Section I

GENERAL INFORMATION

WELCOME TO VALUEOPTIONS COLORADO MEDICAID NETWORK SERVING COLORADO HEALTH PARTNERSHIPS, FOOTHILLS BEHAVIORAL HEALTH PARTNERS, AND NORTHEAST BEHAVIORAL HEALTH PARTNERSHIP

As a ValueOptions Colorado Medicaid Network provider, you join with some of the most accomplished behavioral health care professionals in the country — people who share our commitment to making quality behavioral health care more accessible for our members. This handbook was developed to answer your questions about the Colorado Medicaid Network and about how we manage and coordinate the delivery of behavioral health care to Colorado Medicaid members. It includes compliance with Medicaid requirements, services, clinical guidelines, policies and procedures, member rights and responsibilities and provider resources. Following these guidelines will assist us in giving you timely treatment authorizations and claims reimbursement.

If you have any questions or comments while reading the handbook or at any other time, please call Provider Relations at our toll-free Provider Line, 1-800-804-5040.

Provider Relations Needs:	**1-800-804-5040**
Clinical Authorization and Claims Needs:	
Colorado Health Partnerships	1-800-804-5008
Foothills Behavioral Health Partners	1-866-245-1959
Northeast Behavioral Health Partnership	1- 888-296-5827

Thank you for your participation in our network. We look forward to a long and rewarding relationship with you as we work together to provide high quality Member care.

ABOUT THE VALUEOPTIONS COLORADO MEDICAID NETWORK

ValueOptions Colorado serves three separate Colorado partnerships, each of which is contracted by the Colorado Medicaid Community Behavioral Health Services Program as a Behavioral Health Organization (BHO). BHOs are tasked with managing Medicaid behavioral health benefits and funds on a regional basis. BHOs must comply with all federal and state regulations regarding administration of the Medicaid program including good stewardship of Medicaid funds.

These three partnerships include Colorado Health Partnerships (CHP), Foothills Behavioral Health Partners (FBHPartners) and Northeast Behavioral Health Partnership (NBHP). Each partnership holds a contract with the Colorado Department of Health Care Policy and Financing for Medicaid funded behavioral health services on a regional service area basis. Together the three BHOs working with ValueOptions encompass 60 counties and over 400,000 Medicaid members throughout Colorado. Members are assigned a BHO based on the county in which they obtain Medicaid eligibility. (NOTE: This may not be their county of current residence. You are responsible for determining the Member's county of eligibility.) Each

Partnership is organized as a Colorado Limited Liability Company owned by Community Behavioral Health Centers local to the service area and ValueOptions.

Colorado Health Partnerships (CHP) includes Mind Springs Health, The Center for Mental Health, Axis Health Systems, AspenPointe Health Services, Spanish Peaks Behavioral Health, Southeast Mental Health Services, West Central Mental Health Center, San Luis Valley Community Mental Health Center, and ValueOptions.

Foothills Behavioral Health Partners (FBHPartners) includes Jefferson Center for Mental Health, Mental Health Partners, and ValueOptions.

Northeast Behavioral Health Partnership (NBHP) includes Touchstone Health Partners, North Range Behavioral Health, Centennial Mental Health Center, and ValueOptions.

Each of these BHOs may have specific requirements and additional information that can be found in the BHO specific addendum that accompanies this handbook.

The Colorado partnerships are based on a unique model pioneered in Colorado in 1995. These partnerships bring together the advanced information and managed care strengths of a national company with the full array of high quality local service providers who practice throughout Colorado. The backbone of this provider system consists of Community Mental Health Centers that are regionally based and have long, local histories and outstanding records of service to local communities and residents. Colorado is one of few states that have such a strong public mental health system and one that delivers services to members at convenient locations throughout the rural and frontier areas of our state. One of the benefits to Colorado of the partnership model is that it strengthens and preserves Colorado's public mental health safety net.

By choosing to participate as a provider in the ValueOptions Colorado Medicaid Provider Network, you are assisting us in increasing capacity for quality services to Medicaid members.

Section 2

CONTINUUM OF SERVICES

The ValueOptions Colorado Medicaid Behavioral Health Services Program is designed to include a wide array of services that support therapeutic interventions at the level of intensity indicated by the strengths and needs of each unique person served. Most of these services are offered through our Community Behavioral Health Center (CBHC) providers. However, routine outpatient assessment, psychotherapy, psychological testing, and medication management services are also offered by our network of independent outpatient providers. Hospitalization and residential levels of care are offered by contracted network facilities and some CBHCs. The care delivery system has been developed to ensure that, from the moment they access services, Medicaid members are directed to the most appropriate level and type of behavioral health care, in geographically convenient locations. Behavioral Health Organization (BHO) providers, facilities and other treatment programs are screened against credentialing standards, qualifications in specialty areas, and managed care experience. Authorizations for payment of services are determined through the application of medical necessity criteria and use of clinical judgment.

CLINICAL SERVICES DESCRIPTIONS

- **Alternative Treatment Unit (ATU):** A 24-hour psychiatric treatment program that provides supervision and treatment in a structured environment, which may or may not be medically staffed twenty-four hours a day. ATU services are designed for members without acute medical conditions who require short-term care. Medical consultation must be available.

- **Crisis Outpatient Services:** Crisis outpatient services are provided in response to a crisis that results in acute destabilization of functioning and are focused on rapid restoration of functioning in the community. These services are provided in an outpatient office, home environment or other community setting. They are time-limited services and may include a wide variety of intensive individual, couples, family treatment and case management services.

- **Crisis Stabilization/Observation:** Hospital-based, medically-staffed services designed to provide evaluation and stabilization for members in crisis and in need of medical care or intensive observation for up to 23 hours. Treatment interventions are focused on mobilizing support and resources so that the Member can be managed in a less restrictive setting.

- **Day Treatment for Children and Adolescents:** Day Treatment programs are designed for treatment of serious covered disorders that cause significant impairment in usual life/school activities. Day Treatment is a time-limited treatment program that offers academic services together with therapeutically intense, multimodal, structured clinical services.

- **Emergency Services:** Services used during a mental health emergency which are unscheduled and immediate, and needed to evaluate or stabilize an emergency condition.

- **Evaluation/Assessment Services:** Diagnostic assessment of the member who presents for treatment to determine the member's needs and strengths and to recommend the appropriate level of care and focus of treatment.

- **Family Preservation Services:** Time-limited, in-home treatment to maintain the child in the home or to facilitate reunification of the child with the family.

- **Home Based Services:** Services, which can vary in intensity and duration, provided in the home to assess and stabilize a member's symptoms, and to maintain and/or improve a member's level of functioning.

- **Inpatient Hospitalization:** Treatment of a mental health condition requiring 24-hour supervision, observation and intervention, in a structured therapeutic medical environment with 24-hour nursing care. This is the most restrictive level of care and generally applies to those members who are experiencing mental health symptoms resulting in behaviors that cause significant danger to themselves or others, or cause the member to be significantly disabled and unable to meet their basic needs.

- **Intensive Case Management:** Services typically provided by Community Behavioral Health Center staff for coordination of services, support, advocacy and to assist members with the recovery process.

- **Medication Management and Medication Assisted Therapy:** Interventions by a psychiatrist or other professional with prescription authority that include evaluation, administration and monitoring of medications prescribed for the treatment of a covered behavioral health disorder. Members may also spend time with a nurse or physician's assistant, who reviews symptoms and side effects, instructs the member in symptom management, administers injections, monitors oral medication, and performs other adjunctive services on behalf of the psychiatrist.

- **Mobile Assessment:** An assessment of a member's treatment needs by a clinician who travels to the member's location in the community, including an emergency room.

- **Outpatient Hospital Based Laboratory Services:** Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the member's behavioral health treatment or condition.

- **Outpatient Treatment:** Least restrictive level of care in which the member participates in face-to-face assessment, counseling and routine case management services delivered in a mental health provider's office or other community setting.

- **Partial Hospitalization Program:** A structured, intensive, time-limited program designed to provide diagnosis and treatment for members who require more structure than is provided by outpatient therapy in order to continue to reside in the community.

- **Post-stabilization Services:** Services that are provided in relationship to an emergency medical condition and are provided after a member is stabilized in order to maintain the stabilized condition.

- **Psychological Testing:** Administration of standardized tests and assessment techniques by a licensed psychologist for the purpose of diagnosis or treatment of a covered mental health diagnosis. Psychological testing supplements standard clinical assessment and evaluation.

- **Psychosocial Rehabilitation:** A comprehensive array of services that supports the recovery of a person with a serious mental illness. Services focus on individualized assessment through application of an approved model, goal setting by the member, and direct skills training.

- **Residential Treatment:** 24-hour services in approved programs that provide extensive structure and individualized treatment for covered diagnoses and significant associated deficits in functioning that results in the inability to live in the community.

- **Respite:** Respite care provides a planned break for families or members in dealing with long-term or severe mental illness. Respite care can be provided in a variety of settings either in the home or away from the home.

- **School-Based Intensive Outpatient Services:** Services that are designed for children at risk of school failure or are candidates for expulsion due to symptoms or behavior that results from a behavioral health diagnosis. They are typically identified by school personnel. Services include family, group, and individual psychotherapy, play therapy, parent support, classroom behavior consultation, mentoring, psychiatric and nursing services coordinated with school nurse. Services are school-based and integrated with the student's academic day.

- **Vocational Services:** Services for any member interested in pursuing educational or work opportunities. Services may include assessment, prevocational training, job training, supported employment, social skills training, coaching, and referral to related agencies.

Section 3

PROVIDER ASSISTANCE & REFERRALS

For access to care and any other member related services, please call:	
Provider Relations Needs:	1-800-804-5040
Clinical Authorization and Claims Needs:	
Colorado Health Partnerships(CHP)	1-800-804-5008
Foothills Behavioral Health Partners (FBHPartners)	1-866-245-1959
Northeast Behavioral Health Partnership(NBHP)	1- 888-296-5827

CLINICAL OPERATIONS DEPARTMENT:

Clinical Care Managers (CCM) are available 24 hours a day, 7 days a week for:

- Pre-authorization for inpatient, ATU, Residential Treatment and any higher level of care
- Utilization review
- Consultation
- Member referrals
- Concurrent reviews and continued authorizations. Providers may also call the Clinical Operations Department to consult with a CCM regarding a Member's treatment needs related to:
    - Medication management referral
    - Psychological testing (prior authorization required)
    - Aftercare (in preparation for program/facility discharge) with an outpatient therapist or structured program.
    - Referral to a different level of care, including discharge
- Authorization of outpatient services when you have been unable to successfully use the TeleConnect or ProviderConnect systems (Authorization must be made within 30 calendar days after initial session.)

CUSTOMER SERVICE DEPARTMENT:

Representatives are available from 8:00 a.m. to 5:00 p.m. (**MST**), Monday through Friday. They are responsible for:

- Verification of Medicaid eligibility
- Verification of member eligibility
- Claims inquiries
- Written inquiries
- Benefit explanations
- Prevention, Education, and Outreach referral information
- CCAR Inquiries

NETWORK CREDENTIALING DEPARTMENT:

Provider Relations/Credentialing staff are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. The Network Credentialing staff is responsible for:

- Credentialing and re-credentialing
- Network monitoring
- Network management
- Application status
- Updating provider demographic data

PROVIDERCONNECT OR TELECONNECT

Outpatient providers are required to use ProviderConnect or the TeleConnect systems to register outpatient therapy. These systems are available twenty-four hours a day. Please follow the instructions below for using the TeleConnect.

USING TELECONNECT 1-888-556-6211 (TOLL-FREE)

PLEASE HAVE READY WHEN YOU CALL:

1. Provider Number
2. Member Medicaid Number
3. DSM Diagnosis Code
4. Member Date of Birth
5. Number of Sessions
6. Requested/Dates of Service for Claims Questions
7. Access to Care Monitoring: Through the member registration process, ValueOptions may collect information on routine appointment availability. When a provider contacts ValueOptions to authorize care for a member (either telephonically or through ProviderConnect) following the initial intake appointment, please be prepared to respond to the following questions:

- What was the date the member called to request an initial appointment?
- What date did you offer the appointment?
- If the appointment offered was outside of the seven business day timeframe, you will be asked to select a reason.

Call within 30 calendar days of initial appointment to register outpatient care. For authorizations other than outpatient, call the ValueOptions Access to Care Line. *Authorization is not required for medication management services.*

INSTRUCTIONS FOR LETTER ENTRY FOR TELECONNECT:

You may enter your alpha character anytime during the message. Please enter the alpha character in the member's ID as follows: An "A" would be entered by pressing the 2 on your touch-tone keypad followed by the pound (#) sign. "B" would be entered by pressing the 2 on your touch-tone keypad twice followed by the pound (#) sign. "C" would be entered by pressing the 2 on your touch-tone keypad three times followed by the pound (#) sign. All alpha characters on each of your touch-tone keypads would be accessed the same except for the letters

"Q" and "Z". To enter the letter "Q", press the number 1 on your touch-tone keypad followed by the pound (#) sign. To enter the letter "Z", press the number 1 on your touch-tone keypad two times followed by the pound (#) sign. Your entry will be verified after you enter the pound sign and you will be given three tries to enter the correct letter before you will error out. Instructions will also be provided on the telephonic menu. If you are familiar with entering information, you may bypass the instructions by simply entering the required information.

PROVIDERCONNECT

ProviderConnect provides an online alternative to telephonic services, giving providers a 24/7 available, easy-to-use tool for completing everyday service requests. The system will allow users to access the following features:

- Eligibility Status
- Claims Search (for specific member(s) and view details of claim such as claim status, paid date, check number)
- Electronic Claims Submission (both Batch and Single Claim)
- View and Print Correspondence including Authorizations and Provider Summary Vouchers
- Access Your Provider Practice Profile (lookup demographic information, validate and submit changes online)
- Submit Inquiry to Customer Service (send a question to ValueOptions online and get a response in the manner you choose)
- Benefit Status
- Register Outpatient Care

PROVIDER AVAILABILITY FOR MEMBER ACCESS TO CARE

Federal regulations prohibit discrimination against Medicaid covered individuals. Any practice which selectively excludes members from available treatment services/appointments may be in violation of those regulations. A statement by your scheduler or voicemail that you are "not currently accepting Medicaid clients" constitutes discrimination.

All ValueOptions Colorado providers must have appointments available for Medicaid members as specified below, according to State/Federal regulation and the provider contract:

1. **ROUTINE ACCESS:** A routine appointment must be available within seven (7) business days of a member's request. Under the Colorado Medicaid provider contract, providers are required to offer a routine appointment within seven business days. If a provider offers a member a routine appointment within seven business days and the member declines and chooses an appointment outside of seven business days, the access requirement is met. Members must be offered the same hours of availability as all other insurance members.

2. **ROUTINE OUTPATIENT APPOINTMENTS FOLLOWING AN INPATIENT OR RESIDENTIAL DISCHARGE:** A routine appointment must be available within seven (7) business days after discharge from an inpatient psychiatric hospitalization or residential facility.

3. **URGENT ACCESS**: Urgent care (appointments) shall be available within twenty-four (24) hours from the initial identification of need.

   Urgent Definition: A request from a member or designated member representative for situations or circumstances for which there is the potential for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR Potential for serious impairment to bodily functions without treatment, OR Potential for serious dysfunction of any bodily organ or part without treatment. The appointment should be scheduled within 24 hours of the initial request.

4. **EMERGENCY:** Emergency services shall be available by phone, including by TTY accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.

   Emergency Definition: A member or designated member representative requests mental health services that include conditions, situations or circumstances for which there is the risk for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR for serious impairment to bodily functions without treatment, OR for serious dysfunction of any bodily organ or part without treatment.

A regional CBHC emergency services team should be consulted prior to inpatient hospital admission or higher level of care. These teams provide assessments at most local emergency rooms. Independent network providers typically do not have emergency room privileges. Thus it is impractical to require IPN providers to conduct emergency evaluations in hospital ERs.

5. Inpatient and Residential Treatment post-discharge follow-up appointments: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

6. Providers who serve only Medicaid members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service. Minimum hours of Provider operation shall include Covered Service coverage from 8:00 a.m. to 5:00 p.m. Monday through Friday and emergency coverage 24 hours a day, seven days a week. Providers are encouraged to offer flexible appointment times or after regular business hours appointments to members whenever possible.

7. Extended hours of operation and Covered Service coverage must be provided at least two days per week at clinic treatment sites which should include a combination of additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.

8. Evening and/or weekend support services for members and families should provide access to clinical staff, not just an answering service or referral service staff.

EXPECTATIONS OF PROVIDERS FOR EMERGENCY ACCESS:

In order to comply with emergency access standards under the provider's contract, our expectations for IPN providers are:

1. If an independent provider is contacted by a member in crisis, the provider will conduct an assessment to determine whether the member's situation can be handled outside of the emergency room. This assessment should follow the standards as indicated in item 4, Emergency Access, above.

2. If the member goes directly to the ER, or if the provider determines the member in crisis is best assessed in the ER, the provider will be available to the CBHC emergency services team to provide background information, diagnosis and other pertinent details on the member in crisis. This will assist the CBHC emergency services clinician in conducting the member's evaluation, and may result in the most appropriate disposition for the member.

3. Providers are requirement to give contact information to members on their voicemail to include one of the following: the provider's pager, the provider's cell phone number, or how to reach a covering clinician with whom the provider contracts with to provide coverage when the treating provider is not reachable.

4. Quarterly test calls are performed at random by the ValueOptions quality improvement staff to monitor provider compliance with these standards. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider's non-response to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services. Outpatient providers are expected to offer 24-hour personal emergency access to their members or have formal arrangements for emergency coverage by another practitioner. An answering service/machine which refers all callers to an emergency room, community behavioral health center, crisis or other agency is **not acceptable unless the provider has established a formal contract for emergency coverage with**

the agency. **In all cases, providers must obtain prior authorization for inpatient care by calling the Access To Care Line 24 hours a day, seven days a week, at 1-800-804-5008**.

Waiting Room Time for Scheduled Member Appointments: A Medicaid Member who arrives on time for their scheduled appointment shall wait no longer than fifteen minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the Member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by reviewing the wait time policy with the Member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

HOW MEMBERS ACCESS MENTAL HEALTH CARE

A member can access mental health care in four ways:

1. A member, family member, provider, or advocate for the member can call toll-free, seven (7) days a week for emergency or non-emergency situations, clinical assessment, and referral to the most appropriate provider.
2. The member can call or walk into any one of the Colorado Community Behavioral Health Centers (CBHC) or contact a network provider office and receive a face-to-face clinical evaluation and request services.
3. The member can be referred by their primary care physician, social services caseworker, court system or other community agency through the access points described above.
4. The member can go to or be brought to any emergency room. A face-to-face evaluation may be arranged with an area crisis evaluator. The crisis evaluator participates in disposition recommendations.

REFERRALS TO NETWORK PROVIDERS:

All care must be authorized with the ValueOptions Service Center. Outpatient prior authorization is not required but authorization must be obtained within thirty business days following the initial appointment. All other levels of care must be pre-authorized. If authorization is not obtained for non-emergency treatment, an administrative denial or reduction of claims payment may result.

OUTPATIENT SERVICES:

The initial authorization will define the number of sessions of psychotherapy allowed by the BHO in which the member maintains eligibility. For individual BHO authorization policies and standards, please refer to the BHO Provider Handbook Addendum. Data is used to monitor utilization and the provider may be requested to provide telephonic or written clinical review upon reauthorization. Psychological testing requires a separate preauthorization. The Medicaid contract limits outpatient services benefit for adults to 35 individual per fiscal year. Sessions provided beyond the 35 session limit may not be covered.

PRIMARY BEHAVIORAL HEALTH PROVIDER:
The first outpatient network provider seen by the member is established as the Primary Behavioral Health Provider. The Primary Behavioral Health Provider is responsible for identifying any additional behavioral health services required by the member and conferring with the ValueOptions Service Center CCM for referrals for additional services if required. The Primary Behavioral Health Provider is **required** to coordinate all services being provided and to **document** that coordination.

COORDINATION OF BEHAVIORAL HEALTH AND PRIMARY CARE :
All members should have a Primary Care Physician. The ValueOptions Service Center can assist members in finding a PCP. Coordination with the PCP is necessary to promote integrated care, particularly related to medication management. Coordination with primary care is the responsibility of the Primary Behavioral Health Provider.

FACILITIES/PROGRAMS:
Facilities/programs receive referrals and authorizations from ValueOptions Service Center CCMs. Prior authorization is always required. ValueOptions CCMs are available 24 hours a day, 7 days a week for prior authorization.

EMERGENCY DEPARTMENTS:
After initial emergency department triage, authorization for further inpatient evaluation and/or treatment must be obtained from a Service Center CCM. At most hospitals, an independent assessment by a CBHC crisis evaluator will be required to assist in diversion, crisis stabilization, and referral to follow-up.

ELIGIBILITY VERIFICATION:
Medicaid eligibility should be confirmed before the first visit. Confirm the member's name, social security number, and Medicaid ID number, by examination of the current Medicaid card or by calling our toll-free number to verify eligibility. We recommend re-verifying eligibility at least once a month as eligibility is subject to change.

ALTERNATIVE OR ADDITIONAL SERVICES:
Providers must call to refer a member to another provider for a second opinion, consultation services or a new level of care. At that time, a ValueOptions CCM will review the case.

AUTHORIZATION AND DENIAL OF SERVICES:
A letter confirming authorization for all levels of care will be posted on ProviderConnect for providers to view and print. When there is a denial, limitation or termination of requested services or of currently authorized services, the member or legal guardian is also sent a notification letter. The letters contain instructions for filing an appeal. The BHO Office of Member and Family Affairs and the Ombudsman for Medicaid Managed Care are available to help a member with the appeal process.

COLLECTION OF CO-PAYMENTS/DEDUCTIBLES:
Members covered through Medicaid are not subject to co-pays or deductibles. Collection of fees directly from a Medicaid member may result in termination as a participating provider. This includes charges for non-covered services, including missed appointments.

Section 4

UTILIZATION MANAGEMENT PROCEDURES

All authorization decisions are based on the determination of medical necessity for the requested service, and based on the Level of Care Guidelines. Services may be authorized only for covered services and covered diagnoses per our contract with the Department of Healthcare Policy and Financing (HCPF). Providers are expected to cooperate fully with Care Management and Medical staff to provide accurate and timely clinical information to assist with this process. This may include submission of verbal reports or written documentation (including treatment plans). Participation in a telephonic or face to face staffings may be required for complex cases. Clinical and Medical staff will make every effort to make decisions in a manner that allows providers to focus on the care of members, and will not ask for more information than is necessary to make an appropriate decision regarding medical necessity of the service in question.

What is Medical Necessity per the Medicaid Contract and how are authorizations decisions made?

A. "Medically Necessary" describes a service that, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care:

1. Is reasonably necessary for the diagnosis or treatment of a covered mental health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and
2. Is clinically appropriate in terms of type, frequency, extent, site and duration;
3. Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
4. Cannot be omitted without adversely affecting the Member's mental health and/or physical health conditions associated with the Member's covered mental health diagnosis, or the quality of care rendered.

B. Clinical Criteria

1. Clinical Criteria utilized for decision making include the definition of "medically necessary services," listed above and the Value Options Colorado Level of Care Guidelines, comprised of admission criteria, exclusion criteria, continued stay criteria and discharge criteria for the specific level of care requested. Additional clinical information, such as CCAR rating scales or LOCUS/CALOCUS data, may also be used to supplement other clinical information used for decision making.

Utilization management is the responsibility of the ValueOptions Clinical Care Managers (CCM) who perform clinical reviews and care management for all levels of care. The frequency

of review varies with the intensity of the level of care being provided and the clinical needs of the member. All care provided to members must be authorized by ValueOptions. Member consent is not required for provider participation in utilization management activities except for those UM activities related to substance use disorder services, when it is specifically required by law (42 CFR, part 2).
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ValueOptions CCMs are responsible for the following functions:

- To conduct reviews with treatment providers to verify medical necessity based on BHO treatment criteria at point of access, for continuing care, and aftercare.
- To ensure that the evaluation of the member includes pertinent psychosocial, medical and psychiatric/mental health information to support the diagnosis and impairments determined by the provider.
- To ensure that service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the provider, are coordinated with other service delivery persons or agencies, and are consistent with the BHO's clinical criteria.
- To ensure that level-of-care and treatment decisions are based on medical appropriateness and necessity, as described in the clinical criteria, and are designed to achieve desired member outcomes within an optimal time frame.
- To ensure that discharge planning begins at admission, that the planning involves the member, significant others and other representatives who will ensure implementation of the discharge plan, that clear and specific criteria for discharging members from treatment are established at the outset of treatment, that the plan is realistic and attainable, and that it is both understood by and agreed to by the member and family/significant others as appropriate.
- To provide consultation to treatment team members when needs of members are complex.

WHEN DOES THE CCM CONDUCT CARE MANAGEMENT FUNCTIONS?

- When the TeleConnect/IVR system or ProviderConnect directs the provider-user to call the CCM.
- When a provider contacts the CCM for initial or **continuing authorization.**
- When there is a need to change the level of care being provided.
- When quality data related to any aspect of member care indicates the need for provider involvement to clarify or take action on identified patterns/trends.

PROVIDER RESPONSIBILITIES IN UTILIZATION MANAGEMENT:

Value Options providers are required to:

- Provide accurate clinical information to support authorization requests

- Keep track of authorizations and their use of authorized services to allow them to make timely requests for re-authorizations
- Begin discharge planning at the time of admission
- Provide services in the least restrictive environment possible for the member
- Follow all documentation requirements, including updated and accurate written treatment plans that guide their services to Medicaid members
- Provide clinical information verbally when requested to assist with an authorization decision
- Provide a copy of the member's written treatment plan when requested
- Respond in a timely manner when Clinical or Medical staff reach out to them to confirm information (clarify their authorization request, confirm member's start or end date of treatment, or other treatment details.)
- Request initial authorizations no more than 30 calendar days after the initial assessment for outpatient services, and prior to admission to inpatient, or higher level of care services.
- Request concurrent authorizations on the last covered day for higher level of care services, or no later than 30 calendar days after the date of service for outpatient services
- Request authorization only for services they feel meet medical necessity guidelines.

OUTPATIENT CARE INITIAL AUTHORIZATION:

1. Providers should complete an initial evaluation then obtain authorization for outpatient care via ProviderConnect or TeleConnect (IVR) no later than 30 calendar days after the initial evaluation. Initial evaluations do not require authorization for contracted providers and can be billed with a deferred diagnosis (799.9) or no diagnosis (v71.09) code if needed.
2. A treatment plan is required for all outpatient services, and must include time limited and measurable objectives. It must be formulated with member or guardian input, and signed by the member and/or guardian. Providers are not required to submit a treatment plan to receive initial authorizations.
3. Initial authorization includes psychotherapy and the evaluation session. See the BHO specific addendum for more information. The initial authorization will indicate a specific provider(s) and type of service, which includes the initial evaluation, case management (if included), individual, family and group psychotherapy, or other covered services. Authorizations will also include start and end dates of the authorization, and the number of units authorized, so the provider will know when to request additional sessions.
4. Family therapy is conducted for the treatment of the identified member's covered diagnosis only and billed under this individual's Medicaid. Separate billing for other family members who participate in the family therapy sessions is not allowed.
5. For contracted providers, medication management does not require authorization.

6. The Colorado Client Assessment Record (required by Colorado Department of Health and Human Services) shall be submitted promptly after authorization has been obtained. See CCAR, Section 12, for a copy of these forms. Providers can fill out CCAR forms on the website at http://www.chneforms.com/ccar/login.cfm. Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.

CONTINUED AUTHORIZATION:

1. If further care is requested and determined to be clinically indicated, subsequent authorization will be made through ProviderConnect or TeleConnect/IVR.
2. Additional care may be authorized if clinically indicated and a provider may request that the authorization be back dated up to 30 calendar days prior to the date of the request. Outpatient authorizations will not be back dated for more than 30 calendar days prior to the request date, whether by telephone, fax, or other submission method.
3. The provider is required to submit their written treatment plan to ValueOptions for Peer Advisor review once the member has completed 25 sessions of service (any combination of individual, family or group therapy) when treating a covered mental health disorder. Providers treating members with substance use disorders should submit their written treatment plan at the time of their request for authorization of additional sessions for treatment of substance use disorders. Additional authorization is typically requested once the initial authorization sessions have been used or the authorization has expired (it is past the end date of the authorization.)
4. Treatment plans may be requested at any other time there is need to review the medical necessity of the services and the provider is requested to submit the plan Providers are not to create a special treatment plan for the authorization request, but to submit the treatment plan they are documenting and keeping up to date as a part of the member's treatment record. The provider may send the treatment plan to ValueOptions for review any time after the 22nd session is used and the provider feels that additional sessions will be needed. This can help the authorization process occur in a timely manner.
5. **The treatment plan will be reviewed by a ValueOptions Peer Advisor before sessions in excess of 25 will be authorized.**
6. **If the treatment plan does not meet clinical criteria, a CCM will address the relevant issues with the provider and refer the case for review.** Routine outpatient care will not be authorized on a retrospective basis (more than 30 calendar days after the date of service), except in cases of retroactive Medicaid eligibility.

HIGHER LEVEL OF CARE (INPATIENT, PARTIAL HOSPITAL, RESIDENTIAL, DAY TREATMENT AND INTENSIVE COMMUNITY SERVICE PRIOR AUTHORIZATION:

Prior authorization is required for all inpatient, partial hospital, residential, day treatment and intensive community based services. . ValueOptions may require an independent assessment by a Community Behavioral Health Center (CBHC) Crisis Evaluator prior to admission. In most cases, the CCM will consult with the local CBHC for availability of diversion services prior to authorizing higher levels of care.

For inpatient care, providers must direct members to a ValueOptions contracted facility to ensure eligibility for hospitalization benefits. If a contracted facility is not available, VO staff will work with a willing noncontracted facility to insure timely admission of a member in need

of inpatient care. Providers are to collaborate with Value Options Care Management and the CBHC evaluators to assist member in receiving treatment at a lower level of care if needed, to meet the requirement that Medicaid members receive treatment at the least restrictive level of care. Collaboration includes the provision of verbal or written treatment information to another provider, if indicated

Inpatient care requires coordination of care with the CBHC for Medicaid admissions, to obtain the best treatment benefit for each member and arrange appropriate aftercare services. This should begin on the day of admission and occur routinely and regularly throughout the hospitalization.

For all levels of care, the Colorado Client Assessment Record (required by Colorado Department of Health and Human Services) shall be submitted promptly after authorization is obtained. See CCAR Section 12, for more information about the CCCAR. To fill out a CCAR our website, visit http://www.chneforms.com/ccar/login.cfm. Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.

CONTINUED AUTHORIZATION:

1. Pre-authorization of continuing higher levels of care requires a telephonic or written review between the provider and ValueOptions CCM. Providers should follow the instructions of the Care Manager regarding the clinical information needed. Most authorizations will be completed with telephonic review, but occasionally, written documentation is needed to determine medical necessity.
2. ValueOptions requires active collaboration with regional CBHC care coordinators in discharge planning. Providers not participating in Care Coordination with CBHC staff members for discharge planning and care coordination may receive an administrative denial of services since this is a required function. CBHC staff often have relevant clinical information to provide which informs the treatment plan and needs to be included. Coordinating care includes timely return of phone calls and potential face to face meetings with CBHC staff members.
3. To evaluate the higher level of care request, the CCM will require detailed information concerning the member's need for continuing care (i.e., measurable treatment goals, and discharge plans, current condition, and any additional services). It is the responsibility of the hospital's designated case manager (social worker or UR representative) to call the Service Center for all scheduled reviews and continued authorization prior to expiration of the current authorization. Late requests may not be retroactively authorized and may be administratively denied.

HOSPITAL PROFESSIONAL CHARGES:

Some facility contracts are all-inclusive. Professional charges may be included in contract rates. It is the responsibility of the facility to negotiate reimbursement with the professional staff.

EMERGENCY SERVICES:

1. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be

expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.
2. **Emergency services do not require prior authorization.**
3. Documentation must accompany claims for emergency services in order to support covered diagnosis. . This documentation will be reviewed on a retrospective basis, after the member has received care.

AUTHORIZATION WHEN LEVEL OF CARE CHANGES

1. Authorization of care does not extend from one level of care to another. CCMs must be notified immediately when a member is discharged from any level of care and a CCM must receive the discharge and aftercare plan in writing or via Provider Connect.
2. Authorization for treatment at a new level will be based on the current clinical presentation, treatment plan and continuity-of-care concerns.
3. A new authorization will be required with any change in the level of care.
4. Any unused portions of prior-to-admission outpatient authorizations are null and void once an inpatient/partial hospital/alternative level of care case is opened.

ELECTROCONVULSIVE THERAPY (ECT)

All inpatient and outpatient ECT requires pre-authorization. ECT requests must be reviewed by the BHO Medical Director.

PSYCHOLOGICAL TESTING (ALL TESTING REQUIRES PRE-AUTHORIZATION)

The use of psychological testing can be very beneficial when it provides information relevant to the treatment of a psychiatric condition in a timely manner. Rather than being considered a routine procedure in an individual's treatment, testing should be requested only when other interventions have not been successful in providing sufficient information with which to develop an appropriate treatment plan.

When psychological testing is necessary, it should be requested in order to address specific questions which may be useful in diagnostic clarification and subsequent treatment planning. Specific testing procedures selected by the psychologist should demonstrate a focused approach toward addressing the referral questions. "Standard psychological test batteries" are discouraged. Educational testing (e.g., learning disabilities assessments), vocational testing, and testing conducted in order to rule out medical conditions (e.g., many neuropsychological assessments) are excluded benefits and will not be authorized. Pre-authorization for up to one hour of screening may be obtained by calling 1-800-804-5008. All testing beyond one hour's screening requires preauthorization based on submission of a Psychological Evaluation Request Form prior to testing. If you are both the treating therapist and a licensed psychologist, complete both sides of the form and mail or fax to ValueOptions' Clinical Management Department. If you are the treating therapist, but not a licensed psychologist, please take these steps to ensure a correctly completed form:

- Call the ValueOptions Access to Care line for assistance with referral to a network psychologist with the appropriate expertise.
- Complete Page 1 of the Request Form and fax/mail to ValueOptions. After the evaluation is assigned to a provider, the testing psychologist may request a phone consultation to insure that he/she has as much clinical information as possible and understands your questions.

- The psychologist must complete Page 2 and mail or fax the form to ValueOptions for authorization:

ValueOptions Colorado
7150 Campus Drive, Suite 300
Colorado Springs, CO 80920
FAX: (719) 538-1439

***NOTE:** Authorization on inpatient psychological testing can be expedited by calling 1-800-804-5008. Most contracts include all professional fees. For reimbursement, all psychological testing must be preauthorized.

GUIDELINES:

- One unit of testing equals one hour.
- Testing is only authorized for face-to-face administration of testing procedures by a psychologist or psychometrician working under the supervision of a psychologist (i.e., chart reviews and testing feedback sessions are not to be authorized as a psychological testing procedure).
- The use of self-administered objective inventories is encouraged prior to requesting more extensive testing. One hour can be authorized by ValueOptions for such screenings. The following is a list of the most frequently requested inventories:

  MMPI-2 Minnesota Multiphasic Personality Inventory-2 (Adult)
  MMPI-A Minnesota Multiphasic Personality Inventory-Adolescent
  MCMI-II Millon Clinical Multiaxial Inventory-II (Adult)
  MAPI Millon Adolescent Personality Inventory
  MACI Millon Adolescent Clinical Inventory
  PIC Personality Inventory for Children

- When such inventories do not provide sufficient information, additional testing may be warranted. Authorization for **personality assessments** varies depending upon the nature of the questions being asked and the specific tests being proposed to address those questions. The following tests are the most often utilized for personality assessment and the standard authorization allowed for each procedure is:

  Rorschach Projective Technique 1.5 hours
  Apperception Technique (TAT, CAT, or Roberts) 1.0 hours
  Projective Drawings (DAP or H-T-P or Kinetic Family Drawing) .5 hours
  Beck Depression Inventory .5 hours
  Reynolds Depression Scales (Child, Adolescent, or Adult) .5 hours
  Sentence Completion or Incomplete Sentences Procedures .5 hours
  Bender Visual-Motor Gestalt Test .5 hours

- The use of intellectual assessments can be authorized only if they are being used to clarify a psychiatric diagnosis or to determine whether treatment might need to be modified because of a member's intellectual disability. Appropriate uses would be for assessment of psychosis, neuropsychological screening, and, in some instances, the assessment of attention deficit disorders. The most often requested procedures for intellectual assessments are the Wechsler Scales:

WPPSI-R (preschool) 1.5 hours
WISC-IV (children & adolescents) 1.5 hours
WAIS-IV (adults) 1.5 hours

- **ATTENTION DEFICIT DISORDER ASSESSMENTS:** There is wide variation between practitioners in conducting these assessments. Focused evaluations can generally accomplish this assessment in one to three hours. Full, comprehensive, neuropsychological evaluations, which are often requested (sometimes from six to twelve hours), are not medically necessary to identify and diagnose ADD or ADHD. The following are the most commonly used procedures for ADD assessments.

  Rating scales (Parent's, Teacher's, Connors scales, etc.) .5 hours
  CBCL (Child Behavior Checklist) .5 hours
  Gordon Diagnostic System 1.0 hours
  TOVA (Test of Variables of Attention) 1.0 hours
  WISC-IV (Wechsler Intelligence Scale for Children – IV) 1.5 hours

- **NEUROPSYCHOLOGICAL ASSESSMENTS:** Neuropsychological assessments will be authorized for individuals receiving mental health services only when treatment planning considerations warrant such an evaluation. Generally, neuropsychological evaluations can be completed within six hours.

GENERAL MEDICAL RECORD REQUIREMENTS (SEE SECTION 19 OF THIS MANUAL FOR DOCUMENTATION REQUIREMENTS)

The State of Colorado requires the completion of the Colorado Client Assessment Record (CCAR). Additionally, ValueOptions has medical record requirements for members receiving services at any level of intensity.

1. CCAR: Form must be completed promptly after initial authorization is received, at discharge and once annually if the member is in treatment for 12 months or longer. Please submit the CCAR to ValueOptions promptly upon completion. (See Section 12 for instructions.) Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.
2. Coordination of Care: All providers are expected to coordinate care with any client's primary care physician and with other treatment providers. If a member does not have a primary care physician, providers are to assist the member in locating one. Assistance is also available at the Value Options Service Center and may be obtained by calling 800 804 5008. Coordination of care is required and should be documented. A release of information is required for the coordination of care with other providers. See the Coordination of Care section within this Provider Manual.
3. Missed Appointments: Providers are expected to contact members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the member's medical record.

4. Medical Record and **Treatment Plan:**

a. All documentation requirements in Section 19 must be contained in the member's medical record. Additionally, all member medical records must contain a comprehensive biopsychosocial assessment, measurable treatment goals, signed progress notes, and a discharge plan. The treatment plan should indicate involvement of a member's family/significant others when clinically indicated. If not clinically indicated, this should be noted as a part of the plan. Medical and psychological treatment documentation and progress notes must be current, dated and signed, and treatment plans must be updated regularly.

b. The provider initiating treatment must formulate an initial treatment plan with input from the member. The treatment plan should describe the specific target problems or symptoms, and identify strengths and supportive resources, as well as the diagnosis, planned interventions at the level of care proposed and clear, time limited and measurable criteria for discharging the member from treatment that are agreed upon by member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan. The treatment plan must be signed by the member or the member's guardian. If the member refuses to sign, this too should be documented in the record.

c. Progress notes must reflect that treatment provided to the member at each session is tied to the goals of the treatment plan.

d. We require thorough documentation of regular communication with other providers, including physical health providers, and an integrated treatment plan.

e. Medical records are subject to quality of care and financial audits. Client consent is not necessary. Providers asked to submit records for audit purposes will be reimbursed according to policy upon receipt of copies and an invoice.

5. Advanced Directives

It is the policy of ValueOptions to inform members of their right to make medical decisions in compliance with the Patient Self-Determination Act ((s. 4206 s. 4751;Pub L No. 101-508) and the Colorado Medical Treatment Decision Act (CRS 15.18.103.) and to assist them in exercising this right. Notification is made through a description of The Act in the Member Handbook.

a. If a member requests additional information on The Act from the provider, the member can be referred to the BHO Office of Member and Family Affairs, the Member Handbook, or the BHO website.

b. For help writing an Advanced Directive, refer the member to her/his PCP or to the Colorado Bar Association. In Colorado, Advanced Directives, as defined in the Patient Self-Determination Act, apply to medical/surgical procedures, not psychiatric conditions.

c. Providers are encouraged to assist members to develop crisis plans that define the member's wishes in time of psychiatric crisis.

d. Providers are required to ask members if they have an Advanced Directive and are encouraged to ask if they would like a copy placed in their mental health record. Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advanced directive. If the member is incapacitated at the time of admission, the provider shall ask the family or significant other if the member has an Advanced Directive and shall give the family information about advanced directives. At such time as the member is able to understand the question, the provider must again ask if the member has an Advanced Directive and, if so, document that in the medical record.

e. A provider may not condition a member's care or treatment on whether or not he/she has executed an advanced directive.

f. Providers must inform members how to report a grievance to the appropriate state agency, if an advanced directive is not followed.

Section 5

MEMBER CHOICE OF PROVIDERS

ValueOptions has developed a large provider network for the Community Behavioral Health Services Program that is capable of providing the types of services needed by Members and in convenient locations. Members and families can choose any ValueOptions Colorado Medicaid Network provider. A Member may request that a provider be added to the network. In cases of a member already in treatment with a provider at the time the member obtains Medicaid eligibility, for the purpose of continuity of care, the member's provider will be offered a Single Case Agreement and treatment may be continued. In cases involving special needs, ValueOptions will offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria.

Under certain circumstances members in rural areas may request an out of network provider. These circumstances may include:

1) The service or type of provider member needs is not available in our network;
2) The network provider refuses to provide the treatment requested by the member on moral or religious grounds;
3) The member's primary provider determines that going to a network provider would pose a risk to the member;
4) The member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship; and
5) The State determines that other circumstances warrant out-of-network treatment.

Section 6

SECOND OPINION

Members/guardians/ Designated Client Representatives (DCR) have the right to a Second Opinion regarding a clinical decision of their treating provider including recommendations about a member's diagnosis, need for treatment or the need for a specific service, at no cost to the member. Providers are required to inform members and legal guardians of this right initially and any time the member/guardian/DCR expresses disagreement with a particular clinical decision or recommendation. The member/guardian /DCR may choose any network provider to obtain a Second Opinion, as long as the provider has the identified appropriate expertise and is able and willing to provide a Second Opinion. In some cases, the BHO will arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member[1].

Note that disagreement with a BHO decision to deny a service request is handled through the Appeal Process (see Section IX) and not through a second Opinion.

A member/guardian/DCR may request assistance from the Behavioral Health Organization Office of Member and Family Affairs (OMFA) in obtaining a referral to an appropriate provider for a Second Opinion. The OMFA staff will also inform members of the right to a Second Opinion during the course of helping the member with any grievance concerning a provider's diagnosis or treatment recommendation.

If a member/guardian/DCR disagrees with a treating provider regarding a diagnosis or treatment recommendation, the member may seek a Second Opinion and transition their treatment to a different network provider.

If the member/guardian/DCR wishes to continue treatment with the first provider and the first and Second Opinions differ, the member/guardian/DCR may express their preference as to which opinion they wish to follow and may request assistance from the OMFA in resolving the disagreement with the first provider. If the Second Opinion and recommendations are clinically acceptable to both the member and the treating provider, the recommendations are implemented. If not, the treating provider may choose to terminate treatment with the member and assist with a referral to another network provider. No provider is obligated to provide a diagnosis or treatment which he/she believes to be ineffective or inappropriate. If the member/guardian/DCR is not satisfied with the results of the Second Opinion, they may seek a third opinion at their own expense.

Any clinical decision, diagnosis, or treatment recommendation made by a provider is subject to the quality and medical review of the BHO in the process of authorization, payment and utilization review. A recommendation from a network provider is not a guarantee of medical necessity or authorization by the BHO.

[1] Code of Federal Regulations 42 CFR 438.206(b)(3).

For Colorado Health Partnerships contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For **Northeast Behavioral Health Partnership** contact the NBHP Office of Member and Family Affairs at **1-970-347-2367**.

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

Section 7

EPSDT PROGRAM

Colorado's Medicaid Fee for Service program offers Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Medicaid eligible children under the age of 21 who have current Medicaid eligibility. EPSDT is a preventative health care program with two purposes: to bring Medicaid children who are receiving little or no care into the medical mainstream; and to detect and correct health problems before they lead to serious, costly, handicapping conditions. The EPSDT program assesses the child's health needs through initial and periodic screening examinations and evaluations also known as well child checks for physicals. The goal of the program is to ensure that health problems are found, diagnosed and treated early. EPSDT screenings include at a minimum, the following:

- Comprehensive health and development history; including behavioral health history.
- Assessment of vision and hearing status.
- Assessment of dental conditions.
- Assessment of physical growth, emotional and developmental status including mental health status.
- Assessment of nutritional status.
- Assessment of cardiovascular and respiratory status.
- Assessment of immunization status.
- Screening tests for anemia, sickle cell trait, lead poisoning, tuberculosis, diabetes, and infectious conditions.

Treatment options may include:

- Dental care including cleanings and fillings
- Immunizations (shots)
- Hearing aids and hearing aid batteries
- Eyeglasses when needed
- Prescriptions, but not those which can be purchased over the counter (like vitamins)
- Lab tests
- Durable medical equipment such as oxygen, walkers or wheelchairs
- Augmentative communication devices
- Therapies such as Occupational (OT), Physical (PT) and Speech (ST)
- Other treatment services which might be found to be medically necessary for your child.

FAMILY HEALTH COORDINATORS (FORMERLY **EPSDT CASE MANAGERS)**

Local communities have Family Health Coordinators that are responsible for providing case management services to children and youth who are receiving EPSDT services. The Family Health Coordinators ensure that EPSDT recipients receive the health services they are eligible for and help them overcome barriers to obtaining these services. The Family Health Coordinators do not make decisions about health care. Their role includes:

- Educate all eligible Members about the EPSDT Program
- Describe the available benefits in greater detail.
- Help find a primary care physician or other medical providers as needed.
- Arrange for an appointment if the member needs help.
- Give options for transportation assistance if necessary.
- Follow-up on screening appointment. Follow-up includes assistance to reschedule the missed appointment.

To locate the EPSDT office serving your member, please call Health Care Policy and Financing at: (303) 866-2267 or (800) 221-3943, go to the web site http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254, or call the BHO Office of Member and Family Affairs.

EPSDT CARE PROVIDERS

Exams are performed by or under the supervision of a certified Medicaid physician, dentist or other provider who is qualified to provide medical services.

ValueOptions providers are required to:

a. Assess new Members to determine that EPSDT screenings have been occurring.
b. Refer Members to their PCP if screenings are not being conducted.
c. Provide behavioral health assessment/treatment upon referral from a PCP who desires additional behavioral health services, in which medical necessity has been determined.
d. Communicate with the PCP regarding any pertinent findings/actions.
e. Document all actions in the Member's medical record.

Because assessing physical health is an important component of providing comprehensive behavioral health care, we suggest our providers ensure that their Medicaid Members under age 21 have had a yearly EPSDT well-child exam. Talk with the child's parent or guardian to determine if this has happened. If the child or youth has not been screened in the past year, you should contact the Family Health Coordinators in your community.

GLOSSARY

EPSDT - (Early Periodic Screening, Diagnosis and Treatment) – Under Federal Medicaid rules, states are required to offer EPSDT services and Case Management to all Medicaid eligible children and youth from birth to 21 years. The goal is to identify and treat problems early to ensure Medicaid eligible children have a good start in life.

Case Management Services – Under the EPSDT program, case management services are the responsibility of the Department of Health Care Policy and Financing and are subcontracted to local agencies. Family Health Coordinators have the responsibility to facilitate the EPSDT screening process, help families select a PCP if requested, give transportation options, do follow-up on screening appointments and arrange for diagnostic and treatment services. In

most cases, the Family Health Coordinators do not provide the services but rather refer to those who are able to provide health care and other needed services within the community.

Section 8

COORDINATION OF CARE

A well-coordinated system of care is necessary to ensure positive outcomes for Colorado Medicaid members. Consequently, the BHOs and ValueOptions require coordination of services for all of their members. The primary outpatient provider is responsible for care coordination unless the member is already assigned a care coordinator through the Regional Collaborative Care Organization. Member consent is required for coordination of care with other providers. Member consent is not required for coordination of care with the BHO and ValueOptions, except in the case of substance use disorder treatment.

The responsibilities of network providers in coordination of care include:

- 24/7 emergency availability to clients and to emergency services staff who may provide care to clients in a crisis.
- Coordination of services and the exchange of relevant healthcare information between the member's Primary Care Physician (PCP) or a physician other than a PCP who is involved in the member's care, and the member's behavioral health service provider.
- Coordination of services with the ValueOptions Care Management Department and field-based BHO care management staff around member transitions to and from higher levels of care.
    - This includes active and prompt response to requests for information and participation in admission evaluation, case staffing, discharge planning, and utilization review, as required.
- Regular ongoing coordination of care and sharing of clinical observations between psychiatric prescribers and psychotherapists:
    - Psychotherapists referring to a prescriber for medication evaluation should send a written summary of presenting symptoms, relevant past treatment history, diagnosis, areas of concern, and 24/7 contact information.
    - Prescribers performing medication evaluations should send a written summary of diagnosis, medications prescribed, target symptoms, risks, expected benefits, possible side effects, and 24/7 contact information.
    - Member consent should be documented in both medical records.
    - Psychotherapists should provide regular updates to prescribers on target symptoms and areas of concern.
    - Prescribers should provide regular updates to psychotherapists on medication(s) prescribed, changes in diagnosis, medication effects and side effects.
- Documentation of regular ongoing coordination of care in the member's treatment record.

- Identifying, providing, arranging for, and coordinating with other social, legal, long-term care and human services that support the member and documentation of that coordination.
- Maintaining a current integrated treatment plan.
- Assisting members in finding a PCP. Health *Colorado* gives referrals to members looking for a PCP and to providers assisting members in finding a PCP. Health *Colorado* can be contacted at 1-888-367-6557 or 1-303-839-2120 in the Denver metro area. Health *Colorado's* website also provides information on how to obtain a PCP: http://www.healthcolorado.net/

COORDINATION WITH OTHER HUMAN SERVICES AGENCIES

ValueOptions and the BHOs have implemented procedures for coordinating mental health services with services offered by other human service agencies including:

- County social services departments;
- Child welfare agencies;
- Residential child care facilities;
- Organizations providing services to older adults;
- Schools;
- Judicial systems;
- Agencies providing substance abuse services;
- Agencies providing translation/interpretation services;
- Agencies providing services to deaf and hard of hearing members;
- And any other agencies providing human services to Medicaid recipients in need of mental health care.

Section 9

REVIEWS, RECONSIDERATIONS AND APPEALS

Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership are Colorado BHOs contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to manage Medicaid behavioral health benefits through the Colorado Community Behavioral Health Services Program, and all three have delegated their utilization management programs to ValueOptions. Each of the three BHOs has an Office of Member and Family Affairs (OMFA) that is available to assist members in exercising their rights to appeal.

All authorization determinations are made within timeframes required by Colorado Medicaid standards. As the ValueOptions Service Center is also accredited by the Utilization Review Accreditation Commission (URAC), its timeframes meet the more stringent of the two standards where they differ from one another. All notifications for authorizations and denials also comply with both Medicaid and URAC standards as does the content of Notice of Action letters. For requirements concerning initial and continued stay authorization of all levels of care, please refer to Section 4, Utilization Management Procedures. At the time of any review, a BHO Medical Director or Peer Reviewer may deny authorization based on the diagnosis, the service requested, or medical necessity criteria. In addition, when a BHO Medical Director or Peer Reviewer is reviewing a case, a provider may be asked to participate in a phone call to discuss service, or to provide a written copy of the member's treatment plan. Clinical Care Managers or any other staff members do not have the authority to deny a service. Denials may only be issued by a BHO Medical Director or Peer Reviewer. If a service is determined not to be a BHO covered service or a diagnosis is determined not to be a BHO covered diagnosis, the service or diagnosis may still be available to the member under Colorado Medicaid, but not through the BHO. For assistance please contact the BHO's Office of Member and Family Affairs.

When a request for service is in whole or in part denied, providers may be asked by members to assist in the Medicaid appeal process. The State of Colorado Medicaid contract allows for an appeal process for its members who are denied any request for covered mental health services as well as under other circumstances referred to as Actions and is defined at the end of this section. The following information identifies the process for the Medicaid member to access his/her appeal rights. The provider is granted Reconsideration rights but the right to appeal is available only to the member, the member's guardian, or the member's Designated Client Representative (DCR). The provider may represent the member in all levels of appeal with the member's written consent, if designated in writing as the member's DCR.

CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND VALUEOPTIONS COLORADO

To obtain assistance for a member to exercise his/her appeal rights:

For Colorado Health Partnerships contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For **Northeast Behavioral Health Partnership** contact the NBHP Office of Member and Family Affairs at **1-970-347-2367**.

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

CLINICAL GUIDELINES

Clinical services are authorized based upon diagnosis, service requested, medical necessity criteria, and the application of established treatment guidelines. Medical necessity criteria are defined by the BHO and aligned with the Medicaid contract established by the Colorado Department of Health Care Policy and Financing. Treatment guidelines are adopted and revised by each BHO with input from members and families. Guidelines are developed using national standards, published research, expert opinions and local "best" practices. Treatment guidelines are periodically reviewed and revised to reflect the growing knowledge of best practice standards. These guidelines are made available at no cost, at:

Colorado Health Partnerships – http://www.coloradohealthpartnerships.com

Foothills Behavioral Health Partners - http://www.fbhpartners.com

Northeast Behavioral Health Partnership – http://www.nbhpartnership.com

CLINICAL PEER REVIEW PROCESSES

When a Clinical Care Manager receives a request for authorization and there is any question as to whether the information provided meets criteria for authorization, the case is referred for a Clinical Peer Review with the BHO medical staff. The BHO medical staff consists of a psychiatrist Medical Director for all 24 hour levels of care and a clinical psychologist Peer Advisor for specific non-urgent, outpatient levels of care. Medical staff will conduct a Clinical Peer Review before denying any service request. A Clinical Peer Review consists of a decision based on review of all available clinical information by an appropriately licensed behavioral health professional (physician or clinical psychologist).

At the completion of a Clinical Peer Review, the BHO Peer Reviewer will inform the provider/facility if services will be authorized or denied. A denial of payment becomes effective at the completion of this review unless otherwise specified by the BHO Peer Reviewer. If a decision is made to deny authorization, written Notice of Action of this decision will be mailed to the member and provider/facility within the earlier of one (1) business day or three (3) calendar days.

PROVIDER'S REQUEST FOR RECONSIDERATION (PEER TO PEER REVIEW)

Reconsideration can be requested by the provider if the provider can offer clinically significant information that was not available to the Peer Reviewer at the time of an adverse determination by Clinical Peer Review. For an adverse determination for Urgent services, the provider has 24 hours following verbal notification of an initial denial to complete a telephonic Reconsideration Peer-to-Peer Review. In the case of a facility, this time interval begins at the time of verbal notification to any member of the facility staff. This process is available for both prospective and

concurrent requests. The provider who requests a Reconsideration Peer-to-Peer Review for Urgent services or an appropriate representative of the facility requesting Reconsideration must be available for telephonic consultation within 24 hours of notification of denial; otherwise a final determination will be made based on the Clinical Peer Review. The re-decision to authorize or deny the request for services will be made at the completion of the Reconsideration Peer-to-Peer Review.

For an adverse determination for non-Urgent services, the provider has 14 calendar days following verbal notification of an initial denial to request a Reconsideration Peer-to-Peer Review. In the case of a facility, this time interval begins at the time of verbal notification to any member of the facility staff. This process is available for both prospective and concurrent requests. The provider who requests a Reconsideration Peer-to-Peer Review for non-Urgent services or an appropriate representative of the facility requesting Reconsideration must be available for telephonic consultation within two (2) calendar days of notification that the request for Reconsideration has been received; otherwise a final determination will be made based on the Clinical Peer Review. The re-decision to authorize or deny the request for services will be made at the completion of the Peer-to-Peer Review. No further reconsideration is available to the provider following a Peer-to-Peer Review. The member/guardian/DCR may request an appeal.

A request for Reconsideration must be made telephonically to a ValueOptions Clinical Care Manager at the Access to Care line (1-800-804-5008). If the denial of the requested service is upheld at the time of the Peer-to-Peer Review, the provider will be notified verbally. Both provider and member will also receive written notification of the decision. Upon conclusion of Reconsideration, any further appeal is a formal appeal and can only be initiated by the member/guardian/DCR. The member may name the provider as his/her DCR but must do so in writing.

RETROSPECTIVE AUTHORIZATION PROCESS

Requests for retrospective authorization will be considered in the following circumstances:

- Member is made Medicaid eligible retroactively;
- Member's condition at the time of initiation of treatment made it impossible for the provider/facility to obtain enough identifying information to determine Medicaid eligibility via the Colorado Medicaid Web Portal;

Providers are expected to check the Colorado Medicaid Web Portal for Medicaid eligibility prior to admission of presumed medically indigent patients. In addition, for members who have Medicaid at admission to a service often have frequent changes to Medicaid eligibility. Therefore, it is recommended that eligibility is checked prior to each outpatient service, and frequently throughout any higher level of care service to insure payment. Authorizations are dependent upon eligibility. If a member becomes ineligible for Medicaid, claims for those dates of service cannot be paid.

Requesting a retrospective authorization:

Providers have ninety (90) calendar days from the first day of non-authorized services, or from the date of the member's notice confirming retroactive Medicaid eligibility, to request a retrospective review. Note that BHO responsibility for payment of services does not extend greater than 90 days prior to the date of the eligibility determination. For consideration of

payment for services more than 90 days prior to the date eligibility is finally determined, please contact Colorado Medicaid.

To obtain consideration the provider/facility must submit a written request including documentation supporting the basis for the request. A retrospective authorization determination requires the submission of the medical records covering the span of the request, which will be considered complete and final at the time of submission of the request for Retrospective Authorization. ValueOptions will make determinations on Retrospective Authorization Requests within 30 calendar days. If granted, retroactive authorization may cover all or only part of a given episode of care depending upon a determination of medical necessity throughout the episode. For any dates of services that are not authorized, a Notice of Action letter will be sent to the provider and the member/guardian. The member/guardian/DCR may appeal a denial of payment for all or any part of the episode of care. The provider may appeal only if designated in writing to appeal on the member's behalf or if designated by the member as the member's DCR.

MEMBER'S REQUEST FOR APPEAL OF AN ACTION

A member/guardian/DCR may appeal any of the Actions listed in the definition at the end of this section. An appeal (Standard or Expedited; see definition at end of this section) may be implemented at the member's/guardian's/DCR's request within 30 calendar days of the date of a Notice of Action. Appeals received outside of this timeframe will not be processed. The appeal request may be verbal but must be followed up in writing. The BHO's Office of Member and Family Affairs is available to assist members with this appeal process, including helping a member put their appeal in writing. The appeal request must be submitted to the Grievance and Appeals Coordinator, ValueOptions, 7150 Campus Drive, Suite 300, Colorado Springs, Colorado 80920, by fax to 719-538-1433, or telephonically at 800-804-5008 for CHP and NBHP, or 866-245-1959 for FBHPartners. A psychiatric physician who was not involved in the initial denial will re-evaluate the original decision based on information received in the appeal letter, any subsequent information the member/guardian/DCR may provide, and on the original clinical documentation. For a Standard Appeal, a determination will be made and resolution mailed to the member within 10 working days of the receipt of the appeal. In the case of an Expedited Appeal, determination and notification will be made within 3 calendar days (72 hours) of the receipt of the appeal.

A member/guardian/DCR may also file a request for a State Fair Hearing simultaneously to filing an appeal with the BHO, or a member or DCR may file directly for a State Fair Hearing without first filing an appeal with the BHO. Instructions for filing for a State Fair Hearing are also included in the Notice of Action.

MEMBER'S REQUEST FOR STATE FAIR HEARING APPEAL

The member/guardian /DCR may request, in writing or telephonically, a State Fair Hearing with an Administrative Law Judge (ALJ) of any Medicaid action as listed in the definitions at the end of this section. A member/ guardian/DCR may skip the BHO appeal step and go directly to an appeal to an Administrative Law Judge for a State Fair Hearing upon notification of an action, or may file an appeal with the BHO and the ALJ at the same time (recommended in order to preserve the member's appeal rights, as either appeal must be filed with the same 30 calendar day timeframe. A member's/ guardian's/DCR's request for either type of appeal must

be submitted within 30 calendar days from the date of the Notice of Action. The individual may represent him/herself or use legal counsel, a relative, a friend, the Medicaid Ombudsman or other spokesperson at the hearing. The member or his/her authorized representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing. Conference telephone hearings may be offered as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings. The hearing shall be private unless the applicant or recipient requests, on the record, that the hearing be open to the public. If the member/member's guardian/designated representative is not fluent in English or has a language difficulty, the Court will arrange to have present at the hearing a qualified interpreter who will be sworn to translate correctly. An ALJ decision is the final decision in the member/member's guardian/designated representative appeal process. To initiate this process, the member/ guardian/DCR can contact the Office of Administrative Courts at 1525 Sherman Street, 4th Floor, Denver, CO 80203, 303-866-2000, fax 303-866-5909.
Assistance with this process is available for member/member's guardian/designated representative from the BHO Office of Member and Family Affairs at the numbers above, or from the Ombudsman for Medicaid Managed Care at 1-877-435-7123, (TTY: 1-888-876-8864) 303 E 17th Street, Denver, CO, 80203, e-mail: help123@maximus.com.

Appeal of Termination, Suspension or Reduction of Previously Authorized Services
An appeal in this category follows the same procedure as a standard appeal except that the timeframe for filing the appeal is 10 calendar days instead of 30 calendar days. This timeframe applies to both the appeal to the BHO as well as for the State Fair Hearing. Appeals in the category also may include a request for services during the appeal process. The timeframe for sending the appeal decision is the same as a standard appeal, within ten(10) working days from receiving the appeal.

Special Circumstances under which Services May be Continued at BHO Expense during the Course of an Appeal

Upon member/guardian/DCR request, services will be continued during the appeal of the termination, suspension, or reduction of a *previously* authorized service. For example, if a valid authorization for 30 days of residential services is terminated after only 15 days. In order to obtain continued services, a member's appeal must be filed on or before the later of the following:

- Within ten (10) days of the BHO mailing the Notice of Action; or
- Within ten (10) days of the intended date of the BHO's proposed action (i.e., before services actually terminate).

Previously authorized services may be continued only if ALL the following criteria are met:

- The member/guardian/DCR or provider with written consent of the member files the appeal timely;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The Member requests extension of benefits (services).

If the requested service continues it is for a limited time until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) days pass after the BHO mails the notice providing the resolution of the appeal upholding the original BHO termination, suspension, or reduction of services, unless the member, within a ten (10) day timeframe makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached;
- A State Fair Hearing Office issues a hearing decision adverse to the member; or
- The time period of the previous authorization of the services expires.

It's important to note that if services are provided during the appeal or State fair hearing, and if the final decision is adverse to the member, the member may have to pay for those services.

Definitions

Actions

An appeal may be filed for events categorized as Actions. Actions include:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service.
3. Denial of payment for a service, in whole or in part.
4. Failure of the BHO to provide a service in a timely manner.
5. Failure of the BHO to act within approved timeframes for grievances or appeals.
6. Denial of a request by a member in a rural area to obtain treatment outside of the ValueOptions Medicaid Provider Network.

Clinical Peer Review

This process involves a review of clinical information provided verbally or in writing by an appropriately qualified and licensed BHO Peer Reviewer.

Peer-to-Peer Review

This process involves telephonic discussion of pertinent clinical information by a provider and an appropriately qualified and licensed BHO Medical Director or Peer Reviewer. The Peer Reviewer has the authority to deny authorization should the member not have a covered diagnosis or not meet medical necessity criteria for the service being requested.

Standard Appeal

A member may appeal any Action, as defined above. The standard appeal process is the most often requested appeal and is initiated when the denial of services does NOT jeopardize the life or health of the member. The standard appeal must be completed within a 10 working day timeframe. When this determination is made, notification will be mailed to the member. This process can be used for any prospective, concurrent or retrospective appeal.

Expedited Appeal

When a denial of services may jeopardize the life or health of a member, an expedited appeal process may be requested. The expedited appeal is to insure a more timely decision than the ten (10) working day standard appeal process. The expedited appeal occurs most frequently at higher levels of care (i.e., inpatient requests, ATU requests etc). In the case of an expedited appeal, determination will be made and a resolution letter mailed to the member within three (3) calendar days (72 hours) of the request for appeal.

Section 10

NETWORK CREDENTIALING

The Network Credentialing and Provider Relations Departments are responsible for monitoring all administrative aspects of the provider network. This includes, but is not limited to, provider credentialing and recredentialing, provider status changes and updates, geographic and specialty access, training, and provider relation activities.

ValueOptions' program for credentialing and re-credentialing providers is designed to comply with the National Committee for Quality Assurance (NCQA) standards for the credentialing of behavioral health providers. This program will be described below as it applies to Colorado Medicaid participating providers.

If you are interested in becoming a provider for the Behavioral Health Organization that administers the Colorado Community Behavioral Health Services Program, please send a letter of intent along with a copy of your resume by fax or email. For facilities interested in Medicaid participating, please include a staff roster and specific information about the program(s) the facility offers. Please review the remainder of this section for information about our credentialing criteria.

Provider Relations:	**1-800-804-5040**
Fax:	**719-538-1433**
Email:	COProviderRelations@valueoptions.com

CREDENTIALING

All providers who participate in the ValueOptions Colorado Medicaid Network must be credentialed according to ValueOptions' standards and policies. Among these requirements is Primary Source Verification (see Glossary) of the following information:

- Current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state.
- Clinical privileges in good standing at the institution designated by the practitioner as the primary admitting facility, as applicable.
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure.
- Board certification, if designated on the application.
- Current, adequate malpractice insurance.
- History of professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner.
- Specialized training for non-traditional practitioners.
- Three years post-licensure experience.

ValueOptions also requires:

- A copy of a current DEA Certificate, as applicable
- Work history
- Information from the State Board of Licensure and the National Practitioner Data Bank
- Information about sanctions or limitations on licensure from the appropriate state
- Medicare and/or Medicaid sanctions.

ValueOptions performs verification of the following elements to meet the State of Colorado Medicaid requirements for providers:

- Background investigation through the Colorado Bureau of Investigation; and
- Background investigation through the Background Investigation Unit Colorado Department of Human Services (TRAILS).

As part of the credentialing process, ValueOptions conducts a structured site visit of high volume provider offices. This site visit includes an evaluation using ValueOptions' standards and includes evaluation of the provider's clinical record-keeping practices to ensure conformity with ValueOptions' standards.

It is the responsibility of the provider to give current information to our Network Credentialing Department within the timeline defined below for the provider to maintain network status. When Network Credentialing receives the new information, they will update the data system and add the documentation to the provider's file. Failure to submit current copies of expired items will result in suspension or termination from the network.

PROVIDER CONTRACT REQUIREMENTS

1. **Providers must notify the BHO within 24 hours upon the occurrence of any of the following:**

- Adverse incidents regarding members, i.e. attempted suicide requiring medical care, suicide, homicide, suspected neglect or abuse of members, incidents that may attract media attention. (See Section 14 Quality Management for more information.)
- Revocation, suspension, restriction, termination, or relinquishment of any of the licenses, authorizations, or accreditation's whether voluntary or involuntary.
- Any legal action pending for professional negligence or alleged malpractice.
- Any indictment, arrest, or conviction for felony charges or for any criminal charge.
- Any lapse or material change in professional liability insurance coverage.
- Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility.
- Any alleged professional misconduct or ethical violations reported to state licensing boards, professional organizations or the National Practitioners Data Bank.

Failure to report any of the above within the specified time frame will result in immediate suspension from the network with possible termination.

2. APPOINTMENT AVAILABILITY AND ACCESS STANDARDS

ValueOptions contracted providers are required to meet all access standards as stated in the Medicaid regulations. Specific information for routine access will be gathered during the initial authorization process for outpatient care. ValueOptions conducts quarterly quality activities to assure compliance with these standards. These activities may include random contacts to providers to measure timeframes for Routine and Emergent appointment access.

The access/availability timeframes required in the Medicaid regulations are as follows:

- **Emergent Access**: Members in a crisis must be contacted by phone within 15 minutes of initial member request. A face-to-face evaluation must be conducted within 1 hour of initial contact in urban areas and within 2 hours in rural areas. Providers are required to have coverage for after-hours emergencies; it is not an acceptable practice to refer members to a Mental Health Center without a prior agreement with the Mental Health Center, or for a phone message to refer clients directly to an emergency room in a crisis. If members are referred to an emergency room or crisis center following a crisis evaluation, the provider must be available by phone 24 hours a day, 7 days a week to offer information and consultation to the emergency services provider.
- **Urgent Access**: Members must be offered an appointment that is within 24 hours of initial contact.
- **Routine Access**: Members must be offered an initial appointment that is within 7 business days of the member's request.

Inpatient and Residential Treatment post-discharge follow-up appointments: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

Waiting Room Time for Scheduled Member Appointments: A Medicaid Member who arrives on time for their scheduled appointment shall wait no longer than fifteen minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the Member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by reviewing the wait time policy with the Member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

If you have questions about these timeframes, please contact the BHO Director of Quality Management.

3. RECREDENTIALING

ValueOptions requires that practitioners and organizational providers undergo recredentialing every three years. Recredentialing begins approximately six months prior to the expiration of the 3-year cycle. Providers are sent a recredentialing application that must be completed in its entirety, signed, and returned to ValueOptions as soon as possible, with all requested verifications attached.

Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use (in accordance with applicable legal requirements such as the Americans with Disabilities Act).

High volume providers (as defined by ValueOptions) must undergo a structured site review to ensure conformity with ValueOptions' standards. This review includes an evaluation of clinical record keeping practices at each site.

LOCAL CREDENTIALING COMMITTEE

The Local Credentialing Committee (LCC) is comprised of representatives of all major clinical disciplines. The LCC functions as an advisory body to the National Credentialing Committee (NCC). Files for credentialing and recredentialing are first reviewed by the LCC; recommendations are forwarded to the NCC regarding the network participation in ValueOptions Colorado Medicaid Provider Network.

NATIONAL CREDENTIALING COMMITTEE

ValueOptions' National Credentialing Committee (NCC) is made up of representatives of all major clinical disciplines, participating providers, and representatives of major departments including the National Network Management and Quality Management departments. The NCC has decision-making authority for all credentialing matters including approvals and denials for network participation during initial credentialing and recredentialing. The NCC also makes decisions regarding provider sanctions. The NCC reports its activities to ValueOptions' Corporate Quality Improvement Committee (CQIC) which provides oversight.

CHANGE OF STATUS OR ADDRESS

Providers can help keep files current by notifying Network Credentialing of change of status or address. Information can be submitted by calling **1-800-804-5040,** faxing to **1-719-538-1433**, sending an email to COProviderRelations@Valueoptions.com , or by writing ValueOptions, Network Credentialing Department, 7150 Campus Drive., Ste. 300, Colorado Springs, CO 80920.

Failure to notify Network Credentialing of changes may result in delay in payment of claims or change in network status to include suspension or termination from the network.

Notify Network Credentialing of new practice affiliations, changes in address or licensure, and facility or program involvement. Remember to include all important information:

- Your name and name(s) of practice, facility, program
- Tax identification number and billing information

- Street address(es), city, state and zip
- Telephone number(s)
- Copies of new or updated licenses or authorizations
- Copies of cover sheets for updated liability coverage

A copy of the form can be obtained by visiting http://www.valueoptions.com or is attached to this handbook.

PROVIDER TERMINATIONS, SANCTIONS AND APPEALS

Voluntary: If a provider chooses to terminate from the network, a written request must be submitted to Provider Relations. Provider Relations will acknowledge receipt of the request, coordinate Member related services with the clinical department, and notify the provider of the final termination date.

Involuntary: Non-adherence to performance standards or criteria, substandard performance, unethical practices, and breaches in professional code of conduct may result in termination from the provider network. Critical areas monitored include:

- professional and ethical conduct
- adherence to contract stipulations
- professional liability claims/disposition involving direct Member care
- patterns of practice contrary to ValueOptions' procedural standards
- patterns of service delivery
- billing fraud
- due process
- violation of state/federal laws
- reporting of all sentinel events.

If performance standards are suspect, ValueOptions will contact the provider by phone, or by authorized mail to alert the provider to the issue(s) and will review the appropriate documentation in compliance with due process/fundamental fairness procedures. A full description for ValueOptions' sanctioning policies and procedures can be obtained on written request from Network Credentialing.

APPEALS

Providers who are terminated from the network or are otherwise sanctioned have the right to appeal. Such appeals are heard by the National Provider Appeals Committee (PAC), which is comprised of representatives of all major disciplines, ValueOptions participating providers, and representatives of certain ValueOptions' departments, including Network Management, Clinical Operations and Quality Management. Members of the PAC must not have participated in the National Credentialing Committee decision under review. Providers who have been sanctioned by the National Credentialing Committee, based on a peer review of a quality of care concern have the right to a fair hearing, if such a hearing is requested within 30 days. Sanctioned or terminated providers are notified about the procedure for requesting the fair hearing at the time they are notified about the adverse action. Providers sanctioned by the

National Credentialing Committee for reasons other than quality of care concerns must submit their appeal in writing within 30 days. Providers eligible for written appeals will be notified of their appeal rights at the time they are notified about the adverse action. Filing an appeal will not stay the sanctions imposed by the National Credentialing Committee.

NOTE: Providers who are convicted of crimes involving sexual misconduct or the violation of a member's civil rights, or who are the subject of malpractice judgements or settlements or licensure actions involving sexual misconduct or violations of a member's civil rights, are excluded from any further network participation. The National Credentialing Committee must approve any exceptions to this policy.

Section 11

BENEFIT EXCEPTIONS

PRESCRIPTION DRUGS
The BHO will not be responsible for the cost of prescription drugs, including those received in the emergency room.

RESIDENTIAL TREATMENT
The BHO covers medically necessary use of residential treatment for minors who have a covered diagnosis, where the need for residential treatment derives from the covered diagnosis, and who are not in the custody of the Department of Social Services or the Department of Youth Corrections. Residential treatment is not a covered service for members diagnosed only with a Substance Use Disorder.

RECIPIENT CO-PAYMENTS
The BHO and its contracted provider network will not assess any charges to Medicaid recipients for covered services. This includes co-payments. Balance billing is also not allowed. Members receiving Substance Use Services who do not feel comfortable allowing their providers to bill Medicaid may work with their provider to find other funding sources for the treatment, including member self pay, if the member chooses this option.

EXCLUSIONS FROM THE COLORADO MEDICAID BEHAVIORAL HEALTH SERVICES PROGRAM
The following Medicaid populations are specifically excluded by the Behavioral Health Services Program:

1. Qualified Medicare Beneficiaries Only
2. Undocumented Aliens (who are entitled to emergency services)
3. Presumptive Eligibility
4. Program of All-inclusive Care for the Elderly (PACE)

Benefits Exclusions and Limitations:

1. Treatment of the underlying condition of organic mental disorders associated with permanent brain dysfunction.
2. Treatment of the underlying condition of mental retardation or pervasive developmental disorder or autism.
3. Treatment for obesity, or weight loss not associated with anorexia nervosa or bulimia except as part of an overall treatment plan.
4. Test or procedures conducted to rule out medical conditions.
5. Medical care, supplies or service required for concomitant medical problems.
6. Care which is predominantly custodial or domiciliary in nature.
7. Speech therapy.

8. Stand-alone smoking cessation programs, unless adjunctive to a comprehensive treatment plan.
9. Treatment for chronic pain, unless of predominantly psychological origin.
10. Inpatient treatment for conditions which are often described as sexual addiction, compulsive gambling, co-dependency, or adult children of alcoholics, or non-abusing family members.
11. Structured sexual therapy programs including sexual offender treatment.
12. Nutritionally-based therapies.
13. Health care services, treatment and/or supplies which are deemed to be experimental by the BHO's Medical Director, or investigational, or mainly for research or not in keeping with national standards of practice, including, but not limited to: crystal healing therapy, Rolfing, regressive therapy, megavitamin therapy, rebirthing therapy and aversion treatment.
14. Ancillary services such as sleep therapy, employment counseling, training and/or educational therapy for learning disabilities, or other educational services. Educational testing will only be considered if pre-authorized by ValueOptions.
15. Discrete services and treatments which are for personal growth, development, or professional authorization (e.g., training analysis).
16. Discrete services and treatments which are required under law to be provided by the school system for children.
17. Services that are court-ordered but not deemed medically necessary.
18. Electroconvulsive therapy (ECT), unless pre-authorized.
19. Psychological testing, including neuropsychological testing, unless pre-authorized.
20. Therapy for behaviors considered to be normal for the development stage.
21. LIMITATIONS:
    - There is a 35 session limit for individual and brief individual outpatient therapy per fiscal year, when the service is provided to treat a mental health disorder. There is no benefit limit for individual therapy when the treatment is to address a substance use disorder, however, the service must meet medical necessity guidelines.
    - There is a 45 day inpatient benefit limit per fiscal year. Inpatient services are not a covered service for the treatment of substance use disorders.

SECTION 12

COLORADO CLIENT ASSESSMENT RECORD (CCAR)

The Colorado Client Assessment Record (CCAR) is a state-required form that must be completed for all members receiving behavioral health treatment. The CCAR form is used to capture demographic, administrative, clinical, and outcome data. It is a clinical instrument designed to assess the behavioral health status of a consumer in treatment. The tool can be used to identify current clinical issues facing the consumer and to measure progress during treatment.

The CCAR consists of an administrative section and an outcomes section:

- The administrative section contains questions related to a consumer's characteristics (e.g., social security number, date of birth, gender, etc.)
- The outcomes section contains questions related to a consumer's daily functioning on 25 clinical domains.

Providers are required by contract to complete a "full" CCAR for every publicly funded client at admission, annually, at discharge, and when there is a change in client status (e.g., change in payer source, admission to inpatient psychiatric hospital, change in living arrangement, etc). Completion of a "full" CCAR means populating all of the fields completely (for example, the complete social security number, the complete first and last name, etc.).

Outpatient psychotherapy providers must complete a CCAR at admission and discharge from treatment, and at least annually for members who are not discharged from treatment within one year. Medication providers must complete a CCAR only if there is no treating psychotherapist. In addition, a CCAR must be completed by a hospital upon a psychiatric hospitalization and discharge.

The CCAR form can be completed online (see instructions below)

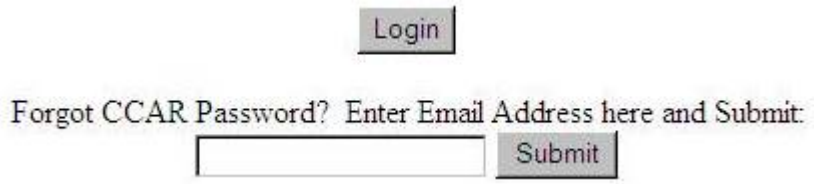
CCAR forms are required to be submitted electronically.

ACCESSING THE CCAR FORM ONLINE

The online CCAR form can be accessed at http://www.chneforms.com/ccar/

When you click on the link provided, the login/password page of the CCAR application will open. Your login will be the email address you have given ValueOptions provider relations staff. If you have not given ValueOptions your email address, please call to have that information added to your provider profile. Providers cannot use this application without a valid email address. A password will be assigned to you and is given at random and cannot be changed. For facilities, only one password/email address combination can be assigned at one time to one facility.

Providers without a password must use the text box at the bottom of the login page called "Forgot CCAR Password?"



Enter your email address and click the Submit button. At that point, you will be emailed your password information with which you can then go back and login to the CCAR application.

WHO NEEDS TO SEND IN A CCAR FORM AND WHEN

The first provider (outpatient therapist) to obtain an authorization for the member is the provider responsible for submitting the CCAR. For example, if an outpatient therapist has an authorization to see the member, and a second therapist gets another authorization for group therapy after the first outpatient therapist, the first outpatient therapist is responsible for completing the CCAR form. For outpatient therapists, an admission CCAR, annual update CCAR, and a discharge CCAR are required.

Although an authorization is not necessary for medication management services, a prescriber is required to submit a CCAR if there is no treating psychotherapist.

If a member in treatment is admitted to a hospital, the hospital will fill out an update CCAR form. If an update CCAR form is needed, that facility will not need to send in a discharge CCAR form. The only time a hospital (or other level of care higher than outpatient) will send in an admit CCAR is when the member is not in any other type of treatment. If an admit CCAR is needed, so is a discharge CCAR.

FREQUENTLY ASKED QUESTIONS (FAQ)

At the bottom of the CCAR login screen there is a link to the CCAR Frequently Asked Questions (FAQ) that also allows you to search for questions concerning CCAR forms.

TECHNICAL SUPPORT

For technical support, please contact the Provider Services staff at 1(800) 804-5040 or send an email to: coproviderrelations@valueoptions.com.

Section 13

Claims Billing Information

ValueOptions Colorado will be processing all claims for Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership, all of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Medicaid Community Mental Health Services Program. For answers to questions about Billing for Professional and Facility/Program Services, call ValueOptions: **1-800-804-5040**

A. Claim Submission Requirements

Timely and accurate processing of claims is important to ValueOptions. Following the instructions below will facilitate efficient processing of your claim within acceptable timeframes.

1. ValueOptions will process claims for dates of service on or after July 1, 2009.
2. ValueOptions will accept the following types of claims. Please see Section B for Electronic Data interchange (EDI) information:
   - 837P file
   - 837I file
   - DirectClaim Submission (claims submitted individually through a secured internet access)
   - EDI Claim Link for Windows (*ValueOptions*' HIPAA compliant software)
   - HIPAA compliant file written from the Provider's Practice Management System
   - Center for Medicare and Medicaid Services/CMS-1500 or a Colorado 1500 form
   - Uniform Billing Form/UB04 (CMS-1450) or HCFA-1450.
3. Detailed instructions on required data elements for completing the claim forms are outlined in sections D1 and D2, below.
4. Completed claim forms may be mailed to:

   ValueOptions
   P.O. Box 12698
   Norfolk, VA 23541
   ATTN: CO Claims

5. **Time Limit for Filing Claims**
   a. **Claims -** Initial claims for covered services must be submitted within ninety (90) days of the date of service to be considered for reimbursement. Initial claims submitted beyond the ninety (90) day time limit may be zero paid (for timely filing) on the *ValueOptions* provider summary voucher (Explanation of Benefits, EOB).

   b. **Medicaid Claims Involving Third Party Liability (TPL)** must be submitted within ninety (90) days of the date of the other carrier's Explanation of Benefits (EOB), or notification of payment / denial. Initial claims involving TPL that are submitted

beyond ninety (90) days from the date of the other carrier's EOB may be zero paid (for timely filing) on the *ValueOptions* provider summary voucher.

6. **Incomplete Claims**
   a. Claims may be "zero-paid" by *ValueOptions* in the case of incorrect or incomplete required data elements.
   b. *ValueOptions* may notify the provider, via the provider summary voucher (EOB), of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections D1 and D2 of this Section.

7. A separate claim form must be submitted for each rendering provider of service. For example, if the member has outpatient individual therapy (99211) rendered by an MD and an outpatient group therapy session (90853) rendered by an LCSW, each of these services need to be submitted on separate claims.

8. The service location must be submitted on all claims. ValueOptions will use this address information in conjunction with the NPI to select the appropriate provider record for processing the claim on our system.

9. **Itemized bills are required.** All pertinent information is necessary to process a claim promptly and accurately. Please make sure to include the following elements when submitting a claim:
   - Dates of service should be listed individually on CMS-1500 claim forms (NO DATE SPANS).
   - Valid ICD-9 diagnosis codes (NOTE: ICD-9 diagnosis codes are required for electronically submitted claims.) The list of diagnosis codes covered under the Community Mental Health Services Program is attached.
   - Rendering provider and provider billing information, including tax identification number entered in appropriate areas of UB04 and CMS1500 forms.
   - Appropriate and valid place of service codes with correlating appropriate and valid CPT or HCPS codes (and Revenue codes, when billing on a UB04 (CMS-1450)).
   - Accurate member/patient information including member identification number, member name and Date of Birth. Please do not use nicknames. NOTE: If the member identification number is not correct the claim will be denied.

10. **Authorization and claim must match:** The services billed must correspond to the care that was authorized. In order for payment to occur, the procedure/revenue code and dates of service must match those authorized.

11. **Claims Payment –** For paper claims received the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. This technology enables ValueOptions to shorten turnaround time and improve quality. The following elements are required to take advantage of this automated process. If you do not follow the guidelines, your claim will still be

processed, however, it will require manual intervention and may take longer to process. NOTE: Claims not submitted on an original "red-line" claim form need to be processed manually, delaying reimbursement.

a. Use machine print
b. Use original red claim forms
c. Use black ink
d. Print claim data within the defined boxes on the claim form
e. Use all capital letters
f. Use a laser printer for best results
g. Use white out or correction tape for corrections
h. Submit any notes on 8 1/2" x 11" paper
i. Use an eight-digit date format (e.g., 10212013)
j. Use a fixed width font (Courier, for example)

12. Please refer to your provider agreement for the covered services that you have been contracted for, and the definition of services included in the reimbursement rates.

13. Medicaid Claims should be submitted with the Member's Medicaid ID Number; failure to use this permanent ID number will result in the denial of the claim on the provider summary voucher (EOB).

14. Claims must be submitted with valid and complete ICD9 diagnosis codes. Claims submitted with any other diagnosis code may be zero paid on the *ValueOptions* provider summary voucher (EOB).

15. Before any payments can be made to any provider or facility, the minimum of a completed W9 Form must be on file with *ValueOptions*.

C. Electronic Media Claim Submission (EDI and DirectClaim Submission)

1. Code Requirements

Under the Health Insurance Portability and Accountability Act (HIPAA), all covered entities must submit files using the transaction and code standards effective October 16, 2003. Technical instructions, Implementation and Companion Guides for these electronic transactions can be found on the ValueOptions Web site at www.valueoptions.com. In using this system, ValueOptions and providers must:

(i) Not change any definition, data condition or use of a data element or segment as proscribed in the Health and Human Services (HHS) Transaction Standard Regulation. (45 CFR 162.915(a)).
(ii) Not add any data elements or segments to the maximum defined data set as defined in the HHS Transaction Standard Regulation. (45 CFR 162.915 (b)).
(iii) Not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not

in the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (c)).

(iv) Not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (d)).

2. Please contact the EDI Help Desk at 1-888-247-9311 for assistance with becoming a *ValueOptions* EDI claim submitter or Single Claim Submitter (Also known as DirectClaim Submission).
    a. The **DirectClaim Submission** feature is a web-based method of submitting one (CMS-1500) claim at a time to *ValueOptions*. This method of submitting claims is recommended for a small provider office that would submit no more than 20 claims at a time.
    b. EDI Claims Link for Windows is an electronic claim submission process developed by *ValueOptions* and is free to providers who wish to submit electronic claims to *ValueOptions*.

3. *ValueOptions* will accept the following HIPAA compliant claim files:
    - Files programmed by the Provider's IT Department;
    - Files submitted using ValueOptions' EDI Claims Link for Windows software;
    - Claims submitted using ValueOptions' Single Claim Submission process. **Note**: **Please see the ValueOptions Provider Guide to using DirectClaim Submission, available on the www.valueoptions.com website, under "Providers".**

4. The following information is required from the provider prior to submitting claims electronically:
    - Completed Account Request Form;
    - Intermediary Authorization Form (if using a billing agent or clearinghouse);
    - Files must be HIPAA compliant (if using EDI Claims Link for Windows software, this software is HIPAA compliant);
    - Must submit a test file to verify accurate information is included in the file.

D. Paper Claim Submission Requirements

1. **Instructions for Completing the CMS 1500 Claim Form. Please note:** The CMS 1500 form is being updated as of January 1, 2014. The information below reflects the updates that will be made to the form. Here is a summary of the changes:
    a. Indicators will be added to differentiate between ICD-9-CM and ICD-10-CM diagnosis codes
    b. There is an expansion of the number of possible diagnosis codes to twelve (12)
    c. Qualifiers to identify the following provider roles
        i. Ordering physician
        ii. Referring physician
        iii. Supervising physician

The information on the following pages must be completed or the claim may be zero-paid on the summary voucher.

Field Number	Field Description	Data Type	Instructions
Member Information (Fields 1-13)			
1	Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box (e.g., if a Medicaid claim is being filed, check the Medicaid box).
1a	Insured's ID number	Required	List the member's CO Medicaid identification number here. Verify that the identification number corresponds to the member listed in item 4.
2	Patient's name	Required	Enter the patient's last name, first name, and middle initial, if any. NOTE: If the patient has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not use any punctuation in this field.
3	Patient's birth date and gender	Required	Enter the patient's birth date and sex. Use the eight digit format (MM|DD|CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the patient. Only one box can be marked. If the gender is unknown, leave blank.
4	Insured's name	Optional	Enter the member's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name.
5	Patient's address, city, state, zip code and telephone number	Optional	Enter the patient's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number. NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
6	Patient's relationship to the insured	Optional	Check the appropriate box for the patient's relationship to the insured when item 4 is completed. Remember that the patient's relationship to the insured is not always "self".
7	Insured's address, city, state, zip code and telephone number	Optional	Enter the member's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
8	Reserved for NUCC use	N/A	

Field Number	Field Description	Data Type	Instructions
9	Other insured's name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.
9b	Reserved for NUCC use	N/A	
9c	Reserved for NUCC use	N/A	
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.
10a - c	Is the patient's condition related to: • Employment? • Auto accident? • Other accident?	Optional	Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.
10d	Claims Codes (Designated by NUCC)	Not required	Please leave blank.
11	Insured's policy group or FECA number	Optional	Enter the Insured's policy or group number as it appears on the insured's health care identification card.
11a	Insured's date of birth and sex	Conditional	Required if the patient is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3.
11b	Other claim ID	Conditional	Enter the insured's employer's name, if applicable. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.
11c	Insurance plan name or program name	Conditional	Enter the member's insurance company or program name.
11d	Is there another health benefit plan?	Conditional	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim. If "yes" complete items 9, 9a and 9b.

Field Number	Field Description	Data Type	Instructions
12	Patient's or authorized person's signature (Medicaid/other information release)	Required	The patient *must* sign and date the claim *if* authorizing the release of medical information. If "signature on file" is indicated, the provider *must* maintain a signed release form or CMS-1500 (formally HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.
13	Insured's or authorized person's signature	Required	The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature are acceptable. If there is no signature on file leave this item blank or enter "no signature on file".
Provider of Service or Supplier Information (Fields 14-33)			
14	Date of current illness, injury or pregnancy (LMP)	Not required	Not applicable.
15	Other Date	Not required	Not applicable.
16	Dates patient unable to work in current occupation	Not required	Required if the patient is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the patient was unable to work in MMDDYY or MMDDCCYY format.
17	Name of referring physician or other source	Not required	Enter the name of the referring physician or other source if applicable.

Field Number	Field Description	Data Type	Instructions
17a	ID number of referring physician	Conditional	The CMS-assigned UPIN of the referring or ordering physician listed in Field 17. Enter only the seven-digit base number and the one-digit check digit. The other ID number of the referring provider, ordering provider, or other source should be reported in 17a in the shaded area. The qualifier indicating what the number represents should be reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1: • 0B – State license number • 1B – Blue Shield provider number • 1C – Medicare provider number • 1D – Medicaid provider number • 1G – Provider UPIN number • 1H – CHAMPUS identification number • EI – Employer's identification number • G2 – Provider commercial number • LU – Location number • N5 – Provider plan network identification number • SY – Social Security number (The Social Security number may not be used for Medicare) • X5 – State industrial accident provider number • ZZ – Provider taxonomy – A list of the valid Taxonomy codes begins on Page 38.
17b	NPI	Required	Enter the NPI of the referring or ordering physician listed in item 17 as soon as it is available. The NPI may be reported as of October 1, 2006. NOTE: Field 17a and / or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.
18	Hospitalization dates related to current services	Not Required	Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.
19	Additional claim information (Designated by NUCC)	Not Required	Not applicable.
20	Outside lab/charges	Not Required	Not applicable.

Field Number	Field Description	Data Type	Instructions
21.A - L	Diagnosis or nature of illness or injury	Required (the primary diagnosis code is required)	Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to twelve codes in priority order (primary, secondary, etc.)
22 caid	Resubmission	Not required	List the original reference (claim) number for resubmitted claims.
23	Prior authorization number	Not required	Not applicable.
24a	Dates of service	Required	Enter “From” and “To” dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column C.
24b	Place of service	Required	Enter the appropriate place of service code from the list provided beginning on Page 19.
24c	EMG	Not required	Not applicable.
24d	Procedures, services or supplies CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.

Field Number	Field Description	Data Type	Instructions
24d	Modifier	Conditional	Enter a valid CPT or HCPCS code modifier for each service entered.** **HIPAA: Billing Code Modifiers** ** When submitting a CPT or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below: **Modifier ONE**: This field is dedicated for modifiers that affect or define the service (e.g., TG modifier to identify a 'complex high level of care') **Modifier TWO**: This field is dedicated for modifiers that identify pricing (e.g., HA modifier to identify 'child/adolescent' or HN modifier to identify 'bachelors level') **Modifier THREE & FOUR**: These fields are dedicated for modifiers that identify statistics (e.g., HV 'funded by State Addictions Agency') If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.
24e	Diagnosis pointer	Conditional	Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, a 1, 2, 3 or 4, is shown. *Do not* enter the ICD-9 diagnosis code.
24f	Charges	Required	Enter the provider's billed charges for each service.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "From" and "To" dates indicated in Field 24a.
24h	EPSDT family plan	Not Required	If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.
24i	ID Qual.	Not Required	If the provider does not have an NPI, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	Rendering Provider ID#	Required	Enter the NPI number in the un-shaded area of the field.

Field Number	Field Description	Data Type	Instructions
25	Federal Tax ID number and type: • Social Security Number or • Employer Identification Number	Required	Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Patient's account number	Optional	Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher.
27	Accept assignment?	Required	Enter an "X" in the appropriate box.
28	Total charge	Required	Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f.
29	Amount paid	Conditional	Enter the total amount paid by the Member for services billed on this claim.
30	Reserved for NUCC Use	N/A	
31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care *must* sign and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter name and address where services are rendered.
32a	a.	Not Required	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
32b	b.	Not Required	Not Applicable
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.
33a	PIN number	Required	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.
33b	Group number	Not Required	

Valid Place of Service Codes for the Colorado Medicaid Account (Field 24B)

Place of Service Code(s)	Place of Service Name
01	Pharmacy
03	School
04	Shelter
09	Prison / Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
19	School
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility (Partial Hospitalization)
53	Community Mental Health Center
54	Intermediate Care Facility
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
57	Non-residential Substance Abuse Treatment Facility
71	State or Local Public Health Clinic
99	Other Place of Service

2. Instructions for Completing the UB04 (CMS1450) Claim Form. The information on the following pages must be completed or the claim may be zero-paid on the summary voucher.

Field	Field description	Field type	Instructions
1	Provider name, Address, and Telephone Number	Required	This field contains the name, and service location and telephone number of the provider submitting the bill.
2	Pay-to Name and Address	Required	This field contains the address to which payment should be sent if different from the information in Field 1.
3a	Patient Control Number	Optional	Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.
3b	Medical / Health Record Number	Optional	In this field, report the patient's medical record number as assigned by the provider.
4	Type of Bill	Required	This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The fourth digit defines the frequency of the bill for processional claims. The leading zero should not be reported on electronic claims. The valid codes are at the end of this section.
5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified using federal tax sub-IDs.
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.
7	Reserved for Assignment by the NUBC	Not Required	N/A
8a	Patient Identifier	Required	This field is for the patient's identification number.
8b	Patient Name	Required	This field is for the patient's last, middle initial, and first name.
9a	Patient Address	Required	This field is for entering the patient's street address.
9b	(unlabeled field)	Required	This field is for entering the patient's city.

Field	Field description	Field type	Instructions
9c	(unlabeled field)	Required	This field is for entering the patient's state code.
9d	(unlabeled field)	Required	This field is for entering the patient's ZIP code.
9e	(unlabeled field)	Required	This field is for entering the patient's Country Code.
10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Sex	Required	Use this field to identify the sex of the patient.
12	Admission Date / Start of Care Date	Required	Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.
13	Admission Hour	Required	Enter the hour in which the patient is admitted for inpatient or outpatient care. **NOTE**: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section.
14	Priority (Type) of Visit	Required	Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.
15	Source of Referral for Admission or Visit	Required	This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.). See valid codes at the end of this section.
16	Discharge Hour	Conditional	This field is used for reporting the hour the patient is discharged from inpatient care. **NOTE**: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section.
17	Patient Discharge Status	Required	Use this field to report the status of the patient upon discharge – required for institutional claims. See valid codes at the end of this section.
18 – 28	Condition Codes	Conditional	Use these fields to report conditions or events related to the bill that may affect the processing of it. See valid codes at the end of this section.
29	Accident State	Conditional	When appropriate, assign the two-digit abbreviation of the state in which an accident occurred.

Field	Field description	Field type	Instructions
30	Reserved for Assignment by the NUBC	Not Required	N/A
31 – 34	Occurrence Codes and Dates	Conditional	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.).
35 – 36	Occurrence Span Codes and Dates	Conditional	This field is for reporting the beginning and end dates of the specific event related to the bill.
37	Reserved for Assignment by the NUBC	Not Required	N/A
38	Responsible Party Name and Address	Required	This field is for reporting the name and address of the person responsible for the bill.
39 – 41	Value Codes and Amounts	Required	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers.
42	Revenue code	Required	Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001.
43	Revenue Description	Optional	This field is used to report the abbreviated revenue code categories included in the bill.
44	HCPCS / Rate / HIPPS Code	Conditional	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes fro specific patient groups that are the basis for payment under a prospective payment system.
45	Service Date	Conditional	Indicates the date the outpatient service was provided and the date the bill was created using the six-digit format (MMDDYY).
46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.
47	Total Charges	Required	This field reports the total charges – covered and non-covered – related to the current billing period.
48	Non-Covered Charges	Conditional	This field indicates charges that are non-covered charges by the payer as related to the revenue code.

Field	Field description	Field type	Instructions
49	Reserved for Assignment by the NUBC	Not Required	N/A
50a, b, c	Payer Name	Required	Enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification Number	Required	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.
52a, b, c	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement form the Member to release information. Refer to Attachment B for valid codes.
53a, b, c	Assignment of Benefits Certification Indicator	Required	Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.
54a, b, c	Prior Payments	Conditional	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.
55a, b, c	Estimated Amount Due	Not required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.
56	National Provider Identifier – Billing Provider	Required	This field is for reporting the unique provider identifier assigned to the provider.
57	Other Provider Identifier – Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field.
58a, b, c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial.
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a, b, c	Insured's Unique Identification	Required	The ID Number from the Member's Medicaid Card should be entered.
61a, b, c	Group Name	Required	Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured.
62a, b, c	Insurance Group Number	Conditional	Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the insured.

Field	Field description	Field type	Instructions
63a, b, c	Treatment Authorization Codes	Optional	Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized.
64a, b, c	Document Control Number	Not Required from the Provider	This number is assigned by the health plan to the bill for their internal control.
65a, b, c	Employer Name (of the Insured)	Conditional	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Required	This qualifier is used to indicate the version of ICD-9-CM being used. A "9" is required in this field for the UB-04.
67	Principal Diagnosis Code	Required	Enter the valid ICD-9-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered.
67 a – q	Other Diagnosis Codes	Conditional	This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay.
68	Reserved for Assignment by the NUBC	Not Required	N/A
69	Admitting Diagnosis	Required	Enter a valid ICD-9-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission.
70 a – c	Patient's Reason for Visit	Conditional	The ICD-9-CM codes that report the reason for the patient's outpatient visit is reported here.
71	Prospective Payment System (PPS) Code	Not required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan.
72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse affects, the appropriate ICD-9-CM diagnosis code is reported in this field.
73	Reserved for Assignment by the NUBC	Not Required	N/A
74 a – e	Other Procedure Codes and Dates	Conditional	This field is used to report the principal ICD-9-CM procedure code covered by the bill and the related date.
75	Reserved for Assignment by the NUBC	Not Required	N/A

Field	Field description	Field type	Instructions
76	Attending Provider Names and Identifiers	Required	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim.
77	Operating Physician Name and Identifiers	Conditional	Report the name and identification number of the physician responsible for performing surgical procedure in this field.
78 – 79	Other Provider Names and Identifiers	Conditional	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.
80	Remarks Field	Not Required	This field is used to report additional information necessary to process the claim.
81 a – d	Code – Code Field	Conditional	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set.

3. UB04 (CMS1450) Reference Information

UB04 (CMS-1450) REFERENCE MATERIAL[1]

Type of Bill Codes (Field 4)

This is a four-digit code; each digit is defined below.

First Digit	Leading Zero

Second Digit – Type of Facility	**Description of Second Digit**
1XX	Hospital
2XX	Skilled Nursing
3XX	Home Health Facility
4XX	Religious Non-medical Health Care Institutions (RNHCI) – Hospital Inpatient
5XX	Reserved for Assignment by NUBC
6XX	Intermediate Care
7XX	Clinic (Requires Special Reporting for the Third Digit)
8XX	Special Facility or ASC Surgery (Requires Special Reporting for the Third Digit)
9XX	Reserved for Assignment by NUBC

Third Digit – Bill Classification	**Description of Third Digit Except for Clinics and Special Facilities**
X**1**X	Inpatient (Including Medicare Part A)
X**2**X	Inpatient (Medicare Part B Only) (Includes HHA Visits Under a Part B Plan of Treatment)
X**3**X	Outpatient (Includes HHA Visits Under a Part A Plan of Treatment Including DME Under Part A)
X**4**X	Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment
X**5**X	Intermediate Care Level 1
X**6**X	Intermediate Care Level II
X**7**X	Reserved for Assignment by NUBC
X**8**X	Swing Beds
X**9**X	Reserved for Assignment by NUBC

Third Digit – Bill Classification	**Description of Third Digit Classification for Clinics Only**
X**1**X	Rural Health Clinic
X**2**X	Clinic – Hospital Based or Independent Renal Dialysis Center
X**3**X	Freestanding
X**4**X	ORF
X**5**X	CORF
X**6**X	CMHC
X**7**X	Federally Qualified Health Center (FQHC)
X**8**X	Reserved for National Assignment
X**9**X	Other

Third Digit – Bill Classification	Description of Third Digit Classification for Special Facility Only
8**1**X	Hospice (Non-hospital based)
8**2**X	Hospice (Hospital based)
8**3**X	Ambulatory Surgery Center
8**4**X	Freestanding Birthing Center
8**5**X	Critical Access Hospital
8**6**X	Residential Facility (Not used for Medicare)
8**7**X	Reserved for Assignment by the NUBC
8**8**X	Reserved for Assignment by the NUBC
8**9**X	Other (Not used for Medicare)

Fourth Digit – Frequency of the Bill	Description of Fourth Digit Frequency of the Bill
XX**0**	Nonpayment / Zero Claim
XX**1**	Admit through Discharge Claim
XX**2**	Interim – First Claim
XX**3**	Interim – Continuing Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX**4**	Interim – Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX**5**	Late Charges Only Claim
XX**6**	Reserved for Assignment by the NUBC
XX**7**	Replacement of Prior Claim
XX**8**	Void / Cancel of a Prior Claim
XX**9**	Final Claim for a Home Health PPS Episode

[1] Ingenix ® *Uniform Billing Editor, November, 2013*

Sex Codes (Field 11)

Code	Definition
M	Male
F	Female
U	Unknown

Type of Admission Codes (Field 14)

Code	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma
6 – 8	Reserved for Assignment by the NUBC
9	Information Not Available

Source of Admission Codes (for Emergency, Elective or Other Type of Admission) (Field 15)

Code	Definition
1	Nonhealthcare Facility Point of Origin (Physician Referral)
2	Clinic or Physician's Office
3	Reserved for Assignment by the NUBC
4	Transfer From a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility, Intermediate Care Facility, or Assisted Living Facility
6	Transfer from Another Health Care Facility
7	Reserved for Assignment by the NUBC
8	Court/Law Enforcement
9	Information Not Available
A	Reserved for Assignment by the NUBC
B	Reserved for Assignment by the NUBC
C	Reserved for Assignment by the NUBC
D	Transfer from one Distinct Unit of a Hospital to Another Distinct Unit of the Same Hospital Resulting is a Separate Claim to the Payer
E	Transfer From Ambulatory Surgery Center
F	Transfer From Hospice Facility
G – Z	Reserved for Assignment by the NUBC

Additional Source of Admission Codes for Newborns (Field 15)

Code	Definition
1 – 4	Discontinued
5	Born Inside this Hospital
6	Born Outside of this Hospital
7 – 9	Reserved for Assignment by the NUBC

Patient Status (Field 17)

Code	Definition
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged / Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged / Transferred to a SNF with Medicare Certification in Anticipation of Covered Skilled Care
04	Discharged / Transferred to a Facility that Provides Custodial or Supportive Care
05	Discharged / Transferred to a Designated Cancer Center or Children's Hospital
06	Discharged / Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
08	Reserved for Assignment by the NUBC
09	Admitted as an Inpatient to This Hospital
10 – 19	Reserved for Assignment by the NUBC
20	Expired
21	Discharged/Transferred to Court/Law Enforcement
22 - 29	Reserved for Assignment by the NUBC
30	Still a Patient

Code	Definition
31-39	Reserved for Assignment by the NUBC
40	Expired at Home (
41	Expired in a Medical Facility such as a Hospital, SNF, ICF or Free-Standing Hospice
42	Expired, Place Unknown
43	Discharged / Transferred to a Federal Health Care Facility
44 – 49	Reserved for Assignment by the NUBC
50	Discharged to Hospice, Home
51	Discharged to Hospice, Medical Facility
52 – 60	Reserved for Assignment by the NUBC
61	Discharged / Transferred Within This Institution to a Hospital-Based Medicare Approved Swing Bed
62	Discharged / Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63	Discharged / Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged / Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare
65	Discharged / Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged / Transferred to a Critical Access Hospital
67 – 68	Reserved for Assignment by the NUBC
69	Discharged / Transferred to a Designated Disaster Alternative Care Site
70	Discharged / Transferred to Another Type of Healthcare Institution Not Elsewhere Defined in this Code List
71 – 80	Reserved for Assignment by the NUBC
81	Discharge to Home or Self-Care with a Planned Acute Care hospital Inpatient Readmission
82	Discharged / Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care hospital Inpatient Readmission
83	Discharged /Transferred to a Skilled Nursing Facility with Medicare Certification with a Planned Acute Care hospital Inpatient Readmission
84	Discharged /Transferred to a Facility that Provides Custodial of Supportive Care with a Planned Acute Care hospital Inpatient Readmission
85	Discharged /Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care hospital Inpatient Readmission
86	Discharged /Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care hospital Inpatient Readmission
87	Discharged /Transferred to Court / Law Enforcement with a Planned Acute Care hospital Inpatient Readmission
88	Discharged /Transferred to a Federal Health Care Facility with a Planned Acute Care hospital Inpatient Readmission
89	Discharged /Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care hospital Inpatient Readmission
90	Discharged /Transferred to an Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care hospital Inpatient Readmission

Code	Definition
91	Discharged /Transferred to a Medicare Certified Long-term Care Hospital with a Planned Acute Care hospital Inpatient Readmission
92	Discharged /Transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare with a Planned Acute Care hospital Inpatient Readmission
93	Discharged /Transferred to a Psychiatric Hospital or Psychiatric Distinct Part unit of a Hospital with a Planned Acute Care hospital Inpatient Readmission
94	Discharged /Transferred to a Critical Access Hospital with a Planned Acute Care hospital Inpatient Readmission
95	Discharged /Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List with a Planned Acute Care hospital Inpatient Readmission

Release of Information Indicator Codes (Field 52 and 837I)

Code	Definition
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim
I	Informed consent to release medical information for conditions or diagnoses regulated by federal statures

Member's Relationship to the Insured Codes (Field 59 and 837I)

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Valid Taxonomy Codes

100000000X	BH & SOCSERV PROVIDERS
101YA0400X	BH & SOCIAL SERVICE, COUNSELOR, ADDICTION (SUBSTAN
101YM0800X	BH & SOCIAL SERVICE, COUNSELOR, MH
101YP1600X	BH & SOCIAL SERVICE, COUNSELOR, PASTORAL
101YP2500X	BH & SOCIAL SERVICE, COUNSELOR, PROFESSIONAL
101YS0200X	BH & SOCIAL SERVICE, COUNSELOR, SCHOOL
101Y00000X	BH & SOCIAL SERVICE, COUNSELOR
103GC0700X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST, CLINICAL
103G00000X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST
103TA0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADDICTION (SUBS
103TA0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADULT DEVELOPME
103TB0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, BEHAVIORAL
103TC0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CLINICAL

103TC1900X	BH & SOCIAL SERVICE, PSYCHOLOGIST, COUNSELING
103TC2200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CHILD, YOUTH &
103TE1000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EDUCATIONAL
103TE1100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EXERCISE & SPOR
103TF0000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FAMILY
103TF0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FORENSIC
103TH0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, HEALTH
103TM1700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MEN & MASCULINI
103TM1800X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MENTAL RETARDAT
103TP0814X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOANALYSIS
103TP2700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY
103TP2701X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY,
103TR0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, REHABILITATION
103TS0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, SCHOOL
103TW0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, WOMEN
103T00000X	BH & SOCIAL SERVICE, PSYCHOLOGIST
1041C0700X	BH & SOCIAL SERVICE, SOCIAL WORKER, CLINICAL
1041S0200X	BH & SOCIAL SERVICE, SOCIAL WORKER, SCHOOL
104100000X	BH & SOCIAL SERVICE, SOCIAL WORKER
106H00000X	BH & SOCIAL SERVICE, MARRIAGE & FAMILY THERAPIST
160000000X	NURSING SERVICE
163WA0400X	NURSING SERVICE, RN, ADDICTION (SUBSTANCE USE DISO
163WA2000X	NURSING SERVICE, RN, ADMINISTRATOR
163WC0200X	NURSING SERVICE, RN, CRITICAL CARE MEDICINE
163WC0400X	NURSING SERVICE, RN, CASE MANAGEMENT
163WC1400X	NURSING SERVICE, RN, COLLEGE HEALTH
163WC1500X	NURSING SERVICE, RN, COMMUNITY HEALTH
163WC1600X	NURSING SERVICE, RN, CONTINUING EDUCATION/STAFF DE
163WC2100X	NURSING SERVICE, RN, CONTINENCE CARE
163WC3500X	NURSING SERVICE, RN, CARDIAC REHABILITATION
163WD0400X	NURSING SERVICE, RN, DIABETES EDUCATOR
163WD1100X	NURSING SERVICE, RN, DIALYSIS, PERITONEAL
163WE0003X	NURSING SERVICE, RN, EMERGENCY
163WE0900X	NURSING SERVICE, RN, ENTEROSTOMAL THERAPY
163WF0300X	NURSING SERVICE, RN, FLIGHT
163WG0000X	NURSING SERVICE, RN, GENERAL PRACTICE
163WG0100X	NURSING SERVICE, RN, GASTROENTEROLOGY
163WG0600X	NURSING SERVICE, RN, GERONTOLOGY
163WH0200X	NURSING SERVICE, RN, HOME HEALTH
163WH0500X	NURSING SERVICE, RN, HEMODIALYSIS
163WH1000X	NURSING SERVICE, RN, HOSPICE
163WI0500X	NURSING SERVICE, RN, INFUSION THERAPY
163WI0600X	NURSING SERVICE, RN, INFECTION CONTROL
163WL0100X	NURSING SERVICE, RN, LACTATION CONSULTANT
163WM0102X	NURSING SERVICE, RN, MATERNAL NEWBORN
163WM0705X	NURSING SERVICE, RN, MEDICAL-SURGICAL
163WM1400X	NURSING SERVICE, RN, NURSE MASSAGE THERAPIST (NMT)
163WN0002X	NURSING SERVICE, RN, NEONATAL INTENSIVE CARE
163WN0003X	NURSING SERVICE, RN, NEONATAL, LOW-RISK
163WN0300X	NURSING SERVICE, RN, NEPHROLOGY
163WN0800X	NURSING SERVICE, RN, NEUROSCIENCE
163WN1003X	NURSING SERVICE, RN, NUTRITION SUPPORT
163WP0000X	NURSING SERVICE, RN, PAIN MANAGEMENT

163WP0200X	NURSING SERVICE, RN, PEDIATRICS
163WP0218X	NURSING SERVICE, RN, PEDIATRIC ONCOLOGY
163WP0807X	NURSING SERVICE, RN, PSYCH/MH, CHILD & ADOLESCENT
163WP0808X	NURSING SERVICE, RN, PSYCH/MH
163WP0809X	NURSING SERVICE, RN, PSYCH/MH, ADULT
163WP1700X	NURSING SERVICE, RN, PERINATAL
163WP2201X	NURSING SERVICE, RN, AMB CARE
163WR0400X	NURSING SERVICE, RN, REHABILITATION
163WR1000X	NURSING SERVICE, RN, REPRODUCTIVE ENDOCRINOLOGY/IN
163WS0121X	NURSING SERVICE, RN, PLASTIC SURGERY
163WS0200X	NURSING SERVICE, RN, SCHOOL
163WU0100X	NURSING SERVICE, RN, UROLOGY
163WW0000X	NURSING SERVICE, RN, WOUND CARE
163WW0101X	NURSING SERVICE, RN, WOMEN'S HC, AMB
163WX0002X	NURSING SERVICE, RN, OBSTETRIC, HIGH-RISK
163WX0003X	NURSING SERVICE, RN, OBSTETRIC, INPATIENT
163WX0106X	NURSING SERVICE, RN, OCCUPATIONAL HEALTH
163WX0200X	NURSING SERVICE, RN, ONCOLOGY
163WX0601X	NURSING SERVICE, RN, OTORHINOLARYNGOLOGY & HEAD-NE
163WX0800X	NURSING SERVICE, RN, ORTHOPEDIC
163WX1100X	NURSING SERVICE, RN, OPHTHALMIC
163WX1500X	NURSING SERVICE, RN, OSTOMY CARE
163W00000X	NURSING SERVICE, RN
164W00000X	NURSING SERVICE, LICENSED PRACTICAL NURSE
164X00000X	NURSING SERVICE, LICENSED VOCATIONAL NURSE
167G00000X	NURSING SERVICE, LICENSED PSYCHIATRIC TECHNICIAN
190000000X	GROUP
193200000X	GROUP, MULTI-SPECIALTY
193400000X	GROUP, SINGLE SPECIALTY
207LA0401X	PHYSICIAN, ANESTHESIOLOGY, ADDICTION MEDICINE
207LC0200X	PHYSICIAN, ANESTHESIOLOGY, CRITICAL CARE MEDICINE
207PE0004X	PHYSICIAN, EMERGENCY MEDICINE, EMERGENCY MEDICAL S
207PP0204X	PHYSICIAN, EMERGENCY MEDICINE, PEDIATRIC EMERGENCY
207P00000X	PHYSICIAN, EMERGENCY MEDICINE
207QA0401X	PHYSICIAN, FAMILY PRACTICE, ADDICTION MEDICINE
207RA0401X	PHYSICIAN, INTERNAL MEDICINE, ADDICTION MEDICINE
2080P0006X	PHYSICIAN, PEDIATRICS, DEVELOPMENTAL BEHAVIORAL
2084A0401X	PHYSICIAN, PSYCH & NEUR, ADDICTION MEDICINE
2084F0202X	PHYSICIAN, PSYCH & NEUR, FORENSIC PSYCHIATRY
2084N0600X	PHYSICIAN, PSYCH & NEUR, CLINICAL NEUROPHYSIOLOGY
2084P0005X	PHYSICIAN, PSYCH & NEUR, NEURODEVELOPMENTAL DISABI
2084P0800X	PHYSICIAN, PSYCH & NEUR, PSYCHIATRY
2084P0802X	PHYSICIAN, PSYCH & NEUR, ADDICTION PSYCHIATRY
2084P0804X	PHYSICIAN, PSYCH & NEUR, CHILD & ADOLESCENT PSYCHI
2084P0805X	PHYSICIAN, PSYCH & NEUR, GERIATRIC PSYCHIATRY
220000000X	RESP, REHAB, & REST SERVICE PROVIDERS
221700000X	RESP, REHAB, & REST SERVICE, ART THERAPIST
225A00000X	RESP, REHAB, & REST SERVICE, MUSIC THERAPIST
225400000X	RESP, REHAB, & REST SERVICE, REHABILITATION PRACTI
225600000X	RESP, REHAB, & REST SERVICE, DANCE THERAPIST
225800000X	RESP, REHAB, & REST SERVICE, RECREATION THERAPIST
226300000X	RESP, REHAB, & REST SERVICE, KINESIOTHERAPIST
250000000X	AGENCIES

251B00000X	AGENCIES, CASE MANAGEMENT
251C00000X	AGENCIES, DAY TRAINING, DEVELOPMENTALLY DISABLED S
251E00000X	AGENCIES, HOME HEALTH
251F00000X	AGENCIES, HOME INFUSION
251G00000X	AGENCIES, HOSPICE CARE, COMMUNITY BASED
251J00000X	AGENCIES, NURSING CARE
251K00000X	AGENCIES, PUBLIC HEALTH OR WELFARE
260000000X	AMB HC FACILITIES
261QA1903X	AMB HC FACILITIES, CLINIC/CENTER, AMB SURGICAL
261QC0050X	AMB HC FACILITIES, CLINIC/CENTER, CRITICAL ACCESS
261QC1500X	AMB HC FACILITIES, CLINIC/CENTER, COMMUNITY HEALTH
261QC1800X	AMB HC FACILITIES, CLINIC/CENTER, CORPORATE HEALTH
261QD1600X	AMB HC FACILITIES, CLINIC/CENTER, DEVELOPMENTAL DI
261QE0002X	AMB HC FACILITIES, CLINIC/CENTER, EMERGENCY CARE
261QF0400X	AMB HC FACILITIES, CLINIC/CENTER, FEDERALLY QUALIF
261QH0100X	AMB HC FACILITIES, CLINIC/CENTER, HEALTH
261QM0801X	AMB HC FACILITIES, CLINIC/CENTER, MH (INCLUDING CO
261QM0850X	AMB HC FACILITIES, CLINIC/CENTER, ADULT MH
261QM0855X	AMB HC FACILITIES, CLINIC/CENTER, ADOLESCENT AND C
261QM1300X	AMB HC FACILITIES, CLINIC/CENTER, MULTI-SPECIALTY
261QM2800X	AMB HC FACILITIES, CLINIC/CENTER, METHADONE CLINIC
261QP0904X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, F
261QP0905X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, S
261QR0400X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION
261QR0401X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR0405X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR1300X	AMB HC FACILITIES, CLINIC/CENTER, RURAL HEALTH
261Q00000X	AMB HC FACILITIES, CLINIC/CENTER
270000000X	HOSPITAL UNITS
273R00000X	HOSPITAL UNITS, PSYCHIATRIC UNIT
273Y00000X	HOSPITAL UNITS, REHABILITATION UNIT
276400000X	HOSPITAL UNITS, REHABILITATION, SUBSTANCE USE DISO
280000000X	HOSPITALS
282NC0060X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CRITICAL A
282NC2000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CHILDREN
282NR1301X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, RURAL
282NW0100X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, WOMEN
282N00000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL
283Q00000X	HOSPITALS, PSYCHIATRIC HOSPITAL
283XC2000X	HOSPITALS, REHABILITATION HOSPITAL, CHILDREN
283X00000X	HOSPITALS, REHABILITATION HOSPITAL
284300000X	HOSPITALS, SPECIAL HOSPITAL
290000000X	LABORATORIES
291U00000X	LABORATORIES, CLINICAL MEDICAL LABORATORY
293D00000X	LABORATORIES, PHYSIOLOGICAL LABORATORY
310000000X	NURS & CUST CARE FACILITIES
3104A0625X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
3104A0630X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310400000X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310500000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
311ZA0620X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311Z00000X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311500000X	NURS & CUST CARE FACILITIES, ALZHEIMER CENTER (DEM

313M00000X	NURS & CUST CARE FACILITIES, NURSING FACILITY/INTE
3140N1450X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
314000000X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
315D00000X	NURS & CUST CARE FACILITIES, HOSPICE, INPATIENT
315P00000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
320000000X	RTC FACILITIES
320800000X	RTC FACILITIES, COMMUNITY BASED RTC FACILITY, MENT
320900000X	RTC FACILITIES, COMMUNITY BASED RESIDENTIAL TREATM
322D00000X	RTC FACILITIES, RTC FACILITY, EMOTIONALLY DISTURBE
323P00000X	RTC FACILITIES, PSYCHIATRIC RTC FACILITY
3245S0500X	RTC FACILITIES, SA REHABILITATION FACILITY, SA TRE
324500000X	RTC FACILITIES, SA REHABILITATION FACILITY
32600000X	RTC FACILITIES, RTC FACILITY, MENTAL RETARDATION A
330000000X	SUPPLIERS
340000000X	TRANSPORTATION SERVICES
3416A0800X	TRANSPORTATION SERVICES, AMBULANCE, AIR TRANSPORT
3416L0300X	TRANSPORTATION SERVICES, AMBULANCE, LAND TRANSPORT
3416S0300X	TRANSPORTATION SERVICES, AMBULANCE, WATER TRANSPOR
341600000X	TRANSPORTATION SERVICES, AMBULANCE
343800000X	TRANSPORTATION SERVICES, SECURED MEDICAL TRANSPORT
343900000X	TRANSPORTATION SERVICES, NON-EMERGENCY MEDICAL TRA
344600000X	TRANSPORTATION SERVICES, TAXI
347B00000X	TRANSPORTATION SERVICES, BUS
347C00000X	TRANSPORTATION SERVICES, PRIVATE VEHICLE
347D00000X	TRANSPORTATION SERVICES, TRAIN
347E00000X	TRANSPORTATION SERVICES, TRANSPORTATION BROKER
360000000X	PA & APN PROVIDERS
363AM0700X	PA & APN PROVIDERS, PA, MEDICAL
363A00000X	PA & APN PROVIDERS, PA
363LA2100X	PA & APN PROVIDERS, APN, ACUTE CARE
363LC1500X	PA & APN PROVIDERS, APN, COMMUNITY HEALTH
363LP0808X	PA & APN PROVIDERS, APN, PSYCH/MH
363L00000X	PA & APN PROVIDERS, APN
364SA2200X	PA & APN PROVIDERS, CLIN NURSE SPEC, ADULT HEALTH
364SC1501X	PA & APN PROVIDERS, CLIN NURSE SPEC, COMMUNITY HEA
364SP0807X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0808X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH
364SP0809X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, ADU
364SP0810X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0811X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHR
364SP0812X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, COM
364SP0813X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, GER
364SR0400X	PA & APN PROVIDERS, CLIN NURSE SPEC, REHABILITATIO
364S00000X	PA & APN PROVIDERS, CLIN NURSE SPEC
367500000X	PA & APN PROVIDERS, NURSE ANESTHETIST, CERTIFIED R
380000000X	RESPITE CARE FACILITY
385HR2050X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE
385HR2055X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2060X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2065X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385H00000X	RESPITE CARE FACILITY, RESPITE CARE

E. Clean Claims

In accordance with Senate Bill 10-16-106.3., *ValueOptions* will pay, deny or settle all electronically received health insurance claims within 30 days days after initial receipt. Additionally, all claims received via hard-copy will be paid, denied or settled within 45 days after initial receipt.

In cases where *ValueOptions* fails to pay clean claims in the time frames referenced in the above paragraph, a penalty in the amount of 10% of the total amount ultimately allowed on the claim will be paid.

Incomplete Claims Are Not Clean Claims

In accordance with Senate Bill 10-16-106.3 *ValueOptions* will notify the provider within 30 calendar days if the resolution of a claim requires additional information. As indicated in this section the provider will be given a full explanation of what additional information is needed.

Claims with invalid or incomplete information will be **denied** with an Explanation of Benefit advising the provider of the incorrect or invalid information. The provider is required to submit a "corrected" claim to ValueOptions providing the updated information for payment consideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher may not be considered for payment.

If ValueOptions is unable to locate a member's Medicaid ID provided on the claim form, the claim will be denied with an Explanation of Payment indicating the member is "unknown". If possible, ValueOptions will indicate the member's name in the patient account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim submitted for consideration. Please be sure to send all requested information within the account-specific timely filing guidelines.

F. Claims Appeal Process

If you feel *ValueOptions* has made an incorrect payment or processing decision on a claim, you may file a claim appeal by writing a letter to *ValueOptions* and provide the reason you believe the claim should be reprocessed. In the letter be sure to include the member's name and ID number, date(s) of service, service, and provider's name. Your letter and supporting documentation should be sent to the following address:

ValueOptions
P. O. Box 1347
Latham, NY 12110
ATTN: Colorado Medicaid Claims Appeals

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included.

G. Third Party Liability (TPL)

1. By Federal mandate, providers must exhaust all other insurance coverage and payment prior to billing Medicaid for covered services.
2. *ValueOptions'* service authorization procedures outlined in the Clinical Section of the Provider Manual must be followed when providing services to a member identified with TPL.
3. The Primary Carrier's Policies and Procedures must be followed in order for *ValueOptions* to coordinate benefits. For example, if the Primary Carrier requires pre-authorization and the claim was denied by the Primary Carrier because pre-authorization was not obtained, *ValueOptions* will not process the claim for payment.
4. For any eligible member with reimbursable TPL, the third party insurance carrier must be billed prior to billing *ValueOptions*. Once the TPL carrier has responded, *ValueOptions* may then be billed. TPL claims for eligible Members must be submitted on a completed standard CMS 1500 or UB04 claim form. The claim form, along with a copy of the Explanation of Benefits or Summary Voucher received from the third party insurance carrier must be mailed to *ValueOptions*. Claims may also be submitted electronically, ensuring the appropriate loop and segment is completed with the primary insurance carrier's information. If there are questions regarding electronic claim submission please contact ValueOptions' EDI Help Desk at **1-888-247-9311.**
5. All claims involving Third Party Liability must be submitted within ninety (90) days of the date of the other carrier's EOB or notification of payment / denial, to be considered for reimbursement.
6. If it is determined that an enrollee had relevant third party coverage after *ValueOptions* has been billed, the third party insurer must be billed. Once the EOB / Summary Voucher is received, an adjustment request for the applicable claim and a copy of the relevant *ValueOptions* and Third Party EOB / Summary Voucher must be sent to *ValueOptions* according to the procedures outlined the Adjustment / Reversal Requests section.

Additional TPL Billing Instructions:

1. One copy of the Explanation of Benefits / Summary Voucher should be attached to each applicable claim.
2. Ensure the level of detail on the claim corresponds to the EOB / Summary Voucher from the primary carrier.
3. If there are multiple third party carriers, all relevant EOBs / Summary Voucher should be attached to the claim.
4. If we find the primary insurance carrier will not cover the service we require one denial from the carrier indicating the non-coverage. This denial notification will be entered as a part of our processing guidelines and additional denials from the primary carrier will not be required.

H. Adjustment / Reversal Requests

Adjustments and Reversal Requests may be requested in one of two ways:

- **Completing the Colorado Medicaid Adjustment Request form , as described below, or**
- **Submitting adjustment and reversal requests on-line using ProviderConnect**
  - http://www.valueoptions.com/providers/Provider Connect.htm
  - Click on the Provider tab
  - Click on ProviderConnect Helpful Resources link
  - Click on the Guide to Using Single Claim Submission (under Claims Resources) for instructions beginning on page 13
  - If ValueOptions does not have one already, a DCS access form, located on ProviderConnect, will need to be completed before adjustment and reversal requests can be submitted using this method

Colorado Medicaid Adjustments and Reversals (original method):

1. Claims requiring reconsideration of payment amounts for any reason must be resubmitted to *ValueOptions* on an Adjustment Request Form within sixty (60) days from the date of the Summary Voucher. Electronic submissions of this form will not be accepted.
2. The Adjustment Form can be found below. One form must be completed for each original claim being adjusted. All items on the form are required. Incomplete forms will not be processed and will be returned. Please mail completed forms to:

   ValueOptions
   ATTN: CO Adjustment Unit
   P.O. Box 12698
   Norfolk, VA 23541

   Or fax to (757) 459-5404.
3. A copy of the Provider Summary Voucher page on which the original claim appears must be included with the Adjustment Form.
4. Any reduction in payment will be applied to the payment cycle following the processing of the form.
5. Instructions for completing the Adjustment Form:
   a. Provider Information: Enter the name, provider number, and address of the provider to whom the payment was made.
   b. Member Information: Enter the member's name and Member ID Number as it appears on the Provider Summary Voucher.
   c. Claim Information: Enter the claim number and date as listed on the Provider Summary Voucher.
   d. Reason for Adjustment: Place an "X" on the line that best describes the reason for requesting the Adjustment and enter the required information. If "Other, Please Explain" is marked, describe the reason for the request.
   e. Provider Signature and Date: An Adjustment request cannot be processed without a typed, signed, stamped, or computer-generated signature and the date that the form was completed.

ValueOptions

Colorado Medicaid Adjustment Form

☐ **Adjustment** ☐ **Reversal** ☐ **Payment Increase** ☐ **Payment Decrease**

Provider Name:	Member Name:
Provider Number:	Member ID Number:
Provider Address:	Claim Number:
	Paid Date:

Reason for Adjustment

☐ Member Name/Member ID #:

Correct Member: _____Correct ID # : _____

☐ Date of Service:

Incorrect Date: _____ Correct Date: _____

☐ Billing Code Error:

Incorrect Code: _____ Correct Code: _____

☐ Units Incorrect:

Incorrect Units: _____ Correct Units: _____

☐ Provider / Vendor Paid:

Incorrect Provider #: _____ Correct Provider #:_____

Incorrect Vendor #: _____ Correct Vendor #:_____

☐ Other Reimbursement Received:

Source: _____ Amount: _____

☐ Authorization Extended:

Authorization Number: _____

☐ Other: (Please Explain)

_____

_____

Provider Signature: _____ Date:_____

***ValueOptions* Use Only**

Processor: _____Code: _____Date Completed:

I. Resubmissions

Incomplete Claims

1. Claims may be "zero-paid" by *ValueOptions* in the case of incorrect or incomplete required data elements.
2. *ValueOptions* will notify the provider via the Provider Summary Voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections D1 and D2 of this manual. Electronic Media Claims (EMC) submission guidelines are contained in the *ValueOptions* EDI Specifications Manual.

Re-submissions

1. Claims "zero-paid" due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days form the date on the Summary Voucher.
2. Providers may resubmit corrected claims (which were zero paid for incomplete or incorrect required data elements) by mail or EMC.
3. Corrected claims should have a clear indication on the claim that the claim is a "Corrected Claim".

J. Refunds and Voids

In order to process refunds and voids, please forward your check, summary voucher and any other information to the address listed below. If additional information is required please contact the Claims Department.

ValueOptions
240 Corporate Blvd
Norfolk, VA 23502
ATTN: Finance Department

Section 14

QUALITY MANAGEMENT

ValueOptions Colorado supports the quality management programs of Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership, all of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Medicaid Community Behavioral Health Services Program. Each of the BHO's Quality Management Programs monitors and evaluates quality across the entire range of behavioral health services provided to Medicaid members. The BHO's QM programs are intended to ensure that the structure and processes in place lead to desired outcomes for members.

The scope of the QM Programs includes:

- Clinical Services/Utilization Management (UM) Programs;
- Care Process and Outcome Measurement/Monitoring for Members in Treatment;
- Clinical Treatment Record Evaluation;
- Service Availability and Access to Care;
- Quality of Care and Patient Safety/Adverse Incident Evaluation;
- Program Integrity/Fraud and Abuse;
- Compliance with all applicable Federal and State regulations in the delivery of services to members.
- Performance Improvement Activities/Projects

Several of the above activities and processes are described in greater detail in other sections of the Provider Handbook.

For more information or to ask questions about specific BHO's Quality Management Programs, contact the Director of Quality Management for the BHO located in your area. More information about individual BHO Quality Management Programs can be obtained by referencing the BHO specific provider addendum reference guides and the respective BHO website.

PROGRAM INTEGRITY OVERVIEW

The BHOs and ValueOptions are responsible to the State of Colorado for overall program integrity in the delivery of services to members. The BHOs and ValueOptions are required to investigate any reported or suspected allegations of fraud and/or abuse. Colorado program integrity activities include:

- Review of alleged illegal, unethical or unprofessional conduct;
- Duplicate payment prevention;
- Treatment record audits verifying services billed are documented in member record, and that documentation includes all required elements;
- Investigation of suspected, reported or alleged fraud or abuse;

Providers are expected at all times to bill only for medically necessary authorized services delivered to members with a covered diagnosis. You may bill only for the authorized services that you provide. Every service provided to a Medicaid Member must have a corresponding

note in the medical record documenting the treatment provided, or a refund of the payment for the service will be required. Treatment reflected in the progress note must be tied to the treatment plan. As required by state and federal regulations, suspected cases of fraud or abuse are reported to the State of Colorado Department of Health Care Policy and Financing immediately upon discovery. Following a fraud or abuse investigation, if allegations are supported, follow-up actions may include implementation and monitoring of corrective actions, recovery of any payments for undocumented services, termination from the ValueOptions network and/or referral of the case to appropriate governmental agencies. For more information on documentation requirements, refer to Section XIX Documentation Requirements.

REPORTING ADVERSE INCIDENTS (VARIANCES/SENTINEL EVENTS)

To manage care effectively and assure the safety of members, the BHOs and ValueOptions investigate and review adverse incidents that have resulted in harm or potential harm to a member or significant other participating in treatment. You are required to complete a report on the following adverse incidents, to be submitted to ValueOptions Colorado:

- Attempted or completed suicide or homicide at any level of treatment
- Death, by any cause, while in psychiatric treatment
- Allegations of sexual or physical abuse or neglect
- Assaults with physical harm in which the Member is the initiator or victim
- Absence without leave, AMA, or missing and considered a danger to self and/or others; and/or endangered and unable to care for self
- Breach of confidentiality by staff
- Accidental injuries either in a facility or provider office
- Medication errors/Adverse drug reactions
- Other variances inconsistent with routine patient care

Providers are expected to report incidents on an Adverse Incident Report Form, included as an attachment to this section, within 24 hours of the occurrence for sentinel events (e.g., unexpected deaths, suicides, homicides), and within 48 hours for all other incidents. Please fax this completed form to ValueOptions Quality Management Department at (719) 538-1456. Depending upon the type of incident and the circumstances, you may be contacted for further information or a review of the incident.

BHO PROVIDER QUALITY PROGRAM (PQP)

The objective of the BHO and VO's Provider Quality Program (PQP) is to assess and improve the quality and effectiveness of care delivered to Colorado Medicaid members. The program is designed to quantify provider performance so data can be used to recognize quality care, identify provider and facility best practices, improve provider network services, and identify areas for continuing education. Multiple measures of member satisfaction and outcome as well as practitioner practice patterns are reviewed. Other areas reviewed include Member satisfaction with their provider, treatment record documentation, compliments, grievances, and quality of care and utilization patterns.

QUALITY OF CARE

The BHOs have a joint Quality of Care Committee that oversees the investigation and resolution of all quality of care issues. Please contact the BHO Quality Management Department to report any quality of care issues identified in the provision of services to members. Potential quality of care indicators monitored by the BHOs and ValueOptions include the following types of quality of care issues:

- Provider inappropriate/unprofessional behavior
- Clinical practice-related issues
- Access to care-related issues
- Attitude and service-related issues

Providers are required to respond to Quality of Care inquiries, assist with investigations, provide corrective action plans when requested, and report on progress toward addressing concerns through corrective actions as requested.

Treatment Record Audits

ValueOptions, on behalf of the BHOs, may request treatment records for documentation reviews, quality of care reviews, state Medicaid audits or reviews verifying that services billed are documented in member's treatment record and include all required elements. As a ValueOptions provider, you are expected to comply with all requests for member treatment records as specified in your contract (Section 2, Compliance with ValueOptions Policies and Programs).

CONFIDENTIALITY

To support quality management responsibilities for oversight of member care, all BHOs and ValueOptions have in place strict confidentiality policies and procedures regarding the protection and disclosure of member information. These policies and procedures ensure that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA) and accreditation requirements. The BHOs and ValueOptions ensure that all such information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. In addition, ValueOptions maintains information systems to collect, maintain, and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as well as a plan for secure storage, maintenance, tracking and destruction of member-identifiable clinical information.

BHO and ValueOptions staff engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information, except when specific reference is necessary to meet the goals of the QM program. Reference to individual providers or members is redacted to safeguard the person's identity. Confidential information used in QM activities may include but is not limited to:

· Protected Health Information (PHI);
· Certification of mental health treatment;
· Claims processing information;
· Utilization review;

· Peer review;
· Response to congressional inquiries (made at the request of the member);
· Appeals; and
· Quality assurance

CONSENTS TO DISCLOSE SUBSTANCE USE DISORDER INFORMATION

For each Covered Person receiving Substance Use Services, Provider shall obtain from the Covered Person an executed consent, compliant with 42 C.F.R. § 2.31, authorizing Provider to disclose information related to the Covered Person and his or her receipt of Substance Use Services to (BHO) for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such information by (BHO) to the Department of Health Care Policy and Financing (the "Department"), as required by and for the purposes set forth in (BHO's) contract with the Department. Provider shall retain and maintain each such consent for a period of at least six (6) years from the last effective date of such consent. If a Covered Person refuses to sign such a consent, Provider shall document its efforts to obtain such a consent and shall notify (BHO) prior to billing (BHO) for the provision of Substance Use Services for such Covered Persons.

Providers and delegated entities are expected to safeguard the confidentiality of treatment record information related to both active and past clients. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.

Section 15

OFFICE OF MEMBER AND FAMILY AFFAIRS (OMFA)

Each of the three Behavioral Health Organizations (BHO) has an Office of Member and Family Affairs. ValueOptions Colorado provides support to the three OMFAs. The three BHOs, Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership, each contract with the state of Colorado for the Medicaid Community Behavioral Health Services Program. The BHOs and ValueOptions comply with all federal and state regulations to protect member rights, educate members about their behavioral health services; and promote recovery and resilience.

As a ValueOptions Provider, you must be aware of and uphold Medicaid member's rights. Per Federal Regulations, Colorado Regulations, and BHO and ValueOptions policies, Medicaid members are entitled to be treated with dignity and respect, to learn about their Medicaid benefits, receive information in a format that they understand, have access to a grievance process, and have their rights and responsibilities upheld. As a ValueOptions provider, you are required to:

- Prominently post member rights statements in waiting areas or hand each Medicaid client a copy at intake (found in the Section XV of the Provider Manual; English and Spanish versions are available).
- Prominently post information about the Ombudsman for Medicaid Managed Care or hand each Medicaid client a copy at intake (found in the Section XV of the Provider Manual in English and Spanish).
- Inform members of their right to file a grievance or appeal an action.
- Provide BHO Member information in Spanish. The BHO OMFA offices can provide you with Spanish materials. OMFA contact information is provided at the end of this section.
- Offer interpreter services for members who are Deaf, hard of hearing, have communication disabilities or have limited English proficiency. If you have a client who is deaf or does not speak English, or their family member is deaf or does not speak English, our contract requires that interpreter services be provided. Contact ValueOptions if you need an interpreter for a client or family member or assistance with a referral to a provider who is fluent in the member's language.

The BHO Office of Member and Family Affairs (OMFA) provides support and advocacy to Medicaid members. The OMFA is administered both at the BHO and local community behavioral health center level and is driven by a belief that people can and do recover from mental illness and substance use disorders and people can achieve success in their lives, despite having a behavioral health diagnosis.

Office of Member and Family Affairs staff are located at the BHO offices and at your local community behavioral health center. You can find up-to-date contact information at the respective BHO websites. OMFA staff:

- Handle grievances including complaint resolution, assisting members with filing grievances and advocating for members.

- Assist members with filing an appeal and supporting members through the appeal process.
- Help members /families understand their rights and responsibilities and work to uphold those rights.
- Assist members with finding a provider who can offer a Second Opinion.
- Provide members/families with information about community resources that will help them with their recovery.
- Help members and family members understand and access their benefits.
- Identify local concerns of members, family members, providers and stakeholders.
- Help members/families have a voice in the behavioral health system by getting involved in committees and advisory boards.

Staff from The Office of Member and Family Affairs also provide:

- Member Handbooks, wellness brochures and tip sheets.
- Educational presentations on a variety of topics including recovery, symptom management, and wellness maintenance.
- Training in crisis planning. A crisis plan is a tool that teaches people who have a mental illness or substance use disorder how to plan ahead to avoid triggers and relapse, and to develop strategies to maintain wellness.
- Information about peer specialists, client-run programs, and support groups. Many Medicaid members benefit from peer support and client-run programs. The OMFA employs trained peer specialists as well as maintains a data base of client-run and self help programs.

MEMBER AND FAMILY INPUT

The three BHOs and ValueOptions Colorado seek member and family input into the design of our programs and services. Members and family members have an opportunity to:

- Participate in focus groups and member surveys
- Serve on member advisory committees and forums
- Participate in survey design and administration.

Any Medicaid member is eligible to participate. Providers should refer interested members to the appropriate OMFA listed at the end of this section.

CULTURAL COMPETENCE

ValueOptions providers are required to provide culturally appropriate care. Providers are expected to incorporate the member's culture and cultural attributes into their care, when appropriate. The OMFA staff conducts provider trainings on cultural issues. To learn more about the trainings, or to get a copy of the BHO Cultural Competence Plan log onto our website at:

Colorado Health Partnerships – http://www.coloradohealthpartnerships.com

Foothills Behavioral Health Partners - http://www.fbhpartners.com

Northeast Behavioral Health Partnership – http://www.nbhpartnership.org

OMFA ASSISTANCE TO MEMBERS WISHING TO FILE A GRIEVANCE OR APPEAL

APPEALING A NOTICE OF ACTION (refer to Section IX - Reviews, Reconsiderations, and Appeals)
The BHO's have a separate process for grievances and a separate process for "actions." Medicaid actions are defined below and are handled through the Appeals process, which is described in detail in Section IX..

Actions
An appeal may be filed for events categorized as Actions. Actions are defined as:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service.
3. Denial of payment for a service, in whole or in part.
4. Failure of the BHO to provide a service in a timely manner.
5. Failure of the BHO to act within approved timeframes for grievances or appeals
6. Denial of a request by a member in a rural area to obtain treatment outside of the ValueOptions Medicaid Provider Network.

Section IX - Reviews, Reconsiderations, and Appeals provides a detailed description of the appeals process.

GRIEVANCES UNRELATED TO AUTHORIZATION OR DENIAL OF AUTHORIZATION
The three BHO OMFAs and ValueOptions offer a grievance resolution process for Medicaid members that is compliant with state and federal regulations. Members, family members and interested others can register concerns or complaints about any issues related to the behavioral health care they receive from the BHOs, ValueOptions or our providers. A grievance is defined as any oral or written expression of dissatisfaction about any matter related to their behavioral health services (other than an action). Examples include:

- Access to Care
- Customer Service
- Failure to respect a member's rights
- Financial/Billing issues
- Non-covered benefits
- BHO failure to follow its appeal process.

Grievances can be filed over the phone, in person, or in writing, within 30 calendar days of the precipitating event. At CHP or NBHP, a grievance may be filed with the Office of Member and Family Affairs, the ValueOptions' Grievance Coordinator or the Client Advocate at a community behavioral health center. At FBHPartners, a grievance may be filed with the FBHPartners' Office of Member and Family Affairs or with the FBHPartners' Client and Family Advocate at the local community behavioral health center.

Any interested party can file a grievance on behalf of the member, including the member's legal guardian, an independent advocate or a designated client representative (DCR). If the grievance is filed by someone other than the member or legal guardian, the member or legal guardian will

be contacted in order to obtain permission to investigate and resolve the grievance, sign a DCR form and sign releases of information. Medicaid members with a diagnosis of a substance use disorder must sign a Part 2 compliant release form which is found at the end of this section.

All grievances must be filed within 30 calendar days from the date of the occurrence. Filing a grievance will not restrict or compromise the member's access to behavioral health services.

The Office of Member and Family Affairs can assist in the grievance process. Staff from the Office of Member and Family Affairs can:

- Explain the grievance and resolution process
- Investigate the grievance by contacting agencies and others to gather information
- Provide a resolution to the grievance
- Provide support to the member during the process

ADMINISTRATIVE GRIEVANCE REVIEW

If the member is not satisfied with the resolution, the member, guardian, or DCR can file an oral or written request to have the decision reviewed by the Department of Health Care Policy and Financing. Requests for review of a decision should be directed to:

Department of Health Care Policy and Financing
(800) 221-3943 or (303) 866 3513

This is the final step in the administrative grievance process and the decision of the Department is final.

COMPLIMENTS

Our providers and staff also want to know what we are doing well. If you have a compliment, please contact the Grievance Coordinator. The compliment will be forwarded to the appropriate person and will be logged in our data base.

OMBUDSMAN FOR MEDICAID MANAGED CARE

The Ombudsman for Medicaid Managed Care is an independent program that provides assistance with grievances and with appeals of actions for Medicaid eligible members who are receiving behavioral health services. Anyone who has filed a grievance on behalf of a member can get help with any portion of the grievance or appeal process. The Ombudsman can be reached by calling:

The Ombudsman for Medicaid Managed Care
877-435-7123 or 303-830-3560

Providers are required to post information about the Ombudsman for Medicaid Managed Care or to give it to the member at intake. Posters in English and Spanish can be found attached to this section.

CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND VALUEOPTIONS COLORADO

To get answers to your questions about the member grievance process, get copies of educational or member materials, or learn how a client can participate on an advisory committee:

For Colorado Health Partnerships and ValueOptions Colorado contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For **Northeast Behavioral Health Partnership** contact the NBHP Office of Member and Family Affairs at **1-970-347-2367 or 1-888-296-5827.**

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

Section 16

TRANSPORTATION

TRANSPORTATION ARRANGEMENTS

Fee for Service Medicaid pays for transportation in some instances when alternative transportation is unavailable, however, it is not a covered benefit under the BHO. Providers should refer members seeking transportation assistance to the member's county Department of Social/Human Services Office, to the local community behavioral health center Member/Family Advocate's Office, or to the BHO Office of Member and Family Affairs. BHO OMFAs are listed below:

For Colorado Health Partnerships contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For **Northeast Behavioral Health Partnership** contact the NBHP Office of Member and Family Affairs at **1-970-347-2367**.

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

Section 17

MEDICAL RECORD DOCUMENTATION STANDARDS

ValueOptions has specific documentation standards that must be adhered to by all providers. These standards incorporate all federal and state Medicaid documentation requirements as well as good professional practice. They are intended to insure the highest quality of care, reduce medical errors, and achieve full compliance with federal, state, and ValueOptions audit requirements.

All providers must maintain a comprehensive medical record for each member served. At a minimum, the medical record substantiates the diagnosis, the medical necessity of care, the quality of care, the progress of care, and the claims submitted for reimbursement.

While network Community Behavioral Health Centers follow the applicable Division of Behavioral Health regulations regarding medical records (2 CCR 502-2 and 2 CCR 502-1), all ValueOptions providers must meet the following minimum standards for their own medical records:

General Requirements:

- Each record includes the member's identification including but not limited to: age, date of birth, gender, address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, and financial information.
- Each record includes appropriate consent forms and guardianship information.
- Each record contains a statement as to whether or not a member over age 18 has an Advanced Directive; and contains a statement that you provided AD information if requested.
- Each record contains a statement as to whether or not a member under age 21 has had a well-child exam (EPSDT) in the last year and results of the exam if related to the mental health condition, or a referral to a Primary Care Physician if no recent exam has occurred.
- Each record contains a copy of Medicaid client rights and responsibilities signed by the member.
- Each record contains a copy of the member’s signed acknowledgement that s/he received your Notice of Privacy Practices.
- Each record contains a copy of your professional disclosure form signed by the client
- Each record contains a copy of any release of information (to PCP or other parties as indicated) signed by the member, or a statement that member refused to sign. Releases meet all HIPAA requirements,
- Each record contains an assessment of transportation needs and documentation that the provider helped to arrange transportation when necessary.
- Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions. current medications, allergies, retardation or organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, vocational, cultural and social conditions affecting the member and family; past or present history of abuse; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances).
    - For children and adolescents, the assessment includes a developmental history (e.g., physical, psychological, social, intellectual and academic).
    - For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues.
- Each record includes a mental status examination documenting the member’s presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought

content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others.

- Each record includes a clinical formulation describing the reasoning and justification for the diagnosis, and a current Diagnostic and Statistical Manual (DSM) diagnosis based on psychiatric, psychological or medical condition. The formulation includes sufficient description of the criteria per the current DSM to support the diagnosis. Any subsequent changes in diagnosis must be similarly documented and explained.
- The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record.

Service/Treatment Plan:

- Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider's intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution.
    - The treatment/service plan is consistent with the member's diagnosis and needs as identified in the assessment.
    - There is documented evidence in a progress note that the member (and parent/guardian, if applicable) participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates.
    - The treatment/service plan must include specific criteria for discharging the member from treatment that are agreed upon by the member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan.
    - The treatment plan addresses coordination of care with other relevant providers.
    - The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the member's condition or service needs occurs. The plan is revised as necessary. For members involuntarily receiving services pursuant to Section 27-65- 101 *et seq*., CRS, the plan must be reviewed monthly.
    - The member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.

Progress Notes:

- Each record includes a progress note for each encounter which describes the goal/objective being addressed during the session, the member's efforts in achieving treatment/service plan goals/ objectives, and the treatment interventions used by the provider to assist the member.
- Each progress note includes information relevant to the claim for payment, including date, start time, duration or end time, CPT code, place of service, diagnosis being treated, persons present, and provider signature with credentials and date signed.
- Case management notes reflect the name and agency of person contacted, start time and duration, and the content of each contact.
- Progress notes document an ongoing assessment of member safety (e.g., dangerous to self or others) and substance use/abuse issues, if applicable, and how these have been addressed.
- For members who become homicidal, suicidal or unable to conduct activities of daily living, the record documents prompt referral to the appropriate level of care.
- Each record documents attempts at outreach for persons who "no show" for scheduled appointments.

Miscellaneous:

- As applicable, each record includes results of laboratory tests, psychological testing, and consultation reports.
- As applicable, each record indicates what medications have been prescribed, the dosages of each, the dates of initial prescription or refills, prescriber information, and informed consent for medication.
- Each record documents preventive and recovery-focused services as appropriate, such as relapse prevention, wellness programs, lifestyle changes, and referrals to community resources.
- Each record documents continuity and coordination of care between the Care Coordinator (Primary Clinician), consultants, ancillary providers and health care institution/providers, and other community services agencies.
- Each record documents the date(s) of follow-up appointments or, as appropriate, discharge plans and summary.
- All entries are dated.
- All entries include the legible identity of the rendering provider's name, professional degree and identification number, if applicable.
- All entries are legible to someone other than the writer, and written/typed in black or blue ink.
- Each page contains the member's name and Medicaid ID.

A documentation training webinar and sample forms are available on the BHO websites or from the VO Quality Department. ***Providers are required to take the documentation training and submit a letter of attestation that the training has been reviewed.***

For assistance with documentation requirements, ValueOptions offers providers the ability to contact Provider Relations with any questions or to assist with any difficulties providers may be experiencing. Provider Relations can be reached at 800-804-5040 or be emailing coproviderrelations@valueoptions.com.