



COLORADO

**Department of Health Care
Policy & Financing**

Community Centered Board Data Entry and Payment Technical Guide

The Department of Health Care Policy and Financing (Department) utilizes a payment methodology based on per activity and deliverable rates for deliverable, administrative case management, State General Fund (SGF) programs, and Targeted Case Management (TCM) activities. For administrative case management activities and SGF programs, the methodology requires Community Centered Board (CCB) agencies to enter information in the Care and Case Management (CCM) system or submit invoices to initiate payment. SGF programs include State Supported Living Services (State SLS), Omnibus Reconciliation Act of 1987 Specialized Services program (OBRA-SS), and Family Support Services Program (FSSP). For TCM activities, the methodology requires CCBs to enter information into the CCM system and bill the Colorado InterChange Medicaid Management Information System (MMIS) for reimbursement. To ensure case management activities are paid accurately, the Department developed the following technical guide to provide specified instructions for data entry into the CCM system and for completing invoices.

Rates associated with each task outlined in this technical guide are listed in the CCB contract and/or on the Department's [Provider Rates and Fee Schedule website](#).

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Appeals

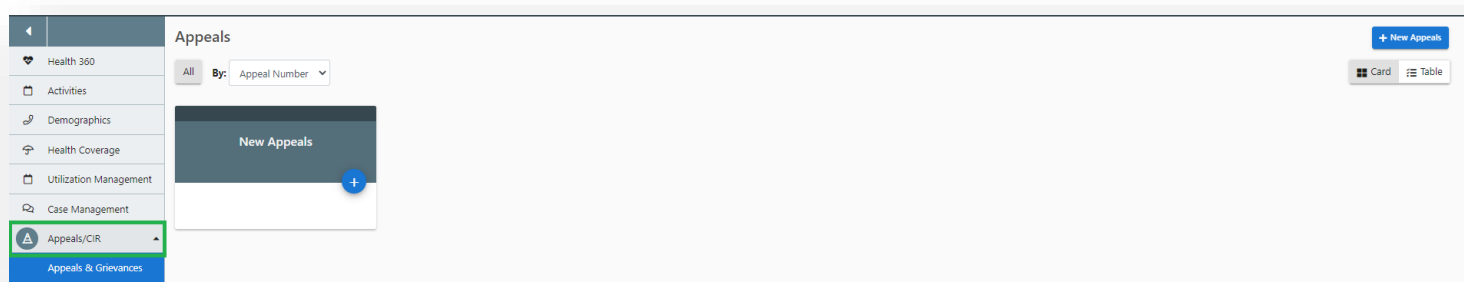
CCBs are required to represent the Department through the appeal process in accordance with 10 CCR 2505-10, Sections 8.057 et. seq. This includes representation of its actions and defense of any adverse action at Administrative Law Judge Hearings, timely creation and distribution of appeal packets, detailed documentation throughout the appeals process, and cooperation with the Office of the State Attorney General. Full requirements of Long-Term Care Appeals are outlined in the CCB Contract.

Each CCB will be required to create their own appeal tracker document for use by their agency. The CCB will use their internal agency appeal tracker to verify that the report received from the Department for reimbursement each month matches their records. The steps below outline the procedure for data entry for Appeals - Creation of Packet and Appeals - Attendance of hearing.

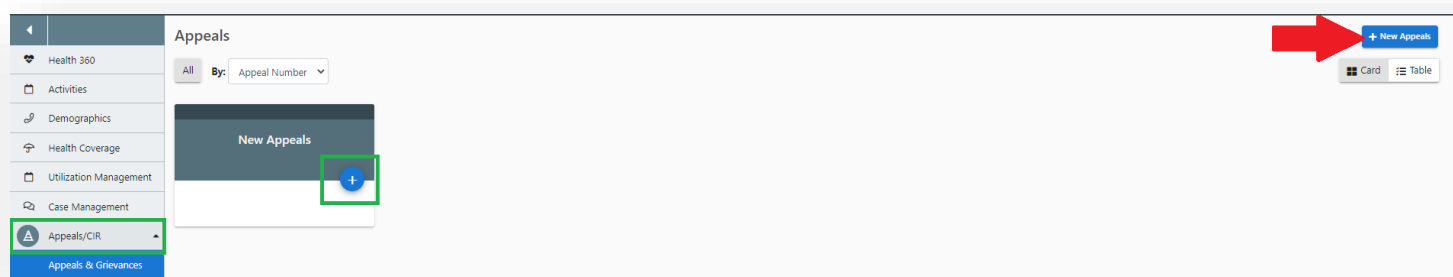
Appeals - Creation of Packet

All appeals documented in the CCM system will be aligned with a Long-Term Care Notice of Action which will have been completed and entered in the CCM system by the Case Manager. Case Managers will follow normal required Long-Term Care Notice of Action procedures as outlined in contract and regulation. The following steps will need to be followed for reimbursement purposes regarding the appeals process.

1. Go to the "Appeals/CIR" tab for the member in CCM system



2. Click "+New Appeals" button or the plus sign on New Appeals card.



- Fill out all required fields and click "Save" Button. "Program Name" must be selected for member to appear on the appeals reports. If the individual is not currently enrolled in a program, use the "Appeal Program" field to indicate the most appropriate program they are seeking enrollment into. Make sure to select Appeal status as "Open"

The screenshot shows the 'Appeals' form with the following fields highlighted:

- Appeal Status**: A dropdown menu with '- Select -' as the current selection.
- Program Name (Required)**: A dropdown menu with '- Select -' as the current selection.
- Appeal Program**: A dropdown menu with 'Supported Living Services Waiver' as the current selection.
- Save Button**: A blue button with a white 'Save' label and a blue arrow pointing to it.

Other visible fields include: Appeal Number (N/A), Appeal Owner (Required), Type, NOA Effective Date, NOA Effective Time, Status Reason, Date Appeal Filed, Time Appeal Filed, Expedited Hearing Request (Yes/No), Notification Method, Appellant, and Service Auth #.

- Return to Appeals/ CIR tab and click on saved Appeal to edit and enter Claims information.

The screenshot shows the 'Appeals' dashboard with the following elements:

- Sidebar**: A list of navigation options including Health 360, Activities, Demographics, Health Coverage, Utilization Management, Case Management, Appeals/CIR, **Appeals & Grievances** (highlighted in blue), Incident Management, and Care Team.
- Filter**: A dropdown menu labeled 'By:' with 'Appeal Number' selected.
- LOC Appeal**: A card showing the appeal number 230307100234, opened by 'Member', notification method 'Letter', and NOA Effective Date '3/7/23'. A blue edit icon is highlighted with a green box.
- New Appeals**: A card with a blue plus icon.

- Attach "LTC Notice of Action" to the correlated Appeal record through documents search on top right-hand side of the page.

The screenshot shows the 'Appeals' page. On the right side, under 'Page Resources', there is a 'Documents (1)' section. A red arrow points to a document titled 'Long Term Care Benefits (decrease, change, denied), English' dated 'Mar 2, 2023'.

- Once corresponding "LTC Notice of Action" is attached scroll down to Claims section of appeal being edited and enter the "Date received notification of hearing from the Office of Administrative Courts" field and save.

The screenshot shows the 'Claims' section. A red arrow points to the 'Date received notification of hearing from the Office of Administrative Courts' field, which is currently empty and has a date picker icon.

If no resolution with the member is determined prior to the scheduled appeal hearing, the Case Manager shall develop an appeal packet which contains all relevant documentation to support the denial or adverse action. The CCB shall develop an appeal packet no earlier than twenty (20) business days prior to the date of a scheduled hearing.

- After the appeal packet is completed and officially sent to the Division of Appeals Court, the Case Manager will go back into the appeal tab for the corresponding 803 Long-Term Care Notice of Action in the CCM system and complete the field for "Date Appeal packet sent to Division of Administrative Hearing" and click "Save". Do not fill in any other fields until after an Initial Decision is received. The CCB will update their internal appeals tracker with this information. The Department will use this field to generate the monthly report for reimbursement of the Appeals- Creation of Packet. Case Managers must create an Activity Log stating the appeal packet was sent to Administrative Courts.

The screenshot shows the 'Appeals & Grievances' tab in the CCM system. The 'Claims' section is highlighted with a green box. A red arrow points to the 'Date Appeal packet sent to the Office of Administrative Courts' field, which is currently empty. The field is labeled 'Date Appeal packet sent to the Office of Administrative Courts' and has a date picker icon. The 'Date received notification of hearing from the Office of Administrative Courts' field is filled with '02 / 22 / 2023'. The 'Extension End Date' field is filled with 'mm / dd / yyyy'. The 'Extension End Time' field is filled with 'hh : mm --'. The 'Client Appealed to District Court?' field is filled with 'No'. The 'Time Forwarded to IRE?' field is filled with 'hh : mm --'. The 'Office of Administrative Court Hearings' section at the bottom shows 'No Records found'.

If an appeal packet is completed within the timeframes described in the CCB contract and the Member withdraws the appeal after that timeframe or the Administrative Law Judge reverses the decision to have the appeal heard, the CCB will still be eligible for reimbursed for the creation of the appeal packet. To receive reimbursement, the Case Manager must complete required documentation in the CCM system.

Required documentation in the CCM system includes:

- Updating the appeals tab with the date the appeal packet was sent to the Division of Administrative Hearing as noted in the above screenshot
- Add an Activity Log and update the section in the appeal tab
- Select Appeal Status Reason: "Cancel" or "Missed Deadline"

4. Once this tab is completed, the Case Manager must save and finalize the appeal information.

The screenshot shows a web form for entering appeal information. The 'Appeal Status' dropdown is set to 'Closed' and the 'Status Reason' dropdown is set to 'Cancel'. Both are highlighted with a green border. Other fields include: Appeal Number (230307100234), Type (LOC Appeal), Appeal Owner (Required) with a search icon, NOA Effective Date (03 / 07 / 2023), NOA Effective Time (01 : 22 : 10 PM), Date Appeal Filed (03 / 07 / 2023), Time Appeal Filed (01 : 36 PM), Notification Method (Letter), Appellant (- Select -), and Expedited Hearing Request (No selected).

Appeals - Creation of Packet – Reimbursement

The CCB shall ensure that all Appeals – Creation of Packet are input in the CCM system and adhere to all requirements listed in the CCB Contract. The Department will pull CCM system data on the eleventh (11th) day of the month for the development of appeals packets from the previous month. The "Date Appeal Packet Send to the Office of the Administrative Courts" field is the primary driver of the payment report. If any appeals are missing from the payment report, the CCB must submit a correction on the Payment Correction Form.

Appeals - Attendance of Hearing

The CCB shall represent its actions at Administrative Law Judge Hearings when the Member appeals a denial or adverse action affecting a Member's program eligibility or receipt of services.

Payment for Attendance of Hearing will not be issued until there has been an initial decision received in writing by the CCB. Appeals -Attendance at Hearing payment will include hearings that must be attended by the CCB in order for a final decision to be made. The CCB will not be reimbursed more than once for multiple hearings attended regarding the same Member's appeal. Steps for reimbursement for attendance of an appeal are as follows:

1. The Case Manager shall attend all hearings associated with an appeal by the Member and create an Activity Log of all actions taken associated with the appeal including: Attending the Hearing, Initial Decision, any exceptions filed and the receipt of the Final Decision.
2. When the Initial Decision is received, the Case Manager will go back to the appeal record and click "+ button" under the Office of Administrative Courts Hearings add on pictured below for the corresponding 803 Long-Term Care Notice of Action and complete the following fields:

Claims

Corrected Claim

☐ Yes
☐ No

Claim Attached

☐ Yes
☐ No

Date received notification of hearing from the Office of Administrative Courts

mm / dd / yyyy

Date Appeal packet sent to the Office of Administrative Courts

mm / dd / yyyy

Extension End Date

mm / dd / yyyy

Extension End Time

hh : mm --

Client Appealed to District Court?

No ☐ Yes ☐

Time Forwarded to IRE?

hh : mm --

Office of Administrative Court Hearings

+

No Records found

Add New Internal Review

- Court Decision Date
- Initial Court Decision and Internal Reviewer Notes
- Click "Save"

The Department will use these fields to generate the report for monthly reimbursement of Appeals - Attendance of Hearing.

Office of Administrative Court Hearings Details

← Back

Save

⋮

Office of Administrative Court Hearings Details

* Court Decision Date

mm / dd / yyyy

Court Decision Time

hh : mm : ss --

Assigned Reviewer

Initial Court Decision

- Select -

* Internal Reviewer Notes

Exception Filed by Case Management Agency/HCPF

☐ Yes
☐ No

- When the Final Decision is received, the Case Manager will go back to the appeal tab and Office of Administrative Court Hearing Details for the corresponding 803 Long-Term Care Notice of Action and must complete all remaining fields starting with Exception filed by Case Management Agency, click "Save".

The screenshot shows a web form titled "Office of Administrative Court Hearings Details". At the top right, there are buttons for "Back", "Save", and a menu icon. The form contains several input fields: "Court Decision Date" (with a date picker), "Court Decision Time" (with a time picker), "Assigned Reviewer" (with a search dropdown), and "Initial Court Decision" (a dropdown menu). Below these is a text area for "Internal Reviewer Notes". Further down, there are radio buttons for "Exception Filed by Case Management Agency/HCPF" with options "Yes" and "No". At the bottom, a section titled "Office of Administrative Court Hearing Decision Details" is highlighted with a green border. This section includes radio buttons for "Exceptions filed by Other Parties" (Yes/No), a "Decided by Name" search dropdown, a "Final Court Decision" dropdown, and "Due Date Met" radio buttons (Yes/No). A "Save" button is located at the bottom right of the form.

If an appeal hearing is attended by the Case Manager and the Member does not attend, the CCB will still be reimbursed for attending the appeal hearing after the initial decision is received and the steps listed above are accurately documented in the CCM system and appeal is finalized.

In the event that an appeal notification is received from a Member and no 803 Long-Term Care Notice of Action was issued by the CCB, the CCB will still be reimbursed for all appeal activities. The Case Manager will document all appeal activities through Activity Log and Appeal Tab in the CCM system.

Appeals - Attendance of Hearing - Reimbursement

CCBs shall ensure that all appeals documentation in the CCM system and adhere to all requirements listed in the CCB Contract. The Department will pull CCM system data on the eleventh (11th) day of the month for attendance of hearing from the previous month. The "Court Decision Date" is the primary drive of the payment report. If any appeals are missing from the payment report, the CCB must submit a correction on the Payment Correction Form.

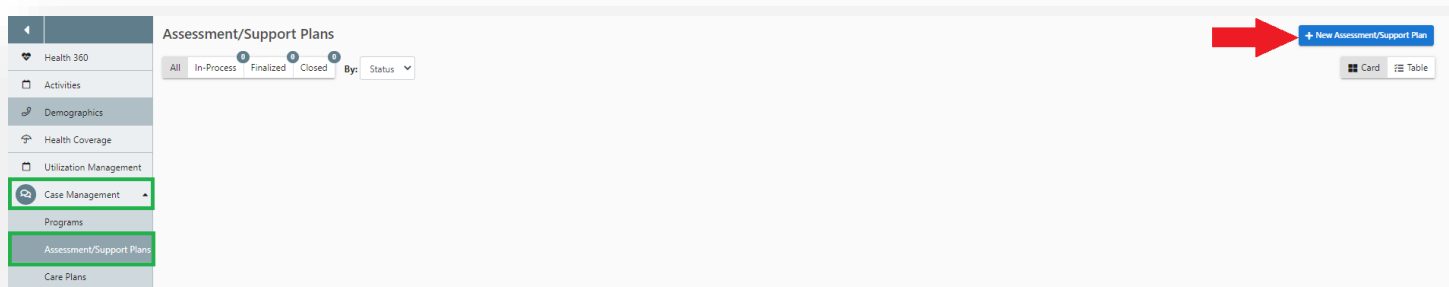
100.2 Legacy Assessments

The CCB shall perform all Initial and Continued Stay Review Functional Eligibility Assessments for the operation of a CCB agency in accordance with §25.5-6-104, C.R.S., 10 CCR 2505-10, Section 8.401, and 10 CCR 2505-10, Sections 8.500 *et seq.*

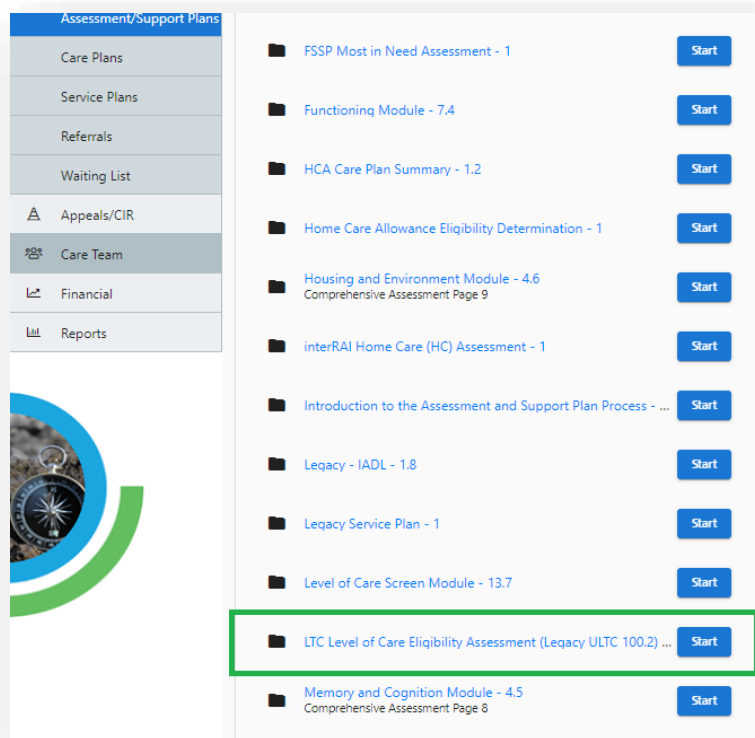
The reimbursement for assessments is provided at two different rates based on the assessment type: Initial Functional Eligibility and Continued Stay Review - Functional Eligibility (CSR). The assessment type is determined by the Event Type selected by the Case Manager during entry in the CCM system.

Description of Assessment Types:

1. Go to *Case Management* tab on the dashboard of the member, then go to + Assessment/ Support Plan. Click New Assessment/ Support Plan to create new assessment.



2. Go to "LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2)" and click Start.



3. **Initial Functional Eligibility** - Initial Review, HCBS-DD Waitlist, Deinstitutionalization (DI), and Reverse Deinstitutionalization (RDI). Initial Functional Eligibility assessments are reimbursed per assessment.

Case Management

Programs

Assessment/Support Plans

Care Plans

Service Plans

Referrals

Waiting List

Appeals/CIR

Care Team

ASSESSMENT INFORMATION

* Assessment Date

mm / dd / yyyy

* Event Type

- ☐ 6 Month Review
- ☐ Appeal - Decision Overturned
- ☐ Continued Stay Review
- ☐ DI
- ☐ Initial Review
- ☐ Nursing Facility Transfer
- ☐ Reverse DI
- ☐ Unscheduled Review
- ☐ Waitlist

4. **Continued Stay Review - Functional Eligibility** - Continued Stay Review and Unscheduled Review assessments are reimbursed per assessment.

ASSESSMENT INFORMATION

* Assessment Date

03 / 02 / 2023

* Event Type

- ☐ 6 Month Review
- ☐ Appeal - Decision Overturned
- ☐ Continued Stay Review
- ☐ DI
- ☐ Initial Review
- ☐ Nursing Facility Transfer
- ☐ Reverse DI
- ☐ Unscheduled Review
- ☐ Waitlist

The CCB shall be eligible for reimbursement for conducting all Initial Functional Eligibility Assessments and Continued Stay Review - Functional Eligibility Assessments as identified in the CCB contract. To be eligible for reimbursement each assessment must have one of the previous pictured Event Types and all of the information outlined in the next three steps entered in the CCM system by the Case Manager or it will not populate on the report the Department pulls for reimbursement.

The steps below outline the procedure to be eligible for reimbursement for an Initial and CSR Assessments:

1. The assessment must have an Assessment Date.

ASSESSMENT INFORMATION

* Assessment Date
mm / dd / yyyy

* Event Type

- ☐ 6 Month Review
- ☐ Appeal - Decision Overturned
- ☐ Continued Stay Review
- ☐ DI
- ☐ Initial Review
- ☐ Nursing Facility Transfer
- ☐ Reverse DI
- ☐ Unscheduled Review
- ☐ Waitlist

2. The Program Approval must have a selection from both drop down options in the "Programs Information" tab.

PROGRAMS INFORMATION

* Target Group
- Select -

* Program Approval
- Select -

HCBS
CCT-Legacy Only
HBU
ICF/IID
Home Connections-Legacy Only
NF
PACE
LTHH Only

PROGRAMS INFORMATION

* Target Group
- Select -

* Program Approval
HCBS

* HCBS

- ☐ HCBS-BI
- ☐ HCBS-CMHS
- ☐ HCBS-DD
- ☐ HCBS-EBD
- ☐ HCBS-CIH
- ☐ HCBS-SLS
- ☐ HCBS-CHCBS
- ☐ HCBS-CWA
- ☐ HCBS-CLLI
- ☐ HCBS-CES
- ☐ HCBS-CHRP

Note: Members who are functionally denied or have withdrawn their assessment request after the home visit is completed will not have a program approval area. The Case Manager will select Denied or Withdrawn from the program eligibility decision options under the long-term care certification information tab and verify the assessment to be eligible for payment.

Note: A member should have their Assessment and Monitoring Visit completed on separate dates. CCBs cannot be reimbursed for an Assessment and an Monitoring visit on the same day.

3. The Verified Date field must be completed in the CCM system by the timelines specified in the contract. The Verified Date can be found at the top of the assessment as shown in the screenshot below. CCBs will not receive payment if this date field is left blank.

Assessment/Support Plans: LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2) Version 2.3

Progress	Version	Assessment/Event Type	Created	Held Date	Verified Date	Date Completed/Verified	Assessor Name	Assessing Agency	Assessment Reason
60/86	2.3	N/A	Jan 11, 2023	N/A	N/A	Jan 11, 2023	System	N/A	N/A

ASSESSMENT INFORMATION DETAILS ACTIVITIES OF DAILY LIVING & LEVEL OF CARE DETERMINATION MEDICAL ASSESSMENT DEMOGRAPHICS

Assessment/Support Plans: LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2) Version 2.3

Progress	Version	Created	Date Completed/Verified	Assessor Name
3/85	2.3	Feb 24, 2023	N/A	N/A

Assessment/Event Type: Initial Held Date: 02 / 03 / 2023 Verified Date: mm / dd / yyyy Assessing Agency: Testing Agency Assessment Reason: New Member

Buttons: Back, Sign, Close, Complete, Save

100.2 Assessments: Initial and CSR Assessments - Reimbursement

CCBs shall enter and verify all Initials and CSR Assessments in the CCM system no later than the tenth (10th) to be included the Department data reports pulled on the eleventh (11th), to be eligible for reimbursement for conducting Assessments. In addition to the reimbursement rate for Initial and CSR Assessments, CCBs designated as rural within the CCB Contract, will receive the reimbursement rate for Rural Travel Add-On based on the member's location in the CCM system. If the Initial and CSR Assessments are not documented as noted in the above steps it will not be recognized in the Department data pull to be eligible for reimbursement.

CCBs will need to ensure the following:

- Assessment must be verified.
- Assessments that are denied or withdrawn are eligible for reimbursement.
- Assessments must be identified as either Initial Assessment or CSR Assessment to be eligible for reimbursement.

Developmental Disability (DD) and Developmental Delay Determination

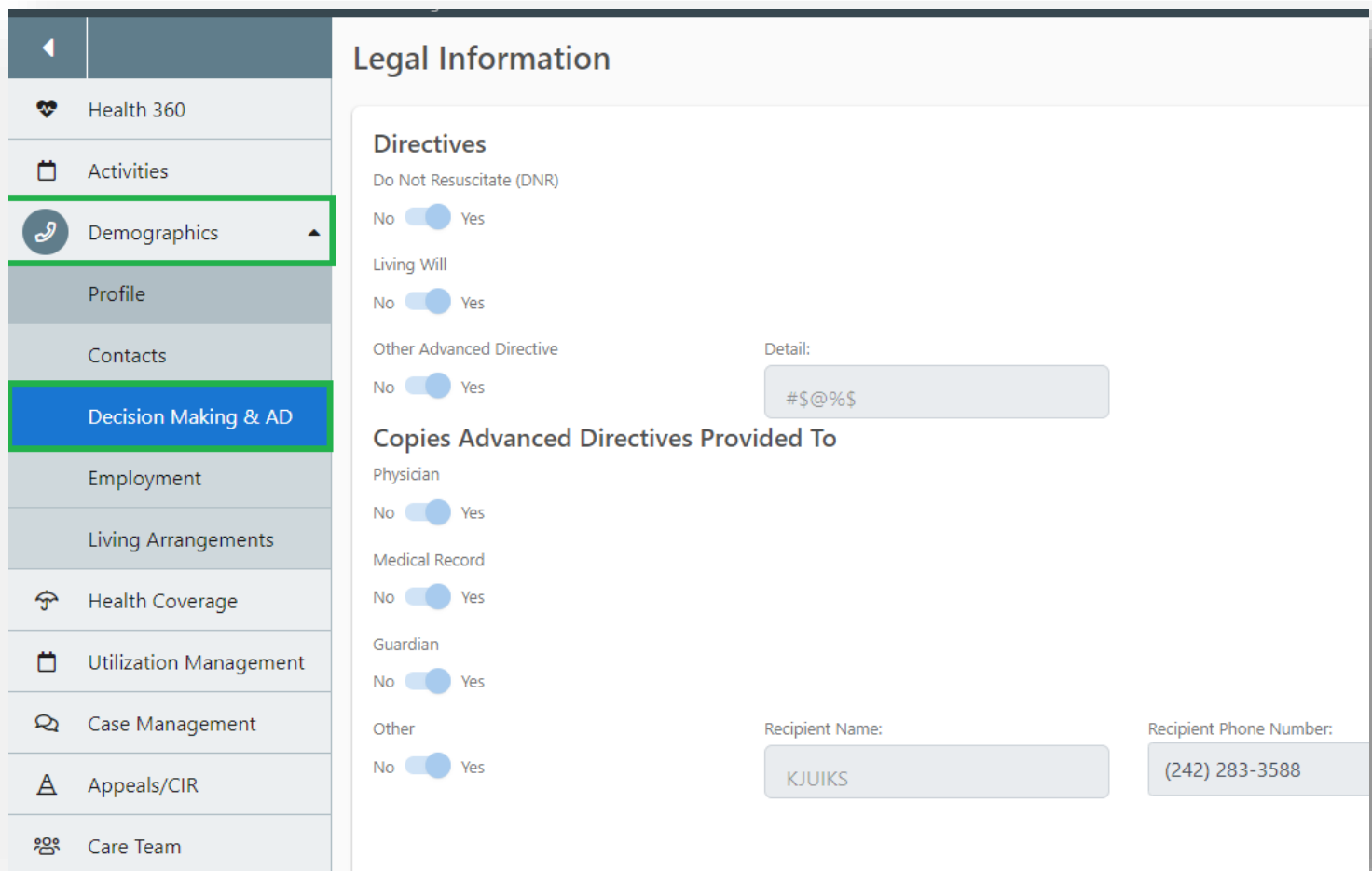
The CCB shall determine whether an applicant meets the definition of an Individual with Developmental Disabilities or Delay as defined under 10 CCR 2505-10, section 8.600.4, in accordance with 10 C.C.R. 2505-10 Section 8.607.2.

The CCB shall complete the individual's determination record and assessment record in the CCM system with all applicable dates and information within ten (10) Business Days after a determination is complete as required by Section 5.1.36.2 of the CCB contract.

1. Developmental Delay Determination - A child meets one or more of the following: A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more conditions identified in 10 C.C.R 2505-10 Section 8.600.4.
2. Developmental Disability Determination (DD Determination) – A disability that: A. Is manifested before the person reaches twenty-two (22) years of age; B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria identified in 10 C.C.R 2505-10 Section 8.600.4.

To ensure the correct field for each contact is updated correctly, there are directions and screen shots below from the CCM System on how to find the correct fields:

1. From the side menu, select the Demographics drop down and then Decision Making & AD.



Legal Information

Directives

Do Not Resuscitate (DNR)
No ☒ Yes

Living Will
No ☒ Yes

Other Advanced Directive
No ☒ Yes
Detail: # \$ % & ' ()

Copies Advanced Directives Provided To

Physician
No ☒ Yes

Medical Record
No ☒ Yes

Guardian
No ☒ Yes

Other
No ☒ Yes

Recipient Name: KJUIKS

Recipient Phone Number: (242) 283-3588

2. Scroll down to the “Developmental Delay or Developmental Disability Determination” section and select the + button to create the Determination record.

The screenshot shows the 'Legal Information' section of a software interface. On the left is a sidebar with various menu items. The main content area is titled 'Legal Information' and contains several sections: 'Directives', 'Copies Advanced Directives Provided To', 'Decision Making', and 'Developmental Delay or Developmental Disability Determination (0)'. The 'Developmental Delay or Developmental Disability Determination (0)' section is highlighted with a green border at the bottom of the page.

This screenshot shows the 'Developmental Delay or Developmental Disability Determination (0)' section. The header bar displays the title and a count of zero. Below the header, it states 'No Records found'. On the right side of the section, there is a green button with a plus sign and a red arrow pointing to it, labeled 'Add new Disability Determination'.

3. Complete all required fields for the determination. Once a decision has been made, open back up the determination record and record the outcome under the “Determination Decision” and “Decision Date” fields.

The screenshot shows the 'Developmental Delay or Developmental Disability Determination' form. The left sidebar contains a menu with 'Decision Making & AD' highlighted. The main form area is divided into several sections. The 'Determination Type' section includes a dropdown menu, a 'Request Date' field with a calendar icon, and a 'Determining Agency' dropdown. Below this is a section for 'Professional Completing Developmental Delay or Developmental Disability Determination' with an 'Add Another Professional' button. The 'Determination Decision' section includes a dropdown menu and a 'Decision Date' field with a calendar icon. Below this are 'Prior Determination' and 'Determination completed for PASRR' sections, each with 'Yes' and 'No' radio buttons. The 'Disability/Neurological Condition' section includes a dropdown menu. The 'Determination Decision' and 'Decision Date' fields are highlighted with a green border.

DD and Delay Determination - Reimbursement

Reimbursement is based off the "Determination Type" and "Decision Date" fields. CCBs will be paid based off which type of Determination was completed, Disability or Delay, and the Decision Date.

The CCB shall input all disability and delay determinations into the CCM system within the required timeframes. The Department will pay disability determinations, based on data pulled from the CCM system on the eleventh (11th) day of the month for determinations from the previous month.

Learn more about how to complete a DD Determination on the [Long-Term Services and Supports Training Page](#).

Critical Incident Reporting (CIRs) and Investigation

The Case Manager is responsible for entering Critical Incident Reports (CIR) in the Department prescribed system as soon as possible, but no later than 24 hours (one business day) following notification as required by Section 4.3.1.1 of the CCB contract.

CCBs should refer to the [critical incident training resources](#) available online for additional information on how to enter all required fields for critical incidents.

CIRs include all initial entries and any follow up entries requested by the Department.

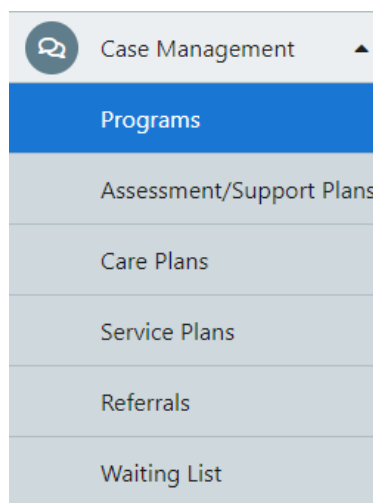
The CCB shall ensure all CIRs have been entered in the CCM system within the required timeframe.

CIRs Per Member Per Month (PMPM) – Reimbursement

The Department will reimburse CCBs a PMPM payment for CIRs based on members with an open program in the CCM system and an approved Prior Authorization Request (PAR) in Interchange (Bridge). The Department will pull data on the eleventh (11th) day of the month, for enrollments from the previous month.

Open Program in the CCM system:

CCBs must ensure that the member has an open program within the CCM system as shown in the screenshots below to be included on the payment report:



Program Information

Eligibility Determination mm / dd / yyyy	* Program Name Supported Living Services Waiver	* Program Status Open	Program Number ←
* Program Open Date 01 / 01 / 2023	Enrollment Counted ←	CM Assigned N/A	Program Closure Date mm / dd / yyyy
Reason for Program Closure - Select -	Other Closure Reason	Declined Reason - Select -	Reopen Date mm / dd / yyyy
Reopen Reason - Select -	Other Reopen Reason		

Active PAR in the Bridge:

CCBs must ensure that the member has an active PAR within the Bridge system and the "PA Status" in InterChange (Bridge) must be Approved as shown in the screenshot below:

Bridge PPA Number	104996	Client Last Name	PUDDING
PA Status	APPROVED	Client First Name	APPLE
Process Status	ACCEPTED BY IC	Client Birth Date	01/01/1947
Amendment Status		Support Level	
Process Status Date	07/27/2018	Receive Alert	NO

Each CCB will be able to use data pull from the Enrollment report in COGNOS for active PARs to identify members that will qualify for CIR and HRC PMPM payment in addition to the PMPM payment report.

Please refer to the [COGNOS training](#) provided by the Department for any questions on running the Enrollment report.

Please refer to the [Critical Incident Reporting training site](#) for any further clarification:

Critical Incidents for State General Fund (SGF) Programs – Reimbursement

The Department will pay for each CIR, MANE or Non-MANE, pulled from the CCM system on the eleventh (11th) day of the month, for SGF CIRs completed in the previous month. If a SGF CIR is not reflected on the CCB's payment for the previous month, it will need to be submitted through the Payment Correction process.

CIRs Quarterly Follow-Up Completion and Entry Performance Standard - Reimbursement

CCBs are eligible to receive a performance-based payment for the timely completion of the requested CIR follow-up action each quarter. To receive this quarterly performance-based payment, the CCBs must have ninety percent (90%) of all CIRs assigned follow-up completed and entered into the CCM system within the timelines assigned by the Department and/or Department Quality Improvement Organization. The Department will calculate the CCB's performance at the close of each quarter to determine if the payment will be awarded. If the CCB does not agree with the Department's calculations, the CCB must notify the Department in writing within ten (10) business days of receiving the payment summary. The Department will request supporting documentation and will determine if the performance standard was met based on the information provided. HCBS and SGF CIRs Performance Standards are calculated and reimbursed separately.

Human Rights Committee


The CCB shall establish and facilitate a Human Rights Committee (HRC) in accordance with 25.5-10-209(h), C.R.S. and 10 C.C.R. 2505-10 Section 8.608.5. The CCBs shall keep proper documentation and record of all HRC recommendations and assure that all documentation is a part of the individual's main record.

HCBS Human Rights Committee – PMPM Reimbursement

The Department will provide the CCB with an HRC PMPM payment for each member enrolled in HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS with an approved Prior Authorization Request (PAR) in Interchange (Bridge). The Department will pull data on the eleventh (11th) day of the month, for enrollments from the previous month.

SGF Human Rights Committee – Per Packet Reimbursement

The CCB shall submit all HRC packets on the invoice template provided by the Department by the fifteenth (15th) day of the month for packets completed in the previous month. In the event a CCB excludes an HRC packet on an invoice to the Department, the CCB shall request reimbursement on the next invoice submitted to the Department within the fiscal year the packet was complete. All fields within the invoice must be completed for the packet to be reimbursed.



COLORADO
Department of Health Care
Policy & Financing

Human Rights Committee (HRC) Reviews

Community Centered Board:
Contact Name & Email:
Billing Month:

Member Count:

Meeting Date	Member's Name Reviewed	Member ID (Medicaid, SSN, Consumer)	Program	Reason for Member Review	Determination	Other Type of Determination	Date of Next Review	Provider Setting for Member

Support Intensity Scale (SIS) Assessments

All SIS assessments must be completed in accordance with the criteria in 10 CCR 2505-10, Section 8.612.1.H. Reassessments must be approved by the Department prior to completion and reimbursement. The CCB shall ensure all SIS assessments have been entered in SIS Online within the required timeframe.

SIS Assessments - Reimbursement

The Department will pay per SIS assessment completed based on assessments completed pulled from the SIS Online and the case management agency listed in the CCM system on the eleventh (11th) day of the month.

HCBS-Children's Extensive Support Application (HCBS-CES)

The CCB shall submit all HCBS-CES applications to the Department's vendor for review and approval as outlined in [Operational Memo 18-020](#). The Department will pay for initial application per person applying for HCBS-CES per year, as well as CSR HCBS-CES application each year thereafter. The Department will not pay for initial or CSR applications that were denied due to being incomplete.

Incomplete applications include any application that did not contain:

- A signature page
- A completed Level of Care
- DD or Delay Determination date
- Dates of service

HCBS-CES Application - Reimbursement

The Department will pay for HCBS-CES applications from reports received by the Department's vendor on the eleventh (11th) day of the month for assessments from the previous month.

Expedited Developmental Disability Determination Testing

The CCBs may expedite psychological or adaptive behavior testing for Developmental Disability determinations requested to complete PASRR Level II assessments for individuals residing in skilled nursing facilities when there are delays due to issues identifying a provider or scheduling testing with a provider in alignment with CCB Contract requirements under the Developmental Disability and Delay Determinations section.

Expedited Developmental Disability Determination Testing Reimbursement

The CCBs shall submit all the costs of expediting testing for DD Determinations necessary for the completion of a PASRR II evaluation by the fifteenth (15th) day of the month for the determinations completed in the previous month. All invoices shall be submitted on the templated provided by the Department. The Department will pay for the actual cost for each expedited DD Determination once the invoice has been reviewed and accepted. All fields within the invoice must be completed for the assessment to be reimbursed.

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**Expedited DD Determinations for PASRR Level II Evaluations
Billing Invoice**

Community Centered Board: _____
Contact Name & Email: _____
Billing Month: _____

Individual's Name	Identifier (DOB, Medicaid ID, SSN)	Test(s) Completed	Type (PAS or RR)	Reason for Expedited Testing	Total Costs Not to Exceed Maximum	Comments

HCBS-CHRP Support Need Level Assessments

CCBs shall conduct a Support Need Level Assessment for all HCBS-CHRP enrollments and re-assessments as set forth by the Department's prescribed guidelines.

HCBS-CHRP Support Need Level Assessments Reimbursement

The CCB shall submit all HCBS-CHRP Support Need Level (SNL) assessments on the invoice template provided by the Department by the fifteenth (15th) day of the month for assessments completed in the previous month. HCBS-CHRP SNL assessments are required for all enrollments and re-assessments as required by the Department. In the event a CCB excludes an assessment on an invoice to the Department, the CCB shall request reimbursement on the next invoice submitted to the Department within the fiscal year the assessment was complete. All fields within the invoice must be completed for the assessment to be reimbursed.



Support Need Level Assessment Billing Invoice

Community Centered Board:
Contact Name & Email:
Billing Month:

Individual's Name	Medicaid ID	Assessment Date	Reassessment Y/N

Waiting List Management Annual Contacts

CCBs shall conduct and document an annual follow-up with individuals on the waiting list as outlined in the CCB Contract requirements under the Waiting List Management section.

Waiting List Management Reimbursement

CCBs must document the required annual contacts with members to ensure their waiting list status is still accurate on the Waiting List Contact Invoice. All waiting list contacts must be submitted on the invoice template provided by the Department by the fifteenth (15th) day of the month for contacts completed in the previous month. In the event a CCB excludes a waiting list contact on an invoice to the Department, the CCB shall request reimbursement on the next invoice submitted to the Department within the fiscal year the assessment was complete. All fields within the invoice must be completed for the contact to be

reimbursed. After phase 2 of the CCM tool is launched, the Department will transition back to report-based payments using information documented in the CCM.



Waiting List Contact Invoice

Community Centered Board: _____
 Contact Name & Email: _____
 Billing Month: _____

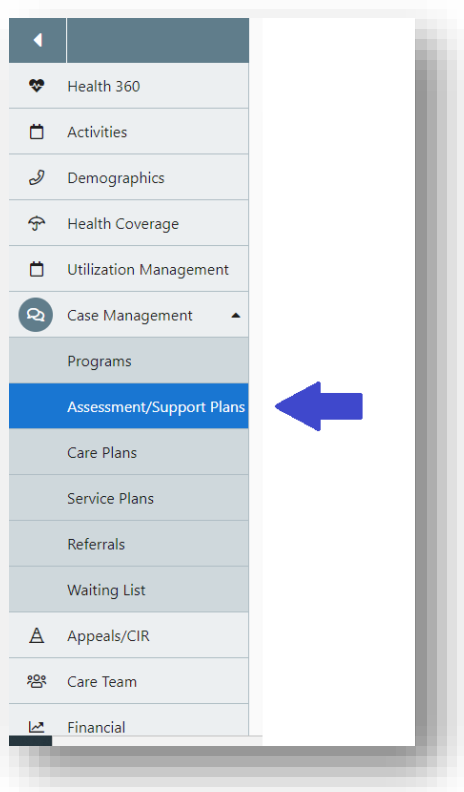
Total Waiting List Contact Count: 0

Member's Name	Unique Identifier (Medicaid, SSN, Consumer)	Program	Date of Contact	Waiting List Status, if Member Requested a Status Change

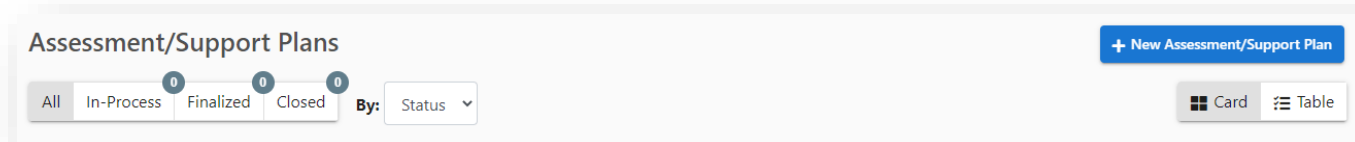
FSSP Most in Needs Assessment

CCBs must complete a Most in Need Assessment for member's enrolling into FSSP or being placed on the Waiting List each year. The Most in Need Assessment must be completed in the CCM system prior to creating the program for FSSP. To ensure the correct field for each Most in Need Assessment is entered correctly, there are directions and screen shots below from the CCM System on how to find the correct fields:

1. Under the Case Management dropdown select Assessment/Support Plan



2. Select "+ New Assessment/Support Plan



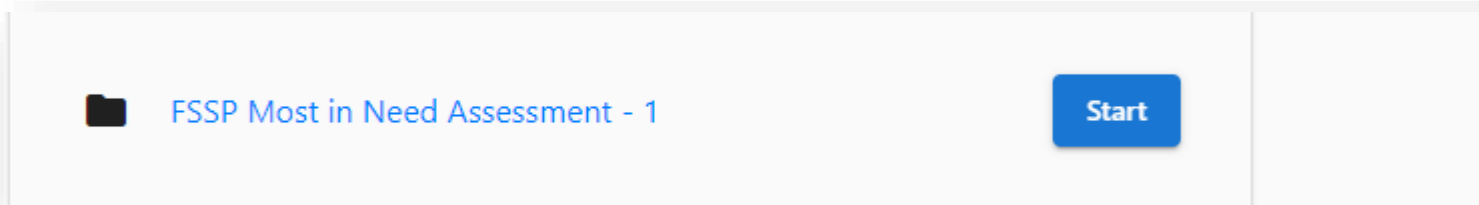
Assessment/Support Plans

+ New Assessment/Support Plan

All In-Process 0 Finalized 0 Closed 0 By: Status ▾

Card Table

3. Select "Start" on the FSSP Most in Need Assessment – 1 option

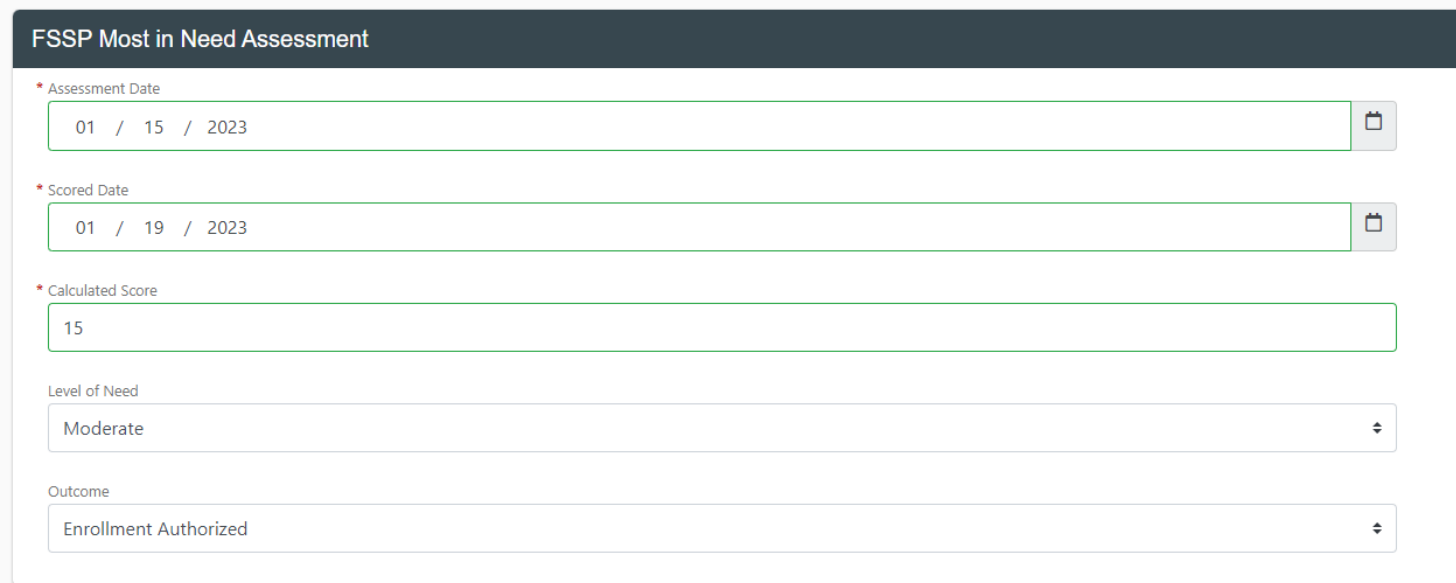


FSSP Most in Need Assessment - 1

Start

On the FSSP Most in Need Assessment page, complete the following fields:

- Assessment Date
- Scored Date
- Calculated Score
- Level of Need
- Outcome



FSSP Most in Need Assessment

* Assessment Date
01 / 15 / 2023

* Scored Date
01 / 19 / 2023

* Calculated Score
15

Level of Need
Moderate

Outcome
Enrollment Authorized

FSSP Most in Needs Assessment - Reimbursement

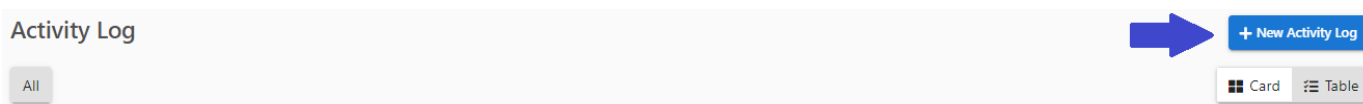
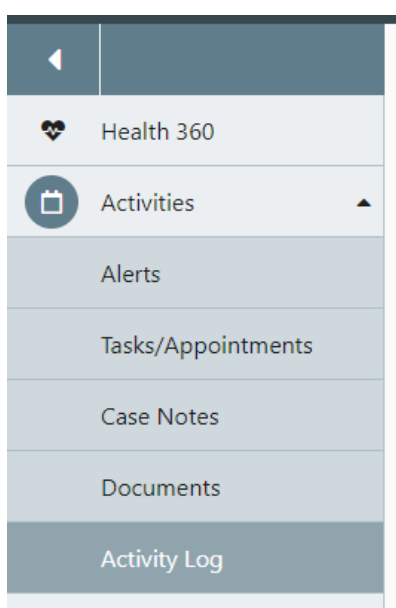
CCB are eligible for payment for one Most in Needs Assessment for members enrolled or on the waiting list for FSSP per fiscal year. The payment report will be primarily pulled using the "Assessment Date" field shown above. Department will pay for FSSP Most in Need Assessments based on a report pulled from the CCM system on the 16th day of the month for assessments completed in the previous month. If a Most in

Need Assessment is not reflected on the CCB’s payment for the previous month, it will need to be submitted through the Payment Correction process outlined in the CCB contract.

Ongoing Case Management – State SLS, OBRA-SS, FSSP

CCBs must document ongoing case management activities in the CCM system within the timeframes outlined in the CCB Contract. With SGF, members must have an active service plan to bill for Ongoing Case Management. To ensure the case management activities are entered correctly, there are directions and screen shots below from the CCM System on how to find the correct fields:

1. Under the Activities section of the side menu, select Activity Log.



2. Select + New Activity Log and enter required fields.
 - a. "Contact Date" will be automatically generated by the system when the case manager is entering the activity. If the activity occurred on a different date from when it is entered, the case manager will need to update the contact date to reflect the date the contact took place. The Contact Date will be used as the primary date filter for the payment reports as it is the only required date field within the activity log.
 - b. Select the Member button to pre-populate the Member’s First and Last Name.

- c. Under "Person Contacted" select the person/group contacted or select Not Applicable

Activity Log

Targeted Case Management: No

Confidential Note?: No

* Contact Date: 04 / 13 / 2023

Contact Time: 09 : 01 AM

Event Date: mm / dd / yyyy

Populate information with: Member Contacts

* First Name: Wonder

Last Name: Ful

* Person Contacted: Member / Self

Cell Phone Number: +1

Home Phone Number:

Work Phone Number: +1

Fax: +1

Email Address:

3. Under the Activity Log Details section, complete the following fields:
- Under "Program" select the program the contact is being recorded for:
 - State SLS
 - Nursing Facility OBRA-SS
 - FSSP
 - Under "Method of Contact" select the format of contact/activity that was completed:
 - Email
 - Face to Face
 - Fax
 - Mail
 - Telephone
 - Text
 - Virtual
 - Under "Category" select "Case Management"
 - Under "Type of Contact" select the appropriate type. **Any of the following selection will trigger an ongoing case management payment:**
 - Case Assigned
 - Case Conference
 - Case Documentation
 - Complaint
 - Correspondence
 - Critical Incident
 - Discharge and Termination
 - Enrollment
 - Financial Eligibility
 - Hospitalization
 - Mandatory Report
 - Medical

- xxiii. Nursing Facility Placement
- xxiv. Referral
- xxv. Rights Modification
- xxvi. Risk Mitigation Planning
- xxvii. Risk Mitigation Response
- xxviii. Summary Report – Closure
- xxix. Summary Report – CSR
- xxx. Summary Report – Initial
- xxxi. Support Plan Development
- xxxii. Transition Coordination
- xxxiii. Waiting List/Enrollment

Populate information with:

* First Name Last Name

Cell Phone Number Home Phone Number

Fax Email Address

Activity Log Details

Program Program Type

* Method of Contact Category

* Narrative

- Select -

- Appeal
- Assessment
- Case Assigned
- Case Conference
- Case Documentation
- Complaint
- Correspondence
- Critical Incident
- Discharge and Termination
- Enrollment
- Financial Eligibility
- Hospitalization
- Mandatory Report
- Medical
- Monitoring Contact -Scheduled
- Monitoring Contact -Unscheduled
- Nursing Facility Placement
- Prior Authorization (PAR)
- Referral

Enrollment

- e. Under “Narrative” enter member specific details that thoroughly documents the case management activity that took place. The narrative should be sufficient to determine whether the activity was an allowable case management activity for reimbursement.
 - f. If any of the activities should not have counted as an ongoing case management payment, the CCB will need to submit a payment correction.
 - g. System generated log notes will not be included in the criteria for payment.
 - h. **Note:** This will be used to determine whether the activity was allowable and met ongoing case management requirements during post payment reviews.
 - i. **Note:** For rural CCBs, the “Face to Face” selection under Method of Contact and “Support Plan Development” under Type of Contact will be used to trigger the rural add-on payments.
 - j. **Note:** Member’s must have an active program in the CCM for ongoing case management activities to populate on the report.
4. Under the Activities Log Additional Details, complete all required fields, and hit save.

Activity Log Additional Details

* Is this activity log note related to a restrictive intervention?

☐ Yes ☒ No

* Does the member have a restrictive intervention/Rights Modification Plan?

☐ Yes ☒ No ☐ N/A

* Was the restrictive intervention/Rights Modification implemented according to the authorized plan?

☐ Yes ☒ No ☐ N/A

Save

SGF Ongoing Case Management – Reimbursement

CCB are eligible for payment for an SGF Ongoing Case Management payment for each member each month when the CCB has completed the required documentation within the CCM system and has met all requirements outlined in contract. The payment report will be primarily pulled using the following fields under the Activity Log:

- Contact Date
- Program
- Method of Contact
- Category
- Type of Contact

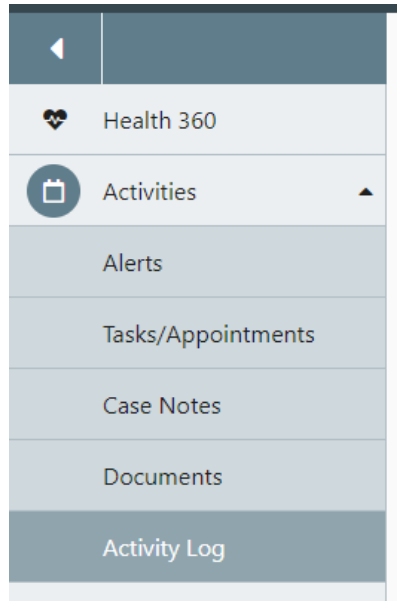
The Department will pay for SGF Ongoing Case Management activities based on a report pulled from the CCM system on the 16th day of the month for activities completed in the previous month. If an ongoing case management activity is not reflected on the CCB’s payment or should not have been included in the payment, the CCB must submit a payment correction for the activity.

Rural CCBs will receive a Rural Add-On payment for allowable State SLS and OBRA-SS activities based on “Face to Face” being selected for the Method of Contact.

Monitoring – State SLS and OBRA-SS

CCBs must document monitoring activities in the CCM system within the timeframes outlined in the CCB Contract. With SGF (specifically State SLS and OBRA-SS), members must have an active service plan to bill for Monitoring (without it, members will not appear on the payment reports). To ensure the case management activities are entered correctly, there are directions and screen shots below from the CCM System on how to find the correct fields:

1. Under the Activities section of the side menu, select Activity Log.



Activity Log

All

+ New Activity Log

Card Table

2. Select + New Activity Log and enter required fields.
 - a. "Contact Date" will be automatically generated by the system when the case manager enters the activity. If the activity occurred on a different date from when it is entered, the case manager will need to update the contact date to reflect the date the contact took place. The Contact Date will be used as the primary date filter for the payment reports as it is the only required date field within the activity log.
 - b. Select the Member button to pre-populate the Member's First and Last Name.
 - c. Under "Person Contacted" select the person/group contacted or select Not Applicable

Targeted Case Management	Confidential Note?
<input type="text" value="No"/>	<input type="text" value="No"/>
* Contact Date	Contact Time
<input type="text" value="03 / 17 / 2023"/>	<input type="text" value="02 : 00 PM"/>
Event Date	
<input type="text" value="mm / dd / yyyy"/>	
Populate information with:	
<input type="button" value="Member"/> <input type="button" value="Contacts"/>	
* First Name	Last Name
<input type="text" value="Sally"/>	<input type="text" value="Ride"/>
* Person Contacted	
<input type="text" value="Not Applicable"/>	

3. Under the Activity Log Details section, complete the following fields:
 - a. Under "Program" select the program the contact is being recorded for:
 - i. State SLS
 - ii. Nursing Facility OBRA-SS
 - b. Under "Method of Contact" select the format the contact/activity that was completed:
 - i. Face to Face
 - ii. Telephone
 - iii. Virtual
 - c. **Note:** Only the three options for Method of Contact indicated above will trigger a monitoring payment.
 - d. Under "Category" select "Case Management"
 - e. Under "Type of Contact" select the appropriate type. **Any of the following selection will trigger a monitoring payment:**
 - i. Monitoring Contact – Scheduled
 - ii. Monitoring Contact- Unscheduled

Note: Any other Type of Contacts selected will not trigger a monitoring payment.
 - f. Under "Narrative" record member specific details that thoroughly documents the monitoring activity that took place. The narrative should be sufficient to determine whether the activity was an allowable monitoring activity for reimbursement.

Note: This will be used to determine whether the activity was allowable and met ongoing case management requirements.

Activity Log Details

Program <div style="border: 1px solid green; padding: 2px;">State SLS - Open (3/23/2023-tbd) ▾</div>		Program Type <div style="border: 1px solid #ccc; padding: 2px;">State SLS ▾</div>
* Method of Contact <div style="border: 1px solid green; padding: 2px;">Face to Face ▾</div>	Category <div style="border: 1px solid green; padding: 2px;">Case Management ▾</div>	* Type of Contact <div style="border: 1px solid green; padding: 2px;">Monitoring Contact -Scheduled ▾</div>
* Narrative <div style="border: 1px solid green; padding: 5px; min-height: 30px;">Narrative that is member specific and outlines the activity completed by the case manager.</div>		

- g. **Additional Notes Impacting Payments:**
 - i. If any of the activities should not have counted as a monitoring payment, the CCB will need to submit a payment correction.
 - ii. System generated log notes will not be included in the criteria for payment.
 - iii. For rural CCBs, the Face to Face selection under Method of Contact will be used to trigger the rural add-on payment for monitoring contacts.
 - iv. Member's must have an active program in the CCM for monitoring activities to populate on the report.

4. Under the Activities Log Additional Details, complete all required fields, and hit save.

Activity Log Additional Details

* Is this activity log note related to a restrictive intervention?

☐ Yes ☒ No

* Does the member have a restrictive intervention/Rights Modification Plan?

☐ Yes ☒ No ☐ N/A

* Was the restrictive intervention/Rights Modification implemented according to the authorized plan?

☐ Yes ☒ No ☐ N/A

Save

State SLS and OBRA-SS Monitoring – Reimbursement

CCB are eligible for payment for an SGF Monitoring payment when the CCB has completed the required documentation within the CCM system and has met all requirements outlined in the CCB Contract. The payment report will be primarily pulled using the following fields under the Activity Log:

- Contact Date
- Program
- Method of Contact
- Category
- Type of Contact

The Department will pay for SGF Monitoring activities based on a report pulled from the CCM system on the 16th day of the month for monitoring activities completed in the previous month. If a monitoring activity is not reflected on the CCB's payment or should not have been included in the payment, the CCB must submit a payment correction for the activity.

Rural CCBs will receive a Rural Add-On payment for allowable State SLS and OBRA-SS activities based on "Face to Face" being selected for the Method of Contact.

Family Support Council Meetings

The CCBs shall submit meeting minutes to the Department for FSC meetings attended by the fifteenth (15th) day of the month for meetings attended in the previous month, and by June 30th or the Fiscal Year end close date determined by the Department for all meetings attended in June. The Department will pay for up to six FSC meetings attended within the Fiscal Year once the supporting documentation has been reviewed and accepted.


Direct Service Expenditure Reporting – State SLS, OBRA-SS, FSSP

CCB shall submit all State SLS, OBRA-SS, and FSSP direct service expenditures on the invoice templates provided by the Department within thirty (30) days of the end of each month, except for the June expenditure report. The June expenditure report shall be due June 30th, or the Fiscal Year end close date determined by the Department. In the event a CCB excludes an expenditure on an invoice to the Department, the CCB shall request reimbursement on the next invoice submitted to the Department within the fiscal year the service was complete. All fields within the invoice must be completed for the services to be reimbursed.

CCBs can use the monthly reporting option, which includes expenditures one month at a time or the year-to-date reporting option, which includes expenditures for the full fiscal year. Each program has its own reporting tab that the CCB must complete. If the CCB does not have expenditures for a program, that tab can be left blank. FSSP has two sections that can trigger reimbursement, the individual member/family table and the multiple family table.

CCBs shall only bill for allowable services and at the rate established by the Department. Service rates for State SLS and OBRA-SS can be found on the [Provider Rates and Fee Schedule website](#) under the Provider Rates and Fee Schedule and State General Fund Programs Direct Service Rates Fee Schedule (formerly CCB). Services for FSSP must be billed at \$1 per unit. All available services for each program can be found on the Provider Rates and Fee Schedule and on the "Approved Services" tab on the deliverable template. CCBs must ensure the dropdown is used for the service description to ensure correct data entry.

FSSP Individual Member/Family Table:



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FSSP Direct Service Expenditure Reporting - Year to Date

CCB Name:
 Payment Month:
 Contact Name & Email:

GRAND TOTAL \$ -
 UNIQUE INDIVIDUAL COUNT 0
 TOTAL FSSP PAYMENT: \$ -


Month Reported to the Department	Individual's Full Name or Family Contact Name <small>(Last, First)</small>	Individual Identifier <small>(SSN, Consumer ID, Medicaid ID)</small>	Service Description	Month of Service	Date Provider/Family Paid	Service Provider Legal Name or Family Member Name	Type of Payment <small>(Reimbursement, Direct Payment, or Advance)</small>	Total Amount Expended

FSSP Multi Family Table:

FSSP Multiple Family Direct Service Expenditure Reporting				
MULTI FAMILY GRAND TOTAL		\$	-	
TOTAL INDIVIDUALS IMPACTED			0	

Month Reported to the Department	Service Description	Month of Service	Number of Individuals Impacted	Total Amount Expended

Monthly Reporting Option:



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 Policy & Financing

State SLS Direct Service Expenditure Reporting


CCB Name:
 Payment Month:
 Contact Name & Email:

GRAND TOTAL \$ -
 UNIQUE CLIENT COUNT 0

Individual's Full Name (Last, First)	Individual Identifier (SSN, Consumer ID, Medicaid ID)	Service Description	Month of Service	Service Provider Name	Service Rate	Units Paid	Total Amount Expended

CCBs must complete all fields to include the payment month.

Year to Date Reporting Option:



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State SLS Direct Service Expenditure Reporting - Year to Date

CCB Name:
 Payment Month:
 Contact Name & Email:

GRAND TOTAL \$ -
UNIQUE CLIENT 0

Jul-20 \$ -
 Aug-20 \$ -
 Sep-20 \$ -


Month Reported to the Department	Individual's Full Name (Last, First)	Individual Identifier (SSN, Consumer ID, Medicaid ID)	Service Description	Month of Service	Service Provider Name	Service Rate	Units Paid	Total Amount Expended

CCBs must complete all fields to include the "Month Reported to the Department" column. This column should be entered in with the following date format XX/1/XXX (Examples: 7/1/2023, 5/1/2023). This will automatically calculate the total expenditures reported for the month at the top of the spreadsheet by month. Please note that dates entered incorrectly, such as 12/21/2023, will not automatically calculate at the top of the invoice.

Note: Any service missed on the previous submission should be included on the next report for payment, with exception to June services which must be submitted by the Fiscal Year end close deadlines. If the CCB identifies an overpayment on the expenditure report, a negative entry can be made on the next payment report to offset the overcharge. Any overpayments identified at the close of the fiscal year must be returned via check.

Payment Correction Form

The CCB shall review all payments made by the Department to ensure accuracy within ten (10) business days of receiving the payment summary. Any errors in billing or payment must be submitted through the



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CCB Contract Payment Correction Form

Community Centered Board:
 CCB Contact Name:
 Email:

Name of Individual	Identifier (Medicaid ID, SSN, Consumer ID)	Program	Contract Activity	Billing Month/Year	Change to Payment	Comments

payment correction form, shown below, which is available on each CCB's SharePoint page. Once the Department has received and reviewed the payment correction form, over and underpayments will be corrected on the following month's payment. Please ensure all fields are completed so that the correction can be reviewed and completed.

Running Reports in the CCM System

CCBs can run their own reports within the CCM system to assist with managing case management and payment purposes. The following reports are available:

1. Billing 01 – Appeals Payment – Court Decision Dates
 - Available to CMA Supervisors and CMA Administrators
 - Used to process Appeal payments for hearing attendance
2. Billing 01 – Appeals Payment – Packet Dates
 - Available to CMA Supervisors and CMA Administrators
 - Used to process Appeal payments for creating packets
3. Billing 02 – Per Enrollment Payment
 - Available to CMA Supervisors and CMA Administrators
 - Used to process CIR and HRC PMPM payments
4. Billing 04 – Monitoring Log Notes Payment – Legacy Service Plan
 - Available to CMA Supervisors and CMA Administrators
 - Used to process State SLS and OBRA-SS monitoring payments
 - Data includes all programs and types of contacts so filters must be applied to view only State SLS and OBRA-SS monitoring contacts and allowable monitoring contacts under type of contact
5. Billing 06 – LOC Assessment Payments – Legacy 100.2 Assessments
 - Available to CMA Supervisors and CMA Administrators
 - Used to process 100.2 assessment payments
6. Billing 07 – DD and Delay Determinations
 - Available to CMA Supervisors and CMA Administrators
 - Used to process DD and Delay determination payments
7. Billing 10 – Waitlist Payment
 - Available to CMA Supervisors and CMA Administrators
 - Will be used to process waiting list contact payments once available
8. Billing 11 – Critical Incident Follow-up Payment
 - Available to CMA Supervisors and CMA Administrators
 - Will be used to process Quarterly CIRs Follow-Up Performance Standard deliverable payments starting in the fall 2023
 - Report will be ready for use later this fall

9. Billing 12 – Case Management Activities

- Available to CMA Supervisors and CMA Administrators
- Used to process State SLS, OBRA-SS, and FSSP ongoing case management payments
- Data includes all programs and activities so filters must be applied to view only State SLS, OBRA-SS, and FSSP and allowable ongoing case management activities

10. Billing 13 – FSSP Assessment

- Available to CMA Supervisors and CMA Administrators
- Used to process FSSP Most in Need assessment payments

11. Agency 03 – Referral Report

- Available to CMA Supervisors and CMA Administrators
- Can be used to view referrals
- Can be used to view incoming referrals and timelines of intake/enrollment

12. Agency 04 – Waiting List Client Detail

- Available to CMA Supervisors and CMA Administrators
- Can be used to track and monitor individuals on the waiting list
- Should be used in conjunction with Department 08 – Summary Report – Waiting List Report

13. Agency 05 – Critical Incidents by CIRS ID

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to search for a specific incident using the incident number

14. Agency 05 – Critical Incidents

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to track and monitor all critical incidents in specific timeframes
- Can be used to gather trend analysis on incident types, by waiver and CIR status

15. Agency 06 – Log Notes Monthly Summary by Type

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to get a snapshot of the case management contacts that were completed by individual case managers or as an agency for a specific timeframes
- Will display both the Primary Case Manager and user that entered the Activity Log so view can be used in coverage cases as well

16. Agency 07 – Support Plan Report – Legacy Service Plan

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to track and monitor service plan status and confirm service plan has been completed for concurrent certification period

17. Agency 08 – Detailed Log Notes

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to assist in Targeted Case Management billing and to track and monitor ongoing case management and monitoring activities completedCan be used to view all log note activity with narratives included for quality assurance with monitoring contacts

18. Agency 09 – Caseload Report – Legacy 100.2 Assessment

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to track and monitor 100.2 assessments
- Can be used as an end date report if run monthly per Case Manager to ensure certification end dates are not missed
- Can be used to verify Ongoing Case Managers current caseload, verify tracking and caseload size per Case Manager

19. Agency 10 – Agency Transition Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see the program status of all members assigned to your agency

20. Department 01 – Summary Caseload Report – Legacy 100.2 Assessment

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to as a snapshot of member's Level of Care and Service Plan start and end dates that are current
- Can be used to view current caseloads for both Ongoing Case Managers and Intake Case Managers along with status of program for members for tracking

21. Department 03 – Critical Incident Trending Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to track and monitor the details of all critical incidents entered by your agency
- Can be used in conjunction with Agency 05 reports
- Can be used to monitor the types of critical incidents occurring per month to identify trends that may be larger issues in your catchment area
- Can be used to view timeliness of entering critical incidents and critical incident follow ups by Case Managers

22. Department 08 – Summary Report – Waiting List

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- This report is a summary count of members on the waiting list and matches the data available in Agency 04 – Waiting List Client Detail
- Should be used in conjunction with Agency 04 – Waiting List Client Detail

23. Department 11 – Total Enrollment by Program

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used as a snapshot of all members enrolled in a program
- Can be used to view number of members enrolled per waiver and case status that each Case Manager is currently managing for your agency that is assigned in the CCM

24. Department 13 – Appeal

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to track and monitor the status of appeals entered by your agency for a current snapshot and to verify billing for appeals per month

25. Appeals System Generated Log Note Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all systems activity related to appeals
- Will provide CMA with all Appeals created in system for your agency for a desired timeframe
- Can be used in conjunction with Department 13 as an appeal tracker for your agency

26. Assessment System Generated Log Note Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all systems activity related to assessments
- Will provide overview off all system generated log notes related to Assessments and CIRs, will include Intake, Legacy LTC 100.2, Service Plans, DD assessments and Needs Assessment
- Provides snapshot of when assessments were verified, completed or closed

27. Critical Incidents System Generated Log Note Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all system generated activity related to critical incidents
- Provides information on if CIRs were saved or edited for member, can filter search by Case Manager, User or Member for quick reference

28. Legal Contacts System Generated Log Note Report

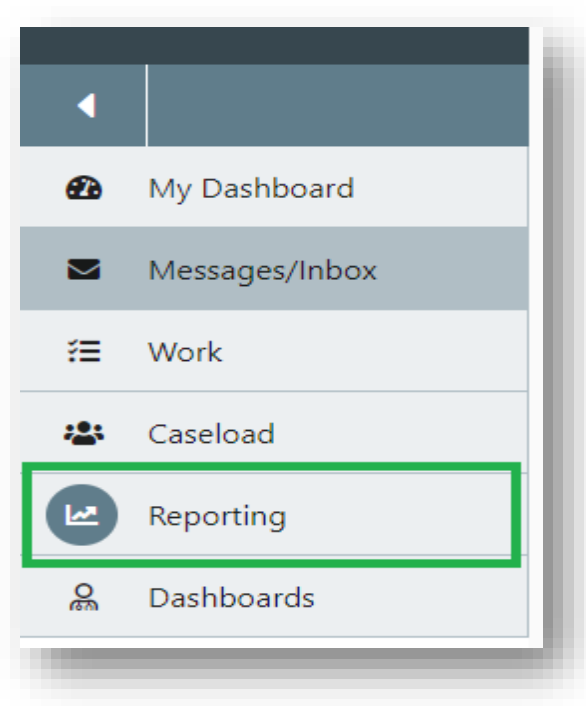
- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all systems activity related to legal contacts
- Will give an overview of any members with legal contacts added in the system that should be involved in decision making processes for member
- This would be data added in the “Decision Making and AD” section under Demographics for the member

29. Programs System Generated Log Note Report

- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all systems activity related to programs
- Will give an overview of any program(waiver) that is added or value that is changed for the member in the program area along with the field that was updated by the Case Manager
- Will also provide LTC Notice of Action activity in relation to the program(waiver) for the member

To access and run the reports, log in as the appropriate role and follow the steps below.

1. From your homepage Dashboard click on “Reporting”



2. Select the report to run:

Reports	
Name	
Agency Report 03 - Referral Report	
Agency Report 05 - Critical Incidents Report	
Agency Report 06 - Log Notes Monthly Summary By Type	
Agency Report 07 - Support Plan Report-Legacy Service Plan	
Agency Report 08 - Detailed Log Notes Report	
Agency Report 09 - Caseload Report - Legacy 100.2 Assessment	
Agency Report 10 - Agency Transition Report	
Billing Report 01 - Appeals Payment Report - Court Decision Dates	
Billing Report 01 - Appeals Payment Report - Packet Dates	
Billing Report 02 - Per Enrollment Payment Report	
Billing Report 04 - Monitoring Log Notes Payment Report - Legacy Service Plan	
Billing Report 06 - LOC Assessments Payment - OAD Edits - Legacy 100.2 Assessment	
Billing Report 07 - DD and Delay Determinations	
Billing Report 11 - Critical Incident Followup Payment Report	

3. Populate all required fields and select "View Report." See the example below:

Billing Report 01 - Appeals Payment Report - Court Decision Dates

Report Start Date: 03 / 01 / 2023

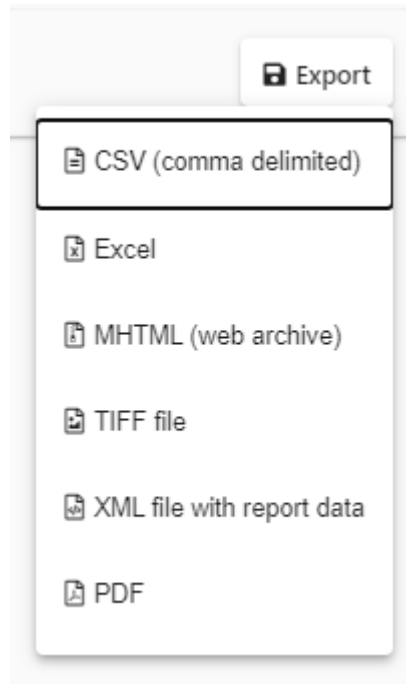
Report End Date: 03 / 31 / 2023

Program: Brain Injury Waiver (BI), Children with Life Limiting Illness Waiver (CLLI), Children's Extensive Support Waiver (CES), Children's Habilitation Residential Program Waiver (CHRP), Children's Home & Community Based Services Waiver (CHCBS), Community Mental Health Supports Waiver (CMHS), Complementary and Integrative Health (CIH) Waiver, Developmental Disabilities Waiver (DD), Elderly, Blind & Disabled Waiver (EBD), Family Support Services Program (FSSP), HCBS Waiver, Hospital Back Up Plan (HBU), Intermediate Care Facility/Intellectual/Developmental Disability (ICF/IID), Long Term Home Health (LTHH), Nursing Facility, Nursing Facility OBRA Specialized Services, PACE, State SLS, Supported Living Services Waiver (SLS)

View Report

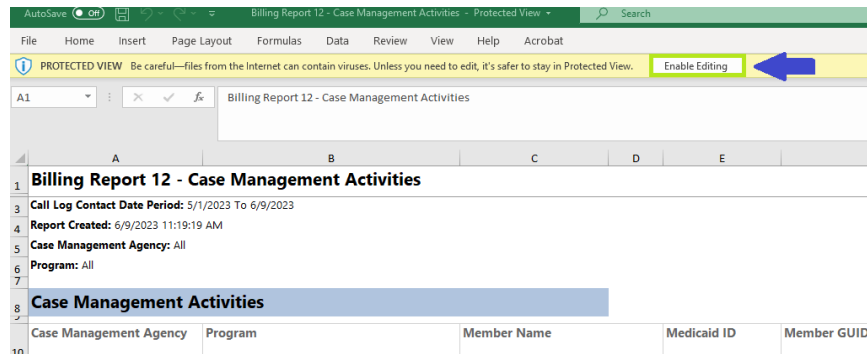
Back

4. The data will generate on the same screen below.
- a. Some of the reports have a summary of the data ran
 - b. The reports will also have the raw data
5. The report can also be exported into Excel by selecting the "Export" button and selecting "Excel" from the dropdown.

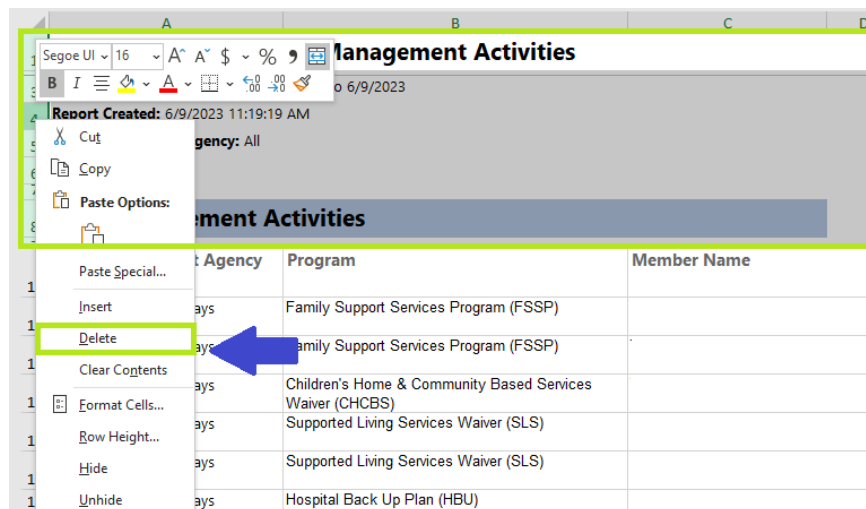


6. Once the file finishes downloading, the file will pop up at the bottom of your screen and within your downloads to open and use as needed.

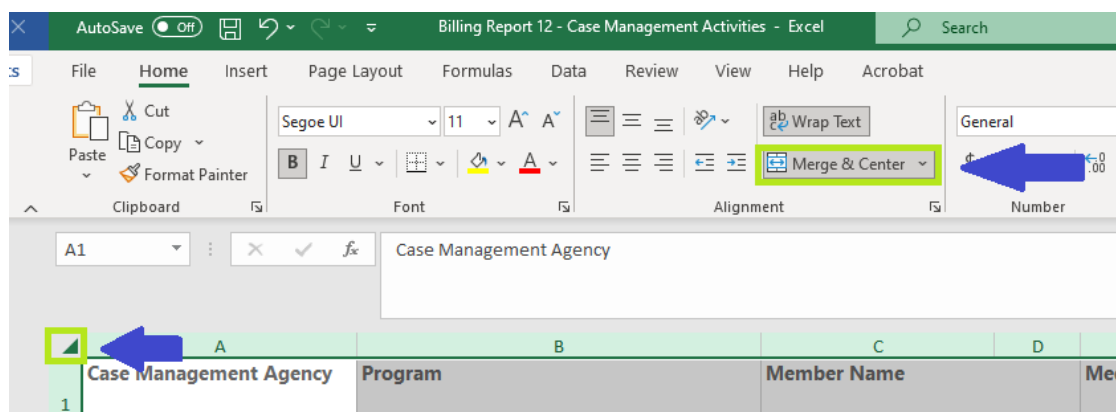
7. Once you have exported the file to Excel, users may need to adjust the report to sort and filter and get to the data in the way that works best for the user. Please follow these steps to do so:
 - a. For reports without a summary table:
 - i. Select "Enable Editing:



- ii. Select the top set of rows that do not contain the header or raw data as shown in the image below and right click to delete those rows.



- iii. Then select all data on the workbook to highlight all fields and select "Merge & Center" as shown below. This will remove all merged cells and allow you to add a filter to the data. You may have to remove blank columns.



- b. For reports with a summary table, you will need to cut and paste the summary table to another tab, and then follow the steps above to be able to sort and filter the data as needed.

Targeted Case Management (TCM)

The CCBs shall bill for all TCM activities through the agency's Medicaid Provider Agreement through the Colorado interChange MMIS. TCM activities include:

- Ongoing Case Management
- Monitoring
- Rural Add-On

CCBs should refer to the [Provider Rates and Fee Schedule website](#) for the most up to date TCM rates.

TCM Ongoing Case Management

The CCB will bill for performing and log noting any allowable TCM activity each month in accordance with 10 CCR 2505-10, Section 8.761.

To bill for TCM Ongoing Case Management each month the Member must have case management activities documented in the CCM system for that month and a Prior Authorization Request (PAR) is in Approved status in Interchange (Bridge). The member must also be financially eligible and coded for their waiver program in the Colorado Benefits Management System and Interchange (Bridge). "Date of Contact" must be in the month of payment requested and reflect the date the contact took place. Log Note can be any "Type of Contact" as long as it is an allowable case management activity in accordance with TCM regulations.

1. "Contact Date" must be in the month of payment requested. Case Managers should update the contact date to match the date the actual contact took place. Log Note can be any "Type of Contact" as long as it is an allowable case management activity in accordance with TCM regulations

The screenshot shows the 'Activity Log' form. A green box highlights the 'Contact Date' field, which is set to '02 / 24 / 2023'. Another green box highlights the dropdown menu for 'Log Note' type, which includes options like 'Appeal', 'Assessment', 'Case Assigned', 'Case Conference', 'Case Documentation', 'Complaint', 'Correspondence', 'Critical Incident', 'Discharge and Termination', 'Enrollment', 'Financial Eligibility', 'Hospitalization', 'Mandatory Report', 'Medical', 'Monitoring Contact - Scheduled', 'Monitoring Contact - Unscheduled', 'Nursing Facility Placement', 'Prior Authorization (PAR)', and 'Referral'.

2. "PA Status" in InterChange (Bridge) must be Approved

Bridge PPA Number	104996	Client Last Name	PUDDING
PA Status	APPROVED	Client First Name	APPLE
Process Status	ACCEPTED BY IC	Client Birth Date	01/01/1947
Amendment Status		Support Level	
Process Status Date	07/27/2018	Receive Alert	NO
Selected Benefit Plan	HCBS-Elderly, Blind and Disabled (EBD)	Cert Start Date	10/01/2017
Provider ID	40770141	Cert End Date	09/30/2018
Current Benefit Plan	EBD 01/01/2014-12/31/2299	Authorized SPAL/CES Limit	

Claims for TCM Ongoing Case Management may be submitted, for members with a non-system generated log note, documenting a TCM activity, and an approved PAR.

TCM - Monitoring

The CCB may bill for the required Case Management Quarterly Monitoring. The CCB shall document the four required Monitoring activities in the CCM and maintain detailed documentation with the following steps to be eligible for reimbursement.

CCBs that serve individuals who reside in a Rural or Frontier service area, as determined by the Department, may also bill for the Rural Travel Add On for monitoring contacts completed Face to Face.

1. Under "Method of Contact" select the format of contact/activity that was completed
 - a. Face to Face
 - b. Virtual
 - c. Telephone
2. Under "Type of Contact" select:
 - a. Monitoring Contact – Scheduled
 - b. Monitoring Contact – Unscheduled
3. Under "Narrative" record member specific details that thoroughly documents the monitoring activity that took place. The narrative should be sufficient to determine whether the activity was an allowable monitoring activity for reimbursement.
 - a. Note: This will be used to assist in determining whether the activity was allowable and met ongoing case management requirements during post payment reviews.

The screenshot shows the 'Activity Log Details' form. A blue box highlights the 'Method of Contact' dropdown menu, which currently shows '- Select -'. A green arrow points from this box to the 'Type of Contact' dropdown menu, which is also highlighted with a blue box. The 'Type of Contact' dropdown menu is open, showing a list of options: Medical, Monitoring Contact - Scheduled, Monitoring Contact - Unscheduled, Nursing Facility Placement, Prior Authorization (PAR), Referral, Rights Modification, Risk Mitigation Planning, Risk Mitigation Response, Summary Report - 6 Month Review, Summary Report - CDASS Reassessment, Summary Report - Closure, Summary Report - CSR, Summary Report - Initial, Summary Report - Monthly Contact, Summary Report - Quarterly Contact, Summary Report - Transfer, Support Plan Development, Transition Coordination, and Waiting List/Enrollment. Below the form, there is a section titled 'Activity Log Additional Details' with two questions: 'Is this activity log note related to a restrictive intervention?' and 'Does the member have a restrictive intervention/Rights Modification Plan?'. Both questions have radio button options for Yes, No, and N/A.

Required Monitoring visits will be reimbursed per Monitoring visit not to exceed four visits per year. If the Monitoring activity is not documented as noted in the above steps it will not be recognized by the Department as eligible for reimbursement and may be subject to overpayment recovery by the Department.

Note: A member should have their Assessment and Monitoring contact completed on separate dates. CCBs cannot be reimbursed for an Assessment and Monitoring contact on the same day.

Contact Information

If you have questions, please contact the appropriate Department contact outlined below:

Contract, Deliverable, Payment, Payment Corrections, and Payment Report Questions:

- Amanda.Allen@state.co.us Financial Compliance & Monitoring Section Manager
- Lauren.Stanislaw@state.co.us Subrecipient Monitoring Specialist

Case Management Questions:

- hcpf_hcbs_casemanagement@state.co.us

TCM Billing Questions:

- Fiscal Agent Provider Services Call Center at 1-844-235-2387 or see the Department's [Home and Community Based Services Billing Manual](#).