PROVIDER MANUAL

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

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Search Tip:
You can search quickly and easily by using the command Control+F. This will display a search box for you to enter what you want to find.

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

Colorado ACCESS

Behavioral Health – Specific Policies and Standards

SERVICES PROVIDED

We have many kinds of behavioral health care services for individuals and families and will help clients find what works best for them. Services include:

- Outpatient treatment
- Day treatment
- Psychosocial rehabilitation
- Case management
- Medication management
- Emergency services
- Inpatient services
- Residential services
- Home-based services for children and adolescents
- Evaluations/assessments
- Deaf and hard of hearing services
- Vocational services
- Senior services
- Peer support

For more information on services, please visit coaccess.com/services-offered.

BILLING AND CODING REQUIREMENTS

All billed services must have an applicable modifier. Please note that many services can have more than one applicable modifier, and all must be included in order for the claim to be paid.

All services must be in compliance with the Uniform Service Coding Standards found here: https://www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0.

ARRANGING TRANSPORTATION SERVICES

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

WAITING ROOM GUIDELINES

Our expectation of all Providers is that members are seen promptly for outpatient appointments. Members should not be made to wait for long periods of time past their scheduled appointment. We understand that unexpected circumstances arise that may delay appointments or force schedule changes, however, these should be communicated as soon as is reasonable to members to avoid long waits.

Our guidelines for waiting room time are as follows:

- Members will wait no longer than 10 minutes past their scheduled appointment.
- If there is a known situation that occurs prior to a member's appointment that will force an anticipated wait longer than 10 minutes, the Provider should attempt to contact the member by phone or other means to reschedule.
- If the Provider is unable to contact the member, the situation should be communicated to the member at check-in.
- The member should be given the option of rescheduling their appointment.
- If the member cannot or does not wish to reschedule, the Provider will attempt to reach a compromise solution for the member's appointment.
- If a compromise cannot be reached, the member will be given the opportunity to contact Colorado Access concerning the situation.
- If a situation arises during the member's wait that will force a longer wait time, the member must be notified of this as soon as possible and the steps described above must be followed.

We will monitor Providers from time to time regarding their adherence to these guidelines. All Providers must develop a mechanism to document appointment time and actual time seen.

Note: Waiting time guidelines apply only to the scheduled appointment time. If a member arrives early for their appointment, the time spent between their arrival and the appointment time does not count as excessive wait time.

Provider Sites

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

MISSED APPOINTMENTS

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

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

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

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

MEMBER COPAY

There are no feeds for medically necessary, covered services to members. Providers may not require a copay for covered services rendered to members enrolled with Access Behavioral Care.

MEMBER HANDBOOK

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

MEMBER AND FAMILY AFFAIRS

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

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

The member Partnership meeting is help quarterly and all members are invited to be active participants through our member newsletter. Members are given updates on quality initiatives taking place within Colorado Access and are given an opportunity to interact with staff members for individual staff members and departments. For more information, call 800-511-5010.

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

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

THE OMBUDSMAN FOR MEDICAID MANAGED CARE

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

COLORADO CLIENT ASSESSMENT RECORD (CCAR)

The Colorado Client Assessment Record (CCAR) is a multipage state-mandated form for assessing a member's clinical status, level of functioning, and available strengths and resources. The CCAR must be completed upon a member receiving four or more mental health service encounters during any continuous six-month period or six or more short-term, non-chronic behavioral health services in an integrated care setting, during any continuous six-month period.

Providers that are electronically submitting the CCAR directly to the State's Office of Behavioral Health (OBH) should continue to do so; others may complete and submit it through our website at coaccess.com/for-providers. A hard copy of the electronically submitted CCAR must be printed at the Provider site to remain in the member's chart. The CCAR manual is also available on our website at coaccess.com/access-behavioral-care-provider-information.

Training on CCAR completion may be obtained from your provider relations representative or through OBH. Colorado Access will send notification of the periodic CCAR training offered by OBH.

EPSDT SERVICES

For children and adolescents through age 20, Providers are expected to contact the PCP for results of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exams.

EPSDT is a health care program for Medicaid recipients, up to and through 20 years of age. The EPSDT program detects and treats health problems early by providing regular medical, dental, vision, and hearing check-ups, diagnosis, and treatment. Under federal Medicaid requirements, any service necessary to treat health care needs identified through an EPSDT screening must be provided through the Medicaid program even if the identified service is not included in the State's Medicaid plan.

The mental health Provider should determine if the EPSDT screening has been conducted by the PCP. With the member's or guardian's permission or as otherwise allowed by law, the mental health Provider can obtain and review the results of the screening, especially those findings that indicate a need for mental health services. If an EPSDT screening has not been done, the mental health Provider should refer the family to their PCP with a recommendation that an EPSDT screening be done. If the youth does not have a PCP, the family may be referred to their Medicaid health plan, if they are enrolled in one, or to Health First Colorado Enrollment (formerly known as Health*Colorado*), at 303-839-2120 or 888-367-6557 (toll free). Families should request a PCP to conduct screening under the EPSDT program.

Colorado Access Providers, with written consent from the member, are expected to communicate with the member's PCP to coordinate any significant physical and behavioral health care needs, or attempt to link members to a PCP through referral to their health plan or Medicaid (as stated above). This is particularly important for members who may be taking prescription psychiatric medication.

We ask that Providers inquire about medical issues with members and as soon as it is therapeutically appropriate, the mental health Provider should request any necessary authorizations from the member to communicate with the member's PCP and other medical providers to obtain any pertinent medical information that might be a factor in mental health treatment and diagnosis. This should be done as early in the intake evaluation or treatment episode as possible, preferably at the first face-to-face contact. The attempt to obtain any required release(s) of information should be documented in the member's clinical record if the member or guardian declines to give authorization.

To facilitate continuity of care, the Provider should communicate with the PCP when any of the following occur:

- Initiation of treatment
- Initial prescription of psychiatric medications
- Significant changes in prescribed medications
- Changes in the member's clinical condition that could potentially impact his or her overall medical care

Any communication by phone must be documented in the clinical record and any written communications should be contained in or copied for the clinical record. Coordination of care efforts should be documented on the service plan as a case management function.

As part of the Colorado Access Quality Assessment and Performance Improvement Program (QAPI) documentation or Provider care coordination activities may be reviewed, including:

- Presence in the clinical record of a signed Authorization(s) to Release Information
- Presence in the clinical record of a letter or other treatment notification form to the PCP (if authorized or otherwise allowed by law), inclusion of documentation in the member's clinical record of communication with the PCP including when the communication took place, a general description of information shared, and method of communication
- Documentation of any refusals to share information with other providers
- Documentation of coordination of care functions in the member's individualized service plan

CHILD MENTAL HEALTH TREATMENT ACT

The Child Mental Health Treatment Act became part of Colorado law in 1999. The Act gives children with Medicaid access to some mental health services in the community. This includes residential services. It also includes transitional treatment services. The Act also has special

appeal steps, if needed. Members may qualify for these services. First, the child must have a mental illness. Second, the child must be younger than 18. Third, the child must be at risk to be placed out of the home. Call Colorado Access to find out more about these services at 800-511-5010.

NOTIFICATION OF EMERGENCY ROOM AND OBSERVATION SERVICES

Members identified as needing emergency services should be referred directly to the nearest hospital emergency department.

While prior authorization for emergency room and observation services is not required, Colorado Access requires notification of all emergency care rendered. A Colorado Access Emergency Services Notification form is located online at coaccess.com/access-behavioral-care-provider-information and must be forwarded to Colorado Access, preferably at the time of service, but no later than 24 hours after the delivery of the service. Forms may be faxed to 720-744-5130.

In situations where members access emergency services directly, emergency care Providers are required to contact Colorado Access to communicate post-emergency plans and request authorization of post-emergency are. Requests for authorization can be submitted 24 hours a day, seven days a week.

INITIAL TRIAGE ASSESSMENT

Members can access mental health services by calling Colorado Access for assistance with finding and scheduling an appointment with a Provider, or by contacting a Colorado Access Provider directly. Calls requesting specific needs will be referred to a care manager, most of who are licensed and experienced clinicians. Care managers may conduct a brief triage assessment by phone to assist a member, family member, or representative with referrals to the most appropriate Provider.

All assessments performed by Providers will identify service needs by evaluating the member's current clinical status.

Special Populations

If a member accessing services at a Provider site is identified as belonging to a special treatment population, the member may be referred back to a care manager to ensure an appropriate member/Provider match. Special treatment populations would include members with dual diagnoses or comorbidities such as mental illness and substance abuse, developmental disability, and/or active medical problems. Service coordinators are also able to assist members with special language needs, those who are deaf or hard of hearing and members with specific cultural, linguistic, or other identified needs.

PSYCHOLOGICAL TESTING

A request for psychological testing requires the submission of a specialized form, which can be found at coaccess.com/access-behavioral-care-provider-information and faxed to us at 720-

744-5130. Information must include the reason(s) for the request and should include copies of other consultations or assessments performed.

REDUCTION OR DISCONTINUATION OF SERVICES

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

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

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

PRIMARY CARE PROVIDER (PCP) COMMUNICATION EXPECTATIONS

Providers should coordinate care with the member's PCP obtaining any authorizations required to disclose such information. Such communications would ideally occur:

- At the outset of care
- When changes in the member's status occur that may impact medical condition(s)
- When medications are prescribed or changed