



State Managed Care Network General Authorization Rules

Participating v. Non-Participating Providers:

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

Primary Care:

Services provided by participating PCPs do not require prior authorization.

Specialists Referrals:

Specialty office visits for participating specialists do not require prior authorization. Colorado Access encourages Primary Care Providers to direct care for specialty office-based care through clinical referrals. Colorado Access considers a referral to be a clinical communication between the PCP and the specialty provider for the purposes of care continuity and treatment planning. Office visits for non-participating specialists require prior authorization from Colorado Access and will be considered on a case-by-case basis for particular clinical needs.

Inpatient Care:

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

Emergency and Urgent Care:

Emergency services (place of service 23) and urgent care services (place of service 20) do not require prior authorization if the services would be considered urgent or emergent as determined by a prudent layperson.

Ambulance:

Emergency ground or air ambulance transport does not require prior authorization. Scheduled ambulance transport from one facility to another is covered, but does require prior authorization.

Outpatient Hospital / Ambulatory Surgery:

Procedures that are performed in an outpatient hospital (place of service 22) or ambulatory surgery center (place of service 24) may require prior authorization for the professional services. Facility and ancillary services are considered downstream to the procedure and do not require separate authorization for payment. Authorization for procedures is based on medical necessity as determined by InterQual_ criteria. Refer to the prior authorization list to determine whether a procedure requires authorization.

Women's Health / OB/GYN Services:

OB/GYN office-based services do not require referral or prior authorization for participating providers. Certain facility-based procedures may require prior authorization. Refer to the prior authorization list to determine whether a procedure requires authorization. Family planning services do not require prior authorization or referral for participating providers.



Diagnostic Services:

Routine laboratory and imaging services do not require prior authorization. Specialized diagnostic procedures may require prior authorization.

Diagnostic Interpretation Services:

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

Routine Vision Care:

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

Observation Services:

Observation stays (place of service 22) does not require prior authorization for payment. Observation may be allowed for up to 72 hours as defined by Medicare rules.

Home Health Care:

All home health care services require prior authorization for payment.

Durable Medical Equipment (DME):

Durable medical equipment may require prior authorization. In general, basic equipment and supplies or equipment that are ancillary to other procedures do not require prior authorization. Enhanced or specialty equipment or supplies generally require prior authorization. Refer to the prior authorization list to determine whether a supply item or piece of equipment requires authorization.

Therapies:

All physical, occupational, or speech therapy services require prior authorization. For outpatient physical rehabilitation (physical, occupational, and/or speech therapy) the standard CHP+ coverage is limited to 30 visits per calendar year. For children aged 0-3 the benefit of physical, occupational and speech therapy is unlimited.

Behavioral Health:

All behavioral or mental health services require prior authorization.

Pharmacy:

Certain injectable medications require prior authorization. Refer to the prior authorization list to determine whether a medication requires authorization. Retail pharmacy drugs are managed by formulary. Certain formulary drugs may be preferred agents or may require prior authorization. Refer to the Colorado Access formulary for more information.