

Provider Manual



Behavioral Health Providers

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How to Apply for Participation

If you are interested in participating in the CCHA network, visit CCHAcares.com or call **1-855-627-4685**.

CCHA retains the right to add to, delete from and otherwise modify this provider's manual. Contracted providers must acknowledge this provider's manual and any other written materials provided by CCHA as proprietary and confidential.

Material in this provider manual is subject to change. Visit CCHAcares.com/bhprovidertools > **Manuals and Resources** for the most up-to-date version and information. To request a hard copy of the provider manual and/or provider directory from the plan at no cost, call CCHA Provider Support Services at **1-855-627-4685**.

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CHAPTER 1: INTRODUCTION

Welcome

Welcome to the Colorado Community Health Alliance (CCHA) network provider family! We are pleased you have joined our Colorado network, which consists of some of the finest health care providers in the state.

CCHA is a Regional Accountable Entity (RAE) for Health First Colorado's (Colorado's Medicaid Program) Accountable Care Collaborative (ACC). In 2011, Health First Colorado launched the ACC as its primary health plan. The ACC is a central part of Medicaid reform and is designed to improve member health and reduce costs through coordinated, patient-centered care. We administer health care services for ACC members in Region 3 (Boulder, Broomfield, Clear Creek, Gilpin, El Paso, Jefferson, Park and Teller counties).

CCHA's collaborative partnership brings an influential blend of primary care medical providers, specialists, hospitals, behavioral health services, and medical/behavioral health management services to drive innovation within the Medicaid delivery system. This united entity operates with a mutual goal to provide members with access to seamless, integrated care that is patient- and family-centered, quality-focused, and cost-efficient. As a RAE, CCHA will build on and maintain a network of primary care medical providers and behavioral health providers who are committed to delivering integrated, coordinated care for ACC members. All network providers are contracted with CCHA through a participating provider agreement.

CCHA is also responsible for promoting collaborative relationships among the Health neighborhood, bringing together the full spectrum of providers, community services, and supports to address all aspects of a member's health and well-being. The overall goal is to support a coordinated model of care that will better serve the needs of the Colorado Medicaid population, improve health and life outcomes, and optimize resources to avoid duplication of services and reduce the costs of care.

Health First Colorado covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities.

We believe hospitals, physicians, and other providers play a pivotal role in managed care, so we can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. Together, we can arrange for and provide an integrated system of coordinated, efficient, and quality care for our members — your patients.

About This Manual

This provider manual is designed for contracted CCHA providers, hospitals, and ancillary providers. Our goal is to provide a useful reference guide to aid you in providing the most reliable, responsible, timely, and cost-effective quality health care.

We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex health care system. This system encompasses a wide array of services and responsibilities, such as care coordination, proper storage of medical records, and billing for emergencies.

To help navigate these topics, you can select any item in the Table of Contents to view it. This manual also contains hyperlinks to the CCHA website, external websites, and crosslinks to other sections in the manual — just select the hyperlink, and you'll be redirected to the right location.

If you have any questions about the content of this manual, contact CCHA Provider Support Services at **1-855-627-4685**, Monday through Friday, 8 a.m. to 5 p.m..

Additional Resources

To help providers serve a diverse and ever-evolving patient population, we designed a special program, Culturally and Linguistically Appropriate Services, to improve provider and member communications by providing tools and resources to help reduce language and cultural barriers. Written translations are available in each prevalent non-English language. Interpretation services — oral interpretation in all languages and auxiliary aids such as TTY/TDD and American Sign Language — are available to each member free of charge.

All written materials for members adhere to the following standards:

- Easily understood language and format
- Font size no smaller than 12 points
- Alternative formats and auxiliary aids and services that consider the special needs of members with disabilities or limited English proficiency
- Inclusion of taglines in both English and Spanish, and in large print, explaining the availability of written translation or oral interpretation to help members understand the information provided. Written materials for members are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the needs of members with disabilities, members who are visually impaired, and members who have limited reading and/or English proficiency, at no cost.
- Written materials for members include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll-free and TTY/TDD telephone number of the Contractor's member service unit, at no cost.

In addition, CCHA works with nationally recognized health care organizations to stay current on the latest health care breakthroughs and discoveries. This manual provides easy links to access that information, as well as forms and reference guides on a wide variety of subjects.

Accessing Information, Forms, and Tools on Our Website

Throughout this manual, we'll refer you to our website at CCHAcares.com, which contains tools, information, and forms for our provider network.

We offer the provider manual in hard copy upon request at no cost and post it online.

Third-Party Websites

The CCHA website (CCHAcares.com) and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither CCHA nor its related affiliated companies operates or controls, in any respect, any information, products, or services on third-party sites. Such information, products, services, and related materials are provided as is, without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. CCHA disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. CCHA does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability, or otherwise.

CHAPTER 2: LEGAL & ADMINISTRATIVE REQUIREMENTS

Proprietary Information

The information contained in this manual is proprietary. By accepting this manual, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services to CCHA members.
- To protect and hold the manual's information as confidential.
- Not to disclose the information contained in this manual.

Updates and Changes

The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the provider agreement between you or your facility and CCHA, the Provider Agreement governs. Provider manual revisions occur at least annually or as needed. Provider memos or bulletins are sent either by email, standard U.S. mail, fax, or via the CCHA provider newsletter and may serve to amend or update the information in this manual between editions. CCHA will also post changes to this manual on the CCHA website (CCHAcare.com) when enacting any changes.

The manual is not intended to be a complete statement of all CCHA policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications as referenced above. This manual does not contain legal, tax, or medical advice. Consult your own advisors for such advice.

Emergency Notifications

CCHA knows communicating promptly and effectively with our members and providers is critical in an emergency or service disruption. Depending on the nature of the disruption and its impact on members and providers, notification methods may include:

- **Member and provider websites:** We maintain ongoing emergency procedures on our websites, and we may post alerts there notifying members and providers of a service disruption and how it impacts their ability to access services.
- **Automated calls, text messages, and email messages:** We can generate automated phone calls, text messages, and emails to communicate information to our members and providers.
- **Personal calls:** CCHA employees may make personal phone calls to vulnerable members, including those in care coordination.
- **Call center:** Our member and provider call center employees will provide up-to-date information to callers on continuing to access services.
- **Local media:** Local radio and television can be used to disseminate emergency information to our members and providers.

Nondiscrimination Statement

CCHA does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person who discriminates on the basis of race, color, or national origin in providing aid, benefits, or services to beneficiaries. CCHA does not use or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. CCHA does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, CCHA may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization, or person that discriminates on the basis of age. CCHA provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, sexual orientation, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a CCHA representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at ocrportal.hhs.gov/ocr
- By mail to:
U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201
- By phone at: **1-800-368-1019** (TTY: **1-800-537-7697**)

Complaint forms are available at hhs.gov/ocr/complaints.

CCHA provides free tools and services to people with disabilities to communicate effectively with us. CCHA also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling CCHA Member Support Services.

If you or your patient believes CCHA failed to provide these services or discriminated in any way on the basis of race, color, national origin, sexual orientation, age, disability, gender, or gender identity, you can file a grievance via:

- Mail: Colorado Community Health Alliance Grievances
P.O. Box 13406
Denver, CO 80202
- Phone: **1-855-627-4685/TTY 711**
- Email: Providers@CCHAcare.com

Equal Program Access on the Basis of Gender

CCHA provides individuals with equal access to health programs and activities without discriminating on the basis of gender. CCHA must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, sexual orientation, gender, gender identity, age, or disability).

CCHA may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

CHAPTER 3: CONTACTS

Overview

In many cases, the most efficient way to get in touch with CCHA may be through Availity.

Provider and Facility Digital Guidelines

CCHA understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

CCHA expects providers and facilities will use digital tools unless otherwise prohibited by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business with CCHA. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass [Availity.com](https://www.availity.com), electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital functionality available through Availity Essentials includes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment and Network Management
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

CCHA expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must transmit directly to the Availity EDI gateway and/or Availity Essentials platform. Certain transactions may require you to have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software, commercial clearinghouses, and billing vendors.

Providers and facilities that do not transition to digital applications may experience delays when using non-digital methods, such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. CCHA expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and facilities should leverage these Availity clearinghouse-hosted channels for electronic eligibility and benefit inquiry and response:

- **EDI transaction: X12 270/271:** eligibility inquiry and response
 - CCHA supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- **Availity Essentials:** The Eligibility and Benefits Inquiry verification application allows a provider and facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- **Provider desktop integration via B2B APIs:** CCHA has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

- **EDI transaction: X12 278:** prior authorization and referral:
 - CCHA supports the industry-standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- **EDI transaction: X12 275:** patient information, including HL7 payload for authorization attachments:
 - CCHA supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation, including medical records, via the HL7 payload.
- **Availity Essentials:** The Availity Essentials multi-payer authorization application facilitates prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.

- **Provider desktop integration via B2B APIs:** CCHA has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment), and status:

- **EDI transaction: X12 837:** Professional and institutional Claim submission (version 5010):
 - CCHA supports the industry-standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
 - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- **EDI transaction: X12 276/277:** Claim status inquiry and response:
 - CCHA supports the industry-standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- **Availity Essentials:** The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
 - The Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of CCHA that electronic Claim payment disputes are adopted when and where they are integrated.
 - **Provider desktop integration via B2B APIs:** CCHA has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic Claim attachments from [Availity.com](https://www.availity.com):

- **EDI transaction: X12 275:** Patient information, including HL7 payload attachment:
 - CCHA supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation, including medical records, via the HL7 payload.
- **Availity Essentials:** Claim Status application enables a provider or facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
 - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation, including medical records, is needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. CCHA supports the industry standard X12 835 transaction as mandated by HIPAA.

Providers and facilities can register, enroll, and manage their ERA preferences through [Availity.com](#). Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer include the ability to search a two (2)-year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces, which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY (282-4548)**. To re-enable receiving paper remittances, contact CCHA Provider Support Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT):** Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit health care payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest-cost payment method. For help with enrollment, use this convenient [EnrollSafe User Reference Manual](#).

To disenroll from EFT: Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.

- **Virtual Credit Card (VCC):** For providers and facilities that do not enroll in EFT, CCHA is shifting some reimbursements to a virtual credit card (VCC) in lieu of paper checks. VCC allows providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

Note that CCHA may receive revenue for issuing a VCC.

Opting out of virtual credit card payment. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

OR

- To opt out of virtual credit card payments, contact **1-800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination:** The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included, together with additional services. For more information, go to Zelis.com. Zelis may charge fees for its services.

Note that CCHA may receive revenue for issuing ZPN.

ERA through Availity is not available for providers and facilities using ZPN.

To disenroll from ZPN payment, there are two (2) options:

- Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

OR

- To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **1-877-828-8770**.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

Simplified enrollment process: Providers and facilities can enroll as a new care provider in our network for professional, ancillary, institutional and facility provider types through Availity Essentials.

Real-Time Tracking: Providers and facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Contract Changes

Streamlined Contract Change Requests: Providers and facilities can easily submit certain requests for contract changes through Availity Essentials:

- Amendment requests to add a network or line of business
- Change of Ownership notice
- Contract, line of business, or Network Termination requests
- TIN Change

My Roster:

Providers and facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to [Availity.com](https://www.availity.com) > **Payer Spaces** > **Select Payer Tile** > **Provider Enrollment and Network Management** > **Request Current Roster**.
- Providers and facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by selecting **Download Requested Roster**. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and facilities can edit the downloaded roster and upload the updated version via Provider Data Management **Upload Roster File** screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

*See Section 7: Demographic Updates section for more information about Provider Data Management.

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to [Availity.com](https://www.availity.com) > **Payer Spaces** > **Select Payer Tile** > **Provider Enrollment and Network Management** application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates **Provider Data Management (PDM)**

Availity Essentials Provider Data Management (PDM) is the digital intake application for providers and facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters and follow the prompts.

For Providers and Facilities using the roster upload option, additional resources are available:

- **Error Report:**
 - Providers and facilities can use this error report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
 - Providers and facilities are responsible for using the error report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems.
- **Results Report:** When a roster has the status partially complete or complete, a Results Report will be created for any rosters received on and after June 15, 2024. The results report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the Roster Submission Guide:** For providers and facilities using the roster upload option, additional information about the error report and results report can be found in our Roster Submission Guide. Find it online at [Availity.com](https://www.availity.com) > **Payer Spaces** > **Select Payer Tile** > **Resources** > **Roster Submission Guide using Provider Data Management**.

CCHA Contacts

Department	Contact Information	Support
Behavioral Health (BH)	CCHAcared.com Phone: 1-855-627-4685 • Providers or facilities, select 1 • Choose 2 for calls regarding BH claims payments, appeals, or other provider-related items. • Choose 3 for calls requesting authorization for BH services. Behavioral Health Provider Contact List	• Claims payment • Provider credentialing and contracting • Complaint and grievance reporting • Provider support
Care Coordination	HealthTeam@CCHAcared.com Phone: 1-855-627-4685	Member coordination including: • Disease education and self-management • Transitions of care • Pregnancy and family planning • General medical guidance • Discharge planning • Connecting to community resources such as housing, childcare, food, etc. • Navigating plan benefits
Physical Health	Providers@CCHAcared.com Phone: 1-855-627-4685	• Contractual issues • New provider orientations

Department	Contact Information	Support
		• Provider office orientation and training • Tax ID change (requires a copy of W9) • Complaint and grievance reporting • Policies and procedures • Eligibility issues • Data analytics • Portal questions and training
Practice Transformation	Providers@CCHAcares.com Phone: 1-855-627-4685	• Clinical quality improvement initiatives • Clinical practice guidelines • Population Health Management

CCHA Communications

Monthly Newsletter

CCHA sends a monthly update communication via email to CCHA providers and office staff. Topics may include information such as a new specialty practice added to the network, new quality or other program updates, clarification of CCHA contract provisions, or new CCHA key contacts you might encounter, as well as billing and coding reminders. Review the newsletter library and register to receive the provider newsletter via email at CCHAcares.com/newsletters.

Provider Town Hall Meetings

Information of a broader nature is communicated in provider town hall meetings. It is expected that CCHA providers attend these meetings when scheduled. CCHA will present training programs for PCMPs and behavioral health providers on topics related to the coordination of behavioral health and physical health care. Some of these training events will include the opportunity for providers to obtain continuing medical education (CME) credits/continuing education units (CEUs) for participation. Provider town hall meetings will be announced via the monthly newsletter and on CCHAcares.com/providertools.

CHAPTER 4: BEHAVIORAL HEALTH SERVICES

Overview of Behavioral Health at CCHA

The mission of CCHA is to coordinate the physical and behavioral health care of members, offering a continuum of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for CCHA members. CCHA works collaboratively with health care providers — individual behavioral health practitioners, comprehensive safety net providers (CSNP), substance use disorder providers, and a variety of community agencies and resources — to meet the needs of members with mental health (MH) and substance use disorders.

Goals

The goals of the CCHA behavioral health program are to:

- Ensure adequacy of service availability and accessibility to eligible members.
- Assist members and providers to use the most appropriate, least restrictive medical and behavioral health care in the right place at the right time.
- Promote integration of the management and delivery of physical and behavioral health services to members.
- Achieve the CCHA quality initiatives, including those related to HEDIS®, the National Committee for Quality Assurance, and the Colorado Department of Health Care Policy & Financing (HCPF) performance requirements.
- Work with members, providers, and community supports to provide tools and an environment that supports members toward their recovery and resiliency goals.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Values and Principles

The following values are incorporated into our policies and practices:

- Hope and respect for members and families, based on the knowledge that personally valued recovery is possible
- A belief in member dignity and self-determination
- The encouragement to strengthen empowering relationships
- The elimination of stigma and discrimination

CCHA adheres to the following principles related to the delivery of behavioral health services:

- Members are allowed to choose their behavioral health professional(s) to the fullest extent possible and appropriate.
- We support the involvement of the member and those significant in the member's life as appropriate, in decisions about services provided to meet the member's health needs.
- We establish and promote strategies to engage members who may have histories of inconsistent involvement in treatment.
- For adult members who have a serious mental illness and child members with a severe emotional disturbance (SED), services focus on helping the member maintain their home environment, education and employment, and on promoting their recovery and resiliency.
- Mental health services for children are most appropriately directed toward helping a child and the child's family develop resiliency and maintain a stable and safe family environment for the child.
- We are committed to the use of emerging technology (for example, telehealth) as a way to expand access to services and extend the reach of mental health and substance use disorder service professionals, particularly into rural areas of the state.
- We facilitate the coordination of services to eliminate both gaps in service and duplication of services.
- We promote quality improvement initiatives as well as monitoring and tracking outcomes such as member satisfaction, health status and clinical improvement, and service utilization.

Objectives

The objectives of the CCHA Behavioral Health program are to:

- Work with providers to ensure the provision of medically necessary and appropriate care and services to our members at the least restrictive level of care, including inpatient care, alternative care settings, and outpatient care, both in- and out-of-network.
- Provide high-quality care coordination services designed to identify member needs and address them in a person-centered, holistic manner.
- Promote continuity and coordination of care among physical and behavioral health care practitioners.
- Maintain compliance with local, state, and federal requirements as well as accreditation standards.
- Use evidence-based guidelines and clinical criteria and promote their use in the provider community.
- Enhance member satisfaction by working with members in need of services to implement an individually tailored and holistic support and care plan that allows the member to succeed at achieving their recovery and resiliency goals.
- Enhance provider satisfaction and success by working to develop collaborative and supportive provider relationships built on mutually agreed-upon goals, outcomes, and incentives.
- Promote all health care partners to work together to achieve quality and recovery goals through education, technological supports, and the promotion of recovery ideals.
- Initiate quality improvement activities: plan, do, study, act (PDSA).
- Establish systems to monitor and track outcomes annually.

We support our CCHA-contracted providers in delivering behavioral health and substance use disorder (SUD) services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by HCPF.

Recovery and Resiliency

“Recovery is a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.” — Townsend, W., S. Boyd, G. Griffin, and P. L. Hicks. 2000. *Emerging best practices in mental health recovery*. Columbus: Ohio Department of Mental Health.

“Recovery involves living as well as possible.” —Slade, M. (2009) *Personal Recovery and Mental Illness; A Guide for Mental Health Professionals*. New York: Cambridge University Press.

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”— Substance Abuse and Mental Health Services Administration (SAMHSA, 2011)

CCHA believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance, and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn, and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery, as elucidated by SAMHSA, include the following:

1. **Self-direction:** Consumers lead, control, and exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines their own life goals and designs a unique path toward those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual’s unique strengths and resiliency, as well as their needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and

aspirations. Through empowerment, an individual gains control of their own destiny and influences the organizational and societal structures in their life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (for example, partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process, especially for children and youth (and their families), that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, and maintenance of hope and optimism within the context of significant adversity.

Services provided to children and youth with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- Community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Led by the guiding principles of a system of care, which include:
 - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational, and cultural needs.
 - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
 - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
 - Children should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
 - Children should be provided with care coordination or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
 - Children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics.

Colorado Child and Youth System of Care

The Child and Youth Medicaid System of Care (CO-SOC) is an intensive behavioral health service model implemented as part of Colorado's Capitated Behavioral Health Benefit. It was established to fulfill the requirements of the G.A. v. Bimestefer Settlement Agreement, aiming to improve behavioral health outcomes for children and youth under 21. The CO-SOC is designed to be family-driven, youth-guided, strengths-based, trauma-informed, and culturally and linguistically competent. It emphasizes delivering services in the least restrictive and most community-integrated settings possible.

CO-SOC services are guided by evidence-based models such as High-Fidelity Wraparound (HFW), Intensive Home-Based Treatment (IHBT), and Intensive Care Coordination (ICC). Eligibility is determined by state criteria, which will expand with a phased rollout of the program. Services are coordinated across providers, agencies, and systems to ensure seamless delivery, with a focus on maintaining youth in their homes and communities and reducing reliance on emergency departments, residential treatment, and out-of-state placements.

General Provider Information

How to Become a Behavioral Health Provider in the CCHA Network

See the [Credentialing](#) chapter for more information. If you have questions about the CCHA credentialing process before joining our network, call our CCHA Provider Support Services at 1-855-627-4685. If you're being recredentialed, you will receive a packet of instructions and contact information for questions or concerns. If responding to the recredentialed packet, do so timely.

For professional providers, reference information on [CCHAcres.com](#) for how to submit a Provider Enrollment application online through Availity Essentials at [Availity.com](#). Go to [CCHAcres.com/bhprovidertools](#) > **Resources and Tools**.

For facility providers, contact to your contract manager. Reference the Behavioral Health Contact List if you do not know your designated contract manager. Go to [CCHAcres.com/bhprovidertools](#) > **Manuals and Resources** > **Behavioral Health Provider Contact List**.

CCHA's Commitment to Providers

CCHA believes the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Prior authorization rules, referrals, claims, and payment processes to help providers reduce administrative time and focus on the needs of members.
- Using reasonable prior authorization requirements that minimize administrative burden.

Services Requiring Prior Authorization

If a provider asks for prior authorization of a service and a decision is made that the service is not medically needed, the provider can discuss this decision with the CCHA medical director. If the decision remains the same, the member, the member's approved representative, or the provider (on the member's behalf and with their written consent) can appeal the decision. See the [Reconsiderations, Disputes, Grievances, and Appeals](#) chapter.

For more information on services requiring prior authorization. Go to [CCHAcres.com/bhprovidertools](#) > **Utilization Management**.

Member Records and Treatment Planning

Member records must meet the standards explained in the State Behavioral Health Services manual. They must contain the elements listed in the Outpatient Behavioral Health Services Audit Tool to permit effective service provision and quality reviews:

The latest version of the Outpatient Behavioral Health Services Audit Tool can be found at hcpf.colorado.gov/bhreform.

Psychotropic Medication

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment. The medical record is expected to reflect such conversations as having occurred.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side effects and risks of medications and regularly assess for any adverse effects. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per FDA and American Psychiatric Association (APA) guidelines.
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers.
- Glucose tolerance test or hemoglobin A1C tests, especially for those members on antipsychotics or mood stabilizers.
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers.
- ECG checks for members placed on medications with a risk of significant QT-prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the APA, among others. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and interventions are expected to be documented, at minimum, in the member's medical record.

Utilization Management Process

Utilization Management Decision-Making

Individuals involved in utilization management (UM) decisions are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- CCHA does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Our Behavioral Health Customer Service Staff

Calls during regular business hours are taken by our experienced team of behavioral health customer service staff, who assist providers with routine inquiries about member eligibility, benefits and claims or with referrals to network providers. Calls about prior authorization for a service that requires prior authorization and clinical review are referred to clinical staff to initiate a review of the request.

Provider calls after business hours are taken by our after-hours clinical staff, who will issue you a reference number for prior authorization requests for urgent/emergent care. Requests for routine/outpatient care are taken during normal business hours. All requests for prior authorization will be reviewed by appropriate behavioral health staff within decision and notification timeliness standards.

Behavioral Health Authorization Time Standards

CCHA will make authorization determinations within time frames that facilitate timely access to care, per the standards outlined in the [Access Standards and Access to Care](#) chapter. For this to occur, it is critical CCHA receives all necessary clinical information in a timely manner.

Our Clinical Staff

We have assembled a highly trained and experienced team of clinical care coordinators and support staff to provide high-quality care coordination services to CCHA members and work collaboratively with our providers. All clinical staff are licensed and meet experience requirements, which generally include at least four years of prior clinical experience.

Notification or Request Prior Authorization

The quickest, most efficient way to request prior authorization is via the Availity Essentials multi-payer secure provider website at [Availity.com](https://www.availity.com). Through the secure provider website, you can access the authorization application, which offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for CCHA members. Providers can use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, Availity, or other online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. The application allows detailed text, photo images, and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, Availity, or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Access the** authorization application from Availity Essentials. Select **Patient Management > Authorizations and Referrals**.

To access the digital authorization application, you must have the appropriate role assignments:

- **Authorization & Referral Request:** To create, submit and update authorizations
- **Authorization & Referral Inquiry:** To follow up and view the status of an authorization.

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Chrome, Microsoft Edge, or Firefox.

You may also request authorization for inpatient mental health services by calling **1-855-627-4685**, 24/7, 365 days a year. Be prepared to provide clinical information in support of the request at the time of the call.

Fax forms are on our website at [CCHAcres.com/bhprovidertools](https://www.CCHAcres.com/bhprovidertools) > **Utilization Management**.

Information Needed for Medical Necessity Determination

Medical necessity determinations are made:

- Via the digital authorization application accessed through Availity Essentials at [Availity.com](https://www.availity.com), by following the prompts to provide all requested information.
- Via fax, by completing the forms found at [CCHAcares.com/providertools](https://www.cchacares.com/providertools) > **Behavioral Health Provider Resources > Utilization Management Forms**, by phone, with the following information available as appropriate to the service request:
 - Member name and Health First Colorado ID number
 - Diagnosis with the ICD code
 - Procedure with the CPT® code
 - Date of hospital/service admission and third-party liability information, if applicable
 - Facility name, if applicable
 - Clinical justification for the request
 - Level of care
 - Medications
 - Treatment plan, including time frames
 - Prognosis
 - Psychosocial status
 - Exceptional or special needs issues
 - Ability to perform activities of daily living
 - Discharge plans

Requests with Insufficient Clinical Information

When the Behavioral Health department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably necessary to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not receive a response, the request will be reviewed with the information originally submitted and denied. A denial letter will be sent to both the member and the provider.

Expedited Requests

Based on the member's condition, you may request an expedited determination. The Behavioral Health department will complete an expedited determination once clinical information is received from the provider. The Behavioral Health department will make a determination as quickly as possible and no later than 72 hours after receipt of the request for service. The authorization decision time period can be extended by up to 14 calendar days if the member requests an extension or if CCHA justifies a need for additional information and shows how the extension is in the member's best interest. Determinations for Special Connections services will be made within 24 hours after receipt of the request.

Standard Requests

For standard requests, the Behavioral Health department will make a determination as quickly as possible, but no longer than seven calendar days following receipt of the request for service. The seven -calendar -day service authorization notice time frame can be extended up to 14 additional days if a member or provider requests an extension, or if CCHA justifies a need for additional information and shows how the extension is in the member's best interest.

Emergency Medical Services

CCHA does not require prior authorization for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24/7. If the emergency room visit results in the member's admission to the hospital, providers should contact CCHA within 24 hours or the next business day.

Emergency Stabilization and Post-Stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact CCHA for authorization of further services. If we do not respond within one hour, we consider the necessary services authorized.

Readmission

CCHA follows the state of Colorado's 30-day readmission policy. We may review hospital admissions on a specific member if it appears that two or more admissions are related based on same or similar conditions. The claim review, which includes a review of medical records if requested from the provider, may result in necessary adjustments. If so, we'll make all necessary adjustments to the claim (including recovery of payments) not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by us may be subject to a recoupment.

Clinical Criteria

CCHA Clinical Criteria

- CCHA uses clinical criteria, including MCG Medical Policies, American Society of Addiction Medicine (ASAM), Colorado Statewide Standardized Utilization Management (SSUM) guidelines, and Enhanced Standardized Assessments (ESA) to evaluate the medical necessity of requests for care and services.
- Additional level of care criterion will be used for services not included in our criteria sets. For more information about additional criteria in use by CCHA, visit CCHAcare.com/bhprovidertools.
- All criteria used by CCHA are approved by the medical advisory committee and the medical policy and technology assessment committee.
- For information about how to access the CCHA medical necessity criteria, call CCHA Provider Support Services at **1-855-627-4685**.

Medical necessity is defined by Colorado as a service, procedure or supply:

- 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. Assists the member to achieve or maintain maximum functional capacity.
- c. Is provided in accordance with generally accepted professional standards for health care in the United States.
- d. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
- e. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
- f. Is delivered in the most appropriate setting(s) required by the member's condition.
- g. Provides a safe environment or situation for the member.
- h. Is not provided for experimental or investigational purposes.
- i. Is not more costly than other equally effective treatment options.

Behavioral Health Medical Necessity Determination and Peer Review

When a provider requests initial or continued prior authorization for a covered behavioral health service, CCHA utilization managers obtain necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.

If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by a CCHA behavioral health medical director or other appropriate practitioner, as part of the peer review process.

The CCHA reviewer or the requesting provider may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member. If an adverse decision is made by the CCHA reviewer without a peer-to-peer conversation taking place (as may occur when the provider is unavailable for review), the provider may request such a conversation within one business day of the issuance of the adverse decision. In this case, we will make a behavioral health medical director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

Members, requesting providers, and applicable facilities are notified of any adverse decision by CCHA within a peer-to-peer notification timeframe, or, in the absence of an offered peer-to-peer notification timeframe, one that is based on the type of care requested and in conformance with regulatory and accreditation requirements.

Nonmedical Necessity Adverse Decisions

Nonmedical Necessity Adverse Decisions (Administrative Adverse Decision)

A request for prior authorization may result in an adverse decision for reasons other than a lack of medical necessity. Reasons for such an adverse decision may include:

- The notification of admission was late; providers must notify CCHA of admission (including preliminary clinical information) within 24 hours or the next business day of any admission of a CCHA member.
- The provider failed to request prior authorization of a service that requires it.
- The member was ineligible on the date of service.
- The requested service/benefit was a non-covered service/benefit.
- The limit on the benefit has been reached.
- When an Enhanced Standardized Assessment is canceled due to a member's family or guardian not responding to requests for documents within 72 hours.

Appeals, Grievances, and Payment Disputes

If prior authorization was not received or you disagree with the decision, refer to the [Reconsiderations, Disputes, Grievances, and Appeals](#) chapter.

Avoiding an Adverse Decision

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and prior authorization policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or the member's benefits. Such information is readily available by calling CCHA Provider Support Services at **1-855-627-4685**.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidence-based, national guidelines. CCHA is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. Peer-to-peer conversations between a CCHA medical director and the provider clinicians are one way we're able to ensure the completeness and accuracy of the clinical information and provide --one-on-one communication about the guidelines, as necessary. Medical record reviews are another way to ensure clinical information is complete and accurate. Providers who are able to appropriately respond in a timely fashion to peer-to-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. CCHA is committed to ensuring a process that is quick and easy, working with participating providers to ensure a mutually satisfying process whenever possible.

Reducing Risk to Members With Behavioral Health or SUD Health Care Needs Through the CCHA Care Coordination Process

When a member is identified as having mental health and/or SUD needs requiring some type of intervention to reduce risk, CCHA uses the following strategies:

- Inpatient management: moderate to high-risk hospitalized members:
 - When at-risk members are identified as part of the census management process, UM staff work with provider discharge planners, our transitional care coaches, the member's health home team, and/or CCHA care coordinators to develop a discharge plan that maximizes the likelihood of the member making a successful transition back into the community. Key elements of the discharge plan include, but are not limited to, the following:
 - Understanding the characteristics of each particular member (job, family, education, social activities, family background, prior service utilization, etc.)
 - In the case of rapid readmissions, an admission that occurs within 30 days of discharge from the same level of care:
 - What has worked in the past in helping this member to stay out of the hospital (for example, medications, treatment interventions, services, and supports)?
 - What elements of the previous discharge plan did not work and need to be changed?
 - How do medical issues or complications impact the member?
 - What is the involvement of the family in the treatment process and how do the family and other social supports factor into the discharge plan?
 - Are follow-up appointments scheduled within seven days of discharge?
 - The behavioral health medical director conducts daily UM rounds and participates in complex case rounds to assist in facilitating the member's successful transition back into the community
- Transitional care: moderate- to high-risk hospitalized members:
 - A care coordinator collaborates with UM staff to work with members, their family caregivers, their health home team, and, when appropriate, the hospital's discharge planning staff to develop a discharge plan. The plan may include:
 - Pretransition contacts
 - Assisting the member with planning for follow-up care and ensuring that appointments are scheduled, transportation arranged, etc.
 - Post-discharge contacts
 - Medication reconciliation
 - "Red-flag" education for the member and family/caregiver, as appropriate, about potential problems or relapse triggers
 - Disease-specific interventions
 - Transitional care is a short-term intervention strategy with the goals of reducing the member's risk of readmission and increasing the likelihood that they will make a successful transition back into the community.
- Complex care coordination:
 - Once a member is identified as having complex care coordination needs through the identification methods outlined above, the care coordinator attempts to engage the

member to conduct an assessment to determine the member's care coordination needs.

- The care coordinator works with the member and the member's family/caregiver as appropriate to identify goals that are expressed in member-friendly language.
- The care plan includes interventions that are agreed upon to achieve the member's goals.
- The care coordinator also obtains input from the member's PCMP and other specialty providers in developing the care plan.
- For members with mental health and/or SUD needs, the care coordinator ensures all needed behavioral health and medical care needs are integrated in a holistic manner by facilitating communication among treating providers and scheduling regular case conferences as required. The care coordinator may also use complex case rounds to obtain input on especially difficult integration issues.
- The care coordinator then monitors the member's progress at regular intervals, depending on the member's acuity, in meeting care plan goals. The care coordinator coordinates care and services with all treating providers and assists the member with community resource referrals. Contacts with the member may be done telephonically or through face-to-face contact, depending on the member's level of acuity.
- Care coordination continues until the care plan goals have been substantially met or there is agreement with the member/family/caregiver, as appropriate, that further care coordination is not indicated.

Post-Discharge Outreach, Diversion Plans, and Crisis Assessments

When clinically indicated, CCHA encourages providers conducting crisis assessments for members at risk for admission to higher levels of care to carefully consider the opportunity for developing diversion plans, with appropriate member and family/caregiver involvement, to assist the member in safely achieving stabilization at a lower level of care.

The provider should contact the member/family/caregiver as appropriate and as soon as possible following the diversion to offer needed outpatient services.

To ensure that the least restrictive environment is considered for our members, CCHA recognizes the importance of diversion planning. The Colorado Crisis Services system offers an array of options that support the safety of the individual as well as the efficacy of the intervention, while avoiding inpatient stays when not clinically indicated. When considering diversion options through the Colorado Crisis Services, CCHA will consider assessments equivalent and acceptable for clients, regardless of the modalities offered or rendering facility.

The following diversion options are available through the Colorado Crisis Services. Information on how to access these services can be obtained by calling **988** or visiting coloradocrisiservices.org.

- **Mobile Crisis Response (MCR):** Mobile crisis services provide a timely, in-person response to a behavioral health crisis in the community. Mobile crisis services must collaborate with telephone crisis services, walk-in crisis services, and crisis residential and in-home respite

services. MCR is intended to serve as the primary intervention within the statewide crisis system. An MCR strives to meet the needs of individuals and families in the community who are experiencing a behavioral health crisis and would derive benefit from a face-to-face clinical assessment and targeted interventions. MCR services aim to reduce or ameliorate current crises experienced by individuals and families in the location where the crisis is occurring. A Mobile Crisis Team (MCT) will be dispatched to serve all individuals determined by the Crisis Line or other points of crisis contact to be in need of face-to-face clinical services pursuant to C.R.S. 27-60-103 (1)(b)(III). Mobile Crisis Teams must be available 24/7/365.

- **Walk-in Crisis Center:** Walk-in crisis services facilities offer confidential, in-person support for anyone experiencing a self-defined crisis. Every walk-in crisis services facility must have the ability to provide information and referrals to anyone in need, including, if appropriate, access and clinically appropriate transportation to crisis stabilization for up to five days in a crisis stabilization unit.
- **Community Clinic (CC):** A CC is designated by the Office of Behavioral Health to provide services pursuant to 27-65-101 C.R.S. A CC Crisis Stabilization Unit (CSU) is distinguished as a facility with delayed egress and intensive support. The individual's clinical presentation is voluntary or involuntary (but not an elopement risk), must be nonviolent and able to respond to verbal redirection with no active intent to harm themselves or others. This level may be available to adults or children/adolescents.
- **Respite:** Respite services provide a protective environment in which the client receives support, structure, and supervision. Crisis Respite Services are provided both in the client's home and in residential facilities, which offer additional support in a safe and neutral environment pursuant to C.R.S. 27-60-103 (1)(b)(IV). Admission to Crisis Respite Services is appropriate for individuals who cannot meet therapeutic goals in a less restrictive environment. All respite services are voluntary, and clients must be able to maintain safety and behavioral control with minimal to no intervention. Clients admitted to Respite Services have the ability to effectively function in their daily lives with minimal to moderate support.
- **CSU:** CSU means a facility utilizing a restrictive egress alert device, which serves individuals requiring 24-hour intensive behavioral health crisis intervention for up to five days and cannot be accommodated in a less restrictive environment. CSUs are licensed by the Colorado Department of Public Health and Environment as an acute treatment unit, pursuant to 6 CCR 1011-1, Chapter 6, or as a CC, pursuant to 6 CCR 1011-1, Chapter 9. Crisis Stabilization Services shall serve individuals who require intensive behavioral health crisis intervention and treatment, including medication evaluation and management, for up to five consecutive calendar days and who cannot be accommodated in a less restrictive environment.

In addition to the above, Acute Treatment Unit could be an appropriate alternative for members in crisis who are not requiring inpatient hospitalization, but are in need of intense and individualized services. This level of care can be requested through the CCHA prior authorization process, as defined in Chapter 5 of this manual.

- **Acute Treatment Unit (ATU):** ATU means a designated facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment. An ATU provides a 24-hour, therapeutically planned, and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, that are available on an outpatient basis, as defined in 27-65-102(1), C.R.S. An ATU is designated by the Office of Behavioral Health to provide services pursuant to C.R.S. 27-65-101 et. seq. and has the capacity, physical plant, and policies and procedures to use seclusion, restraint, emergency medication, and all other services as defined in C.R.S. 27-65-101 et. seq. C.R.S. and 2 CCR 502-1, Section 21.280.4 (2017); 27-65 designated by the Office of Behavioral Health and with the capacity, physical plant, and policies and procedures to use seclusion, restraint, emergency medication, and all other services as defined in 27-65, C.R.S. and 2 CCR 502-1, Section 21.280.4 (2017). An ATU is distinguished as a locked unit, providing seclusion, intensive support, and emergency medications. The individual's clinical presentation is voluntary or involuntary, has active intent to harm themselves during treatment, needs intensive de-escalation, or has difficulty understanding and/or responding to verbal requests or redirection.

Clinical Practice Guidelines

All providers have ready access to evidence-based clinical practice guidelines for a variety of behavioral health disorders, including ADHD, bipolar disorder for adults and adolescents, major depressive disorder, schizophrenia, and SUDs, as well as evidence-based information on the use of psychotropic medications. See the [Clinical Practice Guidelines](#) section for more information.

Coordination of Behavioral Health and Physical Health Treatment:

- CCHA emphasizes the coordination and integration of physical and behavioral health services wherever possible. Key elements of the CCHA model of coordinated care include:
 - Ongoing communication and coordination between PCMPs and specialty providers, including behavioral health (mental health and substance use) providers.
 - The expectation that providers screen for co-occurring disorders, including:
 - Behavioral health screening by PCMPs.
 - Medical screening by behavioral health providers.
 - Screening of mental health patients for co-occurring SUDs.
 - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders.
 - Screening tools for PCMPs and behavioral health providers can be located at CCHAcare.com/providertools.

- Referrals to PCMPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders.
- Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans.
- Care coordination and disease management programs to support the coordination and integration of care between providers.
- As a CCHA network provider, you're required to notify a member's PCMP when a member first enters behavioral health care and anytime there is a significant change in care, treatment, or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
 - Patient demographics.
 - Date of initial or most recent behavioral health evaluation.
 - Recommendation to see a PCMP if medical condition is identified or the need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments).
 - Diagnosis and/or presenting behavioral health problem(s).
 - Prescribed medication(s).
 - Vital signs.
 - Allergy/drug sensitivity.
 - Pregnancy status.
 - Behavioral health clinician's name and contact information.

Provider Training

CCHA must monitor and ensure all participating providers who deliver behavioral health services provide relevant staff with training in accordance with Colorado HCPF requirements. As a contracted provider of CCHA, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, CCHA will implement measures to monitor compliance with training requirements.

Additional Training

CCHA will present training programs for PCMPs and behavioral health providers on topics related to the coordination of behavioral health and physical health care. Some of these training events will include the opportunity for providers to obtain CME/CEU credit for participation. Consult the CCHA website at CCHAcare.com/providertools for a schedule of these training events.

Quality of Care Grievance (QOCG) Reporting and Management

CCHA has a quality of care grievance reporting and management system for incidents and quality of care concerns that occur where a member is receiving services. As a participating CCHA provider, you will be required to participate in quality of care grievance reporting.

QOCG are those events considered critical or adverse in nature, including significant events or conditions that may be of public concern and/or reasonably perceived as jeopardizing the health, safety, and/or welfare of members, providers, and/or staff.

QOCG categories include unexpected death (not due to natural causes), physical and/or sexual assault, hospitalization for a suicide attempt or self-inflicted injury, elopement from court-ordered treatment, breach of confidentiality, medication diversion, and other incidents deemed critical by the Program/Agency/Facility Director.

Providers must immediately take steps to prevent further harm to all members and respond to any emergency needs of members.

Providers must report QOCGs to CCHA in accordance with applicable requirements and as outlined in the provider agreement. The maximum timeframe for reporting to CCHA is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency, or entity making the initial report will submit a follow-up written report within 48 hours.

Suspected abuse, neglect, and/or exploitation of members must be immediately reported to the appropriate agency. Reports of suspected child abuse and dependent abuse must be made by calling the Colorado Abuse Hotline at **1-844-264-5437**.

Reports can be sent to CCHA via secure fax: **1-303-256-1834** or via email to HealthTeam@CCHAcared.com.

Steps for Reporting a Quality-of-Care Concern

Complete the CCHA [Quality of Care Concern Notification form](#). The CCHA form is available on the CCHA website at [CCHAcared.com/providertools](https://www.cchacared.com/providertools) under the CCHA Quality of Care Concerns Reporting for Providers tab.

For questions about Quality of Care Grievance Reporting, contact HealthTeam@CCHAcared.com. Providers must cooperate with any investigation conducted by CCHA or outside agencies (for example, Adult Protective Services, Child Protective Services, and Law enforcement).

QOCGs will be tracked, trended, and presented in redacted form to the Quality Improvement Committee for review.

CHAPTER 5: COVERED & NONCOVERED SERVICES

Covered Services

For the most up-to-date information on covered services, refer to [CCHAcared.com](https://cchacares.com). Because covered benefits periodically change, verify coverage before providing services.

For benefits available from out-of-network providers, contact CCHA Provider Support Services at **1-855-627-4685** to determine the requirements.

State-Covered Services

Some services are covered by the state instead of CCHA. These services are labeled as carved-out services. Although CCHA does not cover these services, providers and specialists must provide all required referrals and assist in setting up these services. For more information, refer to the state website at colorado.gov/hcpf.

Services Requiring Prior Authorization

For the most up-to-date information on prior authorization requirements, refer to [CCHAcared.com/bhprovidertools](https://cchacares.com/bhprovidertools). View detailed information regarding the Availity tool on Availity Essentials. The Availity tool allows providers to inquire about and submit prior authorization requests online via Availity Essentials. Go to [CCHAcared.com/bhprovidertools](https://cchacares.com/bhprovidertools) > **Availity Essentials**.

Out-of-network providers are required to pre-authorize services before the service is provided, except in the case of an emergency.

Providers may also use the Precertification Look Up Tool in Availity Essentials to confirm if outpatient services require a prior authorization/precertification. Log in to [Availity.com](https://availity.com) > **Payer Spaces** > **CCHA** > Under the *Application* heading, select **Precertification Look Up Tool**.

Fee-for-Service Billing

In certain circumstances, CCHA providers will need to bill fee-for-service (FFS) through Colorado Department of Health Care Policy and Financing (HCPF)'s fiscal agent, DXC, for rendered services instead of billing CCHA. These circumstances may include:

- When a Health First Colorado member under the age of 21 needs a medically necessary service that is not covered by the RAE (refer to HCPF's webpage on EPSDT for more information: hcpf.colorado.gov/epsdt).

In order for a member to receive FFS behavioral health benefits, they must meet one of the following requirements:

- The member does not have an active RAE enrollment or,
- The member is being treated for a condition that is not covered by the RAE.

If you have questions regarding whether a claim needs to be billed through FFS or are experiencing denials due to an above circumstance, contact to your dedicated Provider Experience team member. If you do not know your Provider Experience associate, reference the **Behavioral Health Provider Contact List**. Go to CCHAcares.com/bhprovidertools > **Manuals and Resources** > **Behavioral Health Provider Contact List**.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents aged 20 and under as specified in Section 1905(r) of the Social Security Act.

CCHA arranges for the provision of all medically necessary services under EPSDT, which include vocational services, intensive care coordination, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, and respite services. CCHA provides referral assistance for treatment not covered by the plan but deemed necessary as a result of conditions disclosed during screening and diagnosis. CCHA assists with transportation and scheduling appointments for services if requested by the member/family. CCHA makes use of appropriate state health agencies and programs, including vocational rehabilitation, maternal and child health, public health, mental health, and education programs; Head Start social services programs and Women, Infants and Children (WIC) supplemental food program. Should barriers exist related to navigating and/or accessing the EPSDT benefit, CCHA provides assistance to providers and members via Member Support Services, CCHA Provider Support Services, and the Care Coordination teams.

CCHA network providers must be aware of their responsibilities regarding the provision of all applicable required components of the capitated behavioral health benefit related to EPSDT, specifically:

- The provision of all appropriate mental and/or behavioral health developmental screenings.
- The provision of all diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure.

CCHA may use materials developed by HCPF to inform its network providers about the benefits of well-childcare and EPSDT. Any trainings or updates related to EPSDT will be communicated to providers through the CCHA website, as well as the provider newsletter, on at least a biannual basis.

EPSDT maintains its own definition of medical necessity that differs from other medical necessity definitions.

EPSDT medical necessity: a service, procedure, or supply that:

- 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. Assists the member to achieve or maintain maximum functional capacity.
- c. Is provided in accordance with generally accepted professional standards for health care in the United States.
- d. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
- e. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
- f. Is delivered in the most appropriate setting(s) required by the member's condition.
- g. Provides a safe environment or situation for the member.
- h. Is not provided for experimental or investigational purposes.
- i. Is not more costly than other equally effective treatment options.

Telehealth

Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video, or interactive data communication instead of in-person contact.

Telemedicine includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission). Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.

Telemedicine services may be provided under two arrangements:

1. The first arrangement is when a member receives services via a live audio/visual connection from a single provider. This is the predominant arrangement for telemedicine.
2. The second arrangement is when a member and a provider are physically in the same location, and additional services are provided by a second (distant) provider via a live audio/visual connection. In this arrangement, the provider who is present with the member is called the "originating provider," and the provider located at a different site, acting as a consultant, is called the "distant provider."

The member must be present during any telemedicine visit.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education, and other provider training sessions.

To find out more about telehealth, or for contracting questions, call CCHA Provider Support Services at **1-855-627-4685**.

Requirements for telemedicine services include:

- Services can be provided between a member and a distant provider when a member is in their home or another location of their choice. Additionally, the distant provider may participate in the telemedicine interaction from any appropriate location.
- The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service.
- Providers may only bill procedure codes that they are already eligible to bill.
- Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.
- Providers must document the member's consent, either verbal or written, to receive telemedicine services.
- Contact with the provider must be initiated by the member for the service rendered.
- The availability of services through telemedicine in no way alters the scope of practice of any health care provider, nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law.
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine.
- The use of telemedicine does not change prior authorization requirements that have been established for the services being provided.
- Record-keeping and patient privacy standards should comply with normal Medicaid requirements and HIPAA.

Telemedicine does not include consultations provided by facsimile machines, text, email, or instant messaging.

Service Standards

- **Access:** CCHA pays for telehealth care services delivered by care providers contracted with the health plan. The telehealth providers must confirm member eligibility every time members access virtual visits, similar to in-person visits.
- **Staffing Credentials:** All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education, and/or experience in accordance with state and federal laws.
- **Staff Orientation and Ongoing Training:** The telehealth providers must comply with all applicable state, federal, and regulatory requirements relating to their obligations under contract with CCHA. Telehealth providers must participate in initial and ongoing training programs, including policies and procedures.
- **Service Response Time:** The telehealth provider will comply with the response time requirements outlined.
- **Compliance & Security** — The telehealth platform should be HIPAA compliant and meet state, federal, and 508 compliance requirements. The telehealth providers will conduct all member Virtual Visits via interactive audio and/or video telecommunications systems using a secure technology platform and will maintain member records in a secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.
- **Certification:** CCHA strongly encourages providers to obtain CHIQ, URAC, or ATA accreditation.
- **Regulatory Assessment Results:** CCHA reserves the right to request access to any applicable regulatory audit results.
- **Utilization:** The telehealth provider will comply with the reporting requirements outlined in their contract.
- **Electronic Billing/Encounter Coding:** The telehealth provider will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.
- **Eligibility Verification:** The telehealth provider will use existing eligibility validation methods to confirm Virtual Visit benefits.
- **Case Communication:** The telehealth provider will support patient records management for Virtual Visits using existing EMR systems and standard forms. Its EMR records should contain required medical information, including referrals and authorizations.
- **Professional Environment:** The telehealth provider will help ensure that, when conducting Virtual Visits with members, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct member Virtual Visits in vehicles or public areas.

All laws regarding the privacy, security, and confidentiality of health care information and a patient's rights to their medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support health care when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means, i.e., live audio/video feed. Participating providers and facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such a platform must, at a minimum, include technical, administrative, and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law, utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act ("HIPAA").

CHAPTER 6: MEMBER ELIGIBILITY

How to Verify Member Eligibility

Real-time member enrollment and eligibility verification for Health First Colorado is available 24/7 by calling the hotline or using the website to determine the member's specific benefit plan and coverage:

- Website: hcpf.colorado.gov/providers:
 - Resource guide for verifying member eligibility: [Verify Member Eligibility and Co-Pay | Department of Health Care Policy and Financing](#)
 - Automated voice response: **1-844-235-2387** (24/7)
- To verify member eligibility, log on to Availity Essentials at [Availity.com](https://www.availity.com) (limited to CCHA members only).
- From Availity Essentials, select **Patient Registration > Eligibility & Benefits**.

CHAPTER 7: CLAIMS SUBMISSION & GUIDELINES

Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, CCHA has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service, and electronic data processing agents:

- Submit clean claims, making sure the required information is in the appropriate field on the claim form.
- Submit claims within the contracted filing time limit of 120 days from the date of the service.
- Submit claims as soon as possible after providing service.

Submitting Clean Claims

Claims are defined as clean when they are submitted without any defects, with all required information required for processing and in the timely filing period.

A claim submitted with incomplete or invalid information may be rejected. If you use Electronic Data Interchange (EDI), claims will be rejected for incomplete or invalid information. Claims may be rejected if they are not submitted with the proper HIPAA-compliant code set. For claims submitted via EDI, an error report would be generated by the provider's clearinghouse and sent to the provider for claims not accepted. If a paper claim is submitted, you will receive a letter advising you of the error; paper claims will no longer be returned to protect PHI. You and your staff are responsible for ensuring claims are corrected and submitted as an original claim until the claim is shown as accepted.

While CCHA makes every effort to deny claims if they are not billed using correct coding guidelines and with the direction provided in the State Behavioral Health Services Billing Manual per state statute, under certain circumstances, we are required to recoup overpayments. CCHA recommends that providers consult the current State Behavioral Health Services Billing Manual for guidance on billing and coding claims.

Generally, there are two types of claim submissions, Professional or Institutional, which you'll need for reimbursement. Submissions are available in electronic, web portal, and hard copy/paper formats (see Claims Submission Methods section for details). Not using one of the methods correctly or completely causes the claim to be returned or rejected, resulting in processing and payment delays.

Electronic Submissions

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advice (835), allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity Essentials for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity Essentials EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit [Availity.com](https://www.availity.com) > **Provider Solutions** > **EDI Clearinghouse**.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity Essentials EDI Gateway).

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse, billing vendor or Availity Client Services at **1-800-AVAILITY (1-800-282-4548)**.

Availity Essentials EDI Payer ID

Colorado Community Health Alliance (CCHA) Payer ID is COCHA

Note: If you use a clearinghouse, billing service or vendor, work with them directly to determine the payer ID.

Electronic Remittance Advice (ERA)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity Essentials to register and manage ERA account changes with these three easy steps:

1. Log in to [Availity.com](https://www.availity.com)
2. Select **My Providers**
3. Select **Enrollment Center** > **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, work with them on ERA registration and receiving your ERAs.

Contact Availity

Contact Availity Client Services with any questions at **1-800-AVAILITY (282-4548)**.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and faster way to receive payment, reducing administrative processes. An EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (enrollsafe.payeehub.org) to register and manage EFT account changes.

EDI Submission for Corrected Claims

For corrected electronic claims, use the following frequency code:

- 7 – Replacement of Prior Claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Work with your vendor on how to submit corrected claims.

Useful EDI Documentation

- **Availity Essentials EDI Connection Service Startup Guide:** This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity Essentials, from registration to ongoing support.
- **Availity Essentials EDI Companion Guide:** This Availity Essentials EDI Guide supplements the HIPAA TR3s and describes the Availity Essentials Health Information Network environment, interchange requirements, transaction responses, acknowledgments, and reporting for each of the supported transactions as related to Availity Essentials.
- **Availity Essentials Registration:** Availity Essentials register page for users new to Availity Essentials.
- **Washington Publishing Company:** X12 code descriptions used on EDI transactions.

Claim submissions through Availity Essentials

Availity Essentials offers a variety of online functions to help you reduce administrative costs, eliminate paperwork, and decrease phone calls. Providers must register with Availity Essentials to access the secure portion of the website. Once registered, you can log in to a single account and perform numerous administrative tasks for members covered by CCHA or other selected payers.

Single claim submissions can be made by logging into [Availity.com](https://www.availity.com) > **Claims & Payments** > **Professional or Institutional claim**. Providers also have the option to submit corrected claims and upload attachments using this method.

Providers can confirm the status and payment details of their claims by logging in to [Availity Essentials](https://www.availity.com/essentials) with their username and password. When viewing the status of a claim, there may be options available to submit medical records or an itemized bill or dispute the claim. From Availity Essentials home page, select **Claims & Payments**> **Claim Status** or **access Chat with Payer** through *Availity Essentials Payer Spaces*.

Submit your attachments using any of the following methods:

- Submit a PWK segment with your electronic claim and either submit documentation using the EDI 275 transaction or by going to [Availity.com](https://www.availity.com) > **Claim & Payments** > **Claims** > **Attachment New**.

Locate your PWK intake in the Attachment Dashboard inbox and upload your documentation. The PWK intake will be available for seven calendar days.
- Locate your claim using Availity Essentials Claim Status by navigating to **Claims & Payments** > **Claim Status** > select Attachment button and upload your documents. You can view the status of the attachment by navigating to **Claims & Payments** > **Attachment New**.
- Submit an online claim submission using Availity Essentials. Navigate to **Claims & Payments** > **Professional or Institutional claim** > attach your documentation directly to the online claim form.

For more information about Availity Essentials, such as how to register, training opportunities, and more, visit [Availity.com](https://www.availity.com). Providers may also access Availity Essentials from our website at [CCHAcared.com](https://www.cchacares.com) by selecting **Behavioral Health Claims Portal** in the top -right corner.

Reference our training document online at [CCHAcared.com/bhprovidertools](https://www.cchacares.com/bhprovidertools) > **Availity Essentials** > **How to Submit a Claim using Availity Essentials** for step-by-step instructions on how to submit a claim through the web portal submission process.

Paper Submissions

We do not recommend paper submissions; we offer free electronic claims submission via [Availity.com](https://www.availity.com).

If electronic or web portal cannot be submitted, then paper claims can be used with the following forms:

- CMS-1500 for professional services: [cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1188854](https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1188854).
- CMS-1450 (UB-04) for institutional services: [cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1196256](https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms1196256).

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets CMS standards.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- **Do not stamp or write over boxes on the claim form.**
- Do not use whiteout or correction tape.
- Send the original claim form to CCHA and retain a copy for your records.
- Do not staple original claims together; CCHA will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a quarter-inch border on the left and right sides of the form after removing the perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- If using a dot matrix printer, do not use “draft mode” because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

Submit paper claims to:

Colorado Community Health Alliance
Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

If you submit paper claims, you must include the following provider information:

- Provider name
- Rendering provider group and billing provider
- Federal provider TIN
- NPI

Note: Some claims may require Coordination of Benefits (COB) information. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper.

After filing a paper claim, you will typically receive a response from CCHA within 30 business days but no later than 45 days after we receive the paper claim. If the claim contains all required information, CCHA enters the claim into the claims system for processing and sends you either a remittance advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

National Provider Identifier (NPI)

The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the state in which they practice or their specialty. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI was established to improve efficiency and reduce fraud and abuse. All CCHA participating providers must have an NPI number. NPIs are divided into two types:

- **Type one:** Individual providers, including, but not limited to physicians, dentists, and chiropractors
- **Type two:** Hospitals and medical groups, including but not limited to hospitals, group practices, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- If you have a type two NPI, it is required that you submit it in addition to your type one NPI when submitting claims to CCHA.

The Department (HCPF) requires all providers to adhere to the Colorado NPI law. Failure to do so can cause claims rejections, denials, or recoupment.

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov. Or request a paper application by calling NPPES at **1-800-465-3203**.

The following websites offer additional NPI information:

- CMS: cms.gov
- NPPES: nppes.cms.hhs.gov
- Workgroup for Electronic Data Interchange: wedi.org
- National Uniform Claims Committee: nucc.org

Enrollment in Colorado Medicaid

To be reimbursed for services by CCHA, providers must successfully complete Colorado Medicaid's provider enrollment process. Providers enroll by completing an online enrollment application at colorado.gov/hcpf/providers. All NPIs for all services and service locations must be registered with Medicaid.

Claim Filing Limits

Filing limits are determined as follows:

- If CCHA is the primary payer, the time period is 120 days from the date of service.
- If CCHA is the secondary payer, the time period is 365 days from the date of service.
- For corrected claims, the time period is 365 days from the date of service.

The time period is determined from the last date of service on the claim through the CCHA receipt date. Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied for timely filing.

Note: CCHA is not responsible for a claim that was never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

The following table outlines which form to use for different services and the time limit to file.

Claim Forms and Filing Limits

Refer to the provider contract to confirm the time limits to file.

Form	Type of Service to be Billed	Time Limit to File
CMS-1500	Physician and other professional services; specific ancillary services, including the following:	120 days from service date
	• Clinics • Community mental health clinics • Behavioral health providers	
	Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	
UB-04	Hospitals, institutions, federally qualified health clinics and home health services	120 days from service date

Retro-Eligibility of Members

Description	Time Frame
In instances where a member is made retro-eligible to CCHA, the provider must submit the claims within 90 days of the date that they are made retro-eligible. However, the provider is responsible for obtaining authorization for services on a go-forward basis.	Submit the claim within 90 days of the date the member is made retro-eligible. The claims may deny for timely filing initially, and a reconsideration may be requested per the Claims Payment Reconsideration and Dispute Process.

Check claim status at any time by calling CCHA Provider Support Services or accessing Availity Essentials at CCHAcared.com/bhprovidertools. Refer to the [Monitoring Submitted Claims](#) section of this chapter for details.

Claims from Noncontracted Providers

The filing limit for out-of-network provider submissions of claims to the contractor is 12 months from the date of service. This conforms with the filing limit under the Medicaid state plan (42 C.F.R. § 447.45d4).

CCHA accepts the following claims from noncontracted providers under certain conditions and within certain time frames:

- Emergency services: 365 days from date of service or discharge date
- Medicaid-enrolled out-of-state providers can enroll with Colorado Medicaid in certain circumstances: 365 days with prior authorization if services are not available in Colorado

Billing Members

Providers contracted with CCHA may not balance bill members for covered services above the amount CCHA pays to the provider.

CCHA does not hold its members liable for:

- Its debts in the event of CCHA's insolvency.
- Covered services provided to the member for which the state does not pay CCHA.
- Covered services provided to the member for which the state or CCHA does not pay the provider that furnishes the service(s) under a contractual, referral, or other arrangement.
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the contractor provided the services directly.

Colorado state law (C.R.S. § 25.5-4-301(I)) prohibits the billing of members for services that are covered by Medicaid, regardless of whether CCHA reimburses the provider for the service.

Coordination of Benefits

If a member carries insurance through multiple insurers, CCHA will coordinate the benefits to ensure maximum coverage without duplication of payments. As Medicaid is the payor of last resort under Federal regulations, providers must submit coordination of benefits (COB) claims to the primary carrier before submitting them to CCHA. After submitting the claim to the primary carrier, submit a claim for the total billed charges to CCHA, along with a copy of the primary carrier's remittance advice (RA). Indicate the Other Coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other health care program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be denied and should be submitted to the other health care program first. Make sure the information you submit explains all coding listed on the other carrier's remittance advice or letter. We will deny the claim without this information. Providers that are not contracted with a member's primary carrier at the time of service are subject to having their secondary claims denied by CCHA, even if they are contracted with CCHA and the member is attributed to CCHA.

Cost Avoidance Exceptions

Providers are not always required to coordinate first with the liable third party. In the following situations, we will first pay the provider and then coordinate with the liable third party: i) when the claim is for prenatal care for a pregnant woman; ii) when the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the state Title IV-D agency, and the provider of service has not received payment from the third party within 30 calendar days after the date of service; or iii) when the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Coordination of Benefits Agreement

CMS developed the Coordination of Benefits Agreement (COBA), which standardizes the way eligibility and Medicare claims payment information within a claims crossover context is exchanged. In accordance with our participation in this agreement, we submit our Medicaid enrollment data to CMS to obtain Medicare claim payment information. The exchange is used to create a claim to process the coordination of benefits.

The COBA allows greater efficiency and simplification via consolidation of the claims crossover process; the provider does not need to submit any Medicare primary claim to the secondary carrier for reimbursement.

Subrogation

For personal injury and workers' compensation claims: If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill Medicaid for services provided without regard to the possible liability of another party or the employer. Alternatively, the provider may elect to seek payment by joining in the recipient's personal injury claim or workers' compensation claim, but in no event may the provider seek payment from both Medicaid and a personal injury or workers' compensation claim. After the provider accepts the Medicaid payment for services provided to the recipient, the provider cannot seek or accept payment from the recipient's personal injury or workers' compensation claim.

Providers must choose which method of payment they will pursue at the time of treatment and submit claims either to CCHA or to the member's personal injury/workers' compensation carrier. The law does not allow providers to submit claims to both carriers. If a provider submits to both carriers, receives payment from both carriers, and subsequently sends a refund to CCHA, submission of the refund still could be considered a fraudulent action. Seeking or accepting payment from both carriers is prohibited by law.

CCHA agrees to first pay the provider and then coordinate with the liable third party. We will not require providers to bill the third party prior to CCHA in the following situations: i) the claim is for prenatal care for a pregnant woman; ii) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within 30 calendar days after the date of service; or iii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Claims Filed with the Wrong Plan

If you file a claim with the wrong insurance carrier, CCHA will process your claim within 120 days from the date of service. Claim dispute includes an explanation for the delay or other evidence that establishes the reason. CCHA will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. CCHA will contact the provider for clarification or additional information necessary to make a good cause determination.

Payment of Claims

After filing a paper or electronic claim, you will typically receive a response from CCHA within 30 days, but no later than 45 days after we receive the claim. If the claim contains all required information, CCHA enters the claim into the claims system for processing and sends you either a remittance advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

CCHA will finalize a clean electronic or paper claim within 20 days, 90% of the time, and 99% within 45 days from the date the claim is received.

A clean claim is one in which all information required for processing is present.

Monitoring Submitted Claims

After submitting paper or electronic claims and the claim is processed, you can monitor:

Checking claim status on [Availity.com](https://www.availity.com). From the Availity Essentials, select **Claims & Payments>**

Claim Status:

- Access Chat with Payer through Availity Essentials Payer Spaces.
- Call CCHA.
- Confirm receipt of Plan Batch Status Reports from your vendor/clearinghouse to ensure claims have been accepted by CCHA.
- Correct and resubmit Plan Batch Status Reports and error reports electronically.
- Correct errors and immediately resubmit to prevent denials due to late filing.

Claims Overpayment Recovery Procedure

Refund notifications may be identified by two entities — either CCHA/our contracted vendors or the providers. If CCHA/our contracted vendors identify the refund notification, we'll research and notify the provider of an overpayment and request a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by CCHA, CCHA will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment, a refund can be submitted to CCHA in the following options:

1. Submit overpayment back to CCHA via a check using the [Behavioral Health Refund Notification Form](#).
2. Submit overpayment back to CCHA via authorizing payment through future claims payments using the [Behavioral Health Recoupment Notification Form](#).

Forms are available online at CCHAcared.com/bhprovidertools > **Claims and Billing**.

For Federally Qualified Health Centers (FQHCs), in instances where we're required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. CCHA will determine the cumulative adjusted reimbursement amount based on the new rates. If the outcome of this reconciliation results in a net amount owed to CCHA, CCHA will work with the provider and provide the appropriate notice prior to the commencement of any recovery activities, including through an offset against future claims payments. Such recoveries are

not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act. The provision directly links the retention of overpayments to false claim liability.

The language of 42 U.S.C. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including triple damages. To avoid such liability, health care providers and other entities receiving reimbursement under Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

Provision 42 U.S.C. § 1320a-7k, entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the Healthcare Reform Act applies to providers of services, suppliers, and Medicaid MCOs.

Third-Party Recovery

Providers may not interfere with or place any liens upon the rights of the state of Colorado or CCHA (acting as Colorado’s agent) to recovery from third-party billing.

Claim Resubmissions

If you have not heard from CCHA regarding a submitted claim after 90 business days from the submission of the claim, contact us to determine the status. To determine whether you need to resubmit a claim:

- Check the secure provider website at [Availity.com](https://www.availity.com).
- Contact CCHA Provider Support Services at **1-855-627-4685**.
 - Providers or facilities, select **1**
 - Select **2** for calls regarding behavioral health (BH) claims payments, appeals, or other provider-related items.

Corrected Claim Submission Requirements

When submitting a correction for a previously billed claim on a CMS 1500 form or CMS 1450/UB04, include all services on the new submission. If any previously submitted changes or services are not billed on the corrected claim form, they will be removed in the adjustment. Any reduction in payment amount would result in a negative account balance and/or a refund request.

CCHA does not accept individual lines for correction on a CMS 1500 form; this mirrors the process for institutional replacement claims submitted on CMS 1450 claim forms.

Timely filing guidelines apply to all corrected and replacement claims. Clearly identify the corrected claim as such by referencing the original claim number and including “corrected claim” on the claim form.

Claims Payment Reconsideration and Dispute Process

Online (for reconsiderations and claim payment appeals): Use Availity Essentials Appeal functionality at [Availity.com](https://www.availity.com). Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgment of your submission.

Locate the claim you want to dispute using Claim Status from the Claims & Payments menu. Select Dispute Claim to initiate the dispute. From the Claims & Payments menu, select Appeals to locate the initiated dispute, upload supporting documentation, and submit.

For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you’ll need the Medical Attachments role.

For more information on the claim’s payment reconsiderations and disputes, refer to the [Reconsiderations, Disputes, Grievances, and Appeals](#) chapter.

Clinical Submissions Categories

The following is a list of claims categories for which we may routinely require submission of clinical information before or after payment of a claim. If the claim:

- Involves prior authorization, predetermination, or some other form of utilization review, including but not limited to claims that are:
 - Pending due to lack of prior authorization.
 - Involving medical necessity or experimental/investigative determinations.
- Requires certain modifiers or the use of certain modifiers that require documentation.
- Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, specific benefit exclusions.
- Involves possible inappropriate or fraudulent billing.
- Is the subject of an internal or external audit, including high-dollar claims?
- Involves individuals under care coordination or disease management.
- Is the subject of a dispute, including claims being mediated, arbitrated, or litigated?

Other situations in which clinical information might be requested include the following:

- | | |
|---|--|
| • Accreditation activities | • Recovery/subrogation |
| • Coordination of benefits | • Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues |
| • Credentialing | |
| • Quality improvement/assurance efforts | |

Note: Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Common Reasons for Rejected and Returned Claims

Many of the claims returned for further information are returned for common billing errors.

Problem	Explanation	Resolution
Incomplete or Incorrect Member ID	The member's ID number is incomplete or incorrect.	Use the member's ID number on the Health First Colorado card.
Duplicate Claim Submission	Overlapping service dates for the same service create a question about duplication. Claim was submitted to CCHA twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read EOPs and CDNs for important claim determination information before resubmitting a claim. Additional information may be necessary.
Missing Codes for Required Service Categories	Current HCPCS and CPT manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association (AMA) or the Practice Management Information Corporation.	Verify all services are coded with the correct codes (see lists provided). Check the codebooks. Review the codes in the State Behavioral Billing manual.
Unreasonable Numbers Submitted	Unreasonable numbers, such as "9999", may appear in the Service Units fields.	Check your claim for accuracy before submission.
Submitting Batches of Paper Claims	Stapling claims together may make the subsequent claims appear to be attachments, rather than individual claims.	Clearly identify each individual claim and do not staple to another claim.

Provider Reimbursement and Fee Schedules

CCHA takes state Medicaid reimbursement methodologies into consideration when determining provider reimbursements and monitors the state website for any changes in fee schedules at colorado.gov/hcpf/provider-rates-fee-schedule. CCHA will also use CMS methodologies and other external sources to establish rates, as applicable.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's CCHA benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes that indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, CCHA may:

- Reject or deny the claim
- Recover and/or recoup claim payment

CCHA reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, CCHA strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payment must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Schedules and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state, federal, or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a CCHA business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical coding

The Medical Coding Department ensures that correct coding guidelines have been applied consistently through CCHA. Those guidelines include but are not limited to: Correct modifier use, effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes), code editing rules, appropriately applied and within regulatory requirements, and analysis of codes, code definitions, and appropriate use.

Reimbursement by code definition

CCHA allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal, or CMS requirements.

CHAPTER 8: BILLING PROFESSIONAL & ANCILLARY CLAIMS

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow the CCHA professional and ancillary billing requirements. These requirements include using industry-standardized codes for most health services. This chapter is broken down into categories to help you find the specific requirements for each one.

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider's NPI number in Box 24J of the CMS-1500 form. Missing or invalid numbers may result in nonpayment or recoupment of payment.
- Submit only state-registered NPIs. Ensure all provider NPIs are kept updated with HCPF.
- Use the member's ID number from the Health First Colorado ID card.

Coding

To process claims in an orderly and consistent manner, we use standardized codes. HCPCS, sometimes referred to as national codes, provides coding for a wide variety of services. The principal coding levels are referred to as Level I and Level II:

- **Level I:** CPT codes maintained by the American Medical Association (AMA) and represented by five numeric digits.
- **Level II:** Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes are sometimes called alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier code(s) should accompany the Level I or Level II coding.

Reference guides useful for coding claims are:

- The CPT manual published by the AMA.
- The HCPCS manual published by CMS.
- The State Behavioral Health Services Billing Manual

Behavioral Health

Bill all claims for behavioral health services to CCHA. CCHA Behavioral Health has contracted with a network of hospitals, group practices, and independent behavioral health providers to offer behavioral health services to our members. When rendering medically necessary behavioral health services, bill CCHA using behavioral health CPT codes.

Emergency and Related Professional Services

Emergency services, as defined by state and local law, the provider agreement, and our member handbook, are reimbursed in accordance with the CCHA provider agreement.

Note: Prior authorization is not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member's health in serious jeopardy or, with respect to a pregnant woman, the health of the woman and her unborn child.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction to any bodily organ or part.

All members should be referred back to their PCMP for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

CMS-1500 Form

All professional providers and vendors should bill CCHA using the most current version of the CMS-1500 claim form, which is available at cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.

CHAPTER 9: BILLING INSTITUTIONAL CLAIMS

Overview

Billing for hospitals and other health care facilities and services can require special attention because major services have their own set of billing requirements. This chapter will take a look at specific coding guidelines for hospital and health care facilities.

Basic Billing Guidelines

In general, the basic billing guidelines for institutional claims submitted to CCHA include the following:

- Use HCPCS, CPT codes or revenue codes. Valid HCPCS, CPT, or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Provide medical records. Medical records for certain procedures may be requested for the determination of medical necessity. Use modifiers in accordance with your specific billing instructions.

Note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be rejected.

The following reference books provide detailed instructions on uniform billing requirements:

- CPT, published by the American Medical Association (AMA)
- HCPCS, National Level II (current year), published by CMS
- ICD (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. These requirements include room and board, including nursing care.

Note: Prior authorization is required for all admissions. Medical Management approval is required for all admissions.

CMS-1450 (UB04) Claim Form

All state-sponsored business-approved facilities should bill CCHA using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

- **Level I:** CPT codes determined by the AMA and represented by five numeric digits.
- **Level II:** Other codes identifying products, supplies, and services not included in the CPT codes, such as ambulance services and DME. These are sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level I or Level II coding.

CMS-1450 revenue codes are required for all institutional claims.

The CMS-1450 (UB-04) claim form is available at cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.

Institutional Inpatient Coding and Outpatient Coding

For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider's CPT manual published by the AMA.

For institutional outpatient coding, use the guidelines in the following code manuals:

- The CPT manual published by the AMA
- The HCPCS published by CMS

Note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

CHAPTER 10: RECONSIDERATIONS, DISPUTES, GRIEVANCES & APPEALS OVERVIEW

We encourage providers and members to seek resolution of issues through our grievances and appeals processes. Verbal complaints and written grievances are tracked and trended, resolved within established time frames, and referred to peer review when needed. The CCHA grievances and appeals process meets all state requirements, National Committee for Quality Assurance (NCQA) standards, and federal laws. The member, or the member's authorized representative, with written consent, has a right to be informed about:

- How to obtain a hearing and the representation rules involved.
- Filing grievances and appeals and the requirements and time frames for filing.
- Assistance is available with filing grievances and appeals.
- The toll-free number to file oral grievances and appeals.
- The right to request continuation of benefits during an appeal or state fair hearing (SFH) filing, although the member may be liable for the costs of any continued benefits if the action is upheld.
- Any state-determined appeal rights that allow individuals to challenge the failure of the organization to cover a service.

The building blocks of this resolution process are the grievance and the appeal.

The member or the member's authorized representative (including a provider with the member's written consent) can file a grievance or appeal.

CCHA does not discriminate against providers for filing a grievance or an appeal on the member's behalf. In addition, providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Grievances

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination, as defined below. Examples include but are not limited to:

- Access to health care services.
- Care and treatment by a provider.
- Issues with how we conduct business.
- The member is unhappy with the quality of the care.
- The doctor the member wants to see does not have a contract with us to provide services to the member.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by CCHA.
- Rights and/or dignity were not respected.
- The member is recommending changes in policies and services.
- Any other existing access to care issues.

The term is also used to refer to the overall system of grievances and appeals handled by CCHA, as well as access to the state fair hearing process.

The member may file a grievance at any time. Grievances must be submitted to us by phone or in writing. Members have the right to file a grievance regarding any aspect of our services. An urgent grievance is for urgent or emergency care services.

Members: Filing a Grievance

Our goal is to resolve verbal and written grievances in a timely and equitable manner and in accordance with state, NCQA, and federal regulations. Members are encouraged to discuss their concerns with a Member Support Services representative, who can help the member submit a grievance. The representative interviews the member and records details in the Member Services tracking system.

The member may file a grievance verbally with our Member Support Services department, or they can submit a written grievance at any time with as much information as possible, including:

- Who is part of the grievance?
- What happened?
- When did the incident happen?
- Where did the incident happen?
- Why was the member unhappy with the health care services?

The member may attach documents that will help us investigate the problem and should mail the written grievance to:

Colorado Community Health Alliance
Grievances
P.O. Box 13406
Denver, CO 80202

The following processes apply to grievances:

- We may request medical records or an explanation from the provider(s) involved in the case.
- We notify providers of the need for additional information in writing or by phone. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If a member is dissatisfied with the disposition of a grievance, the member may file the unresolved grievance with the Colorado Department of Health Care Policy and Financing.

The following are available at no cost to support members with the grievance and appeals process:

- Interpreter services
- Translation of materials into non-English languages and alternative formats
- Toll-free numbers with TTY/TDD capabilities to assist members who are hearing impaired

Members: Grievance Resolution, Notice, and Confidentiality

CCHA investigates the member's grievance to develop a resolution in a nondiscriminatory manner. After we make a determination, we send a resolution letter to the member outlining our findings.

We notify members of our grievances process in the member handbook. Members may request a translated version in languages other than English by calling **1-855-627-4685 (TTY 711)**.

All grievances are handled in a confidential manner, and we do not discriminate against a member for filing a grievance or requesting a state fair hearing.

Appeals

An **appeal** is a request for a review of an adverse benefit determination. It is a clear expression by the member, or the member's authorized representative, with written consent, following a CCHA decision that the member wants the decision reconsidered or reviewed. Examples of an adverse benefit determination or CCHA decisions a member may choose to appeal include, but are not limited to:

- Denial or limited authorization of a requested service, including the type and level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner as defined by the agency.
- Failure of CCHA to act within the required time frames set forth in the contract.
- For a resident of a rural area with only one MCO, the denial of the member's request to obtain services outside the network.

Providers may appeal on a member's behalf related to adverse determinations. This can only be done with the member's written consent. Written consent should be submitted along with appeal documents in order to ensure timely processing of the appeal.

Note: CCHA offers expedited appeals for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision-maker or involved in previous levels of review or decision-making. All information submitted will be taken into account. In cases of clinical care, decision-makers will have the appropriate clinical expertise in treating the member's condition or disease.

An **adverse benefit determination** is a denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity. It can mean any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner as defined by the state
- Failure of CCHA to act within the time frames in § 438.408(b) (1) (2)
- For a resident of a rural area with only one MCO, the denial of a member's request to exercise their right, under § 438.52(b) (2) (ii), to obtain services outside the network

CCHA informs members of their grievance, appeal, and state fair hearing rights in the member enrollment materials.

Members: Filing an Appeal

Members and authorized representatives have 60 calendar days to file an appeal from the date of the Notice of Adverse Benefit Determination letter. The request for an appeal may be verbal or written. Providers may submit appeals on a member's behalf with written consent from the member. When a provider, or provider on a member's behalf, expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal rather than a complaint. Written appeals should be mailed to:

Colorado Community Health Alliance
Behavioral Health Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

Fax: **-877-376-3194**

Email: BHAppealsIntake@Anthem.com

Verbal appeals may be requested by phone at **1-855-627-4685 (TTY 711)**.

Upon receipt of the notice of appeal, CCHA will send a written acknowledgment of receipt of the appeal to the member, member's representative, or both within two business days of receipt. We'll keep a copy of the acknowledgment of receipt of the appeal on file.

Note: Appeals for physical health services are handled by HCPF. The information in this manual is specific to behavioral health services.

CCHA complies with NCQA, state, and federal standards.

Appeals are divided into two categories:

- **Standard appeal:** The appropriate process when a member, or their representative, with written consent, requests that CCHA reconsider the denial of a service or payment for services, in whole or in part. Colorado's standard appeal process requires resolution within 10 business days of receipt of the written appeal request. The time frame for processing an appeal can be extended by up to 14 calendar days if the member requests an extension or if CCHA and the HCPF determine it's in the best interest of the member to extend the decision time frame.
- **Expedited appeals:** An expedited appeal may be requested when the amount of time necessary to complete a standard appeal process could jeopardize the member's life, health, or the ability to maintain or regain maximum function. Colorado's expedited appeal process requires resolution as expeditiously as the member's health condition requires, not to exceed 72 hours after receipt of the expedited appeal request. The time frame for processing an expedited appeal may be extended for up to 14 calendar days if the enrollee requests an extension or if CCHA and the HCPF determine there is a need for additional information, and the delay is in the best interest of the enrollee to extend the decision time frame.

Upon request, CCHA will provide members and their representatives with the member's case file, including medical records and any other documents or records considered during the appeals process, free of charge and sufficiently in advance of the appeal resolution time frame. The appeal decision notice will describe the actions taken, the reasons for the action, the member's right to request a state fair hearing, and the process for filing a state fair hearing request.

The appeal process must be exhausted through CCHA before a state fair hearing is granted. Once the appeal process is complete, a notice of decision will be issued by us and will identify further appeal rights, if applicable.

Members: Response to Standard Appeals

After CCHA receives a verbal or written appeal request, the Grievances and Appeals department takes the issue into consideration and investigates the case. The member, their representative, or the provider, on behalf of the member with written member consent, is given the opportunity to submit written comments and documentation relevant to the appeal. CCHA may request medical records or a provider's explanation of the issues raised in the appeal by phone or in writing, with a signed and dated letter. Members and providers, on behalf of the member, are expected to comply with the request for additional information within 10 days.

When the appeal is the result of a medical necessity determination, a physician reviewer of the same or similar specialty who was not involved in the initial decision and has experience treating

the condition being appealed reviews the case. The physician reviewer may contact the provider, if needed, to discuss possible alternatives.

Members: Resolution and Notice of Standard Appeals

Standard appeals are resolved within 10 business days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any.

If we extend the time frame and it was not at the request of the member, we must notify the member/representative in writing of the extension and the reason for the delay and must complete all of the following:

- Make reasonable efforts to give the member prompt oral notice of the delay
- Within two calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if they disagree with that decision
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires

Members: Expedited Appeal Requests

When an expedited appeal is requested, CCHA will inform the member and member's authorized representative of the limited time available to present evidence and allegations of fact or law. CCHA ensures punitive action isn't taken against a provider who either requests an expedited resolution or supports a member's appeal.

If CCHA denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution, which is 10 business days.
- Give the member prompt verbal notice of the denial and follow up within two calendar days with written notice.

CCHA may request medical records or a provider explanation of the issues raised in an expedited appeal by phone or mail, with a signed and dated letter. Providers are expected to comply with the request for additional information within 24 hours.

For notice of an expedited resolution, CCHA will make reasonable efforts to provide oral notice to the member and/or provider on behalf of the member. Written notice of the resolution will be issued in writing within two calendar days of the expedited appeal decision.

Members: State Fair Hearing

Members, or the member's representative, with written consent, may request a state fair hearing (SFH) after they have exhausted our internal appeal process. The request must be filed within 120 calendar days of the resolution letter.

Members, or the member's representative with written consent, may appeal in person, by fax or in writing to:

Colorado Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203
Fax: **1-303-866-5909**

Members (or the member's representative) may also call **1-303-866-2000**. For more information, go to colorado.gov/pacific/oac/public-benefits.

The process is as follows:

1. The state sends a notice of the hearing request to CCHA.
2. Upon receipt of the request, we forward all documents related to the request to the state.
3. The state schedules a hearing, which is held by teleconference unless the member requests an in-person hearing.
4. The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine witnesses and offer rebutting evidence.
5. An Administrative Law Judge renders a decision in the hearing.
6. If any party disagrees with the judge's decision, they can request a Director's review, and a decision will be rendered after the review is complete.
7. If our position is overturned, we must adhere to the final decision and ensure the decision is carried out.

If the member needs special arrangements to attend the hearing due to a disability or needs language translation services, call **-855-627-4685**.

All requests for a state fair hearing are handled in a confidential manner. We do not discriminate against a member, their representative, or provider acting on a member's behalf with written consent for requesting a state fair hearing. We notify members of the state fair hearing process in the member handbook; members may request a translated version in languages other than English.

Members: Continuation of Benefits During Appeal

CCHA provides for continuation of benefits/services when requested by the member (may not be requested by the provider due to potential financial implications) while the CCHA-level appeal is pending if:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The member files an appeal, defined as on or before the later of the following:
 - Within 10 calendar days from the date CCHA mailed the notice of adverse benefit determination.
 - The intended effective date of the proposed adverse benefit determination.
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits.

CCHA provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if:

- The SFH involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The originally approved services were ordered by an authorized provider.
- The member continued services during the appeal.
- The appeal resolution was adverse to the member.
- The member requests an SFH and requests continued services in a timely manner, defined as:
 - Within 10 days of CCHA mailing the notice of adverse appeal resolution

Note: the member must request continued benefits from the health plan while the filing for an SFH is done through the administrative courts. The health plan is required to help the member fill out the SFH form, if needed.

If, at the member's request, CCHA continues or reinstates the benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs (the end of the authorization period does not apply to when benefits end):

- The member withdraws the appeal or request for a State Fair Hearing
- CCHA issues an appeal decision adverse to the member **and** the member fails to request a continuation of benefits during an SFH within 10 calendar days after CCHA sends the notice of an adverse appeal resolution to the member.
- A State fair hearing officer issues a hearing decision adverse to the member.
- The service authorization expires, or the authorization limits are met.

Regarding the member's responsibility for continued services: CCHA may recover the cost of the continued services furnished to the member while the appeal or State Fair Hearing was pending if the final resolution of the appeal or State Fair Hearing upholds CCHA's adverse benefit determination.

Providers: Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the CCHA provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

There are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly below. They are:

- **Claim inquiry:** a question about a claim, but not a request to change a claim payment
- **Medical necessity appeals:** a pre-service appeal for a denied service; for these, a claim has not yet been submitted
- **Claims correspondence:** when CCHA requests further information to finalize a claim, typically includes requests for medical records, itemized bills, or information about other insurance a member may have

For more information on each of these, refer to the appropriate section in this provider manual.

The CCHA provider payment dispute process consists of two internal steps and a third external step. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the CCHA provider payment dispute process.
The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the CCHA provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Mediation and arbitration:** The state of Colorado supports an external review process if you have exhausted both steps in the CCHA payment dispute process but still disagree with the outcome.

A claim payment reconsideration may be submitted for multiple reasons, including:

- Contractual payment issues.
- Disagreements over reduced or zero paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues. *

* CCHA will consider reimbursement of a claim that has been denied due to failure to meet timely filing requirements if you can: 1) provide documentation that the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Providers: Claim Payment Reconsideration

The first step in the CCHA claim payment dispute process is called the reconsideration. It's your initial request to investigate the outcome of a finalized claim. Note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally, and through our provider website within 120 calendar days from the date on the Explanation of Payment (EOP) (see below for further details on how to submit). Reconsiderations filed more than 120 calendar days from the date of service will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical CCHA professionals.

CCHA will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by an additional 30 calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter that will include:

- Statement of the provider's reconsideration request.
- Statement of what action CCHA intends to take or has taken.
- Reason for the action.
- Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- Explanation of the provider's right to request a claim payment appeal within 60 calendar days of the date of the reconsideration determination letter.
- Address to submit the claim payment appeal.
- Statement that the completion of the CCHA claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

Providers: Claim Payment Appeal

If you're dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. We accept claim payment appeals through our provider website or in writing within 60 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 60 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, include as much information as you can to help us understand why you think the reconsideration determination was in error. Note, we cannot process a claim payment appeal without a reconsideration on file. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical CCHA professionals.

CCHA will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claim payment appeal request.
2. A statement of what action CCHA intends to take or has taken.
3. The reason for the action.
4. Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and EOP will be sent separately.

Providers: How to Submit a Claim Payment Dispute

We have several options when filing a claim payment dispute:

- **Online (reconsiderations and claim payment appeals):** Use the secure Provider Availity Essentials Payment Appeal Tool at [Availity.com](https://www.availity.com). Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgment of your submission. Locate the claim you want to dispute by selecting **Claim Status** from the *Claims & Payments* menu. Select **Dispute Claim** to initiate the dispute. From the *Claims & Payments* menu, select **Appeals** to locate the initiated dispute, upload supporting documentation, and **submit**.

For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you'll need the Medical Attachments role:

- **For training opportunities, log into [Availity.com](https://www.availity.com) > Help & Training > Get Trained.**
Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed, along with the Claim Payment Appeal Form or the Reconsideration Form, to:

Colorado Community Health Alliance
Provider Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599
- **Verbal (reconsiderations only):** Verbal reconsiderations may be submitted by calling CCHA Provider Support Services at **1-855-627-4685**.

Required Documentation for Claims Payment Disputes

CCHA requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their CCHA or Medicaid ID number
- A listing of disputed claims, which should include the CCHA claim number and the date(s) of service(s)
- All supporting statements and documentation

Providers: Mediation and Arbitration

If the provider is not satisfied with the outcome of a review conducted through the appeal process on the member's behalf, additional steps may be taken as stated in the provider agreement:

- Mediation
- Arbitration

If these processes have been exhausted and the provider has the member's consent, the provider may request a state fair hearing. For more information, see the [Members: State Fair Hearing](#) section.

Dissatisfaction or Concerns Relating to Plan Operations

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue, including claims processing and reimbursement.

Providers may contact CCHA regarding their concerns or dissatisfaction at any time, utilizing the [Provider Assistance Contact Form](#) located on our website. CCHA will respond to provider inquiries within two business days.

Providers are notified in writing of the issue resolution.

When to Expect Resolution for an Issue

CCHA will investigate and resolve provider issues within 60 business days of receipt of the explanation. For expedited issues, CCHA will investigate and respond within three business days of receipt to resolve.

Providers cannot file an appeal on their own behalf.

Providers: Substance Use Disorder Independent Review Organization

Per Senate Bill, SB 21-137, Section 9, you may request an independent review organization contracted with Health Care Policy and Financing (HCPF) to conduct an external medical necessity review when there is a denial or reduction for residential or inpatient substance use disorder treatment and the Medicaid appeals processes have been exhausted.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of a claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue. Contact the PSU by phone at **1-855-627-4685**:

- Providers or facilities, select **1**
- Select **2** for calls regarding BH claims payments, appeals, or other provider-related items.
- Select **3** for calls requesting authorization for BH services.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when CCHA requires more information to finalize a claim. Typically, CCHA makes the request for this information through the EOP. The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received, CCHA will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Electronic Rejected Claim(s)	Contact Availity Client Services at 1-800-282-4548 or work with your EDI vendor.
EOP Requests for supporting itemized bills and invoices)	Submit a Claim Correspondence Form, a copy of your EOP, and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a Claim Correspondence Form, a copy of your EOP, and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Corrected Claim Due to Errors or Changes on Original Submission	Submit a Claim Correspondence Form and your corrected claim via Availity Essentials or by mail to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to CCHA to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB. Use an EDI corrected claim For corrected electronic claims, the following frequency code: • 7 – Replacement of Prior Claim EDI segments required: • Loop 2300- CLM - Claim frequency code • Loop 2300 - REF - Original claim number Work with your vendor on how to submit corrected claims.

Type of Issue	What Do I Need to Do?
	Corrected Single claim submissions can be made by logging into Availity.com > Claims & Payments > Professional or Institutional claim . Use frequency code 7 and the original claim number as the Payer Claim Control Number.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a Claim Correspondence Form, a copy of your EOP, and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a Claim Correspondence Form, a copy of your EOP, and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical Necessity Appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

CHAPTER 11: CREDENTIALING & RECREDENTIALING

Overview

Credentialing is the process of validating the professional competency and conduct of providers and health delivery organizations. Providers and health delivery organizations must meet rigorous credentialing standards to be part of the CCHA provider network. The credentialing process involves verifying licensure, board certification, and education. The process also involves identifying malpractice or negligence claims through the applicable Colorado state agencies and the National Practitioner Database.

Note: CCHA may not contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act.

Providers rendering telehealth services must comply with all credentialing requirements stipulated in their provider agreements.

We require recredentialing every three years to stay current with your professional information. Recredentialing is also essential to our members, who depend on the accuracy of the information in the CCHA Provider Directory.

We streamlined the credentialing process by teaming up with the Council for Affordable Quality Healthcare (CAQH), which is nationally recognized for its thoroughness in collecting provider data. It is the medical director's or other designated physician's responsibility to participate in the credentialing program.

Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource (UPD)

CCHA encourages Colorado providers to use CAQH's UPD for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading health care plans and networks whose mission is to improve health care quality and access for more than 165 million Americans covered by these plans. The CAQH data collection system of 800,000 providers allows administrative requirements to be streamlined.

The UPD is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing paperwork for more than 550 participating health care plans. The UPD allows providers to fill out one application to meet the credentialing data needs of multiple organizations. For both CCHA and providers, recredentialing is helpful because this process:

- Supports CCHA administrative streamlining and paper reduction efforts.
- Helps to ensure the accuracy and integrity of the provider database.
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers.
- Enables providers to use the UPD database at no cost.

Our credentialing process for office-based providers is consistent with National Committee for Quality Assurance (NCQA) guidelines and the state of Colorado requirements to practice medicine. Practitioners are notified within 60 calendar days of the credentialing committee's decision.

Approved Provider Types

Practitioners who fall within the scope of credentialing are strongly encouraged to use the CAQH application, with the exception of health delivery organizations. CAQH will accept providers from among the following approved provider types (this list is not all-inclusive; we've only listed the standard provider types):

- Licensed clinical social workers
- Neuropsychologist (NEU)
- Psychiatrists
- Psychiatric nurse practitioners
- Psychologists
- Licensed professional counselors
- Licensed marriage and family therapists

Approved Health Delivery Organizations

All health delivery organizations falling within the scope of credentialing will use a facility/ancillary application:

- Hospitals
- Behavioral health facilities
- Community-based neurobehavioral rehabilitation

CAQH UPD Registration

First Time Users

CCHA providers must have a CAQH provider identification (ID) number to register and begin the credentialing process. Perform the following steps if you are not registered with CAQH:

1. After you obtain a CCHA provider record ID and submit a current signed CCHA agreement, CAQH will add your name to the roster.
2. You can log on to CAQH and register at caqh.org.
3. When you receive your CAQH provider ID, go to the CAQH website to complete your application. Providers who do not have Internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at **1-888-599-1771**.
4. After successfully authenticating key information, you will be able to create your own username and unique password to begin using the CAQH UPD database.

Note: Registration and completion of the online application are free.

Existing Users

If you are an existing CAQH/UPD user through participation in another health plan, log on to the UPD database and authorize CCHA to access your information by following these steps:

1. Go to the CAQH website at caqh.org.
2. Under **Providers**, select **Go to Universal Provider Datasource**. Then, enter your username and password.
3. Select the **Authorize** tab located under the CAQH logo.
4. Scroll down, locate **CCHA** and check the box next to **CCHA**, or select the **Global Authorization** option.
5. Select **Save** to submit your changes.

For more information about the CAQH UPD database and application process, visit the CAQH website.

Completing the UPD Application Process

The UPD standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, indicate which participating health care plans and health care organizations you authorize to access your application data. All of the data you submit through the UPD service is maintained by CAQH in a secure data center.

The following materials will be helpful while completing the UPD online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (Universal Provider Identification Number UPIN, NPI, Medicare, Medicaid, etc.)
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) certificate, if applicable
- Current Controlled and Dangerous Substances certificate, if applicable
- Internal Revenue Service (IRS) W-9 form(s)
- Current malpractice insurance face sheet
- Summary of all pending or settled malpractice cases within the past 10 years
- History of refusal or cancellation of professional liability insurance
- Curriculum vitae
- Disclosure of ownership

After completing the online credentialing application, you will be asked to:

- Authorize access to your information. Check the box next to CCHA or select the **Global Authorization** option.
- Verify your data entry and attestation for accuracy and completeness.
- Submit supporting documents:
 - State license(s) applicable to your provider type in each state in which you plan to provide care to members
 - Board certification or highest level of medical training or education
 - Work history of at least the most recent five years. Include explanations for any gaps in work history exceeding six months
 - Admitting privileges at a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Integrated Accreditation for Healthcare Organizations (NIAHO), American Osteopathic Association (AOA) or a network hospital previously approved by the committee
 - Current DEA certificate or plan to prescribe if no DEA certificate, if applicable
 - Current Controlled and Dangerous Substances certificate, if applicable
 - Copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the network provider agreement, consistent with State law requirements and CCHA policy.
 - Summary of all pending or settled malpractice cases within the past 10 years
 - Curriculum vitae
 - Current signed attestation
 - Written protocol (advanced nurse practitioners only)
 - Supervision form (physician assistants only)
 - Hospital coverage letter, required by CCHA from providers who do not have admitting privileges at a participating network hospital
 - State or federal license sanctions or limitations
 - Medicare, Medicaid or Federal Employees Health Benefits Program (FEHBP) sanctions
 - Disclosure of Ownership

If the credentials verification process indicates any discrepancies between the verification information and the information that was submitted by the participant, the practitioner has the right to:

- Review the information/supporting documents that were submitted in the provider application.
- Correct information after CCHA provides a written summary of the discrepancies. The written information should include the following:
 - Discrepancy information
 - Process to correct incorrect information
 - Time frame for submitting changes
 - Address
 - Review process

CCHA will notify practitioners of:

- Their right to be informed of the status of their application upon request.
- The information it is allowed to share with practitioners.
- Our process for responding to requests for application status.

The quickest, most efficient way of uploading these documents is directly to the CAQH portal at proview.caqh.org.

Note: While the CAQH credentialing data set is substantially complete, CCHA may need to supplement, clarify, or confirm certain responses on your application on a case-by-case basis. Providers may also submit additional documentation by email or mail if unable to upload to:

Email: Documents@Proview.CAQH.org

Mail: CAQH

P.O. Box 696537

San Antonio, TX 78269

If you have any questions about accessing the UPD database, you may contact the CAQH Help Desk for assistance at **1-888-599-1771**.

Additional CAQH Resources

CAQH contact information is as follows:

Phone: 1-888-599-1771 (Monday to Thursday, 7 a.m. to 9 p.m.; Friday, 7 a.m. to 7 p.m.)

Email: Documents@Proview.CAQH.org

Note: Providers with vision and/or hearing challenges may call the CAQH Help Desk and complete the application by phone.

Credentialing Updates

You must inform CAQH and CCHA of changes to your practice; our members rely on the accuracy of the information in our online Provider Directory. CAQH will send you automatic reminders to review and attest to the accuracy of your data every four months. If you are a participating provider, submit most changes online using the Change Your Information form available on the CAQH website at caqh.org.

Recredentialing

When you are scheduled for recredentialing, CCHA sends your name on the CCHA roster of providers to CAQH. We determine if you have completed the UPD credentialing process and have authorized CCHA to access your information or selected the Global Authorization option. If you have made this authorization, CCHA obtains your current information from the UPD database and completes the recredentialing process without contacting you.

If your recredentialing application is not available to CCHA through CAQH for any reason, CAQH mails you a Welcome Kit with access and registration instructions along with your personal CAQH provider ID. You may then obtain immediate access to the UPD database online to complete and submit your application. For detailed instructions, go to the [CAQH UPD Registration](#) section in this chapter. After you have been granted access to CCHA, recredentialing resumes.

CCHA notifies practitioners of their right to:

- Review information obtained from outside sources (for example, malpractice insurance carriers and state licensing boards) to support their credentialing application.
- Correct erroneous information.

We will also notify providers of the time frame and format for submitting corrections.

Where to Submit Corrections

We will document the receipt of corrected information in the practitioner's credentialing file. We are not required to reveal the source of information if:

- It was not obtained to meet verification requirements.
- Federal or state law prohibits disclosure.

CCHA remains responsible for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities. Compliance is monitored on a monthly/quarterly basis, and formal audits are conducted annually.

The CCHA credentialing committee:

- Uses participating practitioners to provide advice and expertise for credentialing decisions.
- Reviews credentials for practitioners who do not meet established thresholds.
- Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician.

Note: You must enter your changes into the UPD database and authorize access to CCHA during the credentialing and recredentialing process. Only health care plans participating in the UPD database and those to which you have granted access, receive these changes.

Professional Liability Coverage

To the extent allowed under applicable law or state agency requirements, verification of professional liability insurance coverage may be accomplished by the use of an attestation signed by the provider indicating the name of the carrier, policy number, coverage limits, the effective date, and expiration date of such insurance coverage.

If attestation is not acceptable, the practitioner's professional liability insurance information is verified by obtaining a copy of the professional liability insurance face sheet from the practitioner or from the insurance carrier. Practitioners are required under applicable law to maintain professional liability insurance in specified amounts. The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. NCQA requires practitioners to attest to the dates and amount of their current malpractice coverage, even if the amount is \$0.

Contracting Process for Hospital or Facility-Based Providers

Hospital or facility-based providers are not subject to credentialing. They are required to submit a request for contracting and participating in the CCHA network.

Hospital or facility-based providers must have the following:

- Colorado Medical Board license (temporary permit is acceptable) or appropriate licensure applicable to provider type Certificate/American Association of Nurse Anesthetists (AANA) number (applicable to CRNA providers only)
- Hospital privileges
- Type 1 NPI number
- Certificate/AANA number (applicable to CRNA providers only)

Note: Having a CCHA provider record ID does not automatically activate the Medicaid network. The effective date for CCHA providers is the date credentialing is complete and contracts are dually executed. A provider is considered participating and in-network on this effective date. Claims will be

processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid network.

To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections as appropriate.

Medical Group Adding a Provider

If you are part of a medical group with a Group Medicaid Agreement, and this group is adding you as a facility-based provider, complete and fax the Medicaid Facility-Based Provider Application to CCHA for processing.

Provider or Medical Group Interested in Contracting with CCHA

If you are a provider or a medical group interested in contracting as a facility-based provider with the Medicaid network and you do not currently have a Medicaid Agreement:

1. Complete the Online Agreement Request Form or request an agreement be mailed or faxed to you by contacting CCHA.
2. Complete and sign either of the following documents:
 - a. Provider or medical group agreement (as applicable). Return to CCHA.
 - b. Medicaid Facility-Based Provider application. Return to CCHA.

All providers are able to participate in the Medicaid program unless that provider has a sanction and is ineligible to participate. CCHA obtains updated information on sanctioned providers on a monthly basis. If the provider is on probation, CCHA will request a written explanation from the provider, which will be reviewed by the credentialing committee. If a provider is confirmed to have any sanctions, we reserve the right to immediately terminate the contract with that provider, as outlined in our policies.

CHAPTER 12: ACCESS STANDARDS & ACCESS TO CARE

Overview

This chapter outlines the CCHA standards for timely and appropriate access to quality health care. Following guidelines set by the National Committee for Quality Assurance (NCQA) and the Colorado Department of Health Care Policy & Financing (HCPF), these standards help ensure medical appointments, emergency services and continuity of care for new and transferring members are provided fairly, reasonably and within specific time frames. We recognize cultural and linguistic barriers may affect our members' ability to understand or comply with certain instructions or procedures. For additional information on cultural diversity and interpreter services, refer to the [Culturally and Linguistically Appropriate Services](#) chapter.

CCHA monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

General Appointment Scheduling

Health First Colorado requires providers to comply with the following standards:

Nature of Visit	Appointment Standards
Behavioral health outpatient follow-up appointments	Within seven calendar days after discharge from an inpatient hospitalization
Behavioral health emergency: life-threatening	Within 15 minutes of the initial contact by phone, including TTY accessibility; in person within one hour of contact in urban and suburban areas; in person within two hours of contact in rural and frontier areas
Behavioral health emergency: non-life-threatening	Immediately: Patients can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner. Patient is directed to 24-hour crisis services, 911 or ER as appropriate.
Behavioral health urgent, nonemergency	Within 24 hours of the initial identification
Behavioral health nonurgent, symptomatic¹	Within seven calendar days of a member's request Within 48 hours of reporting symptoms
Behavioral health initial²	Within 7 business days
Behavioral health routine	Within 30 calendar days of requesting appointment
High-Fidelity Wraparound Services for Children and Youth	For children and youth determined eligible for Enhanced High-Fidelity Wraparound services through the Enhanced Standardized Assessment will initiate services within 30 calendar days of referral
Substance use disorder and pregnancy	Within 48 hours of seeking treatment

Nature of Visit	Appointment Standards
Medication Assisted Treatment	Evaluation for treatment within 72 hours after a member's request
Intravenous drug use	No later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request, and if interim services are made available to the individual no later than 48 hours after such request.

1 Administrative intake appointment or group intake processes are not considered treatment appointments for nonurgent, symptomatic care.

2 Members must not be put on a waiting list for initial routine service requests.

Urgent, nonemergency: the existence of conditions due to an illness or injury that are not life-threatening but require expeditious treatment because of the prospect of the condition worsening without clinical intervention.

Emergency: a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Nondiscriminatory Hours of Operation

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against CCHA members enrolled in Health First Colorado.

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with CCHA are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing, or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices, and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:

- [ada.gov](https://www.ada.gov)
- [ada.gov/resources/medical-care-mobility](https://www.ada.gov/resources/medical-care-mobility)

Interpreter Services

CCHA will ensure members who need interpreter services have access to interpreters 24/7. Services include, but are not limited to, face-to-face assistance during office visits at no cost to you or the member. Language assistance will be provided at all points of contact, in a timely manner, and during all hours of operation.

For more information on these services, refer to the [Interpreter Services](#) section in the [Provider Roles and Responsibilities](#) chapter.

Missed Appointment Tracking

When members miss appointments, providers must do the following:

1. Document the missed appointment in the member's medical record.
2. Make and document attempts to contact the member to determine the reason for the missed appointment.
3. Provide a reason in the member's medical record for any delays in performing an examination, including refusals by the member.

After-Hours Services

CCHA policy and the state requirement is for our members to have access to quality health care services 24/7. This kind of access means providers must have a system in place to ensure members may call after hours with medical questions or concerns. CCHA monitors compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action. Providers must adhere to the answering service and answering machine protocols defined in the following sections.

Answering Services

Answering service or after-hours personnel must:

- Forward member calls directly to the on-call provider or instruct the member that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.*
- Return calls received after normal business hours within one business day.
- Return calls received after midnight the same business day.

If your organization doesn't have a voicemail system, it must have another method to track calls received after normal business hours and return those calls on the next business day.

Answering machine messages:

- May be used when provider office staff or an answering service is not immediately available.
- Must instruct members with emergency behavioral health care needs to dial 911 or proceed to the nearest hospital emergency room. The message also must give members an alternative contact number to reach their PCMP or the on-call behavioral health provider with concerns or questions.
- Must provide instructions on how to contact their PCMP or the on-call behavioral health provider in a nonemergency situation.
- Must provide instructions in English, Spanish, and any other language appropriate to the PCMP's practice.*

* Non-English speaking members who call their PCMP after-hours should expect to get language-appropriate messages.

We offer the following suggested language for answering machines:

Hello, you've reached insert physician office name. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call insert contact phone or pager number. You will receive a return call from the on-call physician within time frame.

Note: CCHA prefers PCMPs to use an in-network provider for on-call services. When this is not possible, PCMPs must ensure the covering on-call provider abides by the terms of the provider agreement.

Continuity of Care

CCHA provides continuity of care for members when behavioral health care services are not available within the network or when the member or provider is in a state of transition.

States of transition may be when the member is any of the following:

- Newly enrolled
- Moving out of the service area
- Disenrolling from CCHA to another Health First Colorado contracted entity
- Exiting CCHA to receive excluded services
- Hospitalized on the effective date of transition
- Transitioning through behavioral health services

A state of transition is also applicable when the provider's contract terminates.

CCHA providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCMPs and specialists, as well as behavioral health providers. In addition, CCHA coordinates care when the provider's contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record, including but not limited to the following:

- Consultations
- Prior authorization
- Referrals to specialists
- Treatment plans

All providers share responsibility for timely communication of clinical findings, treatment plans, discharge plans, prognosis, and the member's psychosocial condition, along with other relevant care plans or documentation as part of the coordination of care process. CCHA care coordinators review member and provider requests for continuity of care and facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new provider.

Note: Only CCHA can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members, and providers, with the member's written consent, may appeal the decision by following the procedures in the [Reconsiderations, Disputes, Grievances, and Appeals](#) chapter. Reasons for continuity of care denials include but are not limited to:

- Course of treatment is complete.
- Member is ineligible for coverage.
- Requested services are not covered.
- Services rendered are covered under a global fee.
- Treating provider is currently contracted with our network.

Note: CCHA does not impose any pre-existing condition limitations on its Medicaid members or require evidence of insurability to provide coverage to any of our members.

Provider Contract Termination

CCHA will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. Providers must give at least 60 days' advance notice before terminating the provider agreement and cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers.

After CCHA receives a provider's notice to terminate a contract, we notify all impacted members. We send a letter at least 30 days in advance to inform the affected members about:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Support Services phone number to request referrals to the Care Coordination team for continued access to care consideration.

Members under the care of specialists may also submit requests for continued access to care, including continued care after the transition period. HCBS providers must continue to provide services to the member in accordance with the member's plan of care and as directed by CCHA until the member has been transitioned to a new provider; this transition may exceed 30 days from the date of notice to us. Members should contact CCHA at **1-855-627-4685 (TTY 711)**.

Newly Enrolled

Our goal is to ensure the health care of our newly enrolled members is not disrupted or interrupted. CCHA ensures continuity of care for our newly enrolled members when the member's health or behavioral health condition has been treated by specialists. We also ensure continuity of care when the member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

CCHA will pay a newly enrolled member of an existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member's records, clinical information, and care are transferred to a CCHA provider. Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by the HCPF. However, we are not obligated to reimburse the member's existing out-of-network providers for ongoing care if the time elapsed has been greater than:

- Ninety days after the member enrolls in CCHA.
- Nine months after the member enrolls in CCHA, if the member was diagnosed with a terminal illness at the time of enrollment in our plan and has been receiving ongoing treatment for the illness.

All new enrollees receive evidence of coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Second Opinions

CCHA will help ensure members have access to a second opinion regarding any medically necessary covered service. When the request involves care from a specialist, a provider of the same specialty must give the second opinion. When no provider exists within the network who meets the qualification, CCHA may authorize a second opinion by a qualified out-of-network provider. This service is provided at no cost to the member.

CHAPTER 13: PROVIDER ROLES & RESPONSIBILITIES

Overview

At CCHA, our goal is to provide quality health care to the right member, at the right time and in the appropriate setting. To achieve this goal, PCMPs, specialists, and ancillary providers must fulfill their roles and responsibilities with the highest integrity. We rely on your extensive health care education, experience, and dedication to our members, who look to you to get well and stay well.

Both primary care medical providers (PCMPs) and behavioral health providers agree to fulfill all obligations outlined in the Colorado Department of Health Care Policy and Financing (HCPF) contract. The provider agrees to participate in all CCHA care coordination and health improvement programs as their clinical and administrative capabilities allow. PCMPs agree to collaborate with CCHA to create and provide medical homes for assigned members.

Clinical Program and Quality Incentives

Pursuant to the contract, providers:

- Will work as a partner with CCHA in providing high-quality care to Health First Colorado members.
- Will work with CCHA to improve performance in 1) delivering value-based services through clinical quality outcomes; 2) providing the patient experience; and 3) reducing the growth in per-capita cost of medical care. This commitment includes:
 - Data -sharing.
 - Access to medical records when requested.
 - Cooperation on referrals to other providers, community resources, and CCHA.
 - Participation in CCHA and HCPF performance improvement activities and initiatives.
- May be asked to serve as leaders on various Health First Colorado and CCHA committees.
- Agree to provide feedback and use the data available to the practice from Health First Colorado and CCHA to manage members and their health needs.
- Agree to use their best efforts to provide CCHA with all patient data and access to such data as required to achieve the goals and performance measures of the ACC.
 - Note: Patient data will be used to further clinical and quality initiatives and support CCHA quality improvement (QI) activities through the use of clinical information systems.
- Agree to share all data in a manner consistent with HIPAA and 42 CFR to facilitate the exchange of relevant patient data for the purposes above.
- Will submit to CCHA all data, including medical records, necessary to characterize the content and purpose of each encounter with a Health First Colorado member upon request.
- Will certify the accuracy, completeness, and truthfulness of the encounter data submitted for Health First Colorado members as required by the Centers for Medicare and Medicaid Services (CMS), including any requirement that the certification be delivered under penalty of perjury.

The parties have entered into this agreement as part of a legitimate effort to foster clinical integration, cost savings, and quality improvement through the use of a shared electronic health information system and shared patient data.

For more information on our quality program, see the [Quality Assessment and Performance Improvement](#) chapter.

New Provider Orientations and Provider Training

In coordination with the contracting process, the CCHA Provider Experience team will conduct new provider orientations for new providers and/or the office staff, as well as offer ongoing provider training opportunities.

CCHA continually develops training materials and offers training on a variety of topics, including but not limited to:

- Health First Colorado/ACC overview
- CCHA overview and resources
- Quality management initiatives

Primary Care Medical Providers

PCMPs are the principal point of contact for our members. The PCMP's role is to provide members with a health home, the member's first stop in the health care process, and a centralized hub for a wide variety of ongoing health care needs. This includes:

- Coordinating members' health care 24/7.
- Having weekly availability of appointments on a weekend and/or weekday outside the typical workday hours (Monday-Friday, 7:30 a.m.-5:30 p.m.) or school hours for School Health Clinics.
- Collaborating with the member, family or caregiver to develop an individual care and treatment plans for members with complex needs, including preventive care.
- Maintaining members' current medical records, including documentation of all services provided by the PCMP, specialists, or referral services.
- Adhering to wait times outlined within the provider agreement and provider manual.
- Referring members to specialists.
- Coordinating with outpatient clinical services.
- Adoption and regular use of universal screening tools, including Behavioral Health screenings, uniform protocols, and guidance/decision trees/algorithms to support members accessing necessary treatments.
- Providing complete information about proposed treatments and prognosis for recovery to our members or their representatives.
- Facilitating interpreter services by presenting information in a language that our members or their representatives can understand.
- Using available data to identify special member populations who may require extra services and support for health or social reasons. PCMPs must have procedures to proactively address the identified health needs.
- Ensuring members' medical and personal information is kept confidential as required by state and federal laws.

The PCMP's scope of responsibilities includes providing or arranging for:

- Routine and preventive health care services.
- Emergency care services.
- Hospital services.
- Ancillary services.
- Interpreter services.
- Referrals to specialists.
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative, or palliative services.

Note: Services must always be provided without regard to race, religion, gender, gender identity, sexual orientation, color, national origin, age, or physical/behavioral health status.

Referrals

PCMPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Note: Specialty referrals to network providers do not require prior authorization.

All PCMPs must perform the following with regard to referrals:

- Help members schedule appointments with other health care providers, including specialists.
- Track the status of referrals and document appointments, clinical findings, treatment plans, and care received by members referred to specialists or other health care providers.
- Refer members to health education programs and community resource agencies when appropriate.
- Coordinate with the Women, Infants, and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
- Report any member who is noncompliant, drug resistant, or who is or may be posing a public health threat to the Colorado Department of Health Care Policy & Financing (HCPF) or the local TB control program.
- Perform screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

The CCHA Provider Directory includes information for these provider types:

- Physicians (including specialists)
- Behavioral health providers
- Hospitals

Hard copies of the provider directories are updated at least monthly. Electronic provider directories are updated no later than 30 calendar days after CCHA receives updated provider information. Provider directories are posted on the CCHA website.

Out-Of-Network Referrals

We recognize that an out-of-network referral may be justified at times. We'll work with the PCMP to determine medical necessity and authorize out-of-network referrals on a limited basis. For assistance, contact us at **1-855-627-4685**.

Behavioral Health requests should be submitted via Availity Essentials at [Availity.com](https://www.availity.com). If you prefer to paper fax, you may submit to **1-844-452-8067** for inpatient and **1-844-442-8015** for outpatient.

Interpreter Services

For those instances when you cannot communicate with a member due to language barriers, telephonic and face-to-face interpreter services are available at no cost to the member for capitated behavioral health services. Request telephonic interpreters for members needing language assistance at:

Phone: **1-855-627-4685 (TTY 711)**

And take the following steps:

1. Provide the member's ID number.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the staff member introduces the CCHA member, explains the reason for the call, and begins the dialogue.

Request face-to-face interpreters for members needing language assistance, including American Sign Language, during business hours at:

Phone: **1-855-627-4685(TTY 711)**

Note: To schedule face-to-face interpreter services allow 72 hours. To cancel, provide a 24-hour notice.

Request telephonic interpreters for members needing language assistance outside of standard business hours:

- Providers and members call Language Line at **1-844-643-1962**
- Indicate the language needed: press 1 for Spanish, press 2 for all other languages

Providers must train their answering services and on-call personnel on how to access interpreter services. CCHA providers should strongly discourage the use of minors, friends, and family members acting as interpreters. Providers also must accommodate non-English speaking members by having multilingual messages on answering machines.

In addition, providers must notify members verbally and through written notices about their right to receive the following language assistance services, as well as how to access them:

- Oral interpretation for any language:
 - Note: Oral interpretation requirements apply to all non-English languages, not just those the state identifies as prevalent.
- Written translation in prevalent languages
- Auxiliary aids and services for members with disabilities (such as TTY/TDD and American Sign Language).

Services for Members with Hearing Loss, Visual and/or Speech Impairment

Members with hearing loss or speech impairment can call the designated TTY number — **711**. The Colorado relay service is also available 24 hours a day. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of Materials

Members can request translation of CCHA materials into non-English languages, at no cost, by contacting Member Support Services.

Note: All required information in this section is sent to current and potential members in an easily understood, readily accessible format.

Responsibilities Applicable to All Providers

The responsibilities applicable to all CCHA providers include the following:

- After-hours services
- Client Overutilization Program
- Collaboration
- Continuity of care
- Disenrollees
- Eligibility verification
- Licenses and certifications
- Medical records standards and documentation
- Misrouted protected health information
- Notification of new construction
- Office hours
- Open clinical dialogue/affirmative statement
- Oversight of nonphysician practitioners
- Prohibited activities
- Provider contract terminations
- Provider rights
- Updating provider information

After-Hours Services

All providers must have an after-hours system in place to ensure our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to a provider or on-call provider or instruct the member that the provider will be in contact within 30 minutes.

For more information about after-hours services, see the [After-Hours Services](#) section in the [Access Standard and Access to Care](#) chapter.

Client Overutilization Program

CCHA is participating in the state's Client Overutilization Program (COUP). Providers will be notified when a member is identified as eligible and enrolled in the COUP. Providers are expected to assist the member in adhering to the COUP.

Collaboration

Providers share the responsibility of giving respectful care, working collaboratively with CCHA specialists, hospitals, ancillary providers, and members and their families. Providers must allow CCHA to use performance data in cooperation with quality improvement programs and activities. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.

Continuity of Care

All providers maintain frequent communication with specialists, hospitals, and ancillary providers to ensure continuity of care. CCHA encourages providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. PCMPs are responsible for being an ongoing source of primary care appropriate to the member's needs.

We established comprehensive mechanisms to ensure continued access to care for members when providers leave our health care program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to the [Access Standards and Access to Care](#) chapter.

Disenrollees

When a member disenrolls, providers are expected to work with CCHA care coordinators responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The care coordinator will coordinate with the member, the member's providers, and the care coordinator at the new health plan to ensure an orderly transition.

Eligibility Verification

All providers must verify member eligibility immediately before providing services, supplies, or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first day of the following month. CCHA is not responsible for charges incurred by ineligible patients. As part of the primary medical group (PMG) lock-in program, a member's PMG assignment also must be verified. Services are considered for payment if rendered by a provider affiliated with the assigned group.

For more information on how to verify eligibility, refer to the [Member Eligibility](#) chapter.

Licenses and Certifications

Providers must maintain all licenses, certifications, permits, accreditations, or other prerequisites required by CCHA and federal, state, and local laws for providing medical services.

Medical Records Standards and Documentation

Medical records must be maintained in a manner that ensures effective and confidential member care and quality review.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition without the patient's or legal representative's consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of HIPAA and be in compliance. For more information on medical records standards, refer to the [Medical Record Documentation Standards](#) section.

Member Dismissal Policy

The member dismissal policy outlined in Section 10 CCR 2505-10-8.205.5 is applicable to behavioral health providers (excluding safety net providers), as well as physical health providers. While behavioral health providers are not expected to hold standing appointment slots for the dismissed member, CCHA expects providers to provide transitional care in the manner that best fits a provider's service array, as well as the member's needs.

Part of this process is to provide the member's Regional Accountable Entity (RAE) with a notice of the member's dismissal from a provider's practice. Providers can submit a referral to CCHA's care coordination team using the following link to meet the regulatory requirement of providing notice: CCHAcare.com/referral.

Misrouted Protected Health Information

You are not permitted to use or disclose Protected Health Information about individuals whom you are not treating or are not enrolled in your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium, including mail, email, fax, or other electronic transmission.

Notification of New Construction

CCHA is required to notify HCPF about any new construction of an emergency department, hospital, or hospital expansion. Providers must notify CCHA of new construction as soon as they are aware by mailing a certified letter to:

Colorado Community Health Alliance
Regional VP Provider Support Services
700 Broadway, Location 0133687
Denver, CO 80273

Then, CCHA will notify HCPF within five business days.

Office Hours

To maintain continuity of care, providers are required to be available for a minimum of 24 hours each week. Office hours must be clearly posted, and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to health care 24/7:

- Providers must be available 24 hours a day by phone.
- An on-call provider must be available to take calls when a provider is not available.

Open Clinical Dialogue/Affirmative Statement

Nothing within the provider agreement or this manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

Oversight of Nonphysician Practitioners

All providers using nonphysician practitioners must supervise and oversee nonphysician practitioners consistent with state and federal laws. The supervising provider and the nonphysician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Prohibited Activities

All providers are prohibited from:

- Billing eligible members for covered services.
- Segregating members in any way from other persons receiving similar services, supplies, or equipment.
- Discriminating against CCHA members or Medicaid participants.

Providers must render care on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, sexual orientation, physical or mental disability, or type of illness or condition.

This includes adherence to the Americans with Disabilities Act (see the [Americans with Disabilities Act](#) section) as well as the standards in the [Nondiscriminatory Hours of Operation](#) section and the [Culturally and Linguistically Appropriate Services](#) chapter. For additional information on our nondiscrimination practices, including the process for filing a grievance and/or a civil rights complaint, see the [Nondiscrimination Statement](#) section.

Provider Contract Terminations

A terminated provider actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination or according to a timeline determined by the medical group contract.

After we receive a provider's notice to terminate a contract, we notify members impacted by the termination. CCHA sends a letter to inform affected members about the:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Support Services phone number to request PCMP changes.
- Referrals to Medical Management for continued access to care consideration.

Members under the care of specialists may also submit requests for continued access to care, including after the transition period, by calling Member Support Services at **1-855-627-4685** (TTY **711**).

CCHA may terminate the provider agreement if we determine that the quality of care or services given by a health care provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, care coordination data, member complaints or grievances, other complaints, or lawsuits alleging professional negligence and quality of care indicators.

Provider Rights

CCHA providers, acting within the lawful scope of practice, will not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care, or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or nontreatment
- The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable law, solely based on that license or certification

The CCHA provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions requiring costly treatment.

Updating Provider Information

Providers are required to inform CCHA of any material changes to their practice, such as:

- Change in their professional business ownership.
- Change in their business address or the location where services are provided.
- Legal or governmental action initiated against a health care professional. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law or against any license or accreditation, which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the provider agreement.
- Change in their federal 9-digit tax identification number (TIN).
- Change of their specialty.
- Services offered to children.
- Languages spoken.
- Change in demographic data.
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the provider agreement's care review and grievance resolution procedures.
- Notification that the provider is accepting new patients.

Review the forms available online to help update your information on CCHAcres.com/providertools. Various forms are available online at CCHAcres.com/bhprovidertools > **Network Application Forms**.

Failure to keep CCHA informed of changes to your provider information could result in denied claims and or returned payments.

Submitting provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, providers may continue to use the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today.*

The resources for this process are listed below and available on our website. Visit CCHAcres.com/bhprovidertools. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the **Facility Forms** section.

Roster Automation Rules of Engagement: Is a reference document available to ensure error-free submissions, driving accurate and more timely updates through automation.

Roster Automation Standard Template: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (User Reference Guide).

Upload your completed roster via the Availity PDM application.

Accessing PDM Application

Log onto [Availity.com](https://www.availity.com) and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

* If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Ownership Disclosure

CCHA follows the CMS process regarding ownership disclosure. You may be periodically required to submit a Disclosure of Ownership questionnaire, located on the CMS website at [cms.gov](https://www.cms.gov).

Restrictions on AI use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (e.g., Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement, and the health plan shall provide a written response in accordance with the notice provisions of the provider agreement.

CHAPTER 14: CLINICAL PRACTICE GUIDELINES

Overview

At CCHA, we believe providing quality health care should extend beyond the treatment of injury or illness. We're committed to helping providers and members become more proactive in pursuing better overall health.

We want providers to have access to the most up-to-date clinical practice guidelines offered by nationally recognized health care organizations and based on extensive research.

Providers need the latest research on treating common conditions, such as asthma, diabetes, and hypertension. The Clinical Practice Guidelines:

- Follow nationally recognized best practices for standards of treatment.
- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
- Consider the needs of our members.
- Are adopted in consultation with contracting health care professionals.
- Are reviewed and updated periodically as appropriate.

The website offers the most up-to-date clinical resources and guidelines at CCHAcare.com/bhprovidertools > **Manuals and Resources**. If you do not have internet access, request a hard copy of the **Clinical Practice Guidelines** by calling CCHA Provider Support Services at **1-855-627-4685**. Members and potential members may also request a copy by calling Member Support Services at **1-855-627-4685**.

Note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contractual obligation. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state.

CHAPTER 15: CARE COORDINATION

Overview

Care coordination is a collaborative effort providing expert assistance to both providers and members in the coordination of complex health care. The program is designed to develop, implement, coordinate, and monitor health care plans to optimize our members' health care benefits.

A care coordinator, through discussions with providers and members, collects data and analyzes information about actual and potential care needs for the purpose of developing a health care plan. Members referred to care coordination may be identified by disease or condition, or high utilization of services.

Note: Our Care Coordination department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction within the health care system. As such, we encourage providers to become familiar with our cultural and linguistic training materials; for more information, see the [Culturally and Linguistically Appropriate Services](#) chapter.

Provider Responsibilities

All providers have the responsibility of participating in the care coordination process by sharing information and facilitating the process as follows:

- Referring members who could benefit from care coordination
- Collaborating with Care Coordination staff on an ongoing basis
- Referring members to specialists as required
- Providing pertinent medical information
- Monitoring and updating the care plan to promote health care goals
- Coordinating county or state-linked services such as public health, behavioral health, schools, and waiver programs

Referral Process

Providers, nurses, social workers, and members or their representatives may refer members to care coordination as follows:

Care Coordination Referral Form: CCHAcres.com/referral

Member and Provider Support Services

CCHAcres.com/contact

303-256-1717

719-598-1540

Toll free: 1-855-627-4685

Limited services 24/7, full services Monday through Friday from 8 a.m. to 5 p.m.

Callers with hearing or speech disabilities: 711 (TTY)

Role of the Care Coordinator

The care coordinator's role is to assess the member's health care service needs, develop a care plan, and:

- Facilitate communication and coordination within the health care team.
- Facilitate communication with the member and their family in the decision-making process.
- Educate the member and provider(s) about care coordination, community resources, benefits, cost factors and all related topics so informed decisions may be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Care Coordination department includes experienced and credentialed registered nurses and licensed professional counselors and social workers. In addition, peer support specialists and outreach care specialists add valuable skills, allowing us to address our members' whole health to include medical, psychological, and social drivers of health. Interpreter services are available to support the care coordination process at no cost to the member.

Care Coordination Procedure

When a member has been identified as having a condition that may require care coordination, the care coordinator contacts the referring provider and member for an initial assessment. With the involvement of the member, the member's representative, and the provider, the care coordinator develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The care coordinator periodically reviews the care plan with the member to:

- Assess progress toward goals.
- Assess gaps in care.
- Modify goals and coordinate services accordingly.
- Determine what actions may be implemented to overcome barriers and enhance positive outcomes.

After goals are met or care coordination can no longer impact the case, the care coordinator closes the case.

Continuity of Care Process

Our care coordination nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until the regimen of care is complete or the member transitions to a new provider.

For more information, see the [Continuity of Care](#) section of this manual.

CHAPTER 16: QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

Overview

Our goal is continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have implemented a Quality Assessment and Performance Improvement (QAPI) program to advance our levels of readiness, service and care.

CCHA strives and reinforces efforts to build a safer health care system, decrease the occurrence of preventable adverse events (PAEs) and hospital-acquired conditions (HACs), and ensure compliance with Federal and State regulatory requirements and CCHA contractual requirements. We are committed to supporting patient safety efforts and working with physicians, hospitals, and other health care partners to create an environment where all members receive safe, equitable, high-quality care.

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the care delivery system. CCHA fosters a supportive and collaborative environment to assist Medical and Behavioral Health providers in improving safety within individual practices and across the health care continuum.

Consistent with the Centers for Medicare & Medicaid Services (CMS) and its payment policy, CCHA strives to eliminate inpatient PAEs as adopted by the CMS and HACs as defined by CMS. Our goal is to support physicians and hospitals in using appropriate processes, technologies, and strategies to address never events and hospital-acquired conditions, and, ultimately, to enhance the quality of care delivered to patients.

Note: If we determine the quality of care or services provided by a health care professional is not satisfactory, CCHA may terminate the provider agreement and related addenda. We make this determination by reviewing member satisfaction surveys, care coordination data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality of care indicators.

Quality Assessment and Performance Improvement Program

The QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings.
- Internal organizational performance.
- Provider/member satisfaction.
- Provider promotion of preventive health programs and exams.
- Provider management of member health status.
- Provider site facilities and medical records.

CCHA develops an Annual Quality Report and Quality Improvement Plan based on the results of the previous year's program evaluation. The evaluation is a written description of CCHA's effectiveness in implementing the program, meeting program objectives, and developing and executing plans to improve the quality of care and service to our members. The program requires the medical director's or designated provider's involvement.

Providers support the activities of the QAPI program by:

- Completing corrective action plans, when applicable.
- Participating in the facility and medical record audit process.
- Providing access to medical records for quality improvement projects and studies.
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed.
- Using clinical practice guidelines in member care.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a national evaluation and core set of performance measurements gauging the effectiveness of CCHA and providers in delivering quality care. We are ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our Quality Improvement staff will contact the provider's office when we need to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Quality Management

CCHA analyzes relevant utilization data against established thresholds to detect current utilization levels and to assess the quality and appropriateness of care furnished to members. If our findings fall outside specified target ranges and indicate potential underutilization or overutilization, further analysis will occur based on the recommendation of the CCHA quality improvement committee.

The follow-up analysis may include gathering the following data from specific providers and practice sites:

- Care coordination services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Best-Practice Methods

Best-practice methods are our most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods during site visits to provider offices. Member Support Services and Network Management departments offer policies, procedures, and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services.
- Clinical practice guidelines.
- Care for members with special or chronic care needs.

Member Satisfaction Surveys

Member satisfaction with our health care services is measured every year by the **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** survey, which is designed to measure member satisfaction with:

- Access to care.
- CCHA customer service.
- Provider communications.
- Provider office staff performance.

We distribute the results of the CAHPS survey to both members and providers. Providers should review the results, share the results with office staff, and use the results to inform modifications and strategies to improve member experience.

CCHA may conduct additional satisfaction surveys to evaluate aspects of Members' health care experience. Corrective action plans (CAPs) shall be developed when a pattern of complaint is detected, when trends in decreasing member satisfaction are detected, or when a serious complaint is substantiated.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Provider Satisfaction Surveys

CCHA may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged, and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings, or training sessions.

Medical Record and Facility Site Reviews

We conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing health care.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

HCPF and CCHA have the right to enter the premises of providers to inspect, monitor, audit, or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work in accordance with the provider agreement.

CCHA will implement corrective actions to improve offices that do not meet site criteria. The evaluation of the effectiveness of the corrective action will be performed at least every six months until deficient offices meet the site standards and threshold. Follow-up visits will be documented and presented to the quality improvement committee.

Medical Records

Documentation Standards

CCHA requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- With limited exceptions, health care providers are prohibited from disclosing any individually identifiable information regarding a patient's medical history, mental condition, physical condition, or treatment without the patient's or legal representative's consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar and in compliance with the security requirements of HIPAA and 42 C.F.R. Part 2.

Security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration, or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, CCHA, the Colorado HCPF, or to persons authorized through a legal instrument. Records must be made available to CCHA for purposes of quality review, audits, HEDIS, and other studies.

Storage and Maintenance

Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed, and organized, permitting effective patient care and quality review while maintaining confidentiality. It is the providers' responsibility to ensure inactive records remain accessible for a period of time that meets state and federal guidelines and to work with designated custodians to provide requested records within established timeframes.

Availability of Medical Records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, compliant with documentation standards, and retained for at least seven years after the last day of treatment or 7 years after the member turns 18 years old, whichever is later. Providers are responsible for establishing practice guidelines in accordance with state and federal retention requirements.

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit CCHA and Health First Colorado representatives to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. Providers should have procedures in place to permit the timely access and submission of medical records to CCHA upon request. CCHA encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Medical Record Requirements

As clinically indicated, medical records should include the following:

- The patient's name and date of birth, or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers, and marital status
- Entries dated with month, day, and year
- Entries are documented with the author's identification and title. For example, a handwritten signature, a unique electronic identifier, or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions, and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations, and illnesses. In addition:
 - For patients 14 years old and older, the record must include information about substance use
 - For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses
- Notations concerning the use of cigarettes, alcohol, and substance use for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment necessary, and possible risk factors relevant to the particular treatment, if applicable
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records must be legible, dated, and signed by the providers involved in the member's care
- Up-to-date immunization records for children or an appropriate history for adults
- Evidence of preventive screening and services, as clinically indicated
- Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information
- Notations of patient appointment cancellations or "no shows" and the attempts to contact the patient to reschedule
- No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used during a visit

Advance Directives

Recognizing a person's right to dignity and privacy, our members have the right to execute advance directives to express their wishes concerning health care decisions should they become incapacitated. Colorado supports the use of a psychiatric advance directive (PAD), also known as a mental health advance directive, for members suffering from a mental disease that describes what a person wants to happen if, at some time in the future, it is determined that they are deemed unable to decide for themselves or to communicate effectively. Providers are required to adhere to the following guidelines:

- Respect and honor valid advance directives in accordance with applicable law.
- Discuss the sensitive issues raised by advance directives with patients and their families.
- Advise members of their right to change or revoke their advance directive at any time.
- Inform members that they may contact Member Support Services to request additional information about advance directives.
- Document in the member's medical record the discussion about advance directives.
- Document in the member's medical record whether an advance directive has been completed.
- Place a copy of a completed advance directive in the member's medical record.
- Not condition the provision of care or otherwise discriminate against individuals based on whether they have executed an advance directive.
- Maintain written policies and procedures on advance directives for all adults receiving medical care, including any limitations placed on implementation as a matter of conscience.
- Educate staff concerning advance directive policies and procedures.

Providers must comply with all State and Federal regulations regarding advance directives, including, but not limited to: The Colorado Medical Treatment Decision Act (C.R.S. 15-18-101), the Colorado Medical Assistance Act- General Medical Assistance, Part 4 Providers- Reimbursement (C.R.S. 25.5-4-413), and the Behavioral Health Orders for Scope of Treatment (C.R.S. 15-18.7-202).

CCHA provides education to network providers on advance directives through the For Providers section of the CCHA website, provider newsletters, and meetings, such as provider town halls. This education includes:

- What constitutes an advance directive;
- Information that an advance directive enhances an incapacitated member's control over medical treatment; and,
- Description of applicable State law concerning advance directives.

Additional resources, including the updated Colorado Medical Orders for Scope of Treatment (MOST) form, are available at the Colorado Advance Directives Consortium website: coloradoadvancedirectives.com.

411 Encounter Data Validation Audit

Each year, the Department of Health Care Policy and Financing (HCPF) (Department) contracts with Health Services Advisory Group (HSAG), an External Quality Review Organization, to validate a random sample of submitted Health First Colorado (Colorado's Medicaid program) claims/encounter data. This validation is commonly referred to as the 411 Audit. The purpose of this audit is to ensure that providers are submitting claims to CCHA that comply with the State Behavioral Health Services Billing manual (SBHS), which can be accessed online at hcpf.colorado.gov/sbhs-billing-manual.

As part of this audit, CCHA will reach out to your facility to request medical records if an encounter from your facility has been included in the random sample. CCHA will review records to ensure they support the service billed. Then, HCPF will select and re-review records. CCHA maintains the right to request and receive medical records timely on request and at no charge for examination and audit purposes. Failure to respond and/or supply records within provided timeframes may result in the retraction of payment of the requested claim(s).

General guidelines and recommendations:

- Providers must ensure the facility/practice contact information is up to date in CCHA systems to allow for timely notification of audit selection. Although reasonable efforts will be made to seek contact information, failure to reach providers in a timely manner may lead to disqualification.
- Every page of the medical record must contain two or more member identifiers, such as name and date of birth. Patient identifiers must match the information in the claim submitted. Pages without patient identifiers will not be reviewed and documentation elements contained in the page are disqualified.
- Documentation for each encounter must be signed with credentials/title and date, legibly, finalized/permanently recorded, and submitted in one PDF file per encounter line.
- Auditors must be able to verify the accuracy and compliance of each of the elements reviewed. Additional documentation may be needed to
- Documentation submitted must match the date(s) of service for the claim requested.
- Each individual service note must contain all documentation elements (in other words, multiple services cannot be bundled under one header and signature). Records must clearly demonstrate compliance with minimum documentation and technical requirements, including provider signatures, credentials, rationale for changes in level of care with clear admission and discharge dates and times, diagnoses associated with services, etc.
- Document the rationale for the lack of minimum documentation requirements. If a component of treatment is not performed, indicate the reason.
- The diagnosis in the document must comply with SBHS specifications, must be clearly associated with the service and match the diagnosis code on the claim.

supplement the service note to support the code/claim and demonstrate compliance with the standards and technical requirements for services rendered.

- It is recommended to indicate the number of pages included within the medical record to ensure all necessary documentation is reviewed (for example, page 1 of 3).

A Corrective Action Plan (CAP), Quality Improvement Plan (QulP), further investigation, or payment retraction may result from the findings of the audit. As a network provider for CCHA, it is your facility's responsibility to actively participate in and fulfill all CAP/QulP deliverables and requirements.

Incentive Performance Measures

We recognize the unique challenges you experience while caring for patients with behavioral health needs. We appreciate the quality of care our providers consistently offer to our members. In recognition of these efforts, CCHA will offer the Behavioral Health Quality Incentive Program (BHQIP) and the Behavioral Health Facility Incentive Program (BHFIP).

The incentive programs reward providers for delivering quality and efficient care while keeping the health care needs of our members as the primary focus. Providers are prohibited from encouraging member selection or deselection and from discriminating against members based on location, ethnicity, culture, race, religion, disability, political belief, sex, age, socioeconomic status, health status, or medical history. Providers are also prohibited from withholding or preventing medically necessary services from being delivered to members. The program is not intended to limit the judgment of providers in treating members or to limit their ability to discuss available treatment options with members. The BHQIP does not discriminate against providers who provide services to any member, including any particular ethnic, cultural, or socioeconomic group, in particular geographic locations, or groups with specific medical conditions.

Behavioral Health Quality Incentive Program (BHQIP)

This program offers incentives to eligible behavioral health providers for providing quality care and services to our members with behavioral health needs. Behavioral health providers participating in the program who meet quality, service, and utilization goals are eligible to receive incentive payments.

For the current performance measurement period, incentive opportunities will be based on the following performance indicators:

Indicator	Definition	Indicator type
Efficiency indicators category		
Acute behavioral health (BH) inpatient 30-day readmissions	Percentage of Attributed members with a BH-related inpatient discharge (from January 1 to November 30 of the performance measurement period) who had a BH-related readmission within 30 days of the BH-related discharge during the performance measurement period	Efficiency indicator

Indicator	Definition	Indicator type
Emergency room (ER) utilization	ER visits per thousand attributed members per year	Efficiency indicator
Quality of care indicators category		
PCP visits	Percentage of attributed members with at least one PCP visit within the performance measurement period	Quality of care indicator
Seven-day follow-up visit after mental health inpatient discharge (FUH7)	Percentage of attributed members ages 6 years and older who were hospitalized for treatment of selected mental health disorders (with discharge dates between January 1 and December 1 of the performance measurement period), and who had a visit with a licensed mental health practitioner within seven days of discharge	Quality of care indicator
30-Day Follow-Up visit after Mental Health Inpatient Discharge (FUH30)	Percentage of attributed members ages 6 years and older who were hospitalized for treatment of selected mental health disorders (with discharge dates between January 1 and December 1 of the performance measurement period), and who had a visit with a licensed mental health practitioner within seven (30) days of discharge.	Quality of care indicator
7-Day Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Treatment (FUA-7)	Percentage of attributed members ages 13 years and older who had an emergency department (ED) visit with a principal diagnosis of alcohol or other drug abuse or dependence and who had a follow-up visit for alcohol or other drug abuse or dependence within seven days of discharge.	Quality of care indicator
Engagement of Alcohol and Other Drug Dependence Treatment (IET-e)	Percentage of attributed members diagnosed with alcohol and other drug dependence (between January 1 and November 15 of the performance measurement period) who initiate treatment and have two or more additional services with alcohol and other drug dependence diagnosis within 30 days of the initiation visit.	Quality of care indicator

Behavioral Health Facility Incentive Program (BHFIP)

This program offers incentives to eligible behavioral health inpatient facility providers (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units) for providing quality care and service to our members with BH inpatient discharges. Participating providers who meet quality-of-care and efficiency goals are eligible to receive incentive payments.

For the current performance measurement period, incentive opportunities will be based on the following performance indicators:

Indicator	Definition
30-Day Readmission Rate	The percentage of discharged members who were discharged between December 1 of the prior year and November 30 of the performance measurement period and had a BH-related inpatient readmission within 30 days of the discharge during the performance measurement period
60-Day Readmission Rate	The percentage of discharged members who were discharged between November 1 of the prior year and October 31 of the performance measurement period and had a BH-related inpatient readmission within 60 days of the discharge during the performance measurement period
90-Day Readmission Rate	The percentage of discharged members who were discharged between October 2 of the prior year and October 1 of the performance measurement period and had a BH-related inpatient readmission within 90 days of the discharge during the performance measurement period
7-Day Follow-Up Visit After Mental Health Inpatient Discharge (FUH7)	The percentage of discharged members 6 years of age and older who were discharged between January 1 and December 1 of the performance measurement period and had a visit with a licensed mental health practitioner within seven days of discharge
30-Day Follow-Up Visit After Mental Health Inpatient Discharge (FUH30)	The percentage of discharged members 6 years of age and older who were discharged between January 1 and December 1 of the performance measurement period and had a visit with a licensed mental health practitioner within 30 days of discharge
EQUITABLE ACCESS BONUS: 7-Day Follow-up Visit After Mental Health Inpatient Discharge (FUH7)	Percentage of Attributed Equitable Access Members ages 6 years and older who were hospitalized for treatment of selected mental health disorders (with discharge dates between January 1 and December 1 of the Performance Measurement Period) and who had a visit with a licensed mental health practitioner within seven days of discharge

Comprehensive Safety Net Provider Pay for Quality Incentive Program (CSNP P4Q)

This program incentivizes eligible Comprehensive Safety Net Providers (CSNPs) for providing quality care and service to our members with behavioral health needs. Providers participating in the Program receive quarterly performance scorecards to drive quality improvement (QI) processes to improve performance and earn incentive payments.

The following CSNP P4Q Performance Indicators, made up of Structural and Administrative Measures, are used to determine each provider's CSNP P4Q performance under CSNP P4Q.

Indicator	Definition
Structural Measures	
Equity	The provider will calculate the screening Social Drivers of Health (SDOH) measure according to Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual and report out performance and analytics details quarterly.
Access	The provider will calculate Time to Services (I-SERV) according to Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual and report out performance and analytics details quarterly. Provider will report out sub-measures: • Time from Initial Contact to Initial Clinical Services • Time from Initial Contact to Initial Evaluation
Experience of Care	The BH Post Visit Survey is a brief four-question survey administered by CCHA monthly to a random sample of members about their satisfaction with recent BH services. CCHA will provide a quarterly scorecard of provider performance on the BH Post Visit Survey (PVS). The provider will use this feedback to identify opportunities to improve member/family access and experience of care.
Administrative Measures	
Timely Access	To earn points associated with this measure, the provider must have Time to Services (I-SERV) according to Quality Measures for Behavioral Health Clinics - Initial clinical service average less than 7 days - Initial evaluation average less than 7 days
Pay For Quality	FUH7: Percentage of members ages 6 years and older who were hospitalized for treatment of selected mental health disorders (with discharge dates between January 1 and December 1 of the Performance Measurement Period) and who had a visit with a licensed mental health practitioner within seven days of discharge.
	FUA7: The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow-up visit for AOD within 7 days of the ED visit.
	FUM7: The percentage of discharged members, six years and older, who were discharged from the ED during the PMP with a primary diagnosis of mental illness and/or intentional self-harm, who had a follow-up visit with a behavioral health provider for mental illness within seven days of the ED visit.
	IET-E: Percentage of members diagnosed with alcohol and other drug dependence (between January 1 and November 15 of the Performance Measurement Period) who initiate treatment and have 2 or more additional services with alcohol and other drug dependence diagnosis within 30 days of the initiation visit.]

Healthy Rewards Member Incentive Program

CCHA's commitment to promoting and instilling health outcomes includes driving quality through member incentives. CCHA's Healthy Rewards member incentive program was designed to financially reward members for participating in healthy activities. The program aims to foster healthy, preventative care coordination. Members and providers are informed about the benefit through newsletter articles, social media campaigns, printed materials in English and Spanish, our webpage, and text message outreach. Rewards include digital or physical gift cards from popular retailers.

Healthy activities, eligibility criteria, and reward information are available at CCHAcare.com/rewards.

Sanctions, Restrictions, Suspensions and Terminations

CCHA is committed to maintaining the highest standards of care and service for its members through comprehensive oversight of its contracted provider network. As part of this responsibility, CCHA reserves the right to impose sanctions, restrictions, suspensions, and/or terminations on providers who fail to meet expected quality and performance standards or who otherwise place member health, safety, or satisfaction at risk.

CCHA's performance evaluation process is informed by multiple data sources used to identify, evaluate, and monitor actual or potential concerns in patient care, service delivery, and compliance with contractual or regulatory requirements. These sources include performance measures specified and collected by the Department of Health Care Policy and Financing (HCPF); quality, access, utilization, and service metrics agreed upon by providers and the Plan; and data derived from internal monitoring activities, audits, grievance and appeal trends, member satisfaction surveys, and other quality improvement initiatives.

Concerns may be identified by various CCHA departments and may involve quality of care, access to care standards, patterns of complaints or substantiated serious complaints, declining member satisfaction trends, or other clinical practice and performance expectations incorporated into CCHA's network agreements. Identified issues are reviewed by a multi-disciplinary ad-hoc workgroup composed of operational and clinical representatives. The workgroup evaluates the nature, scope, and severity of the concern and determines the appropriate course of action based on the circumstances presented.

CCHA's corrective action tools may include written warnings, focused provider education or technical assistance, enhanced monitoring and tracking, or the development and implementation of a Corrective Action Plan (CAP) with defined expectations and timeframes. When warranted, matters may be referred for reductions or limitations of privileges, suspension, or termination from the CCHA network. Corrective actions are not required to be progressive and may escalate depending on the level of risk to members or the integrity of the network.

Providers are expected to respond to CCHA communications in a timely manner, fully cooperate with investigations, provide information deemed relevant to the review upon request, and implement required corrective measures within established timeframes, if applicable. Failure to comply with

required corrective actions may result in additional sanctions up to and including suspension or termination.

CCHA further reserves the right to take immediate protective action when member health or safety is endangered. This may include the immediate withdrawal of any or all members from a Primary Care Medical Provider (PCMP) or its participating providers without prior remediation efforts when warranted by the seriousness of the concern. Certain sanctions, suspensions, or terminations may be reported to state or federal authorities or regulatory and licensing boards, as applicable and/or required by law or regulation.

While CCHA values provider input and considers provider participation throughout the review and corrective action process, final decisions regarding sanctions, restrictions, suspensions, or terminations rest solely with CCHA. There are no predetermined criteria or automatic conditions for reinstatement or revocation of sanctions; however, expected resolutions and applicable timeframes will be communicated to the provider. All decisions are final and are not subject to appeal.

CHAPTER 17: ENROLLMENT & MARKETING RULES

Overview

The delivery of quality health care poses numerous challenges, not the least of which is the commitment shared by CCHA and providers to act in the best interest of our members. We want our members to make the best health care decisions possible. When members ask for our assistance, we want to provide that assistance, so they can make those decisions without undue influence.

We recognize that providers occupy a unique, trusted, and respected part of people's lives. Given the complexity of modern-day health care and the inherent difficulties in communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members' lives better, we may overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by HCPF and to honoring the rules for all state health care programs.

Marketing Policies

CCHA providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that they select membership in a particular plan. The HCPF marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The provider's office staff are employees or representatives of the state, county, or federal government.
- CCHA is recommended or endorsed by any state or county agency or any other organization.
- The state or county recommends that a prospective member enroll with a specific Health First Colorado contracted entity.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific Health First Colorado contracted entity.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising, or recommending to an eligible individual that they select membership in a specific Health First Colorado contracted entity.
- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific Health First Colorado contracted entity.
- Engaging in direct marketing to members designed to increase enrollment in a particular health care plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problems or medical conditions, such as pregnancy, disability, or AIDS.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed health care organizations and excluding others.

CHAPTER 18: FRAUD, WASTE & ABUSE

First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Abuse:** behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.
- **Waste:** Includes overusing services or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at fighthealthcarefraud.com.

Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a CCHA member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Online support to verify member eligibility is available for provider inquiries through the state of Colorado Provider Web Portal at colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider.

Additional assistance for providers is available by calling **1-855-627-4685**.

Understanding the various opportunities for fraud and working with members to protect their health benefit identification cards can help prevent fraudulent activities. Providers should instruct their patients who suspect identity theft to contact Member Support Services if something is incorrect at **1-855-627-4685 (TTY 711)**.

Reporting Fraud, Waste, and Abuse

If you suspect a provider (for example, a provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visit our fighthealthcarefraud.com education site; at the top of the page, select **Report it**, located on right-side of screen, and complete the **Report Waste, Fraud and Abuse** form
- Calling our SIU fraud referral hotline: **1-866-847-8247**.
- Calling Customer Service

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals, as it may potentially compromise an investigation.

Provider Fraud, Waste, and Abuse

Examples of provider fraud, waste, and abuse include:

- Altering medical records to misrepresent actual services provided.
- Billing for services not provided.
- Billing for medically unnecessary tests or procedures.
- Billing professional services performed by untrained or unqualified personnel.
- Misrepresentation of diagnosis or services.
- Soliciting, offering, or receiving kickbacks or bribes.
- Unbundling — when multiple procedure codes are billed individually for a group of procedures, which should be covered by a single comprehensive procedure code.
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed.

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

Member Fraud, Waste and Abuse

Examples of member fraud, waste, and abuse include:

- Forging, altering, or selling prescriptions.
- Letting someone else use the member's identification card.
- Relocating to an out-of-service plan area and not letting us know.
- Using someone else's identification card.

When reporting concerns involving a member, include:

- The member's name.
- The member's date of birth, or case number, if you have it.
- The city where the member resides.
- Specific details describing the fraud, waste, or abuse.

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste, and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory, and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- Written warning and/or education: We send secure/trackable communications to the provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- Medical record review: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- Prepayment Review: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment on future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

Colorado Community Health Alliance
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, GA 30308
Attn: Investigator Name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU are found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation, may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **1-800-AVAILITY (282-4548)** for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain providers (facilities or professionals), or certain Claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation, and/or billing issues, or claims activity that indicates the provider is an outlier compared to their peers.

Once a claim or a provider is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination, the provider's action(s) may involve FWA, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of their prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the provider, even if those guidelines are not used for all providers delivering services to members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the

inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue, or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their provider agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to the Special Investigations Unit (SIU).
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste, or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

CCHA shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to provider or facility against any payments due and payable by CCHA to provider or facility with respect to any Health Benefit Plan under any contract with our company, regardless of the cause. Provider or facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by CCHA that an Overpayment Amount is due from provider or facility, provider or facility must refund the Overpayment Amount within the timeframe specified in letter notifying the provider or facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, CCHA shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by CCHA to the provider or facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should provider or facility disagree with any determination, provider or facility shall have the right to appeal such a determination under CCHA procedures set forth in this provider manual, on condition that such

appeal shall not suspend CCHA's right to recoup the overpayment amount during the appeal process unless required by regulatory requirements. CCHA reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The FCA also contains qui tam or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation by their employer under qui tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud, and simplifies the administration of health insurance.

- Our company recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations, or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment, or health care operations.
- Fax machines used to transmit and receive medically sensitive information
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed).
- Use professional judgment when mailing medically sensitive information, such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box, or department at our company.
- Our company voicemail system is secure and password-protected. When leaving messages for any of our employees, leave only the minimum amount of member information required to accomplish the intended purpose.

should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company, and verify the fax was received.

- When contacting us, be prepared to verify the provider's name, address, and TIN or the member's provider number.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least \$5 million (cumulative from all sources) must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste, and abuse. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste, and abuse.

CHAPTER 19: MEMBER RIGHTS & RESPONSIBILITIES

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best health care decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care coverage.

The following member rights and responsibilities are defined by the state of Colorado and appear in the member handbook.

Member Rights

CCHA honors civil rights and provides covered services to all eligible members regardless of the following:

- Age
- Color
- Disability
- Marital status
- National origin
- Race
- Religion
- Gender
- Gender identity
- Sexual orientation
- Taking part in the military
- Arrest or conviction record

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with CCHA, or who refer or suggest services to members, will do so in the same way for all members. Translation or interpretation services for capitated behavioral health services are offered free of charge for those members who need assistance.

CCHA members have the right to:

- Quality Medical Care
 - Be treated with respect and due consideration for their dignity and privacy.
 - Receive information on available medically necessary treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
 - Participate in decisions regarding their health care, including the right to refuse treatment.
 - Get a second opinion about their care from a network provider, or have arranged to obtain a second opinion outside the provider network, at no cost to the member.
 - Freely exercise their choice of provider.
 - Be referred to a non-network provider if CCHA does not have an appropriately trained provider in our network.
 - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - Be free from discrimination based on race, color, ethnicity or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability, or health status.

- Ask CCHA for help if their provider does not offer a service they need because of moral or religious reasons. CCHA does not deny access to service due to moral or religious reasons.
- Obtain available and accessible services covered under the contract.
- Freely exercise their rights without CCHA or its network providers treating the member adversely.
- Have health care services provided in accordance with the requirement for timely access and medically necessary care.
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment or if they simply want someone else to speak for them.
- Have access to emergency care 24 hours a day, 365 days a year for emergency services.
- Choose a primary care provider (PCP), choose a new PCP, and have privacy during a visit with a health care provider.
- Get needed medical services within a reasonable amount of time
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraint.
- Receive information on continuation of certain existing services for new members in accordance with the HCPF's Transition of Care policy.
- Be provided a toll-free number to contact CCHA for assistance.
- Make recommendations regarding the CCHA's Member Rights and Responsibilities Policy.
- Request and obtain information about advance directives at any frequency requested by a member (see CCHA Advance Directives Policy for more information).
- The right to file a Grievance or Appeal:
 - Understand and have available CCHA's grievance and appeals process, including:
 - The ability to express dissatisfaction about any matter except an Adverse Benefit Determination using CCHA's grievance process.
 - Receive assistance in completing grievance forms and other procedural steps related to the process, including interpreter services, toll-free numbers, and State Relay/TTY/TTD capability at no cost to the member.
 - No member or provider will be penalized for filing a complaint or grievance. At no time will CCHA cease medically necessary care pending a complaint or grievance investigation.
 - Provision of language services for the complaint/grievance process will include:
 - Interpretation of documents that are written in English into a member's preferred language.
 - Member notification that documents are available in languages other than English.
- The right to a State Fair Hearing, including:
 - The method for obtaining a State Fair Hearing.
 - Rules that govern representation at the State Fair Hearing.
 - That benefits will continue when requested by the member if the member files a timely Appeal or State Fair Hearing request and if the action is upheld, CCHA shall not recoup

- from members the cost of any benefits or services that were continued during the appeals process. Any Appeal rights the State makes available to providers to challenge the failure of CCHA to cover a service
- Privacy and medical records:
 - Access to CCHA's Privacy Policy, which tells them their rights regarding their PHI, CCHA's responsibility to protect this information, and how to obtain a hard copy of the policy, is included on the CCHA website. Includes members' right to know how CCHA handles, uses, and gives out their PHI.
 - Request and receive a copy of their medical records and request an amendment or correction, as specified in 45 CFR §§ 164.524 and 164.526 (if the privacy rule, as set forth in 45 CFR Parts 160 and 164, Subparts A and E, applies).
 - Look at and get a copy of their enrollment, claims, payment, and care coordination information.
 - Have their medical record and information protected in accordance with HIPAA and all other applicable privacy laws
 - Request and receive a copy of their medical record, and request that the record be amended or corrected.
 - Receive information in accordance with information requirements in 42 CFR 438.10.
 - To ask that their PHI not be used or restricted.

CCHA is committed to ensuring members are free to exercise their rights. A member cannot be treated adversely in any way by CCHA or a contract provider for exercising their member rights. If a member feels they are not free to exercise their member rights or are treated adversely because they exercised their rights, the member can file a grievance. CCHA will work with the member to resolve their grievance quickly and prevent future adverse treatment.

Member Responsibilities

CCHA members have the responsibility to:

- Understand their rights.
- Follow the Health First Colorado Member Handbook, produced by HCPF.
- Work with their PCP to guard and improve their health.
- Find out how their health benefits work and follow the plans and instructions for care that they have agreed to with their practitioner.
- Tell their provider the information they need to care for them, including symptoms.
- Listen to their PCP's advice and ask questions when the member is in doubt. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Take medications as prescribed and tell your provider about side effects or if your medications are not helping.
- Invite people who will be helpful and supportive to them to be included in their treatment.
- Call or go back to their PCP if they do not get better or ask for a second opinion.
- Treat health care staff with the respect members expect themselves.

- Tell CCHA if they have problems with any health care staff and to call the Colorado Ombudsman for Health First Colorado Managed Care at **1-303-830-3560** or **1-877-435-7123** (State Relay **711**).
- Keep their appointments. If they must cancel, call as soon as they can.
- Use the emergency room only for real emergencies.
- Call their PCP when they need medical care, even if it is after-hours.
- Supply information, to the extent possible, that CCHA and its practitioners and providers need in order to provide care.
- Tell their provider and Health First Colorado if they have any changes to their family, income, jobs, other insurance, or address within 10 days of the change.
- Pay for services they receive that are not covered by Health First Colorado.
- Report suspected fraud or abuse to Member Fraud at **1-844-475-0444**, Provider Fraud at **1-855-375-2500** or at hcpf.colorado.gov/how-report-suspected-fraud.

Notification of Member Rights:

- | | |
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| <ul style="list-style-type: none"> • CCHA provides members with the information necessary to understand benefit coverage and obtain health care services. • CCHA provides members with access to their Rights and Responsibilities via the following: CCHA's website, the Health First Colorado Member Handbook, CCHA Provider Manuals, and applicable provider newsletters. • Member Support Services representatives assist members with their Rights and Responsibilities during the course of telephone calls or directly if the member is involved in care coordination. | <ul style="list-style-type: none"> • CCHA provides education to members and providers regarding member rights during the Grievance and Appeal process, as appropriate. • CCHA maintains written policies and procedures regarding advance directives and educates members on advanced planning and care coordination, collective directives, and other related advanced planning documentation. • CCHA hosts on its website advanced planning information for providers and care coordinators. |
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Overview

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. CCHA wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that health care is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid the use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

CCHA ensures providers have access to resources to help support the delivery of culturally and linguistically appropriate services. We encourage providers to access and use the following resources:

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques to help provide the individualized care every patient deserves, regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice — Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, and develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support the needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients, as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients. CCHA also periodically offers cultural competency training at the CCHA Provider Town Hall Meetings and through the monthly newsletter.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

These resources can be accessed at CCHAcared.com/providertools.

CHAPTER 20: CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES

Interpreter Services

CCHA will ensure members who need interpreter services have access to interpreters 24/7. Services include, but are not limited to, face-to-face assistance during office visits at no cost to you or the member. Language assistance will be provided at all points of contact, in a timely manner, and during all hours of operation.

For more information on these services, refer to the [Interpreter Services](#) section in the [Provider Roles and Responsibilities](#) chapter.

APPENDIX A: DEFINITIONS

Accountable Care Collaborative (ACC): A program designed to affordably optimize member health, and self-sufficiency. The primary goals for the program are to improve member health and life outcomes and to use state resources wisely. Under the ACC, RAEs and PCMPs serve as medical homes, working together in collaboration with other health providers and members to optimize the delivery of outcome-based, cost-effective health care services.

Behavioral health (BH): Behavioral health refers to a level of psychological well-being, not just an absence of mental illness. When used in this manual, it is referring to both mental health and substance use disorders.

Capitated behavioral health benefit: A statewide benefit that advances the emotional, behavioral, and social well-being of the member. The benefit promotes psychological health, the ability to cope and adapt to adversity, and the realization of the members' abilities. The benefit provides comprehensive state plan and non-state plan mental health and substance use disorder services. The benefit operates under a monthly capitation.

Care coordination: The deliberate organization of member care activities between two or more participants (including the member and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional long-term services and supports (LTSS), oral health, specialty care, and other services. Care coordination may range from deliberate interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a member's health and social needs.

Medical home: An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers, and, where appropriate, the member's family.

Colorado interChange: HCPF's new Medicaid management information system and supporting services, which include: fiscal agent operations services, provider web portal, online provider enrollment, claims processing and payment, Electronic Data Interchange (EDI), Electronic Document Management System (EDMS), provider call center, help desk, and general information technology functionality and business operations.

Colorado Department of Health Care Policy and Financing (HCPF): A department of the government of the state of Colorado.

Early Periodic Screening, Diagnostic and Treatment (EPSDT): EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21 as specified in Section 1905(r) of the Social Security Act.

Fee-for-Service (FFS): A payment delivery mechanism based on a unit established for the delivery of that service (e.g., office visit, test, procedure, unit of time).

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the member's rights as defined in 42 C.F.R. § 438.400 (b).

Health neighborhood: A network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, local public health agencies, and county social/human services agencies that support members' health and wellness.

Healthcare Effectiveness Data and Information Set (HEDIS): A system developed by the National Committee for Quality Assurance to measure performance on important dimensions of care and service.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Legislation that provides security standards and general requirements for protecting health information.

Patient-Centered Medical Home: An approach to providing comprehensive primary care that facilitates partnerships between individual members, their providers, and, where appropriate, the member's family and community.

Medical record: A document, either physical or electronic, that reflects the utilization of health care services and treatment history of the member.

Member: Any individual client who is enrolled in the ACC program.

Monthly capitation payment: A payment the state makes on a monthly basis to a contractor on behalf of each member enrolled in its plan under a contract. This is based on the actuarially sound capitation rate for the provision of services covered under the contract.

Network provider: Any primary care medical provider or specialty behavioral health provider contracted with the RAE to deliver ACC services to members.

Primary Care Alternative Payment Methodology (Primary Care APM): An HCPF initiative to transition primary care provider reimbursement from a methodology based on volume to a methodology based on value.

Primary Care Medical Provider (PCMP): A primary care provider who serves as a medical home for members. A PCMP may be a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), clinic or other group practice that provides the majority of a member's comprehensive primary, preventive and sick care. A PCMP may also be an individual or pods of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

Provider: Any health care professional or entity that has been accepted as a provider in Health First Colorado, as determined by HCPF.

Regional Accountable Entity (RAE): A single regional entity responsible for the duties currently performed by Regional Care Collaborative Organizations and Behavioral Health Organizations (BHOs).



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