Assessment Record (CCAR)
- ◆ Eligibility Verification
- ◆ Authorization List
- ◆ Colorado Access File Share
- ◆ Clinic Reports:
 - Colorado Access Advantage Clinic Report
 - Colorado Access Health Plan Clinic Report
 - CHP+ offered by Colorado Access (HMO) Clinic Report

- CHP+ State Managed Care Network Clinic Report

The above-mentioned tools open in a new browser window. Enter your Colorado Access Username and Password in the new browser window and click *login*.

The following information located below *Provider Tools & Tips* does not require a Colorado Access Username and Password, and can be recognized by the following icons.



Frequently Used Forms - here you will find the claim appeal form and more.



Pharmacy Services - here you will find plan formularies, prior authorization forms and more.



Referrals and Authorizations - here you will find helpful information about Colorado Access Utilization Management.

Health Plan Specific Information For Our Providers

Provider information that relates specifically to Colorado Access' lines of business, including Colorado Access Health Plan, can be located below the *Health Plan Specific Information For Our Providers* heading.

VII. Eligibility Verification & PCP Assignment

Verifying Eligibility

The provider is responsible for verifying eligibility and Primary Care Provider (PCP) assignment when rendering services. Determination of a member's enrollment with Colorado Access may be verified by any of the following means:

- ♦ Logon to the Colorado Access Web site (www.coaccess.com) and utilize the online eligibility verification tool.
- ♦ Calling Colorado Access Customer Service.

NOTE: Colorado Access will not pay claims for members who are not eligible on the date of service.

Instructions for Verifying Eligibility at www.coaccess.com

NOTE: A Colorado Access Username and Password are required in order to access the online eligibility verification tool.

If you do not have a Colorado Access Username and Password, you can request one at: http://www.coaccess.com/sites/default/files/logon_id_request.pdf.

- ♦ From www.coaccess.com, go to the *For Our Providers* page
- ♦ From the For Our Providers page, click on *Eligibility Verification* located beneath the heading Provider Tools & Tips
- ♦ The Login screen will open in a new browser window. In the new browser window, enter your Colorado Access Username and Password and click on *Login*.
- ♦ Once logged in, you will receive the following eligibility search screen:

Only enter criteria for one of the search options listed below and select Submit. You may search by Colorado Access ID, State or Medicaid ID, CHP+ Subscriber ID, Social Security Number, Medicare HICN or Subscriber First Name, Subscriber Last Name and Subscriber Birth Date.

Colorado Access ID

State or Medicaid ID

CHP+ Subscriber ID

Social Security Number - -

Medicare HIC Number

Subscriber First Name

Subscriber Last Name

Subscriber Birth Date (mm/dd/yyyy)

After entering your search criteria, click *Submit*.

Submit

- ♦ You may search by **ONE** of the following:
 - Colorado Access ID,
 - State or Medicaid ID,

- CHP+ Subscriber ID,
- Social Security Number,
- Medicare HICN or
- Subscriber First Name, Subscriber Last Name and Subscriber Birth Date.
- After you enter the search criteria, click on *Submit*.
- If your search criteria returns a result, you will receive a verification screen.

[Back](#)

Colorado Access ID	123456789
State or Medicaid ID	Z000000
Social Security Number	000-00-0000
CHP+ Subscriber ID	
Subscriber First Name	Sample
Subscriber Middle Name	Q
Subscriber Last Name	Member
Subscriber Birth Date	01/01/01
Subscriber Gender	F
Subscriber Address Line 1	123 Sample Street
Subscriber Address Line 2	
Subscriber City Name	Denver
Subscriber State Code	CO
Subscriber Zip Code	80000
County	Denver
Subscriber Contact Telephone #	
Language	
Other Insurance Name	
Other Insurance Eligibility Begin Date	
Other Insurance Eligibility End Date	
Secondary Insurance Name	
Secondary Insurance Begin Date	
Secondary Insurance End Date	

Subscriber Coverage

Once you verify that the system has returned the correct member, click on *Subscriber Coverage*.

Subscriber Coverage

- ◆ If your search criteria does not return results, you will receive the following disclaimer:

Disclaimer Page

There were no exact matches to the search criteria selected. Please check the information entered and re-enter as needed. If no exact matches are found, please refer to the following for additional assistance.

<i>Access Health Plan</i>	Local	303-751-9005
	Out-of-Area	1-800-511-5010
<i>Colorado Access Child Health Plan Plus</i>	Local	303-751-9021
	Out-of-Area	1-888-214-1101
<i>Access Behavioral Care</i>	Local	303-751-9030
	Out-of-Area	1-800-984-9133
<i>Access Advantage</i>	Local	303-751-2657
	Out-of-Area	1-877-441-6032

[Go Back](#)

- ◆ From the verification screen, verify that the system has returned the correct results, and click the *Subscriber Coverage* button.

[Back](#)
[Return to Eligibility Search](#)

SUBSCRIBER: Sample Member
 Colorado Access ID: 123456789
 State or Medicaid ID: Z000000
 Social Security Number: 000-00-0000
 Birth Date:
 Updated As Of: 06/04/2009 06:00 AM

As described in the provider manual, the provider is responsible for verifying eligibility before rendering services. Please review eligibility dates and print the member's information for your records.

Access Behavioral Care	Access Health Plan	Child Health Plan Plus HMO	Access Advantage	CHP+ State Managed Care Plan	CHP+ State Managed Care Plan
Plan Coverage Description: ABCD Eligibility Begin End Aid Category: Benefit Package: Tier Code:	Plan Coverage Description: AHP Eligibility Begin End Aid Category: Benefit Package: AHP Tier Code: CONV PCP Name: Sample PCP PCP Coverage: Begin End 01/01/01 12/31/9999 PCP Telephone #: 555.555.5555 <input type="button" value="Change PCP"/>	CHP+ Subscriber ID: Plan Coverage Description: Eligibility Begin End CoPay Description: Benefit Package: Code Description: Tier Code: PCP Name: PCP Coverage: Begin End PCP Telephone #: <input type="button" value="Change PCP"/>	Eligibility Begin End Benefit Package: Plan Copays PCP Name: PCP Coverage: Begin End PCP Telephone #: <input type="button" value="Change PCP"/>	Subscriber ID: Plan Coverage Description: Eligibility Begin End CoPay Description: Benefit Package: Code Description: Tier Code: PCP Name: PCP Coverage: Begin End PCP Telephone #: <input type="button" value="Change PCP"/>	Plan Coverage Description: Eligibility Begin End CoPay Description: Benefit Package: Code Description: Tier Code: PCP Name: PCP Coverage: Begin End PCP Telephone #: <input type="button" value="Change PCP"/>

To return to a blank eligibility search screen, click on the *Return to Eligibility Search* link

Eligibility dates indicate the effective dates of coverage. **Green** type indicates that the member is currently eligible and **Red** indicates that the member is ineligible.

Here you will find the name of the member's PCP, PCP effective dates and PCP phone number.

FOR PCPs ONLY
 With the member or guardian's permission, you can click on *Change PCP* to change the member's PCP to your office or clinic.

On the PCP change screen, remember to click on *Commit to Change*. If you do not click on *Commit to Change*, the PCP change request will not be submitted to Colorado Access. After clicking on *Commit to Change*, please screen print the completed request, have the member sign the screen print and add it to the member's file.

Primary Care Provider (PCP) Assignment

Initial PCP Assignment

With the exception of newborns, new enrollees should contact Colorado Access to select a participating PCP. Initial PCP assignments are made effective on the first date of enrollment. If the member does not contact Colorado Access, the member will be assigned to a PCP located near the member's address. Newborns born to a Colorado Access enrolled mother are assigned to the same PCP as the mother until a parent or guardian requests that the newborn's PCP be changed. The change will be made effective on the date of the request. However, the change will not become effective earlier than the first day following the newborn's discharge from the hospital after delivery.

Requesting PCP Change

The member or member's designated client representative (DCR) may request a PCP change, either verbally or in writing. Colorado Access will issue the member a new ID card, with the name of the new PCP.

The provider or provider's office staff may submit a PCP change request by logging on to the Colorado Access Web site eligibility verification tool (see the directions in the previous section). In most cases, the request will be made within 4 business days. Providers must print the PCP change form from the Web site and have the member sign the request. Providers must keep copies of the signed request. They may be audited by Colorado Access to assure the member's involvement with the request.

PCP changes will be made effective on the date of the request with the following exceptions:

- ♦ If the member is inpatient on the date of the request, the change will become effective the day after the member is discharged from the hospital.
- ♦ As stated above, a newborn's PCP will not be made effective earlier than the first day following the newborn's discharge from the hospital after delivery.

VIII. Claims & Provider Reimbursement

Colorado Access Addresses

Claims:

PO Box 17470
Denver, CO 80217-0470

Provider Carrier Disputes (Appeals):

PO Box 17189
Denver, CO 80217-0189

Customer Service/Claim Status

Customer Service




Denver Metro Area (303) 751-5903
Toll Free..... 1-888-380-3726

Customer Service can answer questions regarding benefits, claims, claim appeals, claim status and general questions about Colorado Access policies. Customer Service representatives are available Monday through Friday 8:00 a.m. to 5:00 p.m. Mountain Time.

Providers can also check claim status on the Colorado Access Web site. To do so, you must have a Colorado Access Username and Password. If you do not have a Colorado Access Username and Password, you can request one at http://www.coaccess.com/sites/default/files/logon_id_request.pdf.

For detailed instructions on checking claim status online, please see the end of this section.

Timely Filing

-  Claims must be submitted within 120 calendar days from the date of service or the contractual time limit.
-  Provider Carrier Disputes (claim appeals) must be submitted within 60 calendar days from the date of the voucher on which the claim appears.
-  Claims that involve a third party resource (TPR), such as auto insurance, must be submitted within 120 calendar days from the TPR's denial date or processing date.

Colorado Access Responsibilities

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 all “clean” paper claims within 45 calendar days of receipt, or the time period specified in the provider’s contract.
- ♦ Approve, deny or settle all “clean” electronic claims within 30 calendar days of receipt, or the time period specified in the provider’s contract.
- ♦ Approve, deny or settle all other claims (except fraudulent claims) within 90 calendar days.
- ♦ Apply interest and/or penalties to clean claims paid outside of these guidelines in accordance with Division of Insurance regulations.

NOTE: Colorado Access will not interpret claim information from provider statements or superbills. Also, Colorado Access will not submit fee-for-service claims to the State of Colorado for services rendered to non-Colorado Access members.

Provider Responsibilities

Providers rendering services to Colorado Access members have the following responsibilities in relation to billing for these services:

- ♦ Verify the member’s eligibility and PCP assignment for billed services prior to submitting the claim.
- ♦ Ensure that the appropriate authorization requirements have been met.
- ♦ Verify that place of service codes are correct.
- ♦ Verify that diagnosis and/or procedure codes match the service provided.
- ♦ Complete all required data elements.
- ♦ 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 120 days or as specified by contract (whichever is less).
- ♦ Bill third party or Medicare prior to submitting claims to Colorado Access.
- ♦ Attach all required documentation to the claim.
- ♦ If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim.
- ♦ Do not submit “continuation” claims.
- ♦ Submit paper claims to the appropriate address.

We require providers to submit complete claims for all services rendered to Colorado Access members, whether the services are capitated or fee-for-service. Electronic submission of claims is preferred. However, Colorado Access will accept paper claims in CMS 1500 or UB04/CMS 1450 formats. In order to process claims in a timely, accurate manner, we ask providers to observe standard reporting requirements.

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

- ♦ CMS 1500 Physician’s Manual.
- ♦ UB04 Billing Manual.
- ♦ ICD-9-CM Code Book.
- ♦ Physicians’ “Current Procedural Terminology” (CPT).
- ♦ Health Care Financing Administration Common Procedure Coding System (HCPCS).

Electronic Claims

Colorado Access accepts electronic/EDI claims through direct submission or through the use of a clearinghouse. For more information on direct submissions of electronic/EDI claims, please contact edi_coordinator@coaccess.com.

Registration for Electronic Claim Submissions

Each electronic claim submitter must contact Colorado Access to receive an Electronic Claim Submission (ECS) packet. The information is available on the Colorado Access Web site at <http://www.coaccess.com/electronic-claims-and-electronic-funds-transfer>. Once the Enrollment Form has been completed and submitted to Colorado Access, a Submitter ID will be assigned and the ECS submitter will be placed on the testing schedule. For more information regarding electronic claims, please visit <http://www.coaccess.com/electronic-claims-and-electronic-funds-transfer>.

EDI Clearinghouses

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

- ♦ **ENS:** www.enshealth.com (Payer ID: coacc)
- ♦ **Emdeon** (formally known as WebMD): www.emdeon.com (Payer ID: 84129)
- ♦ **CPSI:** www.cpsinet.com (Payer ID: coacc)
- ♦ **HealthFusion** (formally known as Quadramed): www.healthfusion.com (Payer ID: coacc)
- ♦ **MedAssets/Xactimed:** www.medassets.com (Payer ID: coacc)
- ♦ **Sage Software Healthcare** (formally known as Scinet): www.sagehealth.com (Payer ID: coacc)
- ♦ **Relay Health** (formally known as NDC): www.relayhealth.com (Payer ID: coacc)
- ♦ **SSI Group:** www.thessigroup.com (Payer ID: coacc)
- ♦ **S&S Datalink:** www.sasdatalink.com (Payer ID: coacc)
- ♦ **PNC Bank** (formerly known as Healthcare Admin Tech): www.pnc.com (Payer ID: coacc)
- ♦ **Practice Insight:** www.PracticeInsight.net (Payer ID COA)

If you have questions regarding EDI claims, please e-mail edi_coordinator@coaccess.com.

CMS 1500 Claims Specifications

Providers must file all claims for professional services, including laboratory services performed by an independent laboratory, on the CMS 1500 Universal Billing form. Please see Appendix A for CMS 1500 field requirements.

Colorado Access providers must, at the very least, include the information marked “yes” in the required field of Appendix A.

UB04/CMS1450 Claims Specifications

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, to Colorado Access on the UB04/CMS 1450. Please see Appendix B for UB04/CMS 1450 field requirements. Colorado Access providers must at the very least include the information marked “yes” in the required field of Appendix B.

NOTE: we require providers to bill professional and/or technical components of hospital-based physicians and Certified Registered Nurse Associates separately on a CMS 1500 claim form.

POA Indicator

Effective July 1, 2009, Colorado Access will begin reviewing inpatient claims with a discharge date of July 1, 2009 or after to ensure proper recording of the Present on Admission (POA) indicator.

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

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

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

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

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

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

Diagnosis Coding

Colorado Access requires providers to enter the appropriate diagnosis code on each claim submitted. We will only accept those codes published in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 codes). The provider must enter ICD-9 codes clearly on the claim form and include all digits and characters.

- ♦ Some procedures are appropriate only when specific conditions are present (i.e., 99381- 99387 is valid only with Diagnosis Code V20.2).
- ♦ Colorado Access requires 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 our members include information necessary to process claims, calculate costs and project future funding. In sharing information for these purposes, we do not jeopardize the privacy of the recipient.

Procedure Coding

Colorado Access uses the Centers for Medicare and Medicaid's Healthcare Common Procedure Coding System (HCPCS) to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. In order to ensure that claims are processed promptly and accurately please follow these guidelines:

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

Anesthesia Billing

Anesthesia Service Codes (procedure codes 00100-01999) must appear in field 24-D. Time units must be entered in field 24-G (1 unit equals 15 minutes). When calculating reimbursement on anesthesia claims, Colorado Access does pay for time and units. However, Colorado Access 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 is multiplied by Y. This total is the payment amount.

Immunizations

- ♦ Please report all immunizations given to Colorado Access members on the CMS 1500 claim form with the vaccine procedure code.
- ♦ A separate vaccine code should be listed for each vaccine administered. For example:
- ♦ CPT code 90708 for measles, mumps, and rubella (MMRV)

- ♦ CPT code 90659 for adult influenza injection
- ♦ Providers should bill the appropriate vaccine administration code(s) per CPT guidelines.
- ♦ Immunization information may be used for tracking and reporting purposes.

Multiple Occurrences

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

- ♦ Providers may refer to the CPT or HCPCS Bulletin for more information about unit definitions.
- ♦ DME providers should use the units listed in the Medicaid Fee Schedule.

Non Clean Claims Process

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, Colorado Access will pend/hold the claim in its processing system and include Explanation of Payment (EOP) codes and follow-up instructions on the voucher as to how to resolve the claim.
- ♦ If, within 30 calendar days of Colorado Access' request, a provider fails to submit the additional information, Colorado Access 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 by Colorado Access, absent fraud, within 90 calendar days after the date that the claim was first received by Colorado Access.

Locum Tenens

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

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

Access upon request.

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

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

NOTE: A physician who has left a group and for whom the group has engaged a locum tenens physician as a temporary replacement may still be considered a member of the group until a permanent replacement is obtained. Practitioners who provide services under a substitute physician's agreement must enroll, or be enrolled, in the Colorado Medicaid program.

Out-of-Area Services

Colorado Access is financially responsible for all emergency services and urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a Colorado Access member to Customer Service.

- ♦ Out-of-area providers should submit claims to the Colorado Access claims address (see Colorado Access addresses located in this section) for processing.

Resubmissions

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

Resubmission Process

- ♦ Send a photocopy of the original claim, clearly marked "Resubmission" on the face of the claim or newly completed claim form.
- ♦ The resubmission must be newly dated and signed with an authorized signature.
- ♦ Attach a copy of the voucher listing the originally submitted claim as denied.
- ♦ If one or more items on an original claim have been paid and other items denied, a legible photocopy of the original claim may be used to resubmit the denied lines.
- ♦ Correct the appropriate information clearly and accurately.

- ♦ Adjust total charges to reflect the amount being resubmitted.
- ♦ Mail all resubmitted claims to the Colorado Access claims address (see Colorado Access addresses located in this section).

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

Late or Additional Charges

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

Member Billing or Balance Billing

General Rules

According to CRS § 26-4-403, a Medicaid recipient is not liable for the cost of medical care received during the time the recipient is Medicaid eligible, provided the care is a benefit of Medicaid. In addition, a provider may not bill the Medicaid recipient for the difference between provider's charges and payment by Medicaid, Medicare, or private insurance. These constraints apply, regardless of whether or not Medicaid paid the claim. As Colorado Access is one of the State's contracted agents providing care to Medicaid recipients, this prohibition also applies to Colorado Access Health Plan members.

There are circumstances in which a member can be billed for services. They are:

- ♦ A member sees a doctor or provider who is not in the Colorado Access network.
- ♦ A member does not follow the pharmacy rules (member may have to pay for the medication).
- ♦ A member signs a consent form that says he/she will pay the doctor/provider or hospital.
- ♦ A member receives healthcare services outside of the United States of America.

Third Party Insurance

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

Appeal

A member may have to pay for healthcare services that he/she receives while appealing a healthcare decision or while waiting for a review by the State Fair Hearing. A member may have to pay if he/she does not prevail in the appeal or hearing.

Copayment Information

Colorado Access Health Plan members do not have co-payments for covered services.

Checking Claim Status on www.coaccess.com

In order to check claim status on the Colorado Access Web site, you must have a Colorado Access Username and Password. If you do not have a Colorado Access Username and Password, you can request one at http://www.coaccess.com/sites/default/files/logon_id_request.pdf.

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

- ♦ From the Colorado Access homepage, click on *For Our Providers*.
- ♦ On *For Our Providers* click on the link *Claim Status Lookup*. The login screen will open in a new window.

From the *For Our Providers* page, click on *Claim Status Look Up*. The login screen will open in a new window. Then, enter your Colorado Access Username and Password.

- ♦ Enter your Colorado Access Username and Password and click on *Submit*.
- ♦ From the claim search screen make sure your provider TIN appears at the top of the screen. Then either enter an account number (as submitted on the claim) or leave blank for a list of all accounts that have been recently submitted and click on *Search*.

IX. Provider Carrier Disputes (Claim Appeals)

Colorado Access Address

Provider Carrier Disputes (Appeals):

PO Box 17189
Denver, CO 80217-0189

Submission Process

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

In accordance with Division of Insurance regulations, Colorado Access requires Provider-Carrier disputes to be submitted in writing. Information may be submitted in a brief letter or on Colorado Access' Non-clinical Adjustment Request Form located on our Web site at <http://www.coaccess.com/frequently-used-forms>.



All necessary information should be submitted 60 calendar days from the date of the voucher on which the disputed claim appears to the address highlighted above.

Necessary information for purposes of a Provider-Carrier dispute includes the following:

- ♦ Each applicable date of service;
- ♦ Member name;
- ♦ Patient name;
- ♦ Member identification number;
- ♦ Provider name;
- ♦ Provider tax identification number (TIN);
- ♦ Dollar amount in dispute, if applicable;
- ♦ Provider position statement explaining the nature of the dispute; and
- ♦ Supporting documentation where necessary, (e.g., medical records, proof of timely filing, State Web Portal eligibility screen prints verifying reasonable attempts to capture member eligibility on date of service).

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

Processing Timeframes

Upon receipt of a Provider-Carrier dispute, Colorado Access will review, record, investigate, resolve and provide appropriate and timely notifications in accordance with applicable state and federal rules and regulations.

- ♦ Colorado Access will issue a written confirmation to the provider or the provider's representative within 30 calendar days of receiving a complete dispute resolution request.
- ♦ Colorado Access 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.
- ♦ Colorado Access may choose to use electronic means to send required notification to providers including e-mail or facsimile.
- ♦ Both parties may agree in writing to an extension beyond the 60 calendar days from receipt of all necessary information time frames established by this policy in order to resolve a dispute.

X. Coordination of Benefits

Filing a Claim for a Patient with TPR

- ♦ Providers must submit a hard copy of the 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).
- ♦ Colorado Access does not consider refusals of payment due to claim preparation errors or failure to provide sufficient processing information as proof of denial.
- ♦ If an EOB applies to more than one claim, a copy of the EOB must be attached to each claim submission.
- ♦ Complete the appropriate TPR data fields/form locators on the claim form submitted to Colorado Access. Claim TPR data fields/form locators are specific to third party insurance or Medicare; they cannot be used interchangeably.
- ♦ Submit the claim within 120 calendar days from the TPR's denial date or processing date.

Secondary Benefit Calculation “Lower of Logic”

Colorado Access calculates secondary benefits in the following manner:

- ♦ Colorado Access' benefit allowance is compared to the primary payment.
- ♦ If the primary payment is equal to or greater than the Colorado Access benefit allowance, Colorado Access will not make payment.
- ♦ If the primary payment is less than the Colorado Access benefit allowance, Colorado Access will pay the difference between the 2 amounts. However, payment will not exceed the other insurance's (including Medicare) co-insurance, deductible and/or co-pay.
- ♦ Colorado Access does not automatically pay the other insurance's (including Medicare) copayments, coinsurance and/or deductibles.

NOTE: Providers cannot bill clients for the difference between the primary carrier's health Insurance payments and their billed charges when Colorado Access does not make additional payment.

Authorizations and Coordination of Benefits

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

- ♦ When services are not a covered benefit of the primary payer.
- ♦ When benefits are exhausted by the primary payer.
- ♦ When the primary payer does not have an adequate network to provide the covered service.

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

XI. Authorizations & Referrals

Submitting an Authorization

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

Colorado Access cannot retrospectively deny benefits for treatments that have been pre-authorized **except** in cases of fraud, abuse, or if the member loses eligibility.

Prior to submitting an authorization, we ask that you verify the member's eligibility either via our Web site (www.coaccess.com) or by calling Customer Service at (303) 751-5903 or toll free 1-888-380-3726. Once you have determined that the member is eligible, you may either fax the Service Authorization Form (located on our Web site at <http://www.coaccess.com/frequently-used-forms>) to our Coordinated Clinical Services Department or speak with a representative from the Coordinated Clinical Services Department.

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

Colorado Access Authorization List

A comprehensive list of procedure codes and corresponding authorization requirements is located on the Colorado Access Web site at www.coaccess.com. To access the list, click on *For Our Providers*. Then, click on *Authorization List*. The login screen will open in a new window. In the new window, enter your Colorado Access Username and Password before you can access the list. If you do not have a Colorado Access Username and Password, you can request one at http://www.coaccess.com/sites/default/files/logon_id_request.pdf.

Medical Necessity

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

- ♦ Appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and
- ♦ Within standards of good medical practice within the organized medical community of the treating provider; and
- ♦ Not primarily for the convenience of the Member or the treating provider; and
- ♦ Consistent with the Medical Policy, the Utilization Management Program, Quality Management Program, and Benefit Program Requirements applicable to the Benefit Program under which the Covered Services are rendered; and
- ♦ The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is

necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medical necessity determinations are based on the following:

- ♦ Standardized national criteria, such as InterQual® criteria.
- ♦ Internally developed criteria approved by the Medical/Behavioral Quality Improvement Committee (MBQIC).
- ♦ Review by the Colorado Access Medical Director (or an Associate Medical Director). This may include discussing treatment alternatives and approaches with the provider requesting the service.

Colorado Access considers individual needs as well as the capacity of the local delivery system when applying medical review criteria. A provider may request the criteria used to make a determination from Coordinated Clinical Services at (303) 751-5903 or toll free 1-888-380-3726.

Authorization Categories

Colorado Access' Utilization Management Program has 4 authorization categories:

- ♦ **No Authorization**—Certain services can be provided under specified circumstances with no notification to or authorization by Colorado Access. These include:
 - 911-ambulance calls,
 - emergency department visit,
 - urgent care,
 - and the following services when rendered by a contracted providers or the assigned PCP:
 - well woman OB/GYN services,
 - family planning services,
 - routine vision care,
 - specialty office visit services)
- ♦ **Clinical Referrals**—Colorado Access encourages Primary Care Providers (PCPs) to direct care for specialty office-based service through clinical referrals. Colorado Access considers a clinical referral to be a communication between the PCP and the specialty provider for the purposes of care continuity and treatment planning. Specialty office visits for contracted specialty providers do not require referral/prior authorization from Colorado Access for payment purposes. Certain therapies, DME items, and office visits for non-participating specialists require prior authorization from Colorado Access.
- ♦ **Procedure Authorization:**
 - *Elective Procedures:* For procedures requiring authorization, the provider **MUST** request authorization at least 2 working days in advance of the scheduled service. A review will be done to ensure the following: participating provider, eligible member, covered benefit, and medical necessity.
 - *Emergent Procedures:* the provider must notify Colorado Access within 1 working day of the service being rendered. 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 Colorado Access 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. Failure to request authorization within timeliness guidelines will result in an administrative denial.

♦ **Transportation Authorization:**

- *Emergency Transport Base Rate and Mileage Reimbursement:* The provider must submit the claim with the trip sheet attached. Air ambulance services are covered only if ground transport is inaccessible or the member's condition requires expedited transport. Air ambulance and interstate transportation services are subject to retrospective review.
- *Non-emergent, Scheduled Ambulance Transportation:* The provider must request prior authorization at least 2 working days in advance of the scheduled service. Services are covered for members who are bed confined and if no other means of transportation can be used without endangering the individual's health. A review will be done to ensure the following: eligible member, covered benefit, and medical necessity. Failure to request authorization within timeliness guidelines will result in an administrative denial.

Types of Colorado Access Utilization Review Determinations

Colorado Access will make one of the following determinations after reviewing an authorization request. Colorado Access Utilization review determinations comply with the Colorado Division of Insurance and with line of business contracts.

- ♦ **Authorized**—The requested service meets all utilization review criteria. The claim for this service will be paid. Authorization is not a guarantee of payment. Colorado Access also considers whether the member is eligible with Colorado Access, whether services provided are medically necessary covered benefits, whether a clean claim is submitted timely, etc.
- ♦ **Pended**—A determination cannot be made with current information. The case is pending receipt of additional information and/or documentation.
- ♦ **Adverse Service Determination (“Denied”)**—The requested service is not covered by the benefit plan, is not medically necessary, is a reduction and/or has been discontinued, and/or the authorization request has not met timeliness requirements. A claim for this service will not be paid.
 - Only the Colorado Access Medical Director or the designated physician reviewer can deny an authorization request.
 - For prospective or concurrent determinations, the treating physician may request a reconsideration of the denial.
- ♦ **Administrative Denial**—A provider's failure to follow contractual requirements and/or established procedures regarding authorization requirements (i.e., out of timely notification, failure to submit necessary information, etc.) may result in an Administrative Denial.

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

General Authorization Rules

The following is a summary of Colorado Access' authorization rules and does not guarantee coverage. Please refer to the Colorado Access Health Plan Member Handbook located on our Web site at http://www.coaccess.com/sites/default/files/AHP_MemberHandbook.pdf.



NOTE: For those services that require authorization, failure to request authorization within the timelines noted below will result in an administrative denial.



Participating vs. Non-Participating Providers

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

Primary Care

Services provided by participating Primary Care Providers (PCPs) do not require prior authorization.

Specialists Referrals

Specialty office visits for participating specialty providers do not require a referral to be submitted to Colorado Access from the member's PCP. Colorado Access encourages PCPs to direct care for specialty office-based care through clinical referrals. Colorado Access considers a clinical referral to be communication between the PCP and the specialty provider for the purposes of care continuity and treatment planning.

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

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

Inpatient Care

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

Elective Services, Procedures, or Admissions

The facility must request authorization at least 2 working days in advance of the scheduled service. A review is done to ensure the following: participating provider, eligible member, covered benefit, medical necessity, and allowed length of stay.

Emergent Admissions

The facility must request authorization within 1 working day of the service being rendered. A review is done to ensure the following: eligible member, timeliness of notification, and medical necessity.

Childbirth

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

Concurrent Review

The facility must phone or fax clinical information supporting the medical necessity of admission and/or continued stay within 1 working day of the request for information by Colorado Access. Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria 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 Colorado Access on the next working day following discharge from the facility. A review is done to ensure the following: eligible member, medical necessity, and timeliness of notification. For continuing needs, the provider (vendor) must initiate a procedure authorization.

Emergency and Urgent Care

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

Definition an Emergency Medical Condition

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

Colorado Access covers all emergency department services necessary to screen and stabilize members if:

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

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

Urgent Care

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

Definition of Urgent Care

Urgent care is defined as provision of medically necessary covered services to treat an injury or illness

of a less serious nature than those requiring emergency care but required in order to prevent serious deterioration in the member's health, or to maintain a member's activities of daily living.

Emergent Operating Room & Emergent Admission

- ♦ The facility must request authorization within 1 working day of the service being rendered.
- ♦ A review is done to ensure the following: eligible member, timeliness of notification, and medical necessity.
- ♦ Services performed in an outpatient setting (place of service 22 or 24) do not require a facility authorization.

Ambulance

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

Outpatient Hospital / Ambulatory Surgery

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

Women's Health - OB/GYN Services

- ♦ OB/GYN office-based services do not require referral or prior authorization if the services are obtained from a participating provider.
- ♦ Certain facility-based procedures may require prior authorization.
- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) for authorization requirements.

Family Planning Services

- ♦ Family planning services do not require prior authorization or referral for any provider, both participating and non-participating.
- ♦ Some surgeries and supplies may require authorization.
- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) for authorization requirements.

Gynecological Services that Require Procedure Authorization

- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) for authorization requirements.
- ♦ Gynecological services that require a procedure authorization must be submitted to Colorado Access for review at least 2 working days in advance of the scheduled service in order to ensure payment of professional fees.
- ♦ For emergent procedures, the provider must notify Colorado Access within 1 working day of the service being rendered.
- ♦ Services performed in an outpatient setting (place of service 22 or 24) do not require a facility authorization.

Gynecological Services from Non-participating Specialists

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

Infertility

- ♦ Infertility evaluation, diagnosis and treatments are not covered benefits.

Abortion

- ♦ Abortion is a covered benefit when the life of the mother would be endangered if the fetus were carried to term, or if the pregnancy is the result of rape or incest.
- ♦ All abortion procedures require procedure authorization for medical necessity determination. Multi-fetal pregnancy reduction is considered an abortion procedure and is subject to the same benefit restrictions and procedure authorization requirements.

Maternity Care

NOTE: Please see the Community Resources (section XIII) section of this manual for a list of resources for expectant members.

Per the Colorado Women's Healthcare Act, Colorado Access members do not need a referral to see a participating provider for pregnancy or well-woman care. Please be advised that certain procedures performed by OB/GYNs may require an authorization. Please refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) for authorization requirements.

Basic Maternity Care

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

specialists, or participating Certified Nurse Midwives.

Facilities are responsible for notifying Colorado Access when a member is admitted for inpatient obstetrical care or delivery within 1 working day of admission.

Antepartum Ambulatory Care

- ♦ Authorization is not required to a participating Obstetrician, Gynecologist and/or Certified Nurse Midwife for routine services or participating specialist or sub-specialist.
- ♦ Diagnostic obstetrical ultrasound and fetal monitoring services provided by the participating, treating prenatal care provider (PCP or specialist) and provided in either the office or a par facility do not require authorization or notification.

Inpatient Maternity Care

- ♦ All admissions for 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

- ♦ Newborns are covered under the mother's delivery authorization.
- ♦ For sick newborns that remain in the hospital after the mother's discharge, Colorado Access must be notified and a separate case will be started for the newborn stay.
- ♦ Colorado Access is responsible for any newborn that remains in the hospital from date of birth through discharge.

Postpartum Ambulatory Maternity Care

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

Sub-Specialty Maternity Care

- ♦ Colorado Access encourages PCPs and OB/GYNs to direct members to contracted specialty/sub-specialty providers for office-based care through clinical referrals.
- ♦ Office visits with contracted specialty/sub-specialty providers do not require prior authorization for payment purposes.
- ♦ All care provided by non-participating providers require authorization. The sub-specialty provider will be expected to follow the same requirements for medical necessity authorization as detailed above.

Amniocentesis and Chorionic Villus Sampling

- ♦ Diagnostic amniocentesis and chorionic villus sampling are covered benefits except for instances where the sole purpose is for determination of fetal sex.
- ♦ Amniocentesis and chorionic villus sampling do not require a procedure authorization for medical necessity, but do require a referral authorization if being performed in an outpatient setting by a

perinatologist, reproductive geneticist or maternal-fetal medicine specialist (see sub-specialty 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, testing for inherited disorders and discussion of family history, or testing to determine the sex or physical characteristics of an unborn child.
- ♦ Genetic tests to evaluate risks of disorders for certain conditions may be covered based on medical policy, review, and criteria and after appropriate pre-authorization has been obtained.

Continuity of Care for Pregnant Women

- ♦ Women who become members of Colorado Access in the 1st trimester of their pregnancy will be referred to a participating provider for their maternity care.
- ♦ Women who become members of Colorado Access in the 2nd or 3rd trimester of their pregnancy may continue to receive their maternity care with their existing provider if the patient-provider relationship or the current pregnancy predates the Colorado Access effective date. If the patient-provider relationship predates the effective date and the provider is not a participating provider with Colorado Access, the provider must agree to accept the Colorado Access fee schedule as payment in full and agree to follow Colorado Access Utilization Management and Quality Management policies and procedures.
- ♦ Non-participating providers need to notify Colorado Access that they are seeing a member who needs continuity of prenatal care. A single case agreement will be processed to provide payment for services for this member. Please see **Continuity of Care and Transition of Care for New Members** in this section for more information.

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

Use of Non-Participating Facilities

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

Diagnostic Services

- ♦ Routine laboratory and imaging services do not require prior authorization.
- ♦ Specialized diagnostic procedures may require prior authorization.
- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) to determine authorization requirements.

Diagnostic Interpretation Services

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

Vision Care

Routine Vision Care

- ♦ Routine vision services do not require prior authorization for payment.
- ♦ Vision screening is covered as age-appropriate care.
- ♦ No referral or authorization is required for routine eye examinations, glasses, or contact lenses.
- ♦

Specialty Vision Care

- ♦ Certain specialty procedures may require prior authorization.
- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) to determine authorization requirements.
- ♦ Vision therapy is an excluded benefit.
- ♦ Blepharoplasties, eyelid revisions and other ophthalmologic surgeries require prior authorization.
- ♦ Radial keratotomy and other surgical refractive corrections are not covered benefits.

Observation Services

- ♦ Observation stays (place of service 22) do not require prior authorization for payment.
- ♦ Observation may be allowed for up to 72 hours.

Home Healthcare

NOTE: A list of Single Entry Point (SEP) and Long Term Care resources is available in the Community Resources section (section XIII) of this manual.

- ♦ All home health services require prior authorization for payment. Home health services shall mean skilled nursing, home health aide, occupational therapy, physical therapy, speech therapy, and infusion therapy services rendered by a Medicare-certified home health agency or organization.
- ♦ Covered home health services must be initiated with physician's orders by the 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 Colorado Access by submitting the physician's orders with the request, within 1 working day of service initiation.
- ♦ Authorization will be given for 1 evaluation per service type without medical necessity review.
- ♦ Following the evaluation, a request for procedural authorization must be submitted along with the plan of care within 5 days of the new plan of care for authorization of additional services beyond the evaluation.
- ♦ Any services rendered beyond the initial evaluation without authorization are subject to denial regardless of medical necessity.
- ♦ Any time there is a break in service, the home health agency must notify Colorado Access within 1 working day of the usually scheduled visit.
- ♦ All requests for home health authorization are reviewed for the medical necessity of each specific service in the plan of care, as well as necessity for service to be rendered in the home as opposed to an outpatient setting.
- ♦ Services must be provided in the member's place of residence.
- ♦ Home health aide services strictly for the purpose of providing unskilled personal care, to assist with activities of daily living, and/or homemaker services are not covered by Colorado Access.
- ♦ Nursing visits for the purpose of providing home health aide supervision are not authorized or

reimbursed as separate nursing visits.

- ♦ Home health nursing services provided by an individual who ordinarily resides in the member's home, or is 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 Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) to determine whether a supply item or piece of equipment requires authorization.

Therapy

- ♦ All physical, occupational, and speech therapy services require prior authorization.
- ♦ A prior authorization approved by Colorado Access is required for the initial evaluation.
- ♦ Ongoing services may be requested and approved based on medical necessity.
- ♦ For ongoing services, a procedure authorization is required.

NOTE: Coverage may be subject to benefit limits. Please review the plan's Member Handbook located online at http://www.coaccess.com/sites/default/files/AHP_MemberHandbook.pdf.

Downstream Providers

- ♦ A downstream provider is defined as a group of providers who render services at the direction of other providers.
- ♦ Colorado Access has determined that these providers should be held harmless from the prior authorization and/or referral process.
- ♦ All downstream providers must bill utilizing the 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) services billed by practitioners are considered downstream.
- ♦ **Inpatient** (place of service 21) pathology, radiology, anesthesia and all other physician services not on the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) 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.

Pharmacy and Injectable Medications

- ♦ Certain injectable medications require prior authorization.
- ♦ Refer to the Colorado Access authorization list (located online at <https://providers.coaccess.com/providers/files/MasterAuthorizationList.pdf>) to determine authorization requirements.
- ♦ Retail pharmacy drugs are managed by formulary.
- ♦ The formulary is located online at <http://www.coaccess.com/pharmacy-services>.
- ♦ Certain formulary drugs may be preferred agents or may require prior authorization. Refer to the Colorado Access formulary for more information.
- ♦ Please refer to the Pharmacy Services section of this manual for additional information.

Behavioral Health

Behavioral Health services are covered by the Behavioral Health Organization in a member's area.

Continuity of Care and Transition of Care for New Members

Colorado Access 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 Colorado Access and is not willing to do so, and the service is expected to be ongoing, Colorado Access, as appropriate, will work with the member and provider to have the appropriate services transitioned into the network by the completion of the transition period. Services will be reassessed at the end of the transition period as part of routine authorization to ensure that they continue to be appropriate at the current level of care.

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

If Colorado Access 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 non-participating provider.

Continuity of Care and Transition of Care for Existing Members

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

XII. Clinical Appeals & Grievances

NOTE: Colorado Access maintains separate clinical appeal policies for its lines of business.

Clinical Appeals

Colorado Access has established an appeal process and access to a State Fair Hearing for members or Designated Client Representatives (DCRs) of Colorado Access Health Plan. The Appeal Process complies with the requirements of the Division of Insurance Regulation 4-2-17 Prompt Investigation of Health Plan Claims Involving Utilization Review and Medicaid State Regulations.

A Colorado Access Health Plan member or DCR may request a review of an adverse determination, not involving an urgent care request, through the appeal process either verbally or in writing. A member may designate an individual as a DCR in writing using A Designated Client Representative Form. Colorado Access will allow the member to identify providers to whom the notice of the appeal decision should be sent. An appeal from any other person(s) will not be accepted without a signed DCR form. Subjects of appeals include, but are not limited to, the denial or limited authorization of a requested service; or reduction, suspension or termination of a previously authorized service.

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

Colorado Access Health Plan Appeal Process

1. Colorado Access will provide a written notice of action to members or DCRs in accordance with State Medicaid Rules and Division of Insurance Regulations.¹
2. Colorado Access will make a reasonable effort to provide assistance to a member or DCR in navigating the appeal process including but not limited to, completing necessary appeal forms, and providing interpretive services and toll free numbers that have TTY/TTD capability.²
3. Colorado Access will accept an appeal from a member or DCR that is submitted within 20 calendar days from the date of the notice of action.³
4. Colorado Access will not impose punitive action against a member or DCR for filing an appeal.⁴

¹ 10 C.C.R. 2505-10, § 8.209.4.A (2005) (HCPF Rules).

² 10 C.C.R. 2505-10, § 8.209.4.C (2005) (HCPF Rules)

³ 3 C.C.R. 702-4, §4-2-17, Sec. 10. D (02/2006) (DOI Rules); 10 C.C.R. 2505-10, Sec. 8.209.4.B.

⁴ 10 C.C.R. 2505-10, § 8.209.4.Q (2005) (HCPF Rules); 10 C.C.R. 2505-10, Sec. 8.209.4.C.

5. If Colorado Access or the treating provider determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, an expedited appeal may be requested.⁵
6. For notification purposes, parties to the appeal include the member and/or the DCR or the legal representative of a deceased member estate.⁶
7. Upon receipt of an appeal by Colorado Access, a written acknowledgement of the appeal is provided to the member and/or the DCR within 2 business days of receipt, unless the member or DCR requests an expedited resolution.⁷ Expedited resolutions are addressed later in this section.
8. If the original action was made to deny a service, and substantive new clinical information is received; the appeal request may be returned to the original medical reviewer to evaluate the new information and to see if they are able to overturn their original action and approve the service. If the medical reviewer is unable to overturn their action with the new information, the request will be forwarded to a licensed physician who was not involved in the original decision.
9. Appeal decisions are made by a licensed physician who was not involved in any previous level of review or decision-making regarding the appeal, and who has appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:⁸
 - a) An appeal based on lack of medical necessity; or
 - b) An appeal that involves a clinical decision.
10. Colorado Access provides a process for standard and expedited appeals. Standard and expedited appeals will be resolved and a notice provided to the member or DCR as expeditiously as the member's health condition requires, not to exceed the following:
 - a) A standard appeal is resolved and a written notice of the resolution is provided to the member or DCR within 10 business days.⁹
 - b) An expedited appeal is resolved and a written notice of the resolution is provided to the member or DCR within 3 business days of receipt.¹⁰ Colorado Access will make a reasonable effort to provide verbal notice to the member and/or DCR.¹¹ If a request for an expedited appeal resolution is denied, Colorado Access will make a reasonable effort to give the member prompt verbal notice of the denial with a written notice provided to the member within 2 calendar days. The appeal will then follow the process for a standard resolution.¹²
 - c) Expedited appeals for non-formulary medication requests resulting in an adverse determination may be requested by the member or provider via phone or fax to

⁵ 10 C.C.R. 2505-10, § 8.209.4.P (2005) (HCPF Rules)

⁶ 10 C.C.R. 2505-10, § 8.209.4.I (2005) (HCPF Rules)

⁷ 10 C.C.R. 2505-10, § 8.209.4.D (2005) (HCPF Rules)

⁸ 10 C.C.R. 2505-10, § 8.209.4.E (2005) (HCPF Rules)

⁹ 3 C.C.R. 702-4, §4-2-17, Sec. 10. G. 1-3 (02/2006) (DOI Rules); 10 C.C.R. 2505-10, Sec. 8.209.4.J.1.

¹⁰ 3 C.C.R. 702-4, §4-2-17, Sec. 12. G (02/2006) (DOI Rules); 10 C.C.R. 2505-10, Sec. 8.209.4.J.2.

¹¹ 10 C.C.R. 2505-10, § 8.209.4.L (2005) (HCPF Rules)

¹² 10 C.C.R. 2505-10, § 8.209.4.R (2005) (HCPF Rules)

Colorado Access Pharmacy Services, and will be completed within 12 business hours. The member and provider will be notified of the appeal review determination by telephone, fax or by letter within 1 business day of making the determination. Members and providers have a right to appeal an expedited appeal.

11. Colorado Access may extend the time frame in order to resolve a standard or expedited appeal up to 14 calendar days if the member requests the extension or Colorado Access shows a need for additional information and the delay is in the member's best interest. Colorado Access will provide the member with prior written notice of the reason for the delay.¹³
12. Colorado Access will make a reasonable effort to provide an opportunity for the member or DCR to examine the records and documents associated with their appeal and to present evidence and allegations of fact or law, in person or in writing.¹⁴
13. Colorado Access will provide resolution notices to all parties regarding the appeal which include the results of the appeal process and the date the resolution was completed. For appeals not resolved wholly in favor of the member, the notice will include the right to request a state fair hearing, the right to request and to receive benefits while the hearing is pending and that the member may be held liable for the cost of those benefits if the hearing decision upholds Colorado Access' initial action¹⁵.

State Fair Hearing

- ♦ Colorado Access Health Plan members may request a State Fair Hearing at any time during the appeal process but no later than 20 calendar days from the date of the notice of action. The member need not exhaust the Colorado Access appeal process.
- ♦ Colorado Access informs members of their right to a State Fair Hearing and how to request one primarily through the member's notice of action and the accompanying letter Member Appeal Information. Colorado Access also includes information about this avenue for resolving an appeal in other written member materials such as the Member Handbook.
- ♦ Colorado Access will provide reasonable assistance to a member, DCR, or legal representative in requesting a State Fair Hearing including, but not limited to, putting oral requests for a State Fair Hearing into writing, and providing access to interpretive services and toll free numbers with TTY/TDD capability.
- ♦ Colorado Access will provide for the continuation of benefits while a State Fair Hearing is pending when all of the following criteria are present:
 - The member/provider files the appeal within 20 calendar days of the date the Notice of Denial was received; and
 - The appeal involves the termination, suspension, or reduction of a previously authorized

¹³ 10 C.C.R. 2505-10, § 8.209.4.K (2005) (HCPF Rules)

¹⁴ 10 C.C.R. 2505-10, § 8.209.4.G-H (2005) (HCPF Rules)

¹⁵ 10 C.C.R. 2505-10, § 8.209.4.M (2005) (HCPF Rules)

course of treatment; and

- The services were ordered by an authorized provider; and
 - The original period covered by the original authorization has not expired;
 - The member requests an extension of benefits. The extension of benefits granted when the above criteria is present will extend the original authorization until the earlier of:
 - The member or provider withdraws the appeal whether verbally or in writing; or
 - 10 days after Colorado Access mails the appeal determination to the member and provider; or
 - An Administrative Law Judge issues a final opinion in Colorado Access' favor; or
 - The original authorization expires.
- ◆ Where Colorado Access grants an extension of benefits and the denial is upheld on appeal or an Administrative Law Judge issues an opinion in favor of Colorado Access, Colorado Access may recover the cost of the services furnished to the member while the State Fair Hearing was pending.
 - ◆ If the final resolution of the appeal upholds Colorado Access' action, Colorado Access may recover the cost of the services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of Colorado Health Care Policy and Financing Medicaid Staff Manual Volume 8—Medical Assistance §8.209.
 - ◆ If the State Fair Hearing officer reverses Colorado Access' decision to deny, limit or delay services that were not provided while the appeal was pending, Colorado Access shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.
 - ◆ If the State Fair Hearing officer reverses Colorado Access' decision to deny authorization of services and the member received the services while the appeal was pending, Colorado Access must pay for those services.

Grievances

A grievance is an oral or written expression of dissatisfaction communicated by a Member or a designated client representative (DCR) to Colorado Access and its participating providers about any matter other than an action, including but not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or the failure to respect the Member's rights.

As a partner in serving our members, Colorado Access is reliant upon providers to pass along the concerns of our members. In order to give our joint members/patients a voice, Colorado Access requests that participating providers relay member concerns to our grievance number at (720) 744-5134 or toll free 1-877-276-5184. Providers can call directly on behalf of the member or can refer the member to this phone number. Colorado Access will implement its Grievance Process (identified below) accordingly. Colorado Access requests that participating providers cooperate with the investigation and make themselves reasonably available to answer any questions pertaining to that grievance.

In order to provide support to Members who believe that they may have reported concerns to the appropriate person or entity, Colorado Access shall contact high volume clinics, IPAs, and hospitals who are Participating Providers to determine whether any Members have expressed dissatisfaction or grievances.

Grievance Process

Colorado Access has established a grievance and appeal process for Members or DCRs of Colorado Access. This process complies with the requirements of the Division of Insurance Regulation 4-2-17 Prompt Investigation of Health Plan Claims Involving Utilization Review. Colorado Access will adhere to the rule or regulation that is more restrictive in order to comply with both.

- ♦ Colorado Access will accept a grievance from a Member or DCR that is expressed within 20 calendar days of the incident. Quality of care concerns are addressed in accordance with the Colorado Access' Quality of Care Concerns policy.
- ♦ Upon notification of a grievance, Colorado Access will send a written acknowledgement of each grievance to the member or DCR within 2 business days of knowing that the member expressed dissatisfaction.
- ♦ Grievance decisions are made by a designated employee who was not involved in any previous level of review or decision-making regarding the grievance.
- ♦ Grievances are resolved as expeditiously as the member's health condition requires, not exceeding 15 business days from notification of the grievance. A written resolution notice that explains the results of the grievance and the date it was completed is sent to the member.
- ♦ Colorado Access may extend the resolution time frame of a grievance up to 14 calendar days if the member requests the extension, or Colorado Access shows a need for additional information and the delay is in the member's best interest. Colorado Access will provide the Member with prior written notice of the reason for the delay.

XIII. Community Resources

Resource Name	Description	Contact Information
Prenatal/Family Resources		
The Family Healthline	The Family Healthline helps pregnant women, children, families and individuals find free or low-cost healthcare and other services.	General line: (303) 692-2229 (Metro Denver) 1-800-688-7777 (Toll free)
WIC (Women, Infants and Children)	The Special Supplemental Nutrition Program for Women, Infants, and Children – better known as the WIC Program - serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to healthcare.	Web site: http://www.cdphe.state.co.us/ps/wic/ General line: (303) 692-2400 Please refer patients to the County Human/ Social Services.
Prenatal Plus Program	The goal of the Prenatal Plus program is to improve birth outcomes by reducing the prevalence of low birth weight infants among Medicaid-eligible women in Colorado. A low birth weight infant weighs less than 5 pounds, 8 ounces or 2500 grams.	Web site: http://www.cdphe.state.co.us/pp/womens/PrenatalPlus.html General line: (303) 692-2495
Nurse Family Partnership	Nurse-Family Partnership is an evidence-based, nurse home visiting program that improves the health, well-being and self sufficiency of low-income, first time parents and their children.	Web site: http://www.nursefamilypartnership.org/index.cfm?fuseaction=home Site: Adams & Arapahoe County: Tri-County Health Department E-mail: mneal@iik.org Boulder County: Boulder County Health Department (303) 413-7500 Broomfield County: Jefferson County Department of Health and Environment (303) 232-6301 Denver County: Denver Health and St. Anthony Central Hospital E-mail: mneal@iik.org

Resource Name	Description	Contact Information
		Weld County: Weld County Department of Public Health and Environment E-mail: mneal@iik.org
Aurora and Arapahoe County Healthy Start Project	The Health Start Project was developed to combat infant mortality in high risk groups. The program focuses on prenatal and infant care.	General Line: (303) 761-1977 ext 4121; 2202 or 2207 Site: 1300 S. Potomac St., Suite 156 Aurora, CO 80012-4526
Colorado Bright Beginnings	Colorado Bright Beginning's Mission: To provide a <i>bright beginning</i> for all Colorado children by helping families support their children's physical, emotional, and intellectual development during the critical first 3 years of life	Website: http://www.brightbeginningsco.org/index.htm General Line: (303) 433-6200
Single Entry Point (SEP)/Long Term Care Resources		
Longterm Care Options, LLC	Colorado's largest case management agency serving individuals with disabilities and older adults. Longterm Care Options is a nonprofit agency specializing in the personal coordination of longterm care services in community settings.	Website: http://www.lcoptions.org/index.html General Line: Adams County: (720) 974-2439 Arapahoe County: (720) 974-2379 Denver County: (720) 974-2397
Adult Care Management (Boulder & Broomfield Counties)	Helps families, through Medicaid and private insurance, set up in-home care. No age requirements. There are separate programs for special needs assistance.	General Line: (303) 964-2441
Weld County Area Agency on Aging	Weld County Area Agency on Aging is a support system for Weld County residents 60 years of age and older and their caregivers. Our primary concern is to help maintain an individual's independence and dignity in their home and community.	Web site: http://www.co.weld.co.us/departments/agencyonaging.html General Line: (970) 353-3800 Option 4
Pueblo County Department of Social Services	Pueblo County Department of Social Services provides adult services including options for long term care.	General Line: (719) 583-6160

Additional member resources can be located on our Web site at <http://www.coaccess.com/our-members>

CMS 1500 Box Number	Data Element	Description	Required
1	Type of Insurance	The type of health insurance coverage carried by the patient	Yes
1a	Insured's I.D. Number	Patient's ID Number	Yes
2	Patient's Name	Patient's last name, first name and middle initial exactly as they appear on the MAC	Yes
3	Patient's Birth Date Sex	Patient's DOB using MMDDYY format. Patient's sex (M = Male, F = Female).	Yes
4	Insured's Name		Yes
5	Patient's Address		No
6	Patient's Relationship to Insured	Relationship between the patient and the policyholder (insured) of the third party insurance.	Required if patient has 3rd party coverage
7	Insured's Address	Address and telephone number of the policyholder (insured) of the insurance. Thirty party claims refer to subscriber not 3rd party.	Required if patient has 3rd Party coverage
8	Patient Status		No
9	Other Insured's Name	Policyholder's last name, first name, and middle initial.	Required if patient has 3rd Party coverage
9a	Other Insured's Policy or Group Number	Policy Number	Required if patient has 3rd Party coverage
9b	Other Insured's Date of Birth Sex	Date of birth, sex of policyholder	Required if patient has 3rd Party coverage
9c	Employer's Name or School Name		No
9d	Insurance Plan Name or Program Name	Name of insurance company or program providing 3rd party coverage.	Required if patient has 3rd Party coverage
10	Is Patient's Condition Related To	Indicate whether patient's condition is related to employment, auto accident or other accident.	No
10d	Reserved For Local Use	Enter the accident date in MMDDYY format	No

CMS 1500 Box Number	Data Element	Description	Required
11	Insured's Policy Group or FECA Number	Enter the Colorado Access group number. Refer to the patient's Colorado Access ID Card for appropriate group numbers.	Optional. Including the Group Name may assist in adjudicating the claim more quickly.
11a	Insured's Date of Birth Sex		No
11b	Employer's Name or School Name		No
11c	Insurance Plan Name or Program Name		No
11d	Is There Another Health Benefit Plan	Indicate whether or not patient has 3rd party coverage. If yes, complete boxes 9 a-d.	Required if patient has 3rd Party coverage
12	Patient's or Authorized Person's Signature	Patient's signature or notation that signature is "on file."	Yes
13	Insured's or Authorized Person's Signature.	Insured's signature or notation that signature is "on file"	Yes
14	Date of Current Illness, Injury or Pregnancy	Date of first symptoms, accident or last menstrual period using MMDDYY format.	Yes
15	If Patient Has Had Same or Similar Illness Give First Date		No
16	Dates Patient Unable to Work in Current Occupation		No
17	Name of Referring Provider or Other Source	Name of Physician	No
17a	I.D. Number of Referring Physician	Provider Tax ID number of the referring physician.	No
17b	NPI	NPI number of the referring physician	No
19	Reserved for Local Use		No

CMS 1500 Box Number	Data Element	Description	Required
20	Outside Lab / \$Charges	Indicate whether ALL laboratory work was performed outside of the physician's office by an independent lab. If yes, no payment will be made to the physician for laboratory fees. Do not check yes if ANY laboratory work was performed within the physician's office.	No
21	Diagnosis or Nature of Illness or Injury	Enter up to four ICD-9-CM diagnosis codes. Decimal points should not be entered. A written description is optional. Note: Up to four additional diagnoses may be reported by attaching a second claim form.	Yes
22	Medicaid Resubmission Code - Original Ref. No.	Code and the original reference number.	No
23	Prior Authorization Number	Prior Authorization number received from Colorado Access or from the Primary Care Provider (PCP).	No
24 A	Dates of Service	Dates that service began and ended using MMDDYY format	Yes
24 B	Place of Service	<p>Colorado Access requires providers to use the correct CPT™ code that is appropriate for the place of service listed on the claim form.</p> <p>The following is a list of place of service codes used by Colorado Access. In order for claims to be processed, these codes must be used. Single digit or alpha place of service codes will be considered invalid codes.</p> <p>Code: Description:</p> <ul style="list-style-type: none"> 11 Office 12 Patient's home 20 Urgent Care effective 06/01/03 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room-hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Air ambulance 51 Inpatient psychiatric 52 Psychiatric facility partial hospital 53 Community mental health center 	Yes

CMS 1500 Box Number	Data Element	Description	Required
24 B <i>(Continued)</i>		54 Interim care facility (ICF) 55 Residential substance abuse facility 61 Comp IP rehabilitation facility 62 Comp OP rehabilitation facility 65 End stage renal treatment facility 71 ST/Local disease treatment facility 72 Rural health clinic 81 Independent laboratory	Yes
24 C	EMG	Enter an "X" if the service provided is emergency related. An emergency is defined as care for any condition which is life threatening or which requires immediate medical intervention.	Required if Applicable
24 D	Procedures, Services or Supplies	CPT-4 or HCPCS code (including any valid modifier codes for the service code).	Yes
24 E	Diagnosis Pointer	Number 1, 2, 3, or 4 from field 21 to indicate which diagnosis is related to the procedure on each billing line. Do not enter the ICD-9-CM code.	Yes
24 F	\$ Charges	Usual and customary charge for each service.	Yes
24 G	Days or Units	Number of service units for each procedure. Days or units must be whole numbers.	Yes
24 H	EPSDT Family Plan		No
24 I	ID. Qual		No
24 J	Rendering Provider ID #		No
24 J	NPI	Enter the NPI number of the provider that rendered the service.	Yes
25	Federal Tax ID Number (SSN/EIN)	Enter the nine-digit Provider Tax ID number of the provider or agency that will receive payment for these services (Check the box that applies - SSN or EIN).	Yes
26	Patient's Account No	The account number assigned by the provider's office. If entered, the account number will appear on the Colorado Access voucher for the claim.	Yes
27	Accepts Assignment	All Colorado Access claims are reimbursed to the provider.	No
28	Total Charge	Sum of all charges listed in field 24 F	Yes
29	Amount Paid	All amounts paid by a third party. If not applicable, input \$0.	Required if Applicable
30	Balance Due	The net amounts of line 28 and line 29.	Yes
31	Signature of Physician	Authorized signature or printed name and date of the physician. Note: including a legible (printed) name assists Colorado Access in more quickly adjudicating the claim.	Yes

Appendix A

CMS 1500 Box Number	Data Element	Description	Required
32	Service Facility Location Information	Name and address of the facility where services were rendered - if other than home or office.	Yes
32 A	NPI	The NPI number of the facility where services were rendered.	Yes
33	Billing Provider Info & PH #	The provider's billing name, payment address, and telephone number.	Yes
33 A	NPI	The NPI number of the billing provider.	Yes

UB04/CMS 1450 Box Number	Data Element	Description	Required
1	Provider Data	Provider name, address and telephone number.	Yes
2	N/A		N/A
3a	Pat CNTL #	Patient Control Number - Account or bill control number assigned by the provider.	Yes
3b	Med Rec #	Medical Record Number - Medical record number assigned by the provider.	No
4	Type of bill	Type of facility (1st digit), bill classification (2nd digit), and frequency (3rd digit). Refer to the AHA UB04 Uniform Billing Manual for a list of codes.	Yes
5	Fed Tax No.	The Federal Tax ID Number.	Yes
6	Statement Covers Period	Beginning and ending service dates of the period included on the bill	Yes
7			N/A
8a	Patient Identifier	The patient's ID number.	Yes
8b	Patient Name	The patient's Last, First and Middle Initial.	Yes
9a	Patient Address	The patient's street address.	Optional
9b	Patient's City - <i>not labeled</i>	The city in which the patient resides.	Yes
10	Birthdate	The patient's date of birth.	Yes
11	Sex	The patient's gender, enter M or F.	No
12	Admission Date	The date care began (the date of admission or the date care was initiated).	Yes
13	Admission HR	The hour in which the patient was admitted for care. The hour should be entered in military time (00-24).	No
14	Admission Type	<p>The single digit code that describes the reason for admission:</p> <ol style="list-style-type: none"> 1. <i>Emergency</i> – Patient requires medical intervention for severe, life-threatening or potentially disabling conditions. Documentation must be attached. 2. <i>Urgent</i> – Patient requires immediate attention. 3. <i>Elective</i> – Patient's condition permits time to schedule services. 4. <i>Newborn</i> – Patient is a newborn. The newborn source of admission code must be entered in field 15 (see below). 	No

UB04/CMS 1450 Box Number	Data Element	Description	Required
15	Admission SRC	<p>The code that best describes the source of the admission:</p> <ol style="list-style-type: none"> 1. Physician Referral 2. Clinical Referral 3. HMO Plan Referral 4. Transfer from Hospital 5. Transfer from Skilled Nursing Home 6. Transfer from other Health Care Facility 7. Emergency Room 8. Court/Law Enforcement 9. Information not available <p>Newborns (Refer to Field 19)</p> <ol style="list-style-type: none"> 1. Normal Birth 2. Premature Birth 3. Sick Newborn 4. Extramural Birth 	No
16	DHR	The hour in which the patient was discharged. The hour should be entered in military time (00-24).	No
17	STAT	<p>The code that best describes the patient's status for this billing period:</p> <ol style="list-style-type: none"> 1. Discharged to home or self care 2. Transferred to another short-term hospital 3. Transferred to a skilled nursing facility 4. Transferred to an intermediate care facility 5. Transferred to another type of institution 6. Discharged to home under care of an Organized Home Health Services Organization 7. Left Against Medical Advice 8. Discharged/Transferred to Home under Care of Home IV Provider 20. Expired 30. Still a Patient 40. Expired at Home 41. Expired in Hospital, SNF, ICF or Hospice 42. Expired, Place Unknown 	No
18 - 28	Condition Codes	Codes used to identify conditions related to the claim that may affect processing.	No
29	ACDT State	Accident State - if the claim is related to an accident, enter the abbreviation of the state in which the accident occurred.	No
30			N/A
31 - 34	Occurrence Code and Date	The code and associated date defining a significant event relating to the claim that may affect processing.	No
35 - 36	Occurrence Span Code, From Through	The beginning and end dates of the event relating to the claim.	No

UB04/CMS 1450 Box Number	Data Element	Description	Required
37			N/A
38	Name & Address of Responsible Party		No
39 - 41	Value Code and Amount	Codes used to identify payment variations	No
42	Revenue Codes	Codes that identify a specific accommodation, ancillary service, or billing calculation. Accommodation days should not be billed on outpatient bill types. Revenue codes are to be billed in the following sequence: chronologically for accommodation dates; in descending order for non-accommodation revenue codes.	Yes
43	Description	Description of the related revenue code.	No
44	HCPCS/Rate/HIPPS Code	Accommodation rate for inpatient bills and the HCPCS code for all ancillary services and outpatient bills. HCPCS codes & rates should be submitted on lab claims that fall under the Colorado Access Lab Contract.	Yes
45	Serv. Date	Date of outpatient service in MMDDYY format	Yes
46	Serv. Units	Services units provided. If accommodation days are billed, the number of units billed must be consistent with the Statement Covers Period (Box 6). Service units should be billed in whole numbers. Round any fractions to the nearest whole number.	Yes
47	Total Charges	Total Charges for Field 47 are obtained by multiplying the units of service (Box 46) by the value of the revenue code (Box 42).	Yes
48	Non-Covered Charges		No
49			N/A
50 A, B, C	Payer Name	Name of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement. Colorado Access should be the last entry.	No
51 A, B, C	Health Plan ID	Identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement.	No
52	REL Info	Release of Information - Enter "Y" if the provider has signed written consent from the patient to release medical/billing information. Otherwise, enter "R" for restricted or modified release or "N" for no release.	No

UB04/CMS 1450 Box Number	Data Element	Description	Required
53	ASG. BEN.	Assignment of benefits - A code showing whether the provider has a signed form authorizing the party payer to pay the provider.	N/A
54	Prior Payments	Amount received toward payment from any payer, including the patient. If no payment was received as a result of billing, enter "0." The "0" indicates that a reasonable attempt was made to determine available coverage for the services provided.	No
55	Estimated Amount Due		No
56	NPI	National Provider Identifier - The NPI number of the billing provider.	Yes
57	Other Prv ID	Other Provider ID - Number assigned to the provider by the payer indicated in Box 50 A, B, C.	No
58	Insured's Name	Name of the insured who is covered by the payer listed in Box 50.	No
59	P. Rel	Patient's Relationship to the Insured - Code indicating relationship of the insured to the patient. For Medicaid, code will be 01.	No
60	Insured's Unique ID	The patient's member ID Number.	Yes
61	Group Name	Insured's group name. Refer to Colorado Access ID card.	No
62	Insurance Group No.	The Insurance Group Number - Refer to the Colorado Access ID.	Yes
63	Treatment Authorization Codes	If applicable, enter the Colorado Access authorization number for the services rendered.	Yes - if applicable
64	Document Control Number	N/A	N/A
65	Employer Name		No
66	Dx	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - Enter "9"	Yes
67	Principal Diagnosis Code	Principal diagnosis, determined after study, using ICD-9-CM codes. The codes should match those on the Colorado Access prior authorization letter if an authorization has been obtained.	Yes
67 A - Q	Other Diagnosis Codes	Other applicable ICD-9-CM diagnosis codes. These should include codes for other conditions that existed during the episode of care being billed, but were not primarily responsible for admission.	Yes - if applicable

UB04/CMS 1450 Box Number	Data Element	Description	Required
68	N/A		N/A
69	Amit Dx	Admitting Diagnosis - ICD-9-CM diagnosis code that represents the significant admitting diagnosis.	Yes - if inpatient
70 A, B, C	Patient Reason Dx	The diagnosis that represents the the reason for the patient's outpatient visit.	Yes - if outpatient
71	PPS Code	Prospective Payment System Code - The code that identifies the DRG.	Yes - if applicable
72	ECI	External Cause of Injury - the E-Code (ICD-9CM code) that represents the cause of injury, poisonings or adverse affects.	No
73	N/A		N/A
74	Principal Procedure Date	Principal procedure code and date the principal procedure was performed during this hospital stay. ICD-9-CM procedure codes are required. If more than one procedure is performed, the principal procedure should be the one related to the principal diagnosis, which was performed for definitive treatment of that condition and requires the highest skill level.	No
74 A - E	Other Procedure Date	Other procedure codes performed during the hospital stay. Enter the codes in descending order of importance.	No
75	N/A		N/A
76	Attending	Attending provider's National Provider Identifier (NPI) number, and the provider's Last and First name	Yes
77	Operating	Operating physician's National Provider Identifier (NPI) number, and the physician's Last and First name	Yes - if applicable
78 - 79	Other	Other providers' National Provider Identifier (NPI) number, and the provider's Last and First name	Yes - if applicable
80	Remarks	Information when applicable.	No
81 a - d	CC	Codes that do not fit in the other code fields of the form, and externally maintained codes approved by NUBC for the institutional data set.	No



Have questions?

Need help?

Call us at (303) 751-5903 toll free at 1-888-380-3726

**Colorado Access Health Plan Provider Information on our
Web site, www.coaccess.com**

<http://www.coaccess.com/colorado-access-health-plan-provider-information>

