

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

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Specific Policies and Standards

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- Communication Expectations
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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.

Provider Responsibilities

COMMUNICATION EXPECTATIONS

Providers should coordinate with the member's other providers to support care management and continuity of care. This includes sharing information from the medical record as allowed by and in compliance with, applicable law.

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

PRIMARY CARE PROVIDERS (PCPS)

Each member may select, or be assigned to, a participating primary care Provider (PCP). The PCP is responsible for managing the member's total health care services. These responsibilities include the following:

- Providing care and services for eligible members
- Being accessible (or have call coverage) to members 24 hours a day, 7 days a week
- Hours of operation must not be less than those offered to members with commercial health plans
- Provide services to members according to the plan's access standards
- Coordinating health care services for members, including referring members to specialists
- Provide preventive health services and offering provision for special needs
- Educating members about healthy lifestyles and prevention of serious illness
- Counseling members about appropriate emergency department utilization
- Providing culturally appropriate health care
- Maintaining confidentiality of medical information in compliance with all state and federal regulatory agencies (including HIPAA and 42 CFR Part 2)
- Maintain legible and comprehensive medical records for each encounter with a member that conform to documentation standards

Administrative Responsibilities Include:

- Participating in our quality management and utilization management programs
- Complying with our credentialing requirements



- Maintaining a separate medical record for each of our members
- Reporting encounter and claim data to Colorado Access, so that we may track service utilization
- Authenticating patient's identity at every office encounter to prevent card sharing and patient identity theft
- Verifying eligibility and enrollment for every office encounter
- Referring members to our participating Providers
- Adhering to the professional code of conduct

Practice Capacity and Acceptance of New Patients

A PCP may determine how many members the practice will accept and at what point the panel is open or closed. To request a change in member capacity or an open/closed panel status change, please contact our provider network services department. To close the panel to new members, the Provider must give a 60-day advance written notice to our provider relations department by emailing ProviderRelations@coaccess.com or calling 800-511-5010. Opening a panel to new members will become effective on the date the notification is received. Upon receipt of the notice, provider network services staff members will provide written notice to the Provider, indicating the effective date for the requested panel status change.

The PCP is responsible for the care of members assigned to the PCP from the date of assignment, whether or not the PCP has previously provided care to the patient.

Coverage

- The PCP must ensure that coverage is available 24 hours a day, 7 days a week, for member services. Access to a qualified health care Provider by phone either onsite, call sharing, or answering service is appropriate. Please note, a recorded message advising a member to seek emergency care does not constitute after hours coverage.
- The call coverage Provider must know and follow the requirements of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

SPECIALTY CARE PROVIDERS

Contracted specialty care Providers have the following responsibilities to members:

- Verify member eligibility on the date of service
- Provide specialty consultation care approved by the member's PCP or by Colorado Access, as necessary
- Obtain appropriate authorization from Colorado Access before treating a member
- Coordinate the member's care with his or her PCP
- Provide a written consultation report to the PCP within five days of providing service

- Maintain confidentiality of medical information in compliance with all state and federal requirements
- Maintain a separate medical record for each of our members
- Maintain legible and comprehensive medical records for each encounter
- Hours of operation must not be less than those offered to members with commercial health plans

Second Opinion

Members have a right to a second opinion. Providers may not charge a member for helping to arrange a second opinion. If a member needs assistance arranging a second opinion, or setting an appointment, please call 800-511-5010 and ask to speak to a care manager.

Coverage

- The specialist must assure that coverage is available 24 hours a day, 7 days a week for member services. Access to a qualified health care Provider by phone either onsite, call sharing, or answering service is appropriate.

Please note: A recorded message advising a member to seek emergency care does not constitute after hours coverage.

- The call coverage provider must know and follow the specifications of the authorization process.
- Coverage responsibilities include outpatient and inpatient care.

If you have questions or concerns regarding the provider responsibilities, please email ProviderRelations@coaccess.com.

EPSDT SERVICES FOR MEMBERS WITH MEDICAID

For children and adolescents under the age of 21, any medically necessary service to treat any physical, dental, or mental health diagnosis is covered under the member's Medicaid. Services may even be covered if it is not a Health First Colorado (Colorado's Medicaid Program) benefit or has service limits. Services covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services include:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations and therapies
- Immunizations
- Lab tests, including lead poisoning tests
- Health and education preventive education
- Vision services
- Dental services
- Hearing services

Some of these services are covered under the capitated behavioral health benefit, and some of these services are covered under the physical health fee-for-service benefit, often through primary care (reimbursed through fee-for-service). In addition to traditional state plan services such as individual, group, and family psychotherapy, inpatient hospitalization, we are also able to reimburse for the following behavioral health services through the capitated behavioral health benefit under the EPSDT program:

- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential treatment
- Assertive community treatment
- Recovery services
- Respite services

Our provider network is expected to facilitate and promote the availability of EPSDT services, both behavioral health and physical health in nature. This includes, but is not limited to, the following:

- Regular communication and coordination with the member's primary care provider (with the member's permission and release of information)
- Informing and educating members and their families about the availability of these services available to them
- Inquiring about utilization of these benefits (i.e. "with your birthday coming up, have you scheduled your annual checkup?" or "have you gotten your flu shot yet this year?")
- Attending an EPSDT webinar and reviewing EPSDT materials provided by the Colorado Department of Health Care Policy and Financing

Behavioral health providers contracted with us are required to screen and assess members' treatment needs (even those not covered by the capitated behavioral health benefit), and provide the clinically appropriate services discovered by any screening or diagnostic procedure. Most EPSDT services do not require prior authorization (residential treatment is the exception and does require prior authorization); however, any EPSDT service is subject to medical record review to assure the following minimum requirements:

- Any request for mental/behavioral health screening or assessment must be accommodated. Any provider unable to complete a requested screening or assessment must contact Colorado Access for assistance.
- Any screenings and services must be performed by a provider who is qualified to furnish mental health services according to the staff requirements in the Uniform Service Coding Standards manual for the relevant service.
- All screenings and services must be performed in a culturally and linguistically sensitive manner.
- Results of all screenings must be recorded in the child's medical record.



- Referrals to the member's primary care provider, Colorado Access, Healthy Communities, or other referral, as appropriate, for services not available at the provider's office.

For more information about EPSDT, please visit <https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt>. The website includes valuable information and resources such as fact sheets and training videos for both parents and providers, request forms, and regulatory information.

Any member or provider who needs assistance accessing EPSDT services, or is experiencing barriers or problems related to EPSDT services (even physical health services not reimbursed by Colorado Access) can contact care management at 720-744-5124 or 866-833-5717 (toll free). The Healthy Communities family health connectors can also assist with accessing services:

- Adams, Arapahoe, Douglas, and Elbert counties: Tri-County Health Department 303-873-4404
- Denver County: Denver Health and Hospital Authority 303-602-6770