CHP+ Billing Manual

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COLORADO
Department of Health Care Policy & Financing

Contents

I. Introduction

A. Overview of Child Health Plan Plus:

Child Health Plan *Plus* (CHP+) is Colorado's low-cost health insurance program for children and pregnant women who earn too much to qualify for Medicaid but cannot afford private insurance. CHP+ helps ensure more families who do not have other health insurance have access to affordable, comprehensive health care coverage. The program covers children under age 19 and pregnant women who meet income and residency requirements and are not eligible for Health First Colorado (Colorado's Medicaid program).

CHP+ provides a broad range of benefits including doctor visits, hospital and emergency services, prescription medications, immunizations, maternity care, and mental and behavioral health services. Dental care is also included. Depending on income, families may pay low monthly premiums and copays, though many preventive services, like well-child checkups and prenatal visits, have no cost to the members.

CHIP programs in each state are governed by Title XXI of the Social Security Act, and 42 CFR Part 457. In Colorado, CHP+ is a managed care delivery system, so the program also adheres to 42 CFR 438 when required. For Colorado, Title 25.5 Article 8 of the Colorado Revised Statute (CRS) deals with the Children's Basic Health Plan *Plus* (CHP+). The Colorado Code of Regulation that holds the source of truth for CHP+ eligibility, enrollment and benefit policy is 10 CCR 2505-3.

B. Purpose of Billing Manual

This manual serves as a key resource for providers, managed care and HCPF staff detailing covered services, billing guidelines, and administrative processes to ensure clarity and smooth access to care. It also outlines exclusions and the reasons behind them, helping members and providers align expectations with program policies. CHP+ is separate from Health First Colorado (Colorado's Medicaid program). While both serve low-income families, CHP+ is not an entitlement program and is funded through a federal block grant. Benefits and coverage under CHP+ may differ from Medicaid Always verify coverage under CHP+ even if a service is available through Medicaid. To verify a member's coverage please visit: Verify Members Eligibility and Verifying CHP+ Coverage.

This billing manual is intended to provide high-level guidance and does not include detailed information about each individual benefit. Procedure codes are not included in the Billing Manual; please refer to the CHP+ Fee Schedules for all applicable codes.

Note: For definitions of key terms and additional terminology used throughout this manual, please refer to Managed Care Organization (MCO) contracts.

C. CHP+ Managed Care Organizations (MCOs):

CHP+ members receive benefits through a Managed Care Organization (MCO). Each MCO contracts with its own network of providers, hospitals, and pharmacies, which vary depending on the counties they serve. A member's county of residence determines their assigned MCO. In counties with more than one available MCO, members are assigned to a plan but may request to change MCOs within 90 days of enrollment and each annual redetermination. This can be done by contacting the Enrollment Broker at 303-839-2120 or 888-367-6557 (State Relay 711).

As a provider, it is important to verify a member's assigned MCO and ensure you are in-network with that plan before delivering services. Additionally, please note that some CHP+ MCOs operate as closed networks and are not required to add new providers unless they identify a gap in services. Please visit the Child Health Plan Plus (CHP+) Provider Page For more information about contracting with a CHP+ MCO, please use the contact information below.

D. Individual MCO Overview:

Managed Care Organization	Phone Number	Counties Served
Colorado Access	800-511-5010	Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Douglas, Eagle, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kit Carson, Kiowa, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Sedgwick, Saguache, Summit, Teller, Washington, Weld, Yuma
Denver Health Medical Plan	303-602-2100	Adams, Arapahoe, Denver, Jefferson
Kaiser Permanente	303-338-3800	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson

Rocky Mountain Health Plans	877-668-5947	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

II. Eligibility and Enrollment

A. Eligibility Procedures

CHP+ eligibility is based on age or pregnancy status, income level, and other criteria. Children from birth through age 18 may qualify, and pregnant individuals can receive coverage during pregnancy and for 12 months postpartum. Household income must fall below 260% of the Federal Poverty Level.

B. Other Health Insurance

According to 10 CCR 2505-3, individuals eligible for CHP+ cannot have other group health insurance coverage, except COBRA, at time of eligibility determination. This policy has exceptions. Children are continuously enrolled in CHP+ for the first 12 months of their eligibility, regardless of other health insurance acquired since application. Postpartum CHP+ members have 12 months of coverage regardless of other insurance acquired. CHP+ will not cover services that are not covered under the CHP+ benefit package, even if another insurer might cover them. See the Coordination of Benefits section for more information.

C. Single Case Agreements (SCA)

In limited circumstances, a CHP+ Managed Care Organization (MCO) may approve a Single Case Agreement (SCA) to allow services from a provider who is not in the provider's network when medically necessary care is not available through contracted providers. SCAs are reviewed and approved at the discretion of the MCO and are typically based on access issues, medical necessity, or continuity of care. Providers must work directly with the member's MCO to request and obtain approval prior to delivering services. Providers should always verify the member's current eligibility and MCO assignment before initiating services.

D. Continuous Eligibility

Children approved for CHP+ receive 12-month continuous eligibility (CE), meaning coverage continues regardless of changes in family circumstances, with some exceptions. Pregnant members receive coverage for 12 months postpartum. Continuous eligibility allows members who are enrolled in CHP+ and who report a decrease in income to automatically move to a Medicaid program (if they meet all other eligibility requirements). Children who move to a Medicaid program will receive a new 12-month CE period.

E. Presumptive Eligibility

Presumptive Eligibility (PE) offers immediate, temporary coverage of specific benefits for individuals who appear to meet eligibility requirements and completed an application for Medical Assistance. Eligible populations include children under the age of 19, and pregnant women *Members* must apply at an approved PE Site. The PE site will help members fill out the Medical Assistance Application. Individuals can also apply through PEAK and print out the completed application and bring it with them to the PE site. Members must complete all pages of the application. Coverage begins immediately and typically lasts up to 45 days while a full application is processed. PE is available only once per pregnancy or enrollment period and must be followed by submission of the full application. All CHP+ benefits, except dental services, are available. For more information visit the Presumptive Eligibility state website.

F. MCO Enrollment

CHP+ operates through managed care organizations (MCOs). When approved for CHP+, individuals are assigned to an MCO based on their geographical location and CHP+ plans contracted in that service area. Members may contact the enrollment broker to change their managed care plan within 90 days of initial enrollment and each annual redetermination if they reside in a county that has multiple MCOs. MCOs coordinate care and services, and coverage becomes effective on the first of the month following eligibility determination. To contact the enrollment broker, call 303-839-2120 or toll-free at 888-367-6557 (State Relay: 711). These lines are available Monday to Friday from 8:00 a.m. to 5:00 p.m.

G. Newborn Enrollment

Babies born to CHP+ members are automatically eligible for coverage for their first year of life. Families must add a newborn either online by reporting a change through the PEAK account at Colorado.gov/PEAK, or reporting the birth to the county of residence human services office or a Medical Assistance (MA) site case worker.

H. Postpartum Coverage

CHP+ provides 12 months of continuous postpartum coverage to members who were enrolled during pregnancy, even if the pregnancy does not result in a live birth. This means that individuals who experience a miscarriage or other pregnancy loss are still eligible for CHP+ coverage for 12 months after the pregnancy ends. The member should report the pregnancy.

I. Coverage Renewal or Cancellation

CHP+ coverage lasts for 12 months and must be renewed annually. Members receive notices before renewal is due and must update information such as address, income and household size. Failure to renew or provide required documentation may result in termination.

J. Termination Policy

CHP+ coverage ends when a member turns 19, exceeds income limits, obtains other insurance or Medicaid, or moves out of Colorado. Prenatal coverage will terminate 12 months after the end of a member's pregnancy. Other termination reasons include member request, fraud, or failure to renew. Notices of termination include appeal rights and information on other available programs. Colorado aims to minimize coverage gaps by connecting members to alternative coverage when possible.

III. Covered Services

A. Scope of Benefits

This section outlines the wide range of healthcare benefits available to CHP+ members, ensuring access to quality care that promotes overall well-being. Designed to meet the needs of Colorado families, the program includes essential services such as preventive check-ups, routine screenings, and vaccinations that keep children healthy and thriving. Maternal health and newborn care provide critical support for expectant parents and their babies, while mental health services ensure access to counseling and substance use disorder treatments. Additional benefits like dental and vision care, as well as comprehensive pharmacy coverage, reflect CHP+'s holistic approach to health care. This section provides a detailed breakdown of the services members can access under the program, equipping members and providers with the information needed to make the most of CHP+ benefits. Below is a basic overview of our covered services. If you have any questions or would like to learn more about the services, please visit the associated link.

B. Overview of Covered Services

Service Category	Description
Doctor Visits & Preventive Care	Outpatient physician services in clinics or offices, including primary care visits, well-child checkups, preventive screenings, and immunizations. This encompasses routine pediatric care, adolescent care, and prenatal checkups for pregnant members. No copay applies to preventive services (e.g., well-child visits, vaccines).
Specialty Care (Outpatient)	Medically necessary consultations and treatment by specialist physicians (e.g., cardiology, orthopedics) and services at outpatient clinics. Includes consultations, evaluations, and minor procedures performed in an office or ambulatory setting. Referral or prior authorization may be required per individual MCO guidelines.
Hospital Services – Inpatient	Inpatient hospital care, including room and board, physician and surgeon services, nursing, diagnostics, and medications during a hospital stay. All medically necessary hospitalizations (emergency or planned) are covered, such as surgeries, treatments, and maternity/newborn deliveries. Prior authorization is usually required for elective admissions.

Hospital Services – Outpatient	Outpatient hospital and ambulatory surgery services, including surgeries, procedures, and emergency department visits that do not require an overnight stay. Covers facility fees, surgical services, diagnostic tests, and therapies provided at hospital outpatient departments or ambulatory surgical centers.
Emergency & Urgent Care	Emergency services are for severe or life-threatening conditions (accessible 24/7 at hospital ERs) and urgent care is for non-life-threatening but immediate needs. CHP+ covers emergency room visits for true emergencies and urgent care clinic visits for pressing but lower-acuity issues. Emergency medical transportation (ambulance) is covered when needed for a life-threatening or critical emergency. (Urgent and emergency services do not require prior approval).
Laboratory & Radiology	Diagnostic lab tests (blood work, urinalysis, etc.) and radiology services (X-rays, MRIs, CT scans, ultrasounds) are covered when ordered by a qualified provider as part of diagnosis or treatment. This includes prenatal labs and imaging for pregnant members, newborn screening labs, and other necessary diagnostics.
Prescription Drugs (Pharmacy)	The CHP+ pharmacy benefit is administered by MedImpact Healthcare Systems, Inc. (Phone: 888-672-7203; Fax: 833-465-8957). Outpatient prescription medications are covered, including generic and brand-name drugs as per the CHP+ formulary. This includes antibiotics, asthma inhalers, insulin and diabetic supplies, prenatal vitamins, birth control, and other medically necessary drugs. Some over-the-counter items are covered if prescribed.
Maternity & Newborn Care	Comprehensive prenatal, labor & delivery, and postpartum care for pregnant CHP+ members, and newborn care for babies born to CHP+ members. CHP+ covers OB/GYN visits, ultrasounds, lab work, hospital delivery (including C-sections), and postpartum checkups. Doula (continuous labor support by a trained doula) and lactation services and support are also covered under CHP+. Newborns are automatically enrolled in the same MCO as the birthing parent from the date of birth. Choline supplements are a covered benefit. For more information, see **Obstetrical Care Billing Manual** **Lactation Support Services Billing Manual** **Doula Billing Manual**
Family Planning Covered Services	Family planning services are services that can help people choose if, or when, to become pregnant or to become a parent. Family planning services include different kinds of birth control, like birth control pills or intrauterine devices (IUDs), and office visits to talk about family planning and how to make healthy decisions about reproduction. For more information, please see Family Planning Services

Gender Affirming Care	Members with a clinical diagnosis of gender dysphoria are eligible for the gender-affirming care services benefit, subject to the service-specific criteria and restrictions detailed in 10 CCR 2505-10 8.735.4. Covered services include behavioral health, hormone therapy (gonadotropin-releasing hormone therapy and gender-affirming hormone therapy), gender-affirming surgical procedures, pre- and post-operative services, permanent hair removal used to treat a surgical site, and physical therapy. Coverage requires medical necessity and informed consent. Members must be informed of potential effects of treatment on fertility prior to initiating gender-affirming hormone therapy or gender-affirming surgery. Prior authorization is required per the criteria in 10 CCR 2505-10 8.735.4. Services are authorized and delivered through the members' CHP+ MCO. For more information, please see Gender Affirming Care Billing Manual
Behavioral Health Services	Mental health and substance use disorder services are covered with parity to physical health. This includes outpatient therapy/counseling, inpatient psychiatric care, medication management, and substance use treatment services. Examples: counseling with licensed therapists, behavioral health day programs, detoxification services, inpatient mental health hospital stays, etc. No visit limits apply to medically necessary behavioral health services, though prior authorization may be required for some intensive treatments. CHP+ members have access to residential treatment (Qualified Residential Treatment Program (QRTP) and Psychiatric Residential Treatment Facility (PRTF)) when recommended by a qualified professional. For more information, please see the Fee For Service Behavioral Health Benefit Billing Manual
Therapy Services (PT/OT/ST)	Outpatient rehabilitative therapies, including Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) are covered to help members regain or improve skills and functions. CHP+ covers therapy when medically necessary (e.g., for developmental delays, post-injury rehab). Per 10 CCR 2505-3, annual visit limits apply – Physical Therapy, Speech Therapy and Occupational Therapy shall be limited to 30 visits per diagnosis per year after the third birthday. For children under age 3, there are no visit limits.
Vision Services	Covered services include age-appropriate vision screening, one comprehensive routine eye exam per member per calendar year, and medically necessary diagnostic exams. Eyewear is limited to one (1) pair of eyeglasses per member per calendar year (one frame and up to two single- or multi-focal clear glass, plastic, or polycarbonate lenses). Contact lenses are covered when medically necessary and when eyeglasses are not sufficient to treat the member's refractive error. One (1) replacement pair per calendar year is covered when glasses/lenses are lost, are damaged beyond cost-effective

	repair, or the prescription changes; second or duplicate pairs are not covered. Prior authorization may apply to non-routine contact lenses and replacements outside standard frequency limits. Members may choose upgrades (e.g., designer frames, premium lens features) at their own expense. For more information, please see **CHP+ Vision Billing Manual**
Dental Services	CHP+ does not impose an annual dollar maximum on dental services, and there is no lifetime dollar maximum on orthodontia. Medically necessary orthodontia continues to require DentaQuest prior authorization and remains limited to CHP+ child members age 18 and younger who. CHP+ orthodontic fees mirror the Health First Colorado (Medicaid) orthodontic fee schedule, and providers may bill members the difference between the contracted fee and the former annual maximum. For more information please see CHP+ Dental Care
Durable Medical Equipment (DME) & Supplies	Medically necessary medical equipment and supplies are covered, such as crutches, wheelchairs, diabetic supplies, oxygen equipment, breast pumps, and prosthetic or orthotic devices. Coverage is determined by medical necessity and managed through utilization controls rather than an aggregate dollar **cap.** Providers must obtain prior authorization for high-cost DME items and supplies per HCPF policy. Repair or replacement of equipment is covered when medically necessary.
Abortion	Effective January 1, 2026, all abortions and related services will be covered for eligible members using State funds only. Treatment related to non-viable pregnancy conditions will continue to be reimbursed through the current federal match methodology. Coverage extends for 12 months postpartum, whether the pregnancy ended in a live birth or not. CHP+ MCOs will be reimbursed with state only funds via a quarterly manual reconciliation process.
Reentry Service for Justice-Involved Youth	CHP+ members will have access to reentry services beginning 90 days prior to release from detention or incarceration. This includes • case management to assess and address physical and behavioral health needs • and health-related social needs; • Medication assisted treatment (MAT) for all types of substance use disorders • (SUDs) as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies; and a 30-day supply of all prescription medications provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid and CHIP state plan coverage authority and policy.

	For more information, please see **Medicaid Reentry and Community Health (M-REACH)**

IV. Non-Covered Services

A. General Exclusions

This section provides examples of services and items that are not covered under the Child Health Plan *Plus* (CHP+) program, along with brief explanations for why they are excluded. These exclusions help define the scope of the CHP+ program by ensuring that only services that are medically necessary, evidence-based, and cost-effective are paid for with public funds. This approach supports clinical best practices in benefit administration and protects the program's financial sustainability while meeting the health needs of enrolled children and pregnant/postpartum women.

B. Cosmetic Procedures

CHP+ does not cover services that are primarily cosmetic in nature, that is, procedures intended mainly to enhance a person's appearance rather than to treat a documented medical condition. Examples include elective plastic surgery such as nose reshaping (rhinoplasty), breast augmentation, liposuction, and cosmetic dermatology treatments (e.g., Botox for wrinkle reduction). These services are not considered medically necessary under CHP+ guidelines unless there is clear documentation that the procedure is required to correct a deformity resulting from trauma, congenital anomaly, or medically necessary reconstructive surgery. Even then, coverage is subject to prior authorization and medical review. Cosmetic procedures performed solely for aesthetic reasons, even if they have psychological benefits, are not a covered benefit. This exclusion does not apply to medically necessary gender-affirming care, which is a covered benefit as described in the Covered Services section.

C. Experimental or Investigational Treatments

Any treatment, procedure, drug, device, or therapy that is considered investigational or experimental is not covered by CHP+. This includes services that have not received approval by the U.S. Food and Drug Administration (FDA), are not recognized as standard of care by national medical organizations or lack sufficient peer-reviewed clinical evidence to support their effectiveness and safety. Experimental treatments may include certain surgical techniques, off-label drug uses not endorsed by clinical guidelines, unapproved gene or stem cell therapies, and some high-cost diagnostics or wearable technologies. The goal is to ensure that covered benefits are grounded in sound, evidence-based medical practice.

D. Alternative and Complementary Medicine

CHP+ excludes alternative and complementary therapies such as acupuncture, chiropractic care, naturopathy, reiki, massage therapy (unless integrated into physical therapy by a licensed professional), homeopathy, and other non-conventional medical systems. These treatments are generally excluded due to insufficient evidence demonstrating medical necessity and cost-effectiveness for the populations served by CHP+. While some of these therapies may provide anecdotal benefit, they are not considered standard medical treatment under CHP+ and are therefore not reimbursable. Providers should avoid referring members for services that fall into this category unless they are paying out-of-pocket.

V. Services Beyond Program Scope

Some services are excluded from the CHP+ benefit package because they fall outside the program's intended scope of coverage. CHP+ is designed to provide comprehensive health coverage for children and pregnant/postpartum individuals, but it does not offer the full range of benefits available through Medicaid or private insurance plans. The following are examples of services that are outside the scope of CHP+ benefits.

A. Weight Loss Programs

Weight loss programs, medications, dietary supplements, and other interventions that are primarily intended for cosmetic or lifestyle reasons are not covered. This includes commercial programs such as Weight Watchers, weight loss camps, or nutrition products unless they are part of a medically supervised program to treat a documented obesity-related condition (e.g., metabolic syndrome, type 2 diabetes). Anti-obesity drugs or surgical interventions such as bariatric surgery are also not covered unless they are explicitly listed as covered and authorized by the member's CHP+ plan.

B. Pediatric Behavioral Therapy (PBT) & Autism Spectrum Disorder (ASD) Treatments

CHP+ in Colorado does not cover autism treatment services, including Applied Behavior Analysis (ABA) therapy[2]. Per CRS §25.5-8-107(1)(a)(IV), CHP+ is statutorily prohibited from reimbursing services rendered for ASD treatment. CHP+ families may access PBT and ASD treatment by contacting the Child and Youth Mental Health Treatment Act (CYMHTA) program.

C. Long-Term Residential and Custodial Care

CHP+ does not cover long-term stays in residential or custodial care facilities, including nursing homes, assisted living, group homes, or long-term inpatient rehabilitation centers. These services fall outside the scope of CHP+, which focuses on acute and outpatient medical needs. However, the program does allow exceptions for certain medically necessary, short-term residential treatment settings for children. Specifically, CHP+ may cover care in Qualified Residential Treatment Programs (QRTPs) and Psychiatric Residential Treatment

Facilities (PRTFs) when such care is clinically appropriate, time-limited, and approved in advance. All other forms of residential care are not covered.

D. Vision Therapy

Vision therapy aimed at improving visual skills through structured eye exercises—such as those for conditions like lazy eye, convergence insufficiency, or reading difficulties—is not covered. These services are excluded due to a lack of conclusive evidence demonstrating long-term medical benefit. Standard vision exams, glasses, and medically necessary eye care remain covered, but vision training programs typically offered by optometrists are considered non-covered services under CHP+.

E. Integrated Care

CHP+ does not cover standalone payments for integrated care coordination or collaborative care models unless the individual components are otherwise covered under the CHP+ benefit package. While coordination of care is the best practice and encouraged among providers, services like care team meetings, shared treatment plans, or integration fees are not reimbursable under CHP+ unless tied to a billable medical or behavioral health encounter. Only the covered service itself (e.g., a physical exam or behavioral health session) is reimbursed.

F. Targeted Case Management

Targeted Case Management is not a covered service under CHP+ except for the approved population described above under *Reentry Services for Justice-Involved Youth*. For this population, case management is covered for up to 30 days prior to release and 30 days following release. While formal TCM is generally excluded, all CHP+ members have access to standard care coordination and case management services through their Managed Care Organization (MCO) as part of routine plan operations.

G. Skilled and Private Duty Nursing

CHP+ does not cover long-term private duty nursing (PDN) services or extended in-home skilled nursing care. These services, often required for medically fragile children with 24/7 care needs, fall outside the scope of CHP+, which is designed for short-term, outpatient, and preventive care. While short-term nursing services may be available during inpatient stays or outpatient visits, CHP+ does not reimburse for home-based PDN or extended nursing shifts.

H. Mobile Crisis

CHP+ does not currently cover mobile crisis response services. However, CHP+ members can and should call 988 if they or someone they know is experiencing a mental health or substance use crisis, needs urgent support, or is at risk of harm. Calling 988 is free, and CHP+ members and Managed Care Organizations (MCOs) will not be billed for any services provided through the 988 Lifeline. Mobile Crisis services, as described on the 988 program's

informational materials, are not a covered benefit under CHP+. While these services may be available through community resources, they are not reimbursed by CHP+.

I. Non- Emergent Medical Transport

These intensive community-based behavioral health interventions, while available under Medicaid, are not included in the CHP+ benefit package. Members experiencing a behavioral health emergency should seek assistance through emergency departments, crisis phone lines, or walk-in crisis centers, but face-to-face mobile behavioral health teams are not reimbursable through CHP+. Non-Emergent Medical Transport (NEMT) is also a non-covered service in CHP+.

J. Homeopathic and Herbal Remedies

Non-prescription remedies such as acupuncture, homeopathic tinctures, herbal supplements, essential oils, chiropractic care, and similar alternative medications are not covered under CHP+.

K. Convenience and Luxury Items

Items or services that offer convenience, comfort, or upgraded experiences but are not medically necessary are excluded from coverage. This includes private or upgraded hospital rooms, television or phone rentals during hospital stays, food for family members, or other amenities not directly tied to the member's medical care. Similarly, products that exceed basic medical need—such as designer frames for glasses, enhanced durable medical equipment with luxury features, or transportation upgrades—are not reimbursable.

VI. Cost-Sharing and Payment

CHP+ is designed to be low-cost for members, with limited fees to ensure affordability. This section explains what financial responsibilities members might have (such as copayments) and how providers receive payment for services.

A. Member Financial Responsibility:

CHP+ members do not pay monthly premiums or enrollment fees.[3] Members may have small copayments for certain services. See your MCO member handbook for more information. Preventive care, pregnant members, American Indians, and Alaska Natives are exempt from CHP+ copays. CHP+ also sets a limit on total out-of-pocket costs: no family will pay more than 5% of their annual household income within a plan year. This annual cap protects families from excessive medical expenses. Once a family reaches this out-of-pocket maximum, CHP+ covers all additional covered services at no cost for the rest of the plan year. CHP+ members with a household income at or below 150% FPL are not required to pay any copays above what Medicaid members pay (usually $0 unless services include non-emergent use of emergency care).

B. Balance Billing Protections:

Providers cannot bill CHP+ members for any remaining balance beyond the member's copay or required cost-share for covered services. In other words, balance billing is not allowed – members are only responsible for official CHP+ copays and nothing more for covered benefits. Once the CHP+ MCO pays its portion, the member should not be charged extra by the provider for that service. Non-covered services or out-of-network providers may be subject to member billing.

C. Provider Reimbursement and Fee Schedules:

Most CHP+ services are paid through the provider's contracted MCO plan. Each MCO reimburses providers according to its contract. For any services that are paid by the State directly (fee-for-service), the Department of Health Care Policy & Financing publishes fee schedules online.

D. Interim Fee-For-Service Billing Period:

CHP+ operates through MCOs, but there can be a short period when a member is approved for CHP+ before they are enrolled in an MCO. During this interim fee-for-service (FFS) period, providers must bill the State's fiscal agent directly for services: medical claims go to Gainwell Technologies (the same fiscal agent used for Health First Colorado), and pharmacy claims are processed through MedImpact Healthcare Systems, Inc. (Phone: 888-672-7203; Fax: 833-465-8957**).** Providers should be aware that CHP+ coverage rules apply during this time. If CHP+ does ***not*** cover a service (even if Medicaid would), the provider cannot bill Medicaid for it on the member's behalf. Once the member's MCO enrollment takes effect (usually very soon after eligibility determination), all services should be billed to the MCO going forward.

Because CHP+ does not participate in Vaccines for Children (VFC) as mandated for Medicaid members, the link below lists a fee schedule specific to vaccine codes covered by CHP+ per American Academy of Pediatrics (AAP) guidelines and recommendations.

Please visit the site Provider Rates and Fee Schedule for CHP+ Fee-for-Service fee schedules. CHP+ also follows the Ambulatory Surgical Center (ASC) fee schedule.

E. Coordination of Benefits

CHP+ members generally cannot have other health insurance coverage, excluding COBRA, at the time of enrollment. However, due to continuous and postpartum eligibility policies, other coverage may appear during the coverage period. In such cases, Managed Care Organizations (MCOs) must coordinate benefits as a secondary payer, ensuring claims are only paid for costs not covered by primary insurance. This process must follow applicable federal guidance, including SHO 23-004 and 89 FR 22780, and be implemented consistently across all member claims, this final rule has not yet been implemented.

F. Continuation of Benefits

Continuation of benefits during managed care appeals must now align with federal standards (42 CFR 438.420 and 457.1260), following the June 30, 2025, expiration of Colorado's Section 1902(e)(14)(A) waiver that had previously allowed broader continuation timeframes. Continuation now applies only to previously authorized services when a member timely appeals and requests continuation before the adverse action's effective date does not apply to initial denials of new services. CHP+ is directing MCOs to update NABDs, appeal notices, utilization management procedures, and staff training to reflect this realigned standard, framing the change as a compliance correction rather than a benefit reduction.

VII. Documentation Standards

A. Service Documentation Standards

Providers must maintain complete, legible medical records for all billed services, including client identification, date, detailed description of services provided, diagnosis or reason for the visit, duration, and the provider's name, credentials, and signature. Documentation must clearly support the medical necessity and appropriate level of care for each billed service. Providers are required to retain all medical and billing records for at least seven years after the service date and must provide them promptly upon request by state or federal officials.

Providers are advised to check members' eligibility and Managed Care Organization (MCO) before rendering services and submitting claims. Hospital electronic medical record (EMR) charting systems may not contain all of the eligibility information.

Refer to the Verify Member Eligibility and Co-Pay Quick Guide for instructions on how to check member eligibility in the Provider Web Portal. The batch 270/271 file process can be used to verify eligibility for more than one member at a time. Visit the Electronic Data Interchange (EDI) Support web page for information on batch files.

For all CHP+ members, if the member does not have a Managed Care assignment, claims are submitted to Gainwell Technologies as a fee-for-service claim

B. Timely Filing Requirements

Claims for CHP+ services must typically be submitted within the timely filing limit set by their contracted MCO, no later than 12 months from the date of service per 42 CFR 457.1209. Claims submitted after this period are usually denied. Exceptions include delays due to third-party insurance, which allow submission up to 60 days following the insurer's response, but not beyond 365 days from service date. If a patient becomes retroactively eligible, claims must be filed within 120 days of the eligibility update. Corrected claims or appeals must be submitted within 60 days from the date of the denial or payment notification. In all cases, no claim is payable if submitted more than 12 months after the service date.

C. Telehealth Guidelines

Telehealth involves real-time, interactive audio and video communication to deliver healthcare. It must meet the same standard of care as in-person visits, require documented patient consent, and use HIPAA-compliant technology. Telehealth services are reimbursed similarly to in-person services and should be billed using the appropriate telehealth Place of Service code (02 or 10) and applicable modifiers GT or 95, as required. Most services available in-person are covered via telehealth, but prior authorization requirements and service limitations still apply. Telehealth services must meet the same clinical, privacy, and documentation standards as in-person care using secure, HIPAA-compliant platforms, with documented patient consent for each encounter.

Note: CHP+ does not provide asynchronous eConsult's (electronic consultations between providers) as a separate billable service. Although these tools are helpful for improving access to specialty care, CHP+ requires that services be delivered directly to the member and meet all requirements for medical necessity and direct provider-patient interaction. Interprofessional communication or back-end care coordination between providers is not reimbursed.

D. Definition of Medical Necessity

CHP+ MCO contracts define medical necessity via reference to 10 CCR 2505-10 § 8.076.1.8, where medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the client's condition;

f. Is not experimental or investigational; and

g. Is not more costly than other equally effective treatment options

A physician's order, recommendation, or approval does not, by itself, make a service medically necessary or covered. Coverage may be denied either before or after a service is rendered. Complications

E. Prior Authorizations

Each managed care plan has specific Prior Authorization Request (PAR) procedures for enrolled members and CHP+ does not oversee these PAR requirements. Approved

authorizations specify validity periods and limits. Emergency services do not require prior authorization, but follow-up, non-emergent services generally do. Unauthorized services typically will not be reimbursed.

F. Inpatient Hospital Reimbursement during Eligibility Transition

When a member is determined to be eligible for CHP+ while inpatient and was not previously enrolled in Medicaid or CHP+, enrollment in MCO is delayed until hospital discharge. If the member is eligible for CHP+ but not yet enrolled into an MCO, CHP+ fee-for-service is responsible for those claims associated with the hospital stay. Providers are instructed to bill the State's fiscal agent. In the situation when a member gains Medicaid eligibility during an inpatient hospital stay and loses CHP+ coverage, the CHP+ MCO would be responsible for reimbursing all inpatient days up until the individual's Medicaid eligibility begin date.

G. Transition of Care

CHP+ ensures continuity of care when members change health plans or providers, preventing disruption in treatment. Common transition scenarios include pregnancy, chronic condition management, or post-surgical care. Plans may temporarily authorize continued out-of-network care to safely manage transitions. Plans also facilitate timely communication among providers and members to ensure uninterrupted care, especially during provider network changes. It is the Department's policy that when a member is receiving treatment in a residential setting, the outgoing MCO shall transfer the case to the receiving MCO at the time the member's attribution changed. When a member is receiving treatment in an inpatient/hospital setting, the outgoing MCO shall maintain responsibility until the member is discharged from this setting regardless of when attribution changed.

H. Transitions of Care

Effective January 1, 2026, in alignment with the Accountable Care Collaborative, CHP+ has opened Transitional Care Management codes 99495 and 99496 (Transitions of Care, or TOC, codes) for members following hospital or facility discharge. Providers may bill 99495 or 99496 in place of E/M codes 99214 and 99215 when they assume post-discharge management, reimbursed at the equivalent E/M rate. Billing requires initial contact within two business days of discharge, medication reconciliation by the first follow-up visit, a face-to-face or virtual follow-up within 7 or 14 days, and care coordination through the 30-day post-discharge period. The listed office, home, and domiciliary E/M codes may not be billed on the same date of service.

I. Preventing Fraud, Waste, and Abuse

Providers must comply with state and federal program integrity requirements, including audits, records reviews, and reporting obligations. Accurate billing practices are essential; intentional misrepresentation (fraud) and improper billing practices (abuse) are prohibited. Providers must keep detailed documentation supporting all billed services. If errors or

overpayments occur, providers are required to promptly report and correct them. Suspected fraud or abuse must be reported directly to HCPF for investigation and follow up. Compliance efforts protect the integrity of CHP+ and ensure ongoing program sustainability.

VIII. Grievances and Appeals

A. Process and Timelines

CHP+ members have the right to file grievances and appeals if they are dissatisfied with their health plan or services.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the enrollee's rights regardless of whether remedial action is requested and an enrollee's right to dispute an extension of time proposed by a CHP+ MCO.

An **appeal** is a formal request to review and possibly overturn a denial, reduction, or non-payment of a healthcare service.

Grievances can be filed with the managed care organization (MCO) at any time, by phone or in writing. Appeals must be filed within 60 calendar days from the date of the denial notice. Members receive written instructions on how to appeal when they are notified of a service denial or reduction. The appeals process for CHP+ differs from the Medicaid/Health First Colorado process.

B. Appeals

Members, their authorized representatives, or providers (with written member consent) can file an appeal. CHP+ eligibility, enrollment or cost sharing appeals go to the CHP+ Eligibility Vendor, Colorado Medical Assistance Program (CMAP). For questions about the CHP+ appeals process, contact CHP+ Customer Service at 800-359-1991 (State Relay: 711).

A CHP+ applicant who disagrees with a benefit denial must first follow instructions from their MCO to appeal their health plan decision.

C. Quality of Care Grievances

Quality of Care Grievance (QOCG) is an overarching term that refers to both grievances and Quality of Care Concerns (QOCC), including potentially significant patient safety issues. It encompasses any complaint related to the delivery of covered services or the quality of care provided by a healthcare professional that does not meet professionally recognized standards. While grievance may only be submitted by a member or member representative, a QOCC is a matter regarding quality of care, patient access, or patient safety, and may be initiated by a provider/facility, contractor, case management team, utilization management, etc. This can also be considered a potentially significant patient

safety issue. A QOCC may be identified within a grievance if the member complaint involves concerns about quality of care. The MCE is required to investigate, analyze, track, trend and resolve the QOCG as outlined in the terms and conditions of their contract with the Department.

IX. Revision Log

First Draft	3/10/2026	Summer MacAdam Gorham
July Revision	7/1/2026	Summer MacAdam Gorham