Policy and Procedure

Policy Name: Establishing Prior Authorization Requirements	Policy#: UM107	Version#: 3
Author Department: UM	Origination Date: 09/15/21	
Business Units Impacted: UM, RAE, CHP HMO+	Date Last Reviewed: 11/15/2024	
Products/LOBs: All	Date Approved by CPT: 11/21/2024	

DEFINITIONS:
None

SCOPE: This policy covers the process by which Colorado Access (COA) evaluates new healthcare services for coverage under the benefit structures of CHP+ HMO and the Regional Accountable Entity (RAE).

PURPOSE: Establish a standardized framework for assessing whether new services are covered within each line of business under COA and to determine of those services require prior authorization.

STATEMENT OF POLICY:
Colorado Access will establish a formal process for evaluating whether new services are covered under the benefit structure of each line of business; if covered, there will be an established process for evaluating whether the service should require prior authorization.

PROCEDURES:

1. The CHP+ HMO and Regional Accountable Entity are both state contracts with established, contractual benefit structures. Each new service or procedure must first be evaluated to determine if it is allowable under the contractual benefit structure.
    a. The Regional Accountable Entity has a specific set of behavioral health service procedure codes that are allowable under the Department of Health Care Policy and Financing's capitated behavioral health benefit. Colorado Access does not have the ability to cover services outside of this list of covered services in the RAE contract.[1]
    b. The CHP+ HMO contract has a more general set of inclusions and exclusions established by the Department of Health Care Policy and Financing. New services must be evaluated according to this list of inclusions and exclusions. Due to the high volume of members who move between COA CHP+ HMO and

[1] RAE Contract 14.5, Exhibit I-8

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COA Medicaid regions, COA aligns the behavioral health benefits between CHP+ HMO and RAE wherever possible to avoid changes in benefits for our members.[2]

2. Once COA has determined that a new service is included in a line of business's individual benefit plan, COA will then evaluate the following criteria/characteristics when determining if a new service requires prior authorization. These criteria are utilized for all service types (physical health, behavioral health, and substance use related services).
    a. The restrictive/invasive nature of the service or procedure
    b. The evidence-based nature of the service or procedure.
        i. New, investigational, and/or experimental services outside the current community standards of practice are more likely to require authorization
    c. The presence of any restrictions in the state plan that may restrict the service in certain scenarios (e.g., home health is only a CHP benefit if it will prevent hospitalization)
    d. Whether the service/procedure has a high probability of being mis-utilized or over-utilized
    e. Whether lower levels of care/less restrictive options are available
    f. Cost of the services or procedure

3. In order to facilitate the highest possible standards for access to care, the following services will never require prior authorization, regardless of whether service is designed to address physical health, behavioral health, or substance use disorder needs.
    a. Emergency services, including emergency transportation
    b. Urgent care
    c. Observation
    d. Crisis services
    e. Routine outpatient services
    f. Medication assisted treatment
    g. Screenings
    h. Vaccinations
    i. Routine laboratory and imaging services

[2] CHP+ Contract 2.1.25, 11.1, 11.2, Exhibit H

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REFERENCES:
UM101 Criteria for Utilization Review

ATTACHMENTS: None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 09/15/21, Version 2: 11/17/23, Version 3: 11/21/2024

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE: 11/21/2024**

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