In the Colorado Access Provider Manual, you will find information about:

Section 9. Utilization Management Program

- Urgent and Emergency Care
- Medical Necessity
- Prior Authorization Request Process
- After Hours Discharge Planning Needs
- Downstream Providers
- Peer Review Process
- Continuity of Care for New Members
- Continuity of Care for Existing Members

Search Tip:
You can search quickly and easily by using the command Control+F. This will display a search box for you to enter what you want to find.

If you have any questions, call us at 800-511-5010 (toll free).

Utilization Management Program

Participation in our utilization management (UM) program is a contractual obligation of every network Provider. 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.

We authorize some behavioral health services under the Health First Colorado (Colorado's Medicaid Program) regional organization contract and the Child Health Plan *Plus* contract. Our utilization management service coordinators are available 24 hours a day, 7 days a week to take authorization requests.

We authorize some physical health services for the Child Health Plan *Plus* HMO contract. Our utilization management service coordinators are available Monday through Friday from 8:00 am to 5:00 pm to receive physical health authorization requests.

Below are tables summarizing the types of services that require prior authorization. The Master Authorization List, a comprehensive list of procedure codes and corresponding prior authorization requirements, is on our website at coaccess.com/providers/forms/.

We don't perform prior authorization review on services that have already been rendered. If you provide services without an authorization, your claim may be denied.

This summary of our authorization rules does not guarantee coverage.

1. **Participating vs. Non-Participating Providers:** In general, all services rendered by non-participating providers require prior authorization for payment except where specifically noted.
2. **Primary Care:** In general, services provided by participating primary care providers (PCPs) do not require prior authorization.
3. **Specialist Referrals:** Office visits for participating specialty Providers do not require a referral to be submitted to Colorado Access from the member's PCP. We encourage PCPs to direct care for specialty office-based care through clinical referrals. We consider a clinical referral to be communication between the PCP and the specialty Provider for the purposes of care continuity and treatment planning. Certain services, such as visits with physical, occupational, and speech therapists may require authorization.

Contact the utilization management department for more information.

Medicaid Behavioral Health	
Type of Service	**Authorization Rules**
Ambulance	Emergency ground or air ambulance transport does not require prior authorization.
Emergency Care (POS 23)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required. 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 the Authorization Categories section under Procedure Authorization.
Crisis Stabilization Unit (CSU)	No prior authorization required
Residential	Prior authorization required
Acute Treatment Unit (ATU)	Prior authorization required
Outpatient – Routine	No authorization required
Outpatient – Higher Levels of Care: • Day treatment • Partial hospitalization • Intensive outpatient (IOP) • Electroconvulsive therapy (ECT) • Psychological/neurological testing	Prior authorization required
Any services from non-participating providers (except emergency department)	Prior authorization required

Child Health Plan *Plus* (CHP+)	
Type of Service	**Authorization Rules**
Emergency Care (POS 23)	No prior authorization required
Urgent Care (POS 20)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required. 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 the Authorization Categories section under Procedure Authorization.
Outpatient – office visits (physical/medical)	No prior authorization required

Child Health Plan *Plus* (CHP+)	
Type of Service	**Authorization Rules**
Outpatient medical procedures	May require prior authorization, please check the Master Authorization List
Outpatient physical, occupational, speech therapies	Prior authorization required
Outpatient – behavioral health higher levels of care: • Day treatment • Partial hospitalization • Intensive outpatient (IOP) • Electroconvulsive therapy (ECT) • Psychological/neurological testing	Prior authorization required
Newborns	Coverage of services to a newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother's eligibility alone.
Diagnostic services	Routine laboratory and imaging services do not require prior authorization. Specialized diagnostic procedures may require prior authorization, please check the Master Authorization List.
DME	May require prior authorization, please check the Master Authorization List
Home Health	Prior authorization required
Ambulance	Emergency ground or air ambulance transport does not require prior authorization. Non-emergent scheduled requires prior authorization
Any services from non-participating providers (except emergency department)	Prior authorization required

URGENT AND EMERGENCY CARE

Emergency services (place of service 23) and urgent care services (place of service 20), regardless of provider contract status, do not require prior authorization.

Definitions:

An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, which a prudent layperson could reasonably expect to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ/part, if immediate medical attention is not obtained. We cover all emergency department services necessary to screen and stabilize members if a prudent layperson 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 a specific provider (DOI Regulation 4-2-17).

Post-stabilization services are those covered services, related to an emergency medical condition, which are furnished by a qualified Provider after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition.

For additional information about emergent, urgent, or post-stabilization services, please reference the policy UM103 Emergency and Post-Stabilization Care on the UM Section of the COA website.

MEDICAL NECESSITY

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

For more information about the criteria utilized, please reference the policy UM 101 Criteria for Utilization Review on the COA website. For criteria specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, please reference the policy UM104 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) on the COA website (applicable for RAE only, not applicable for CHP+).

PRIOR AUTHORIZATION REQUEST PROCESS

Submitting Authorization Requests

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

In order to submit a request for prior authorization:

1. Prior to submitting an authorization, please verify the member's eligibility through the Colorado Access website or the Department of Health Care Policy and Financing eligibility portal.
2. Complete a Prior Authorization Form below and fax, with appropriate clinical information, to the number listed on the form. Please complete all required fields –

incomplete forms will not be accepted and will be returned to sender. You can find the following forms on our website at coaccess.com/providers/forms/:

a. Physical Health Prior Authorization Request Form
b. Home Health or Outpatient Therapy Prior Authorization Request Form
c. Durable Medical Equipment (DME) Prior Authorization Request Form
d. Behavioral Health Prior Authorization Request Form
e. Psychological Testing Authorization Request Form
f. Pharmacy Injectable Medication (J-Code) Authorization Request Form

3. You will be notified if additional information is needed, if the service is authorized, or if the service will not be authorized.
4. If you have questions, please call us at 800-511-5010.

Types of Utilization Review Determinations

Our utilization review determinations comply with state and federal guidelines. For additional information about our utilization review, please reference the policy UM102 Utilizations Review Determinations on the COA website.

1. **Authorized** – The requested service meets all utilization review criteria including, but not limited to, member eligibility, medical necessity, and if the service is a covered benefit. Authorization is not a guarantee of payment.
2. **Pended** – A determination cannot be made with current information. The case is pending receipt of additional information and/or documentation.
3. **Adverse Benefit Determination ("Denied")** for detailed information about adverse benefit determinations, please reference the policy UM102 Utilization Review Determinations on the COA website
4. **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.

Concurrent Review and Reauthorization for Continued Services

All requests for ongoing services beyond the initial authorization require reauthorization. Please complete and submit the appropriate prior authorization form and fax as indicated above at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access.

AFTER HOURS DISCHARGE PLANNING NEEDS

For afterhours discharge planning needs (to initiate home health, DME, oxygen supplies), such as on holiday 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; covered benefit; medical necessity; and timeliness of notification. For continuing needs, the Provider (vendor) must initiate a procedure authorization.

DOWNSTREAM PROVIDERS

A downstream provider is defined as any Provider who renders services at the direction of other Providers. These Providers are not subject to the prior authorization and/or referral process.

- **Emergency room** (place of service 23) services billed by Providers are considered downstream.
- **Inpatient** (place of service 21) pathology, radiology, anesthesia and all other physician services not on our Master 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 contracted facility services billed with place of service 22 or 24. The use of a non-contracted facility requires prior authorization.
- **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.

PEER REVIEW PROCESS

When a Colorado Access medical director has issued a denial, the Colorado Access utilization management reviewer will hold off on processing the formal denial letter until after the facility/provider has been verbally notified of the decision. During this verbal notification, the facility will be informed of the process by which to request a peer review.

Prior to the issuance of a formal denial, facilities have the ability to request a peer review with a Colorado Access medical director. During a peer review, a facility physician/prescriber has the ability to discuss the case with a Colorado Access medical director (this may not always be the same medical director who rendered the denial), and present any information that may not have been clear in the initial request.

The Colorado Access medical director conducting the peer review will issue a decision at the close of the peer review call. This decision will either uphold the initial denial or overturn the initial denial. If upheld, the denial will be formally issued via the required denial letters. If overturned, the reviewer will proceed with issuing the authorization per the peer review agreement.

For additional information about the COA peer review process, please reference the policy UM105 Peer Review Process on the COA website.

CONTINUITY OF CARE FOR NEW MEMBERS

We will contact new members who have been identified as having potential continuity of care needs so 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.

If the provider is not contracted with Colorado Access and is not willing to do so, and the service is expected to be ongoing, we, 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 postpartum care directly related to the delivery.

If we do 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 FOR EXISTING MEMBERS

At the time we are 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. CHP+ members will be allowed 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.