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

Section 9. Utilization Management Program

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Search Tip:
You can search quickly and easily by clicking on the binoculars icon on your toolbar, or by using the command Control+Shift+F. This will display a search box for you to enter what you want to find.

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

Utilization Management Program

Participation in our utilization management program is a contractual obligation of every network Provider. This includes:

- Adhering to policies, procedures, and standards;
- Identifying and addressing barriers to the provision of quality care;
- Reporting grievances and/or quality of care concerns;
- Participating in auditing processes; and
- Providing access to or copies of clinical records or other documents, as requested by Colorado Access.

PRIOR AUTHORIZATIONS

Certain services require prior authorization in order to obtain coverage (payment). Below are tables summarizing the types of services that require prior authorization. The Master Authorization List, a comprehensive list of procedure codes and corresponding prior authorization requirements, is on our website at coaccess.com/documents/MasterAuthorizationList.pdf.

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

GENERAL AUTHORIZATION RULES

This summary of our authorization rules does not guarantee coverage. Please refer to the member benefits information located on our website at coaccess.com/plans-services.

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

   Office visits for non-participating specialists do require a prior authorization from Colorado Access and will be considered on a case-by-case basis for particular clinical needs.

Note: Certain services, such as visits with physical, occupational, and speech therapists may require authorization.

Contact the utilization management department for more information.

Access Behavioral Care	
Type of Service	**Authorization Rules**
Ambulance	Emergency ground or air ambulance transport does not require prior authorization Non-emergent scheduled requires prior authorization
Emergency Care (POS 23)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required Professional services and ancillary services rendered during an inpatient stay are considered downstream and do not require separate authorization for both participating and non-participating providers except as described in the Authorization Categories section under Procedure Authorization. Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria and national coverage guidelines.
Crisis Stabilization Unit (CSU)	No prior authorization required
Residential	Prior authorization required
Acute Treatment Unit (ATU)	Prior authorization required
Outpatient – Routine	No authorization required
Outpatient – Higher Levels of Care: • Day treatment • Partial hospitalization • Intensive outpatient (IOP) • Electroconvulsive therapy (ECT) • Psychological/neurological testing	Prior authorization required
Any services from non-participating providers (except emergency department)	Prior authorization required

Child Health Plan *Plus* (CHP+)	
Type of Service	**Authorization Rules**
Emergency Care (POS 23)	No prior authorization required
Urgent Care (POS 20)	No prior authorization required
Observation (POS 22)	No prior authorization required
Inpatient	Prior authorization required Professional services and ancillary services rendered during an inpatient sty are considered downstream and do not require separate authorization for both participating and non-participating providers except as described in the Authorization Categories section under Procedure Authorization. Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria and national coverage guidelines.
Outpatient – office visits (physical/medical)	No prior authorization required
Outpatient medical procedures	Check the Master Authorization List
Outpatient physical, occupational, speech therapies	Prior authorization required
Outpatient – behavioral health higher levels of care: • Day treatment • Partial hospitalization • Intensive outpatient (IOP) • Electroconvulsive therapy (ECT) • Psychological/neurological testing	Prior authorization required
Newborns	Coverage of services to a newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother's eligibility alone.
Diagnostic services	Routine laboratory and imaging services do not require prior authorization Specialized diagnostic procedures may require prior authorization, check the Master Authorization List
DME	Check the Master Authorization List

Child Health Plan *Plus* (CHP+)	
Type of Service	**Authorization Rules**
Home Health	Prior authorization required
Ambulance	Emergency ground or air ambulance transport does not require prior authorization Non-emergent scheduled requires prior authorization
Any services from non-participating providers (except emergency department)	Prior authorization required

Urgent and Emergency Care

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

Definition of an Emergency Medical Condition

An emergency medical condition is defined as a sudden, unexpected onset of a health condition, including pain, which a prudent layperson could reasonably expect to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, if immediate medical attention is not obtained.

We cover all emergency department services necessary to screen and stabilize members if:

> A prudent layperson would have reasonably believed that use of a [contracted] provider would result in a delay that would worsen the emergency; or a provision of federal, state, or local law requires the use of a specific provider (DOI Regulation 4-2-17).

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge from the emergency department.

Definition of Urgent Care

Urgent care is defined as provision of medically necessary covered services to treat an injury or illness of a less serious nature than those requiring emergency care but required in order to prevent serious deterioration in the member's health, or to maintain a member's activities of daily living.

SUBMITTING AUTHORIZATION REQUESTS

It is best to plan ahead and submit an authorization request well in advance of the service being rendered. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that

following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

We cannot retrospectively deny benefits for treatments that have been preauthorized except in cases of fraud, abuse, or if the member loses eligibility.

Prior to submitting an authorization, verify the member's eligibility either through our website at coacces.com/for-providers or by calling us at 800-511-5010. Once you have determined the member is eligible, complete the applicable service authorization form located on our website at coaccess.com/frequently-used-forms and fax to our utilization management department at:

- 303-755-4135 or 877-232-5976 for physical health, DME, home health, outpatient therapy, or pharmacy J code authorization requests
- 720-744-5127 for pharmacy authorization requests
- 720-744-5130 for behavioral health authorization requests

You will be notified if additional information is needed, if the service is authorized, or of an adverse benefit determination (services will not be authorized).

TYPES OF UTILIZATION REVIEW DETERMINATIONS

Our utilization review determinations comply with state and federal guidelines. We will make one of the following determinations after reviewing an authorization request. Only the Colorado Access medical director or the designated physician reviewer can deny an authorization request. For prospective or concurrent determinations, the treating physician may request a reconsideration of the denial. All denials may be appealed.

1. **Authorized** – The requested service meets all utilization review criteria including, but not limited to, member eligibility, medical necessity, and if the service is a covered benefit. Authorization is not a guarantee of payment.
2. **Pended** – A determination cannot be made with current information. The case is pending receipt of additional information and/or documentation.
3. **Adverse Benefit Determination** ("Denied") – is any of the following:
    a. 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.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole, or in part, of payment for a service.
    d. The failure to provider services in a timely manner, as defined by the State.
    e. The failure to act within the timeframes defined by the State for standard resolution of appeals.
    f. The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).

g. For a resident of a rural area with only one managed care plan, the denial of a Medicaid member's request to exercise his or her rights to obtain service outside of the network under the following circumstances:

   i. The service or type of provider (in terms of training, expertise, and specialization) is not available within the network.

   ii. The provider is not part of the network but is the main source of a service to the member – provided that the provider is given the opportunity to become a participating provider. If the provider does not choose to join the network or does not meet our qualification requirements, the member will be given the opportunity to choose a participating Provider and then will be transitioned to a participating Provider within 60 days.

4. **Administrative Denial** – A provider's failure to follow contractual requirements and/or established procedures regarding authorization requirements (i.e., out of timely notification, failure to submit necessary information, etc.) may result in an administrative denial.

MEDICAL NECESSITY

As part of utilization review to authorize a service, we determine medical necessity. A service is medically necessary if it:

- 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;
- Is provided in accordance with generally accepted professional standards for health care in the United States;
- Is clinically appropriate in terms of type, frequency, extent, site, and duration;
- Is not primarily for the economic benefit of the Provider or primarily for the convenience of the client, caretaker, or Provider;
- Is delivered in the most appropriate setting(s) required by the client's condition;
- Is not experimental or investigational; and,
- Is not more costly than other equally effective treatment options.

Medical Necessity Definition for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)

Not applicable to CHP+

For EPSDT, medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

- Is found to be an equally effective treatment among other less conservative or more costly treatment options; and
- Meets at least one of the following criteria:
    - The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
    - The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability.
    - The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
    - The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.
    - Medical necessity may also be a course of treatment that includes mere observation.

Medical necessity determinations are based on the following:

- Standardized national criteria, such as InterQual© criteria.
- Review by our medical director (or an associate medical director). This may include discussing treatment alternatives and approaches with the Provider requesting the service.

We consider individual needs as well as the capacity of the local delivery system when applying medical review criteria. A Provider ay request the criteria used to make a determination from our utilization management department at 844-683-1072 (toll free).

POST-STABILIZATION CARE SERVICES

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

Emergency services and urgently needed services do not require prior authorization. We cover, without prior authorization, regardless of whether the services are obtained within or outside our Provider network and in accordance with the prudent laypersons' definition of emergency medical condition:

> "A person having average knowledge of health services and medicine and acting reasonably, would have believe that an emergency medical condition or limb-or-life threatening emergency existed."

We do not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms that are otherwise covered under its contracts. We may not refuse to cover emergency services based on the emergency room provider, hospital, or agent not notifying the member's primary care provider, Colorado Access, or the applicable state entity of

the member's screening and treatment. The physician treating the member must decide when the member may be considered stabilized for transfer or discharge, and that decision is binding on Colorado Access.

CONCURRENT REVIEW AND REAUTHORIZATION FOR CONTINUED SERVICES

All requests for ongoing non-routine services beyond the initial authorization require reauthorization. The appropriate authorization form must be completed and submitted prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility.

Concurrent Reviews

The Provider must phone or fax clinical information supporting the medical necessity of admission and/or continued stay within one working day of the request for information by Coloration Access. Initial authorization and concurrent review determinations are based on medical necessity as determined by InterQual© criteria and national coverage guidelines or a health plan associate medical director review. Authorizations for inpatient and higher levels of care such as residential treatment or day treatment, are reviewed by service coordinators on a regular and ongoing basis throughout the episode of care. The service coordinator will normally contact the Provider early in the episode of care for initial review of the episode of care, and then will establish a schedule for follow-up reviews. The subsequent reviews are normally conducted by telephone.

Service coordinators conduct inpatient reviews within one business day of notification to verify that the admission meets inpatient criteria, establish continued stay review requirements and timetable, and initiate discharge planning. Subsequent concurrent review assessments are performed to assure continued stay criteria are met. The medical director reviews all admissions and stays that do not meeting medical necessity criteria. If a request for an extended length of stay is denied by the medical director, the Provider and attending practitioner will be notified and may request a peer-to-peer review within one business day. Payment will be made only for the authorized length of stay. We will provide written notice of a denial to the attending Provider, the member, and if appropriate, guardian or individual representing the member. All clinical denials are subject to our appeals procedures.

Requests for peer-to-peer conversations are not considered complaints or appeals.

AFTER HOURS DISCHARGE PLANNING NEEDS

For afterhours discharge planning needs (to initiate home health, DME, oxygen supplies), such as on holiday or weekends, the Provider (vendor) must notify Colorado Access on the next working day following discharge from the facility. A review is done to ensure the following: eligible member; covered benefit; medical necessity; and timeliness of notification. For continuing needs, the Provider (vendor) must initiate a procedure authorization.

DOWNSTREAM PROVIDERS

- A downstream provider is defined as any Provider who renders services at the direction of other Providers. These Providers are not subject to the prior authorization and/or referral process.
- **Emergency room** (place of service 23) services billed by Providers are considered downstream.
- **Inpatient** (place of service 21) pathology, radiology, anesthesia and all other physician services not on our Master Authorization List are considered downstream.
- **Outpatient** (place of service 22) the following services should be considered downstream:
    - Pathology – all professional laboratory procedures
    - Radiology – all professional radiology procedures
    - Anesthesia – all professional services billed within the procedure code range of (00100-01999)
    - Facility – all outpatient contracted facility services billed with place of service 22 or 24. The use of a non-contracted facility requires prior authorization.
- **Skilled nursing facility** (place of service 31 or 32) physician services for care rendered in a skilled nursing facility. However, podiatrists (DPM) are required to obtain prior authorization.
- **Interpretive Services** – all services using modifier 26

CONTINUITY OF CARE FOR NEW MEMBERS

We will contact new members who have been identified as having potential continuity of care needs so a needs assessment may be completed. If the member is in an ongoing course of treatment with a provider, and the provider agrees to continue the service, the member may continue to receive medically necessary covered services at the level of care received prior to enrollment, for a transition period of up to 60 calendar days for primary and specialty care, and 75 calendar days for ancillary services.

If the provider is not contracted with Colorado Access and is not willing to do so, and the service is expected to be ongoing, we, as appropriate, will work with the member and provider to have the appropriate services transitioned into the network by the completion of the transition period. Services will be reassessed at the end of the transition period as part of routine authorization to ensure that they continue to be appropriate at the current level of care.

Members who are in their second or third trimester of pregnancy at the time of enrollment may continue to see their obstetrical provider until the completion of postpartum care directly related to the delivery.

If we do not have the direct capacity to provide a medically necessary covered service within the network, arrangements will be made for the continued service to be provided through a single case agreement with an approved, non-participating provider.

CONTINUITY OF CARE FOR EXISTING MEMBERS

At the time we are notified of a network transition (i.e., Provider group termination or vendor contract termination), a plan will be prepared to provide a coordinated approach to the transition. A good faith effort will be made to provide written notice of a Provider termination (with or without cause) within 15 calendar days to members who are patients of that Provider. CHP+ members will be allowed to continue receiving care for 60 calendar days from the date a participating Provider is terminated without cause, unless it is determined by an associate medical director or designee that continued care with the terminated Provider would present undue risk to the member or to Colorado Access.