



Coordinated Clinical Services Manual



This Provider Manual was last updated on 01/01/2008. 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 (888) 214-1101 or send an email to pns@coaccess.com

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Appendix A: Forms

I. Colorado Access Phone & Fax Numbers

Colorado Access CHP+	Local	(303) 751-9021
.....	Toll Free	(888) 214-1101
Clinical Appeals	Local	(720) 744-5134
.....	Toll Free	(877) 276-5184
Coordinated Clinical Services Fax	Local	(303) 755-4135
.....	Toll Free	(877) 232-5976
Pharmacy Services Fax		(720) 744-5127

II. Submitting an Authorization Request

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

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 website (www.coaccess.com) or by calling our Customer Service Department. Once you have determined that the member is eligible, you may either fax the **Service Authorization Form** to our Coordinated Clinical Services Department or speak directly with a Representative in Coordinated Clinical Services. For behavioral health, please use the **CHP+ Initial Contact and Triage Form** or the **Request for Reauthorization Form**.

A copy of the **Service Authorization Form** the **CHP+ Initial Contact and Triage Form** or the **Request for Reauthorization Form** is provided in **Appendix A**. Please follow all instructions on the forms. Incomplete forms will be returned to sender. You will be notified if additional information is needed, if the service is authorized, or of an adverse service determination.

III. 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;
- ⇒ 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 intensive 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 (888) 214-1101 or (303) 751-9021.

IV. Authorization & Determination Categories

Authorization Categories

Colorado Access' Utilization Management Program has four (4) authorization categories:

1. No Authorization

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

2. Clinical Referrals

Colorado Access encourages Primary Care Providers to direct care for specialty office-based service 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. **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 participating specialists require prior authorization from Colorado Access.

3. Procedure Authorization

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

4. Transportation Authorization

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

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

Types of 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 Colorado Access' contract with Health Care Policy and Financing for the CHP+ lines of business.

1. Authorized

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

2. Pended

A determination cannot be made with current information. The case is pending receipt of additional information and/or documentation.

3. Adverse Service Determination ("Denied")

The requested service is not covered by the benefit plan, is not medically necessary, reduction and discontinuation of services, or failure to submit necessary information. A claim for this service will not be paid. Only the 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.

4. Administrative Denial

A provider's failure to follow contractual requirements and/or established procedures regarding authorization requirements (i.e. out of timely notification, and/or authorization request has not met timeliness requirements) may result in an Administrative Denial.

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

V. General Authorization Rules

The following section is a list of general rules regarding Colorado Access authorizations. To determine if a specific service requires authorization, please call Colorado Access or log onto the Colorado Access website at: www.coaccess.com. Click on **For our Providers** then on **Provider Logon**. You will then be prompted to enter your username and password. If you do not have a username and password, please complete the **Web Based Applications Request Form**.

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 the paneled Primary Care Provider (PCP) do not require prior authorization. All services provided by a PCP who is not the paneled provider will require prior authorization for payment.

The PCP is the Clinician that has been designated by the Member, Member's legal guardian, or by Colorado Access (default), as the Clinician who will attend to the Member's routine medical care, supervise and/or coordinate all of the Member's health care, and initiate all referrals. The Primary Care Provider is responsible for providing and documenting age-appropriate comprehensive and preventive primary care and disease screening services. The PCP must be trained and credentialed in the areas of Family Practice, General Medicine, Internal Medicine or Pediatrics, and should restrict their practice to age groups for which they are appropriately trained.

- ⇒ PCP assignment may be applied at the clinician, group, health center, or mini-network level, at the direction of the provider entity. The default will be group-level assignment. Please see the **Provider Services Manual** for additional information regarding PCP assignment.
- ⇒ All primary care professional services rendered by the assigned PCP or his/her designated call-coverage in the PCP office do not require prior authorization.
- ⇒ Assigned PCPs may designate other primary care providers as call-coverage for the rendering of after-hours care. These providers will be paid without referral authorization, however, only when services are rendered when the assigned PCP is not available. All primary care services to be rendered by any provider other than the assigned PCP, or his/her designated call-coverage, must have a referral authorization from the PCP to the non-assigned provider.
- ⇒ The referral should be submitted by the PCP to Colorado Access at least two (2) working days in advance of the scheduled service.
- ⇒ The exceptions to this requirement are urgent and emergent care rendered in an urgent care clinic or emergency department. *Emergency services* will be paid without authorization or notification.
- ⇒ The PCP may also designate other community providers, such as health department nursing and immunization services (excluding HCP and well-child care), as globally authorized providers that can render services without referral authorization.
- ⇒ Some office-based procedures may require procedure authorization if billed as a separate service (e.g., Synagis® and other injectables), however the professional component of the visit will still be paid if the above procedures are adhered to. Contact Colorado Access for specific procedures in this category.

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

Clinical Referrals For Specialty Care

Specialty care shall mean services rendered by a licensed physician, hospital, dentist, pharmacy or other licensed health professional or facility to which the Primary Care Provider provides a member a referral (modified HCPF definition).

- ⇒ 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.

Specialty office visits with contracted specialty providers do not require referral/prior authorization from Colorado Access for payment purposes. Certain therapies, DME items, and office visits for participating specialists require prior authorization from Colorado Access.

- ⇒ 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.
- ⇒ All requests for authorization of specialty 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.

Downstream Providers

A downstream provider is defined as a group of providers who render services to our members 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 bill utilizing HCFA-1500 billing format. Only the "professional" component of the service is considered downstream. All other billing policies apply (i.e. timely filing and eligibility requirements).

- ⇒ **Emergency Room** – place of service 23 – all services billed by practitioners are considered downstream.
- ⇒ **Inpatient** – place of service 21 – pathology, radiology, anesthesia and all other physician services not on the prior authorization list are considered downstream.
- ⇒ **Outpatient** – place of service 22 – the following services should be considered downstream:
 - Pathology – all professional laboratory procedures.
 - Radiology – all professional radiology procedures.
 - Anesthesia – all professional services billed within the procedure code range of (00100-01999).
 - Facility – all outpatient facility services billed with place of service 22 or 24.
 - Skilled nursing facility – place of service 31 or 32 - physician services for care rendered in a skilled nursing facility. **However, podiatrists (DPM) are required to obtain prior authorization.**
 - Interpretive Services – all services using modifier 26.

Emergency Care and Urgent Care

Emergency Care

Emergency department care does not require prior authorization regardless if the services are rendered by a participating or non-participating provider.

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

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 contracting provider would result in a delay that would worsen the emergency; or a provision of federal, state or local law requires the use of specific provider (DOI Regulation 4-2-17).

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

Emergent Operating Room & Emergent Admission

The facility must request authorization within one (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.

Urgent Care

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

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

Outpatient Hospital / Ambulatory Surgery

Professional services performed in an outpatient hospital (place of service 22) or ambulatory surgery center (place of service 24) may require prior authorization. Please refer to the [prior authorization list](#) to determine whether service requires authorization.

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 or Associate Medical Director review.

Diagnostic Services Diagnostic Interpretation Services

Routine laboratory and imaging services do not require prior authorization. Specialized diagnostic procedures may require prior authorization. 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 care (including eye exams, dilated eye exams, glasses, and medical treatment of eye conditions or medical eye care) provided by a participating optometrist or ophthalmologist does not require prior authorization or referral.

- ⇒ Vision screening is covered as age-appropriate care. No referral or authorization is required for routine eye examinations, glasses, or contact lenses.
- ⇒ Vision therapy is an excluded benefit.

Blepharoplasties, eyelid revisions and other ophthalmologic surgeries require prior authorization. See the sections on Procedure and Facility Authorizations.

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 as defined by Medicare rules.

Home Health Care

All home health care services require prior authorization for payment. Home Health Services shall mean skilled nursing, home health aide, occupational therapy, physical therapy, speech therapy and infusion therapy services rendered by a Medicare-certified home health agency or organization.

Covered home health services must be initiated with physician's orders by the assigned PCP or discharging physician. The physician's orders must be submitted to a participating home health agency. The home health agency must then notify Colorado Access by submitting the physician's orders with the request, within one (1) working day of service initiation.

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

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

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

Any time there is a break in service, the home health agency must notify Colorado Access within one (1) working day of the usually scheduled visit.

All requests for home health authorization are reviewed for the medical necessity of each specific service in the plan of care, as well as necessity for service to be rendered in the home as opposed to an outpatient setting.

Services must be provided in the member's place of residence.

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

Medically necessary durable medical equipment is subject to coverage rules and a \$2,000/year paid by plan maximum. Please see the [Provider Services Manual](#) for additional information.

Therapies

Colorado Access CHP+ covers home-based and outpatient therapy; however, there are plan specific limitations. Please see the [Provider Service Manual](#) or contact Colorado Access for specific benefit information.

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

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 by either a participating provider or non-participating provider are considered downstream and do not require separate authorization except as described in section 4, #3 for elective procedures.

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

Elective Services, Procedures, or Admissions

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

Emergent Admissions

The facility must request authorization within one (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 one (1) working day of request.

Initial authorization and concurrent review determinations are based on **medical necessity** as determined by InterQual® criteria or 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.

Women's Health & OB/GYN Services

Gynecologic and Reproductive Health Care includes services for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy and childbirth, and related preventive care (DOI definition).

Authorization is not required to a participating Obstetrician, Gynecologist and/or Certified Nurse Practitioner for well woman care and pregnancy services.

Colorado Access encourages Primary Care Providers and Obstetricians/Gynecologist 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 referral/prior authorization from Colorado Access for payment purposes. All care provided by non-participating providers require authorization.

Some surgeries and supplies may require authorization. Please refer to **prior authorization list** for Colorado Access participating provider authorization requirements.

Gynecological services that require procedure authorization must be submitted to Colorado Access for review at least two (2) working days in advance of the scheduled service in order to ensure payment of professional fees.

- ⇒ For *emergent* procedures, the provider must notify Colorado Access within one (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.

Family planning services do not require a referral or procedure authorization when provided by the assigned PCP and/or Colorado Access participating OB/GYN practitioner. Family planning services may also be rendered by a certified Medicaid family planning provider who submits to the state for payment.

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

Infertility evaluation, diagnosis and treatments are not covered benefits.

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

Maternity Care

Per the Colorado Women's Healthcare Act, 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 [prior authorization list](#) for Colorado Access participating provider authorization requirements.

Basic Maternity Care

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

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

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

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.

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.

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.

Well newborns are covered under the mother's delivery authorization. For sick newborns who 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 who remains in the hospital from date of birth through discharge.

Postpartum Ambulatory Maternity Care

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

Sub-Specialty Maternity Care

Colorado Access encourages Primary Care Providers and Obstetricians/Gynecologist to direct members to contracted specialty/sub-specialist for office-based care through clinical referrals. Office visits with contracted specialty/sub-specialty providers do not require referral/prior authorization from Colorado Access for payment purposes. All care provided by non-participating providers require authorization.

The sub-specialty physician will be expected to follow the same requirements for medical necessity authorization as detailed above.

Amniocentesis and Chorionic Villus Sampling

Diagnostic amniocentesis and chorionic villus sampling are covered benefits except for instances where the sole purpose is for determination of fetal sex.

Amniocentesis and chorionic villus sampling do not require a procedure authorization for medical necessity, **but do require a referral authorization if being performed in an outpatient setting by a perinatologist, reproductive geneticist or maternal-fetal medicine specialist (see subspecialty care).**

For genetic testing other than standard amniocentesis and chorionic villus sampling, a procedure authorization must be obtained.

Continuity of Care for pregnant women joining Colorado Access

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 for 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 UM and QM policies and procedures.

Non-participating providers need to notify Colorado Access that s/he has a member who needs continuity of prenatal care. A single case agreement will be processed to provide payment for services for this member.

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

Use of Non-Par Facilities

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

Pharmacy & Injectable Medications

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.

Ambulance/Transportation

Emergency ground or air ambulance transport does not require prior authorization. For emergency transport base rate and mileage reimbursement, the provider must submit the claim with the trip sheet attached.

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.

VI. CHP+ Behavioral Health

Please call (888) 214-1101 or (303) 751-9021 and select the prompt to request behavioral health authorizations. Failure to request authorization within timeliness guidelines will result in a denial unless there is documentation of extraordinary circumstances.

CHP+ covers the treatment of mental health disorders, as defined by the American Psychiatric Association Guidelines:

...Clinically significant behavioral or psychological syndrome or pattern that is associated with distress or disability, or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom, and for which improvement can be expected with treatment. (Diagnostic and Statistical Manual of Mental Disorders, 4th ed. DSM-IV, Amer Psychiatric Assoc, Washington, DC page xxxi)

Families can access behavioral health services, either by PCP referral or by directly accessing care from a contracted provider. The provider must obtain authorization in order to be reimbursed for services delivered.

Below is a brief outline of covered and non-covered benefits. For additional assistance, please contact Customer Service.

Inpatient Care

The member must be confined as an inpatient in a hospital or other treatment facility. This includes: Inpatient care (limited to a total of 45 days each benefit year), Partial hospitalization, day treatment, and residential treatment (count two for one against the 45 day inpatient plan limit per benefit year).

Outpatient Treatment for Mental Illness

Coverage is limited to thirty (30) visits per benefit year. This is any combination of service visits rendered by psychiatrists, psychologists, licensed family therapists and social workers. These visits are limited to individual therapy, family therapy, group therapy, or medication management.

Chemical Dependency Treatment – Alcohol and Substance Abuse

Outpatient Chemical Dependency Treatment is limited to twenty (20) outpatient visits per benefit year.

Inpatient Chemical Dependency Treatment

Colorado Access covers only medically necessary inpatient room expenses and ancillary services related to medical detoxification. The following services are not covered:

- ⇒ Chemical dependency rehabilitation.
- ⇒ Services provided or billed by a school, halfway house or residential treatment center, or staff members of any of these institutions.
- ⇒ Psychoanalysis or psychotherapy a member may use as credit toward earning a degree or furthering his/her education.
- ⇒ The cost of any damages to a treatment facility caused by a member.

Biologically-based Mental Illness

These conditions, are by law, treated the same as any other health condition (for example, there are no limits on the number of visits or hospital days covered as the stay is based on medical necessity). These include:

- ⇒ Schizophrenia;
- ⇒ Schizo-affective disorder;
- ⇒ Bipolar-affective disorder;
- ⇒ Specific obsessive compulsive disorder; and
- ⇒ Panic disorder.
- ⇒ Major Depression

VII. Care Coordination

Colorado Access strives to ensure the provision of covered services at the right time and place for members with complex physical and mental health care needs, and thereby improve health outcomes and prevent disease progression.

Care Coordination is a collaborative process between PCPs, specialists, other providers and Colorado Access that actively involves the member, family, caregiver and/or DCR to assist the member in managing high medical risk. The focus is on the member with medical and social care needs that are complex or severe.

Goals

The goals of the Colorado Access Care Coordination Program are:

- ⇒ To identify opportunities and establish action plans to improve access to medical care, community resources, and social supports for members with complex health care needs.
- ⇒ To educate and assist the member in reaching their optimal state of wellness and independent living within their community.
- ⇒ To promote improvements in the health status of members and satisfaction with Care Management services.

Member Identification

Members who may benefit from Care Management are identified by:

- ⇒ Internal data sources such as condition specific profiles from Medstat, Emergency Room Utilization and historical costs;
- ⇒ Telephonic outreach and screening;
- ⇒ Referrals from Primary Care, Specialty Care, Home Health or Ancillary Services Providers, State Transition of Care referrals and community agencies;
- ⇒ Institutional providers (e.g., hospitals, skilled nursing, rehab, and sub-acute facilities);
- ⇒ Referrals from other Colorado Access departments;
- ⇒ Referrals from members, DCRs, or family members.

Process

The Care Management process includes:

- ⇒ Members with complex physical, cognitive, social and emotional health care needs are referred to the Case Management team for individualized assessment and planning.
- ⇒ Gathering of physical, psychosocial and environmental information from the member, family, caregiver, DCR, community agencies and/or providers in order to identify and prioritize the member's health care needs, barriers, and alternatives.
- ⇒ Coordination with the member, family, DCR, PCP, and other involved physical and/or mental health team members on an ongoing basis in order to share assessment findings and to develop an agreed upon action/care plan that addresses the members needs so that care is collaborative, non-duplicative, and outcomes focused. The action/care plan may include but is not limited to, health plan covered benefits, community resource and outside agency referrals, wrap around benefits etc.
- ⇒ Monitoring progress toward action/care plan goals.
- ⇒ Working to ensure that member confidentiality is maintained at all times when collaborating with both internal and external parties, as well as assuring that all confidential member information is maintained in an orderly fashion within the members file.
- ⇒ Coordination of benefits with primary/secondary insurance carriers when applicable, for both physical and behavioral health care needs.
- ⇒ Working with Utilization Management (UM) staff when a member with transition/continuity of care needs is identified in order to ensure that services are uninterrupted and transitioned into the network, when appropriate, within the identified timeframes.
- ⇒ Working with UM staff to facilitate extended referrals for members with Special Health Care Needs (SHCN), when indicated.
- ⇒ Working closely with outside agencies such as Human Service agencies, transportation, Home Community Based Services (HCBS) providers etc,) to coordinate services for all members, in particular for those with special health care needs.
- ⇒ Working with UM staff to ensure that requests for services that are the result of a diminished capacity in a member's ability to live independently are addressed within 24 hours and processed expediently.
- ⇒ To refer a member for care management evaluation, call Colorado Access at (888) 214-1101 or (303) 751-9021.

VIII. Dental Care

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

Colorado Access CHP+ provides coverage for certain accident related dental services, dental anesthesia, inpatient admission for dental care (including room and board, coverage does not include charges for the dental services), and treatment of cleft palate and cleft lip conditions.

All dental services and supplies are subject to pre-authorization guidelines and plan provisions. Please call Colorado Access for benefit information.

IX. Coordination of Benefits

Colorado Access authorization rules apply if Colorado Access is or is expected to be the primary payer. 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
- ⇒ When Colorado Access is responsible for any payment of medically necessary care

A provider may request authorization for services anytime he/she believes Colorado Access will be responsible for payment of these services. However, when the claim is submitted, the provider must attach the primary payer's explanation of benefits (EOB) to coordinate benefits.

When Colorado Access is the primary payer because the service rendered is not a covered benefit of the primary payer or if the primary benefit is exhausted, Colorado Access will deny the submitted claim for no authorization if the authorization has not been obtained. Colorado Access will perform a retrospective review for medical necessity if the claim is resubmitted on appeal. For additional information regarding coordination of benefits, please see the [Claims Manual](#) and the [Provider Services Manual](#)

X. Clinical Appeals

A CHP+ member or DCR may request a review of an action through the appeal process either verbally or in writing. The possible 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.

First Level Appeal

- A) Colorado Access will provide a written notice of action to members or DCRs as described in the Colorado Access policy CSS307-Utilization Review Determinations.

- B) 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.
- C) Colorado Access will accept an appeal from a member or DCR that is submitted within twenty (20) calendar days from the date of the notice of action.
- D) Colorado Access will not impose punitive action against a member or DCR for filing an appeal.
- E) 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.
- F) For notification purposes, parties to the appeal include the member and/or the DCR or the legal representative of a deceased member estate.
- G) Upon receipt of an appeal by Colorado Access, a written acknowledgement of the appeal is provided to the member and/or the DCR within two (2) business days of receipt, unless the member or DCR requests an expedited resolution. Expedited resolutions are addressed later in this section.
- H) 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.
- I) 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:
 - 1) An appeal based on lack of medical necessity; or
 - 2) An appeal that involves a clinical decision.
- J) 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:
 - 1) A standard appeal is resolved and a written notice of the resolution is provided to the member or DCR within ten (10) business days of receipt.
 - 2) An expedited appeal is resolved and a written notice of the resolution is provided to the member or DCR within three (3) business days of receipt. Colorado Access will make a reasonable effort to provide verbal notice to the member and/or DCR. If a request for an expedited appeal resolution is denied, 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 two (2) calendar days. The appeal will then follow the process for a standard resolution.
 - 3) Expedited appeals for non-formulary medication requests resulting in an adverse determination may be requested by the member or provider via phone or fax to the Pharmacy Services, and will be completed within twelve (12) business hours. The member and provider will be notified of the appeal review determination by telephone, fax or by letter within one (1) business day of making the determination. Members and providers have a right to appeal an expedited appeal. An appeal request following an expedited appeal will be considered a second level clinical appeal and the process from Colorado Access policy and procedure Member Grievance and Appeal Process-ADM219 will apply.

- K) Colorado Access may extend the time frame in order to resolve a standard or expedited appeal up to fourteen (14) calendar days if the member requests the extension or 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.
- L) 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.
- M) 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.

Second Level Appeal

Colorado Access has a second-level appeal process for CHP+ members which meets the requirements of the Division of Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Management.

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

- I) If the second level appeal is regarding the applicability of a covered benefit, the determination shall be made on the basis of whether the requested service is a covered benefit, and not solely on the basis of whether the requested service is medically necessary.
- J) The reviewer(s) will issue a written decision to the member within seven (7) calendar days of completing his or her review of a second level appeal.
- K) Notice of the decision on the second level appeal will include the following elements:
 - 1) The name, title and qualifying credentials of the reviewer(s);
 - 2) A statement of the reviewers understanding of the covered person's request for review of the original adverse determination;
 - 3) The reviewers decision in clear terms;
 - 4) A reference to the evidence or documentation used as a basis for the reviewer's decision, including:
 - a) the specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;
 - b) a statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the request for service;
 - c) if the reviewer(s) relied on an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
 - d) if the adverse determination is based on a medical necessity or experimental or investigational treatment, a statement that an explanation of the scientific or clinical judgment for making the determination, applying; and
 - e) if applicable, instructions for requesting:
 - i) a copy of the rule guideline, protocol or other criterion relied on in making the adverse determination;
 - ii) the written statement of the scientific or clinical rationale for the determination.
 - f) a statement describing the procedure for obtaining an independent external review of an adverse determination pursuant to Division of Insurance regulation 4-2-21
- L) For purposes of calculating time periods within which a decision is required to be made and notice provided, the time period begins on the date the request for a second level appeal is filed with Colorado Access, according to established procedures, without regard to whether all of the information necessary to make the determination accompanies the request.



Service Authorization Form AHP/CHP+

Submit completed form (all BOLD fields filled in) to CSS

Fax: 1-877-232-5976 or 303-755-4135

Phone: 1-800-511-5010 or 303-751-9005

Today's Date: _____		
Requesting Provider: _____		Person Completing Form: _____
Provider Phone: _____	Fax: _____	Email: _____

MEMBER INFO	
Member Name: _____	Medicaid or CHP+ ID: _____
DOB: _____	Other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify) _____
Member Phone: _____	Language: _____
Member Address 1: _____	Address 2: _____
? 1. Dx/ICD-9 _____	2. Dx/ICD-9 _____
? Clinical History (attach documentation as needed) _____	

Does member have a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name & phone number: _____	
Is this referral the result of an abnormal EPSDT screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INDICATE SERVICE FOR WHICH AUTHORIZATION IS BEING REQUESTED	
Service Type:	Fill in Specifications:
<input type="checkbox"/> OB Service ?	EDC ___/___/___ (Gravida ___ Para ___) High Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify reason _____ Programs member in: <input type="checkbox"/> Prenatal Plus <input type="checkbox"/> Nurse Family Partnership <input type="checkbox"/> WIC <input type="checkbox"/> No/Unknown
<input type="checkbox"/> Specialist Referral ?	Type: <input type="checkbox"/> Consult Only, 1 visit <input type="checkbox"/> Consult Only, 2 visits <input type="checkbox"/> Eval & Treat, # Visits _____ Specialty Type: _____
<input type="checkbox"/> Co-manage for 1 year ? (unlimited visits allowed)	PCP signature required: _____ Date _____
<input type="checkbox"/> Procedure ?	Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient, Days needed: _____ CPT Code(s): _____ Facility where procedure to be rendered: _____ Phone: _____ Fax: _____
<input type="checkbox"/> Therapy ?	Location: <input type="checkbox"/> Outpatient <input type="checkbox"/> Home Type: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST Duration: <input type="checkbox"/> Evaluation <input type="checkbox"/> Treat, # of Visits _____
<input type="checkbox"/> Home Health ?	Type: <input type="checkbox"/> RN <input type="checkbox"/> CNA/HHA Duration: <input type="checkbox"/> Evaluation <input type="checkbox"/> Treat, # of Visits _____
<input type="checkbox"/> DME ?	Description: _____ CPT/HCPCS Code: _____
<input type="checkbox"/> Other ?	Specify: _____
? Date(s) of Service Requested: (from) _____ (to) _____	
? Provider of service (full name): _____	
Phone: _____ Fax: _____	

COLORADO ACCESS TO COMPLETE	
Authorization Number _____	Authorization For: _____
Dates of Service Authorized from _____ to _____	Units Approved _____
Signature _____	

Form will be returned if all BOLD fields are not filled in. This form does not guarantee payment. You will be notified if the service is authorized or not. Include the authorization number on the claim in order to assure payment for eligible members. Form # CSS01 Approved 1/9/03

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ALL INFORMATION IS REQUIRED FOR AUTHORIZATION.
 AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.
 REIMBURSEMENT DEPENDS ON ELIGIBILITY AT THE TIME OF SERVICE.

Submitted By:

Name: *(print)* _____

Facility: _____

Phone: _____ Tax ID #: _____

Provider Fax: _____

Date Submitted: _____

Fax: (720) 744-5130

CONSUMER INFORMATION (Please Print)

Last Name:		First Name:		Gender:	Age:
Member ID #:			SSN:		DOB:
Legal Guardian:			Phone:		
Parent/Foster Parent:			Home Phone:		
Address:		City:	State:	Zip:	
Primary diagnosis:			Secondary diagnosis:		

THIS C&T IS FOR:

- Initial Authorization for Routine Outpatient Care
- Initial Authorization for All Other Levels of Care
(complete authorization application if checked)

SERVICE TYPE:

- Routine
- Urgent
- Emergent

FOR ROUTINE OR URGENT SERVICES:

Date/Time of Request for MH Services: _____

Date/Time of First Offered Appt.: _____

Date/Time of First Scheduled Appt. *or* Program Start Date:

FOR EMERGENT SERVICES:

Initial Request for Emergency Services:

Date: _____ Time: _____

Face-to-Face Evaluation by Mental Health Clinician:

Date: _____ Time: _____

Dispo: _____

For routine care, does the the consumer/family member/guardian have any specific treatment requests?

<input type="checkbox"/> None requested when asked	<input type="checkbox"/> Therapist:	<input type="checkbox"/> Clinician language:
<input type="checkbox"/> Day and/or time:	<input type="checkbox"/> Clinician gender:	<input type="checkbox"/> Clinician specialty:
<input type="checkbox"/> Service location:	<input type="checkbox"/> Clinician ethnicity:	<input type="checkbox"/> Other:

SERVICES REQUESTED:

<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Residential
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Observation	<input type="checkbox"/> Emergency/Crisis Eval
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Inpatient
<input type="checkbox"/> Case Management	<input type="checkbox"/> Other:	

Application for Authorization/Reauthorization of Services

Fax to (720) 744-5130

Consumer's Name: _____ ID #: _____ DOB: _____
 Provider Agency (if applicable): _____ Clinician: _____
 Provider Phone: _____ Provider Fax: _____

Current Diagnoses, include DSM-IV code(s):

Current Medications, include dosages & times administered:

Axis I: primary) _____
 Axis I: (secondary) _____
 Axis II: _____
 Axis III: _____
 Axis IV: _____
 Axis V: _____

Prescribing Physician: _____
 Psychiatrist Phone: _____
 Next Medication Appointment: _____

Treatment Plan:

Provide a detailed description of problems requiring treatment at this time. Identify **current** symptoms, behavior and functioning by degree of severity, and **please be specific**. _____

Consumer's strengths and resources: _____

Goals	As Evidenced By (Measurable Outcomes):	Percent Attained	Barrier(s) to Completion
1.			
2.			
3.			

For Reauthorization Requests: Provide Information on Significant Events and Progress Toward Treatment Goals:

Services Requested and Frequency, as applicable:

frequency:	frequency:	
<input type="checkbox"/> Individual Tx:	<input type="checkbox"/> Medication Mgmt:	<input type="checkbox"/> Residential
<input type="checkbox"/> Family Tx:	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Emergency/Crisis Eval
<input type="checkbox"/> Group Tx:	<input type="checkbox"/> Case Mgmt:	<input type="checkbox"/> Inpatient
<input type="checkbox"/> Other:		<input type="checkbox"/> Observation

Current coordination issues with other providers or agencies (e.g., medical care, social services, schools, etc): _____

Anticipated date of discharge: _____ Disposition issues or plans (including provisions for transitional, aftercare, and/or follow-up services): _____

Requestor Name (Print): _____

Requestor Signature: _____

Date: _____



Have questions?

Need help?

Call us at (303) 751-9021 or toll free at (888) 214-1101

Colorado Access CHP+ information on our website, www.coaccess.com

Claims Manual

<https://www.coaccess.com/providers/files/ClaimsManual.pdf>

Provider Services Manual

<https://www.coaccess.com/providers/files/ProviderServicesManual.pdf>

Coordinated Clinical Services Manual

<https://www.coaccess.com/providers/files/CCSManual.pdf>

Provider Bulletins

<https://www.coaccess.com/providers/providerUpdate.jsp>

Important Updates

<https://www.coaccess.com/providers/Global.jsp>