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

Section 10. Behavioral Health and Substance Use Specific Policies and Standards

- Services Provided
- Billing, Coding and Documentation Requirements
- Document Standards
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- Member and Family Services
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- EPSDT Services
- Child Mental Health Treatment Act
- Behavioral Health Services in Primary Care Setting (Medicaid Only)

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.

Behavioral Health – Specific Policies and Standards

SERVICES PROVIDED

We have many kinds of behavioral health care services for individuals and families and we can help clients find what works best for them. For more information on services, please visit coaccess.com/members/care/.

Services include:

- Outpatient treatment
- Day treatment
- Psychosocial rehabilitation
- Case management
- Medication management
- Emergency services
- Inpatient services
- Residential services
- Home-based services for children and adolescents
- Evaluations/assessments
- Deaf and hard of hearing services
- Vocational services
- Senior services
- Peer support
- Substance Use Disorders (SUD)
- Intensive Outpatient (IOP)

BILLING, CODING AND DOCUMENTATION REQUIREMENTS

All billed services must have an applicable modifier. Please note that many services can have more than one applicable modifier, and all must be included for the claim to be paid. There are levels of care that require a prior authorization from Colorado Access Utilization Management. Please visit coaccess.com/providers/resources/um/ for a list of codes.

All services must be in compliance with the Uniform Service Coding Standards (USCS) found here: hcpf.colorado.gov/accountable-care-collaborative-phase-ii-provider-and-stakeholder-resource-center. Please note, USCS modifiers are not required for CHP+.

DOCUMENTATION STANDARDS

For information on auditing guidelines, please visit www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0.

Providers must meet the Colorado Access quality documentation standards. Please see the Section 3: Quality Management of the provider manual.

MEMBER COPAY

Providers may not require a copay for covered behavioral health services rendered to Health First Colorado members enrolled with Colorado Access. For CHP+ HMO members, providers may not require a copay for outpatient behavioral health services. Copays may be required for emergency care, urgent care, inpatient treatment, and/or some behavioral health prescription medications.

COMMUNICATION EXPECTATIONS

Upon receiving a release of information (ROI), all behavioral and physical health providers should coordinate care with the member's PCP, obtaining any authorizations required to disclose such information. These communications would ideally occur:

- at the onset of care
- when changes in the member's status occur that may impact medical condition(s), or
- when medications are prescribed or changed

WAITING ROOM GUIDELINES

Our expectation of all Providers is that members are seen promptly for outpatient appointments. Members should not be made to wait for long periods of time past their scheduled appointment. We understand that unexpected circumstances arise that may delay appointments or force schedule changes; however, these should be communicated as soon as is reasonable to members to avoid long waits. We will monitor Providers from time to time regarding their adherence to these guidelines. All Providers must develop a mechanism to document appointment time and actual time seen.

URGENT AND EMERGENT ACCESS

During normal business hours, we expect members to be able to receive urgent and emergent access by calling their established Provider. We encourage all Providers to offer walk-in emergency services whenever this service is feasible. All Providers must have the ability to accept or redirect emergency member calls after hours.

MISSED APPOINTMENTS

Providers are responsible for actively promoting the continuation of services for those members who unexpectedly miss appointments or discontinue services. In all cases, Providers should contact the member at the time of the missed appointment, assess the reason for the missed appointment and the member's clinical condition, and attempt to reschedule the appointment. An outreach letter or phone call from the Provider is necessary when a member

has unexpectedly dropped out of treatment. Clinically appropriate intervention is required in urgent or emergent situations.

Attempts to reengage members who unexpectedly miss appointments will include Provider efforts to determine if there are concerns or barriers that contribute to the missed appointments. When specific problems are identified, Providers should attempt to find a solution. Our care managers are available resources for clinicians and members, to assist in promotion continuation of services.

Providers are required to document evidence of their outreach efforts to determine clinical status and presence of barriers that might be remedied, actions taken to promote continuation of needed services, and the member's response, which may include refusal to continue treatment. In cases involving imminent risk associated with 27-65 criteria, Providers must document efforts to initiate crisis services, including inpatient care, if indicated.

Please refer to Section 3: Quality Management of the provider manual for appropriate voicemail and after-hours requirements.

REDUCTION OR DISCONTINUATION OF SERVICES

Through the care coordination process, we will work in conjunction with the treating Provider to determine the most appropriate, medically necessary services at the least restrictive level. Treatment plan review may show that a discontinuation or a reduction of service is indicated. The treating Provider will discuss the proposed treatment plan with the member. If the member agrees with the proposed treatment plan, the treatment plan will be implemented.

The member's agreement with the changes in the treatment plan should be documented in the member's clinical record.

Remember: members should be full participants in service planning and treatment decisions. The member has the right to not accept a proposed treatment plan that would result in reduction or discontinuance of services. In a situation where the member disagrees with a Colorado Access decision to reduce or discontinue services, he or she can request an appeal, following receipt of the Notice of Adverse Benefit Determination We will mail the Notice at least 10 days before the effective date of reduced or discontinued services. The notification will contain information regarding the member's right to appeal and an explanation of the process to request review.

ARRANGING TRANSPORTATION SERVICES

Members who need transportation to mental health services should be directed to Colorado Access so we may facilitate obtaining such services. A care manager or service coordinator can help members access transportation benefits so that arrangements can be made for transportation to appointments.

MEMBER HANDBOOK

Health First Colorado (Colorado's Medicaid Program, hereto referred to as Medicaid) provides the member handbooks at healthfirstcolorado.com/benefits-services.

MEMBER AND FAMILY SERVICES

Our care management team is available to help members get the mental health services they need. For more information or to refer a member for care management services, contact care management.

The Member Advisory Council provides an opportunity to include the member voice and perspective into member-facing activities and programs. It is designed with intentional representation from different member constituencies and meets on a monthly basis.

Members are given updates on quality initiatives taking place within Colorado Access and are given an opportunity to interact with staff members for individual staff members and departments. For more information, call 800-511-5010.

The newsletter is sent to all members on a quarterly basis. The newsletter has useful information about member and family activities, health education materials, the member Partnership meeting schedule and agenda, and other helpful program information.

Training and education on member and family issues, such as cultural or linguistic matters, is a resource that is available free of charge to Providers. For more information, please contact the director of member affairs at 800-511-5010.

THE OMBUDSMAN FOR MEDICAID MANAGED CARE

Colorado Access will work with the Ombudsman for Medicaid Managed Care, and Health First Colorado (Colorado's Medicaid Program) informs members about its services and how to access them in the member handbook. Please contact the Colorado Access Office of Member and Family Affairs for more information. To contact the Ombudsman directly, call 303-830-3560 or 877-435-7123 (toll free). TTY users should call 888-876-8864.

EPSDT SERVICES

For children and adolescents under the age of 21, any medically necessary service to treat any physical, dental, or mental health diagnosis is covered under the member's Medicaid. Services may even be covered if it's not a Health First Colorado benefit or has service limits. Services covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services include:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations and therapies
- Immunizations
- Lab tests, including lead poisoning tests
- Health and education preventive education
- Vision services

- Dental services
- Hearing services

Some of these services are covered under the capitated behavioral health benefit, and some of these services are covered under the physical health fee-for service benefit, often through primary care (reimbursed through fee-for-service). In addition to traditional state plan services such as individual, group, and family psychotherapy, inpatient hospitalization, we are also able to reimburse for the following behavioral health services through the capitated behavioral health benefit under the EPSDT program:

- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential treatment
- Assertive community treatment
- Recovery services
- Respite services

Our provider network is expected to facilitate and promote the availability of EPSDT services, both behavioral health and physical health in nature. This includes, but is not limited to, the following:

- Regular communication and coordination with the member's primary care provider (with the member's permission and release of information)
- Informing and educating members and their families about the availability of these services available to them (A family-friendly EPSDT fact sheet can be found here)
- Inquiring about utilization of these benefits (e.g., "with your birthday coming up, have you scheduled your annual checkup?" or "have you gotten your flu shot yet this year?")
- Attending an EPSDT webinar and reviewing EPSDT materials provided by the Department of Health Care Policy and Financing here

Behavioral health providers contracted with us are required to screen and assess members' treatment needs (even those not covered by the capitated behavioral health benefit) and provide the clinically appropriate services discovered by any screening or diagnostic procedure. Most EPSDT services to not require prior authorization (residential treatment and respite services are the exception and do require prior authorization); however, any EPSDT service is subject to medical record review to assure the following minimum requirements:

- Any request for mental/behavioral health screening or assessment must be accommodated. Any provider unable to complete a requested screening or assessment must contact Colorado Access for assistance.
- Any screenings and services must be performed by a provider who is qualified to furnish mental health services according to the staff requirements in the Uniform Service Coding Standards manual for the relevant service.
- All screenings and services must be performed in a culturally and linguistically sensitive manner.

- Results of all screenings must be recorded in the child's medical record.
- Referrals to the member's primary care provider, Colorado Access, Healthy Communities, or other referral, as appropriate, for services not available at the provider's office.

For more information about EPSDT, please visit HCPF's website, which includes valuable information and resources such as fact sheets and training videos for both parents and providers, request forms, and regulatory information.

Any member or provider who needs assistance accessing EPSDT services or is experiencing barriers or problems related to EPSDT services (even physical health services not reimbursed by Colorado access) can contact care management at 720-744-5124 or 866-833-5717 (toll free). The Healthy Communities family health connectors can also assist with accessing services:

- Adams, Arapahoe, Douglas, and Elbert counties: Tri-County Health Department (303-873-4404)
- Denver County: Denver Health and Hospital Authority (303-602-6770)

CHILD MENTAL HEALTH TREATMENT ACT

The Child Mental Health Treatment Act became part of Colorado law in 1999. The Act gives children with Medicaid access to some mental health services in the community. This includes residential services. It also includes transitional treatment services. The Act also has special appeal steps, if needed. Members may qualify for these services. First, the child must have a mental illness. Second, the child must be younger than 18. Third, the child must be at risk to be placed out of the home. Call Colorado Access to find out more about these services at 800-511-5010.

BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE SETTING (MEDICAID ONLY)

In order to see the availability of a full continuum of behavioral health services, the Department of Health Care Policy and Financing (HCPF) is promoting the provision of short-term behavioral health services within primary care settings for brief episodic conditions. Providers may bill up to six behavioral health services, with or without a covered behavioral health diagnosis, to Medicaid fee-for-service as you would a medical service. **This process does not apply to CHP+ members.**

This benefit applies to several types of primary care settings, listed below. In order to bill for these services, there must be a Medicaid-enrolled behavioral health clinician on site, employed and/or billed by the primary care provider. If you are part of a co-located arrangement with a behavioral health provider, then whether or not this process applies to you depends on who bills for the services. If the behavioral health provider bills for the services, those claims will always come to Colorado Access to be paid under the Behavioral Health Capitation. If the primary care provider bills for the services, then this process applies to you.

- Primary care clinics
- Federally qualified health centers
- Rural health clinics

- Indian health centers
- Non-physician medical practitioner groups (e.g., nurse practitioners, nurse midwives)

The following procedure codes are included in this benefit.

- Behavioral health diagnostic assessment: 90791
- Individual therapy: 90832, 90834, 90837
- Family therapy: 90846 and 90847

All services must be provided by a Medicaid-enrolled behavioral health provider. While a covered behavioral health diagnosis is not required, there must be an appropriate diagnosis that supports medical necessity. All CPT coding practices and Uniform Service Coding Standards (USCS) documentation requirements must be followed. A link to the USCS can be found here. These procedure codes may be billed to HCPF fee-for-service in any combination for a total of six visits across all providers. The six-visit count re-starts July 1st of each year. If additional services (beyond the first six) are needed, they may be billed to Colorado Access without prior authorization if the provider is contracted. Non-contracted providers will require prior authorization.

If your practice provides other services (e.g., prevention/early intervention services) in the primary care setting, those services will continue to be reimbursed by Colorado Access through the capitated behavioral health benefit. Those services will not be reimbursed if billed to HCPF fee-for-service. These types of services include (but are not limited to):

- Behavioral health screening: H0002
- Behavioral health outreach: H0023
- Behavioral health psychoeducation: H0025
- Group therapy: 90853, H0005

For more information from HCPF about billing, visit hcpf.colorado.gov/behavioral-health-ffs-manual.

If it is found that services were requested and billed to Colorado Access without billing the first six visits to HCPF fee-for-service, payment for those services may be recouped as overpayment.