



COLORADO

**Department of Health Care
Policy & Financing**

Single Entry Point 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 and case management activities. For case management activities, the methodology requires Single Entry Point (SEPs) to enter information in the Care and Case Management (CCM) system and interChange (Bridge) to be eligible for reimbursement. To ensure all case management activities are documented and billed accurately, the Department developed the following technical guide to provide specified instructions for data entry into the CCM system and interChange (Bridge). Rates associated with each task outlined in this technical guide are listed in the SEP contract.

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Appeals

SEPs 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 SEP Contract.

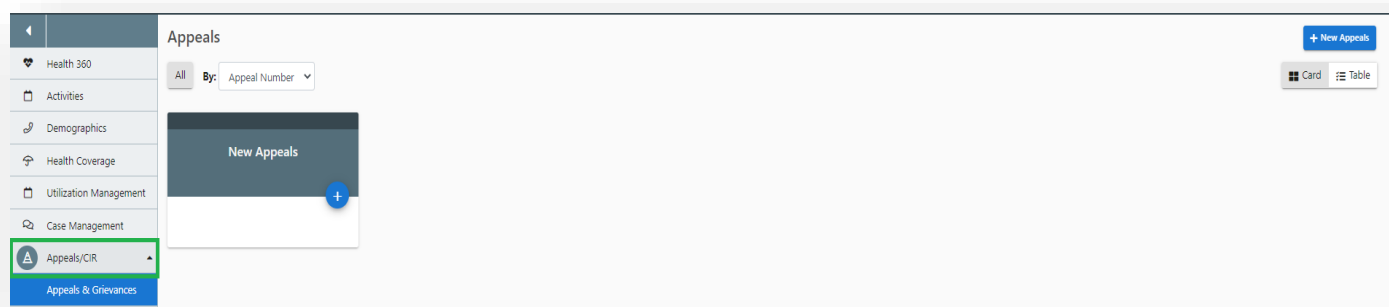
Each SEP will be required to create their own appeal tracker document for use by their agency. SEPs will use their internal agency appeal tracker to verify that the report received from the Department for reimbursement each month matches their records.

The steps below outline the procedure to be eligible for reimbursement for Appeals-Creation of Packet and Appeals-Attendance of hearing.

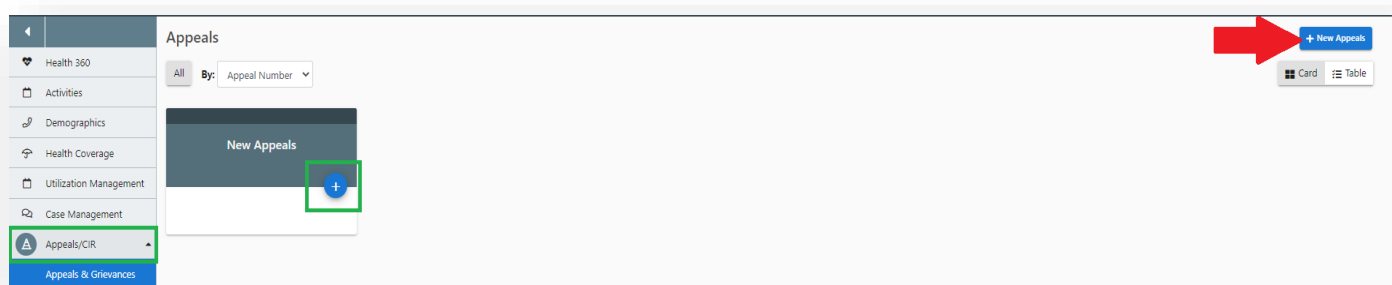
Appeals – Creation of Packet

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. The following steps will need to be followed for reimbursement purposes regarding the appeals process.

1. Go to the "Appeals/CIR" tab from the member's record in CCM system



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



3. Fill out all required fields and click "Save" button. "Program Name" must be selected for member to appear on the appeals reports. Make sure to select Appeal Status as "Open".

The screenshot shows the 'Appeals' form. The 'Program Name' field is highlighted with an orange box. A red arrow points to the 'Save' button in the top right corner. The form includes fields for Appeal Number, Type, Appeal Owner, NOA Effective Date, NOA Effective Time, Appeal Status, Status Reason, Date Appeal Filed, Time Appeal Filed, Opened By, Notification Method, Appellant, Expedited Hearing Request, and Program Name.

4. Return to Appeals/CIR Tab and click on saved appeal to edit and enter "Claims Information"

The screenshot shows the 'Appeals' tab. The 'LOC Appeal' card is highlighted with a green box. The 'New Appeals' card is also visible. The 'LOC Appeal' card shows details: 'Opened By: Member', 'Notification Method: Letter', 'NOA Effective Date: 3/7/23', and a 'Copy' button. The 'New Appeals' card has a blue plus button.

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

The screenshot shows the 'Appeals' form with the 'Documents' search panel open on the right. A red arrow points to the 'Documents (1)' section, which lists a document titled 'Long Term Care Benefits (decrease, change, denied), English, Mar 2, 2023'. The 'Documents' panel also includes sections for 'Correspondence (1)', 'Activity Log (0)', and 'Case Notes (0)'.

6. 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 'Appeals & Grievances' system interface. The left sidebar contains navigation links: 'Appeals/CIR', 'Appeals & Grievances' (highlighted), 'Incident Management', 'Care Team', 'Financial', and 'Reports'. The main content area is titled 'Member' and includes a dropdown menu. Below this, there are radio buttons for 'Expedited Hearing Request' (Yes/No), with 'No' selected. A 'Program Name (Required)' dropdown is set to 'HCBS Waiver - Open (2/3/2023-tl)'. An 'Appeal Program' dropdown is set to 'HCBS Waiver'. A 'Service Auth #' field with a search icon is present. A 'Comments' text area is below. A section titled 'If the dispute is resolved prior to the appeal hearing, Client was informed of procedures to dismiss the appeal.' has 'No' selected. The 'Claims' section is highlighted with a green box and contains the following fields: '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), and 'Time Forwarded to IRE?' (hh : mm --). A red arrow points to the 'Date received notification of hearing from the Office of Administrative Courts' field.

If no resolution with the member is determined prior to the scheduled appeal hearing, the Case Manager shall develop an appeal's packet which contains all relevant documentation to support the denial or adverse action. The SEP shall develop an appeal's packet no earlier than 20 business days prior to the date of a scheduled hearing. In the event an appeal is not entered into the CCM system by the required timeframes for the previous month, it will need to be submitted through the Payment Correction process.

- After the appeals packet is completed and officially sent to the Division of Appeals Court, the Case Manager will go back to 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 complete any other fields until after the Initial Decision is received. The SEP 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 appeals packet was sent to Administrative Courts.

The screenshot shows the 'Appeals & Grievances' form in the CCM system. The left sidebar contains navigation links: 'Appeals & Grievances', 'Incident Management', 'Care Team', 'Financial', and 'Reports'. The main form area includes sections for 'Expedited Hearing Request', 'Program Name (Required)', 'Appeal Program', 'Service Auth #', 'Comments', and 'Claims'. The 'Claims' section is highlighted with a green box and contains fields for 'Corrected Claim', 'Claim Attached', 'Date received notification of hearing from the Office of Administrative Courts', 'Date Appeal packet sent to the Office of Administrative Courts', 'Extension End Date', 'Extension End Time', 'Client Appealed to District Court?', and 'Time Forwarded to IRE?'. A red arrow points to the 'Date Appeal packet sent to the Office of Administrative Courts' field, which is currently empty and has a calendar icon next to it.

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

Required documentation in the CCM system includes:

- Update the appeals tab with the date the appeal packet was sent to the Division of Administrative Hearing as noted in the above screen shot.
- Add an Activity Log and update the section in the appeal tab.
- Select Status Reason: "Cancel" or "Missed Deadline"
- Once this tab is completed, the Case Manager must save and finalize the appeal information.

The screenshot shows the 'Appeal' form in the CCM system. The form includes fields for 'Appeal Number', 'Appeal Owner (Required)', 'Type', 'NOA Effective Date', 'NOA Effective Time', 'Date Appeal Filed', 'Time Appeal Filed', 'Notification Method', 'Appellant', and 'Expedited Hearing Request'. The 'Appeal Status' and 'Status Reason' fields are highlighted with green boxes. The 'Appeal Status' field is set to 'Closed' and the 'Status Reason' field is set to 'Cancel'. The 'Date Appeal Filed' field is set to '03 / 07 / 2023' and the 'Time Appeal Filed' field is set to '01 : 36 PM'.

Appeals - Creation of Packet – Reimbursement

SEPs shall ensure that all appeals documentation is in the CCM system and adhere to all requirements listed in the SEP Contract. The Department will pull data reports from the CCM system on the 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.

Appeals – Attendance of Hearing

The SEP 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 SEP. Appeals-Attendance at Hearing payment will include all hearings that must be attended by the SEP in order for a final decision to be made. The SEP 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 Court 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”.

Office of Administrative Court Hearings Details

Office of Administrative Court Hearings Details

* Court Decision Date
mm / dd / yyyy

Court Decision Time
hh : mm : ss --

Assigned Reviewer
[Search]

Initial Court Decision
- Select -

* Internal Reviewer Notes
[Text Area]

Exception Filed by Case Management Agency/HCPF
☐ Yes ☐ No

Back Save

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

3. 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".

Office of Administrative Court Hearings Details

Office of Administrative Court Hearings Details

* Court Decision Date: mm / dd / yyyy

Court Decision Time: hh : mm : ss --

Assigned Reviewer: [Search]

Initial Court Decision: - Select -

* Internal Reviewer Notes: [Text Area]

Exception Filed by Case Management Agency/HCPF: ☐ Yes ☐ No

Office of Administrative Court Hearing Decision Details

Exceptions Filed by Other Parties: ☐ Yes ☐ No

Decided by Name: [Search]

Final Court Decision: - Select -

Due Date Met: ☐ Yes ☐ No

Save

If an appeal is attended by the Case Manager and the member does not attend, the SEP 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 the appeal is saved.

The SEP shall ensure all areas of the "Appeals - Attendance at Hearing" information is entered in the CCM system and adhere to all requirements listed in the SEP Contract. The Department will review CCM system data on the 11th day of the month for attendance of hearing from the previous month.

If an appeal notification is received from a member and an 803 Long-Term Care Notice of Action was not issued by the SEP; the SEP 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

SEPs shall ensure that all appeals documentation in the CCM system and adhere to all requirements listed in the SEP 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.

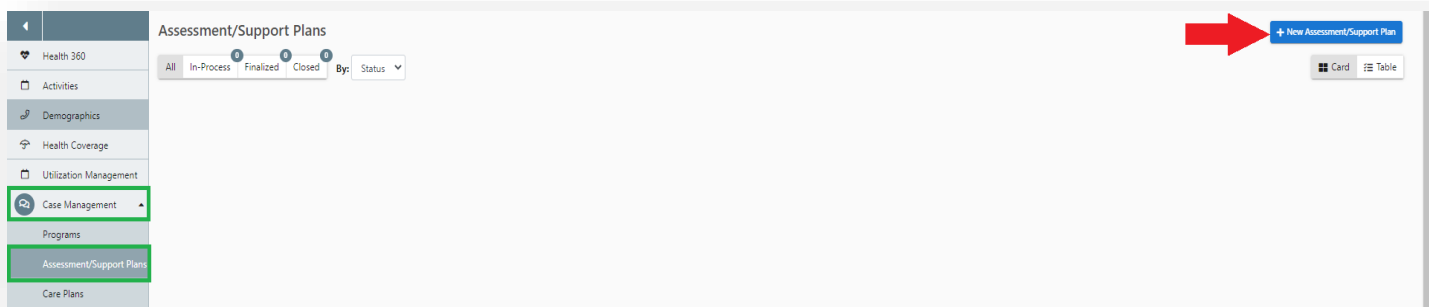
100.2 Legacy Assessments

SEP's shall perform all Initial and Continued Stay Review Functional Eligibility Assessments for the operation of a SEP in accordance with §25.5-6-104, C.R.S., 10 CCR 2505-10, Section 8.401, and 10 CCR 2505-10, Sections 8.393.2 *et seq.*

The reimbursement for assessments is provided at two different rates based on the assessment type: (3) Initial Functional Eligibility and (4) Continued Stay Review - Functional Eligibility (CSR). The assessment type is determined by the Event Type selected by the Case Manager during entry into the CCM system.

Description of Assessment Types:

1. Go to Case Management tab on 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.

The screenshot shows a sidebar menu on the left with the following items: Assessment/Support Plans (highlighted), Care Plans, Service Plans, Referrals, Waiting List, Appeals/CIR, Care Team, Financial, and Reports. The main content area on the right lists various assessment modules, each with a 'Start' button. The item 'LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2) ...' is highlighted with a green rectangular box. Other items include 'FSSP Most in Need Assessment - 1', 'Functioning Module - 7.4', 'HCA Care Plan Summary - 1.2', 'Home Care Allowance Eligibility Determination - 1', 'Housing and Environment Module - 4.6 Comprehensive Assessment Page 9', 'interRAI Home Care (HC) Assessment - 1', 'Introduction to the Assessment and Support Plan Process - ...', 'Legacy - IADL - 1.8', 'Legacy Service Plan - 1', 'Level of Care Screen Module - 13.7', and 'Memory and Cognition Module - 4.5 Comprehensive Assessment Page 6'.

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

The screenshot shows the 'ASSESSMENT INFORMATION' form. The left sidebar menu is identical to the previous screenshot, with 'Assessment/Support Plans' highlighted. The main form area has a dark header 'ASSESSMENT INFORMATION'. Below the header, there is a field for 'Assessment Date' with a placeholder 'mm / dd / yyyy'. Below that is the 'Event Type' section, which has a red arrow pointing to it. The 'Event Type' section contains a list of radio button options: '6 Month Review', 'Appeal - Decision Overturned', 'Continued Stay Review', 'DI', 'Initial Review', 'Nursing Facility Transfer', 'Reverse DI', 'Unscheduled Review', and 'Waitlist'. The 'Initial Review' and 'Reverse DI' options are highlighted with green rectangular boxes.

4. **Continued Stay Review - Functional Eligibility** - Continued Stay Review, Nursing Facility Transfer, Unscheduled Review. Continued Stay Review 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

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

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

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

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 reimbursement.

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

Note: For members who only receive Long Term Home Health (LTHH), it is required to select Target Group and the LTHH only drop down must be selected in Program Approval.

- 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. SEPs will not receive payment if this date field is left blank.

Initial and CSR Assessments - Reimbursement

SEPs shall enter and verify all Initials and CSR Assessments in the CCM system no later than the 10th to be included on the Department data reports. The data reports are pulled by the Department on the 11th. SEPs will be reimbursed for each Initial Assessment and CSR Assessment conducted and completed.

In addition to the reimbursement rate for conducting Initial and CSR Assessments, SEPs designated as rural or frontier, as determined by the Department, are eligible to receive the Rural Travel Add-on reimbursement rate.

SEPs 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.

Critical Incident Reports (CIRS)

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 1.14 of the SEP contract.

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

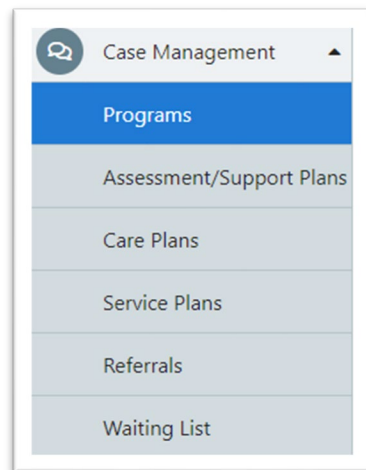
CIRs include all initial entries and any follow up entries requested by the Department.

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

Critical Incident Per Member Per Month (PMPM) – Reimbursement

The Department will reimburse SEPs 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:



SEPs 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:

SEPs 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 SEP will be able to use data pull from the Enrollment report in COGNOS for active PARs to identify members that will qualify for CIR 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 Incident Report (CIR) Quarterly Follow-Up Completion and Entry Performance Standard - Reimbursement

SEPs 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, SEPs must have 90% of all CIRs assigned follow-up completed and entered into the CCM system with the timelines assigned by the department and/or Department Quality Improvement Organization. The Department will calculate the SEP's performance at the close of each quarter to determine if the payment will be awarded.

If the SEP does not agree with the Department's calculations, the SEP must notify the Department in writing within 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.

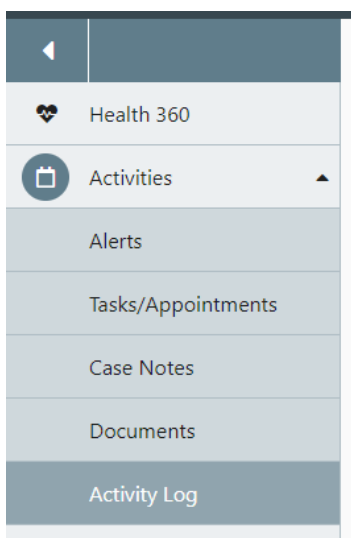
Ongoing Case Management

SEPs must document ongoing case management activities in the CCM system within the timeframes outlined in the SEP Contract. To be eligible for Ongoing Case Management reimbursement, each member must have all the following:

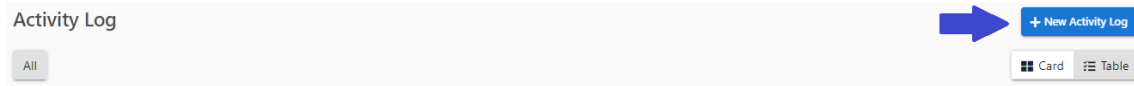
1. An allowable Ongoing Case Management activity
2. Prior Authorization Request (PAR) in Approved status in Interchange (Bridge)
3. Financial eligibility and coded for their waiver program in the Colorado Benefits Management System (CBMS) and interChange (Bridge)

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. Under "Contact Date" enter the date of the ongoing case management activity or date of contact.
 - 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
3. Under the Activity Log Details section, complete the following fields:
- a. Under "Program" select the program the contact is being recorded for:
 - i. HCBS-BI
 - ii. HCBS-EBD
 - iii. HCBS-CIH
 - iv. HCBS-CMHS
 - v. HCBS-CLLI
 - b. Under "Method of Contact" select the format of contact/activity that was completed:
 - i. Email
 - ii. Face to Face
 - iii. Fax
 - iv. Mail
 - v. Telephone
 - vi. Text
 - vii. Virtual
 - c. Under "Category" select "Case Management"
 - d. Under "Type of Contact" select the appropriate type. **Any of the following selection will trigger an ongoing case management payment:**
 - i. Case Assigned
 - ii. Case Conference
 - iii. Case Documentation
 - iv. Complaint
 - v. Correspondence
 - vi. Critical Incident
 - vii. Discharge and Termination
 - viii. Enrollment
 - ix. Financial Eligibility
 - x. Hospitalization
 - xi. Mandatory Report
 - xii. Medical
 - xiii. Monitoring Contact – Scheduled
 - xiv. Monitoring Contact – Unscheduled
 - xv. Nursing Facility Placement
 - xvi. Prior Authorization (PAR)
 - xvii. Referral
 - xviii. Rights Modification
 - xix. Risk Mitigation Planning
 - xx. Risk Mitigation Response
 - xxi. Summary Report – CDASS Reassessment

- xxii. Summary Report – Closure
- xxiii. Summary Report – CSR
- xxiv. Summary Report – Initial
- xxv. Summary Report – 6 Month Review
- xxvi. Summary Report – Monthly Contact
- xxvii. Summary Report – Quarterly Contact
- xxviii. Summary Report – Transfer
- xxix. Support Plan Development
- xxx. Transition Coordination
- xxxi. Waiting List/Enrollment

The screenshot shows the 'Activity Log' form. It includes fields for 'Targeted Case Management', 'Confidential Note?', 'Contact Date' (highlighted with a green box), 'Contact Time', 'Event Date', 'Populate information with:' (with 'Member' and 'Contacts' buttons), 'First Name', 'Last Name', 'Cell Phone Number', 'Home Phone Number', 'Fax', 'Email Address', 'Activity Log Details' (with 'Program', 'Program Type', 'Method of Contact', and 'Category' dropdowns), and a 'Narrative' field. A green box also highlights the 'Category' dropdown menu, which is open and shows a list of options: 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.

- 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 SEP 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 SEPs, 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.

Activity Log Details

Program	Program Type	
<input type="text"/>	Elderly, Blind & Disabled Waiver (<input type="text"/>)	
* Method of Contact	Category	* Type of Contact
Email <input type="text"/>	Case Management <input type="text"/>	Correspondence <input type="text"/>
* Narrative		
<div>Narrative that is member specific and clearly outlines the action taken by the case manager.</div>		
Security Restrict Access		
No <input type="radio"/> Yes <input type="radio"/>		

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

Ongoing Case Management – Reimbursement

SEPs are eligible for payment for an Ongoing Case Management payment for each member each month when the SEP has completed the required documentation within the CCM system. This includes completing an allowable Ongoing Case Management activity, the member has an Active PAR, the member has financial eligibility, and the SEP has met all requirements outlined in the SEP 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 Ongoing Case Management activities based on a report pulled from the CCM system on the 11th day of the month for activities completed in the previous month. If an Ongoing Case Management activity is not reflected on the SEP’s payment or should not have been included in the payment, the SEP must submit a payment correction for the activity.

Rural SEPs will receive a Rural Add-On payment for allowable activities based on “Face to Face” being selected for the Method of Contact.

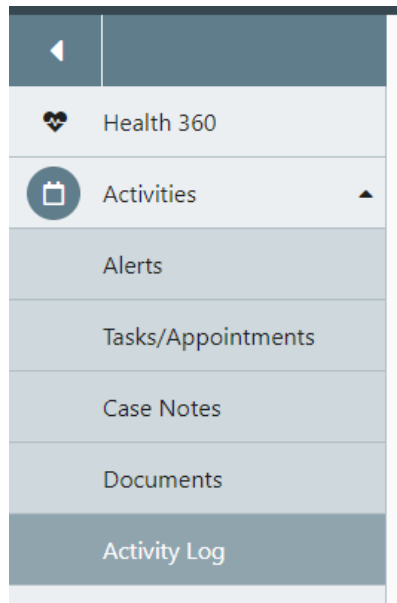
In-Person Monitoring

SEPs must document monitoring activities in the CCM system within the timeframes outlined in the SEP Contract. To be eligible for monitoring reimbursement, each member must have all the following:




1. An allowable monitoring activity
2. Financial eligibility and coded for their waiver program in the Colorado Benefits Management System (CBMS) and interChange (Bridge)

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. Under "Contact Date" enter the date of the monitoring activity or date of contact.
 - 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?
<div>No ▾</div>	<div>No ▾</div>
* Contact Date	Contact Time
<div>03 / 17 / 2023 </div>	<div>02 : 00 PM</div>
Event Date	
<div>mm / dd / yyyy </div>	
Populate information with:	
<div> Member</div>	<div>Contacts ▾</div>
* First Name	Last Name
<div>Sally</div>	<div>Ride</div>
* Person Contacted	
<div>Not Applicable ▾</div>	

3. Under the Activity Log Details section, complete the following fields:
 - a. Under "Program" select the program the contact is being recorded for:
 - i. HCBS-BI
 - ii. HCBS-EBD
 - iii. HCBS-CIH
 - iv. HCBS-CMHS
 - v. HCBS-CLLI
 - b. Under "Method of Contact" select the format the contact/activity that was completed:
 - i. Face to Face
 - c. **Note:** Only the Face-to-Face option 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 selections will trigger a monitoring payment:**
 - i. Monitoring Contact – Scheduled
 - ii. Monitoring Contact – Unscheduled
 - iii. Summary Report – 6 Month Review
 - iv. Summary Report – CDASS Reassessment
 - v. Summary Report – Monthly Contact
 - vi. Summary Report – Quarterly Contact
 - vii. Summary Report – Transfer
 - f. **Note:** Any other Type of Contacts selected will not trigger a monitoring payment.
 - a. Under "Narrative" record member specific details that thoroughly documents monitoring activity that took place. The narrative should be sufficient to determine whether the activity was an allowable monitoring activity for reimbursement.
 - b. If any of the activities should not have counted as a monitoring payment, the SEP will need to submit a payment correction.
 - c. System generated log notes will not be included in the criteria for payment.
 - g. **Note:** This will be used to determine whether the activity was allowable and met ongoing case management requirements.

- h. **Note:** For rural SEPs, the Face-to-Face selection under Method of Contact will be used to trigger the rural add-on payment for monitoring contacts.

Activity Log Details

Program Elderly, Blind & Disabled Waiver (▾)	Program Type Elderly, Blind & Disabled Waiver (▾)	
Method of Contact Face to Face (▾)	Category Case Management (▾)	Type of Contact Monitoring Contact -Scheduled (▾)

* Narrative
Narrative that is member specific and clearly outlines the action taken by the case manager.

Security Restrict Access
No ☐ Yes ☐

Under the Activities Log Additional Details, complete all required fields

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](#)

In-Person Monitoring- Reimbursement

SEPs are eligible for payment for a Monitoring payment when the SEP has completed the required documentation within the CCM system and has met all requirements outlined in the SEP 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 Monitoring activities based on a report pulled from the CCM system on the 11th day of the month for monitoring activities completed in the previous month. If a monitoring activity is not reflected on the SEP's payment or should not have been included in the payment, the SEP must submit a payment correction for the activity.

Rural SEPs will receive a Rural Add-On payment for allowable monitoring activities based on "Face to Face" being selected for the Method of Contact.

Payment Correction Form

The SEP payment process is a coordinated effort between the Department and SEPs. SEPs must enter all case management activities by the tenth (10th) of the following month. SEPs are also responsible for reviewing the Department data reports and submitting Payment Corrections. The Department pulls the data reports to the following business day on the eleventh (11th) and use them for monthly payments.

SEP monthly payments are based on the data reports pulled by CCM system and interChange (Bridge), and data reports are the supporting documentation for payments. All data reports are made available through SharePoint for each SEP. Monthly data reports include the following case management activities:

- (1) Appeals
- (2) CIRs PMPM
- (3) Initial and CSR Assessments
- (4) In-Person Monitoring
- (5) On-Going Case Management

The data reports include a Summary tab and Details tab for each case management activity. The Summary tab is a high-level overview of the activity, waiver, and final number of members. The Details tab includes information on each member who received a case management activity that was completed and entered into the Department's prescribed systems and accounted for on the data report pull. SEP's are encouraged to review the Payment Summary and Data Reports, as Data Reports will be inclusive of case management activities completed in a full month. Example: April will be inclusive of the full 30 days.

Payment Correction

SEP Agencies shall review all payments made by the Department to ensure accuracy within 10 Business Days of receiving the payment summary and data reports. It is the responsibility of the SEPs to identify any errors in payment and submit the payment correction form which is available on SharePoint webpage. It is the responsibility of the SEP to ensure that any payment corrections submitted to the Department is also corrected in the CCM system and interChange (Bridge).



SEP: Payment Correction Form

Single Entry Point Agency	
SEP Contact Name:	
Email & Phone Number:	

*Agency Required to Complete this Section in Grey, additional notes are on <i>Instruction</i> tab.								Department Only	
*Name of Individual	*Medicaid ID or SSN	*Active PAR Date	*Waiver/Program	*Activity	*Month/Year	Change Payment	Comments	Approved/Denied	Dollar Amount Increase/Decrease

How to Complete the SEP Payment Correction Form:

1. Complete the following:
 - a. Add the name of the Member
 - b. Add the Member's Medicaid ID OR Social Security Number (SSN)
 - c. Add the Member's Active PAR date

- d. Add the Member's Waiver or Non-Waiver Program, available in drop down:
 - i. HCBS – BI
 - ii. HCBS – EBD
 - iii. HCBS – CIH
 - iv. HCBS – CLLI
 - v. HCBS – CMHS
 - vi. PACE
 - vii. LTHH
 - viii. Nursing Facility
 - e. Add the Member's Activity that requires correction:
 - i. On Going Case Management
 - ii. Initial Assessment
 - iii. CSR Assessment
 - iv. 1st In Person Monitoring Visit
 - v. 2nd In Person Monitoring Visit
 - vi. CIRs PMPM
 - vii. Appeal – Hearing
 - viii. Appeal – Packet
 - f. Add the Month and Year of the Member's Correction
 - i. If a correction was missed in past month of the current fiscal year, add the month of the correction not the current month the correction is being added.
 - ii. Example: It is January, but the correction is for November, add the November date here, not the January. Ensure the correct data reports are being reviewed.
 - g. Add "Increase" or "Decrease" under *Change Payment* to clarify if this is being add to the Payment Correction to be reimbursed (increase) or recouped (decrease).
 - h. Add the reimbursement rate based on the *Activity*
 - i. Under *Comments*, please add any additional information about the situation regarding the payment correction to provide clarification.
2. The Department will fill in the "Approved/Denied" column, and "Dollar Amount (Increase/Decrease) column.

Running Reports in the CCM System

SEPs can run their own reports within the CCM system to assist with managing case management and billing 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 PMPM payments
4. Billing 04 – Monitoring Log Notes Payment – Legacy Service Plan
 - Available to CMA Supervisors and CMA Administrators
 - Used to process monitoring payments
 - Must be filtered to include only allowable monitoring contacts based on type of contact
 - Can be used as a snapshot of waiver monitoring contacts but does not contain the written narrative (use Agency 08 – Detailed Log Notes Report for narrative)
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
 - CCB Payment Report Only
 - Used to process DD and Delay determination payments
7. Billing 10 – Waitlist Payment
 - Available to CMA Supervisors and CMA Administrators
 - CCB Payment Report Only
 - Will be used to process waiting list contact payments in Phase 2
 - Report will be ready for use later this fall
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 ongoing case management payments

- Data includes all activities so filters must be applied to view only allowable ongoing case management activities
- Can be used as a snapshot of waiver case management activities but does not contain the written narrative (use Agency 08 – Detailed Log Notes Report for narrative)

10. Billing 13 – FSSP Assessment

- Available to CMA Supervisors and CMA Administrators
- CCB Payment Report Only
- 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
- CCB Report Only
- 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 timeframe
- 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 completed
- Can be used to view all log note activity with narratives included for quality assurance with monitoring contacts

- Future state will allow for users to search by a specific member (Member ID) to use as a case review tool and a snapshot of all log note narratives

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
- CCB Report Only
- 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
- Additional summary information will be added to the report in the coming months

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
- Changes to the summary portion of the report will be made in the coming months

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

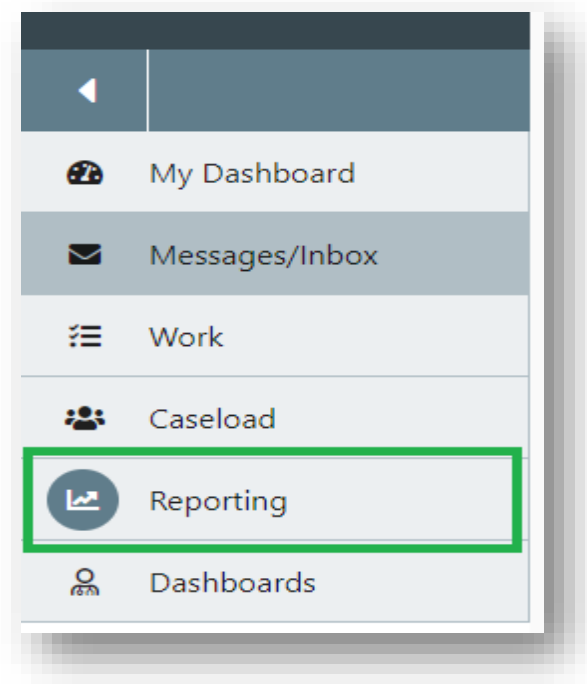
- Available to CMA Case Managers, CMA Supervisors, and CMA Administrators
- Can be used to see all systems activity related to legal contacts
- Will give an overview of any members with legal contacts added in the system that should be involved in decision making processes for member
- This would be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

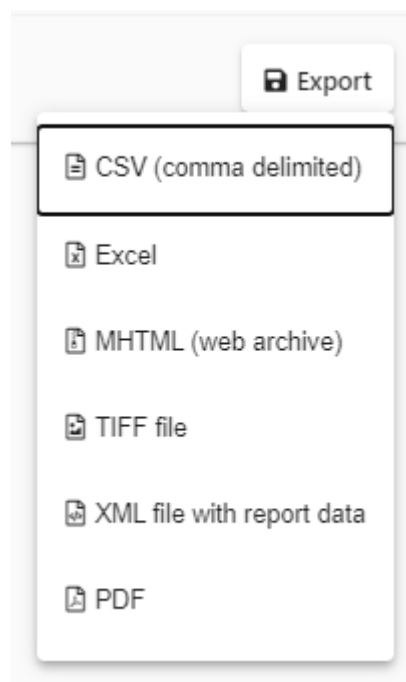
* Report Start Date:
03 / 01 / 2023

* Report End Date:
03 / 31 / 2023

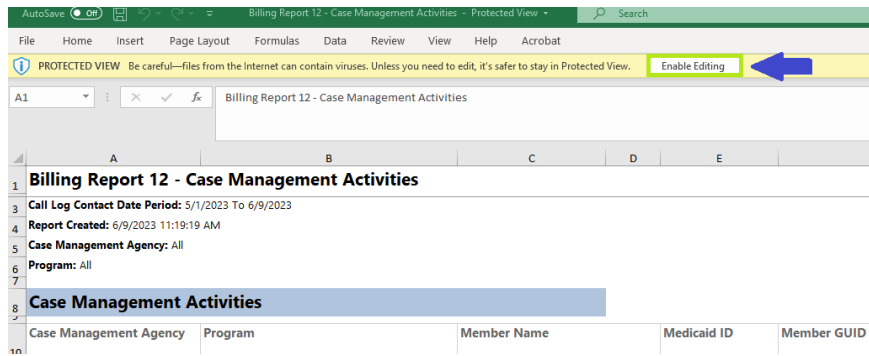
* Program
Brain Injury Waiver (BI), Children with Life Limiting Illness Waiver (CLLI), Children's Extensive Support Waiver (CES), Children's Habilitation Residential Program Waiver (CHRP), Children's Home & Community Based Services Waiver (CHCBS), Community Mental Health Supports Waiver (CMHS), Complementary 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

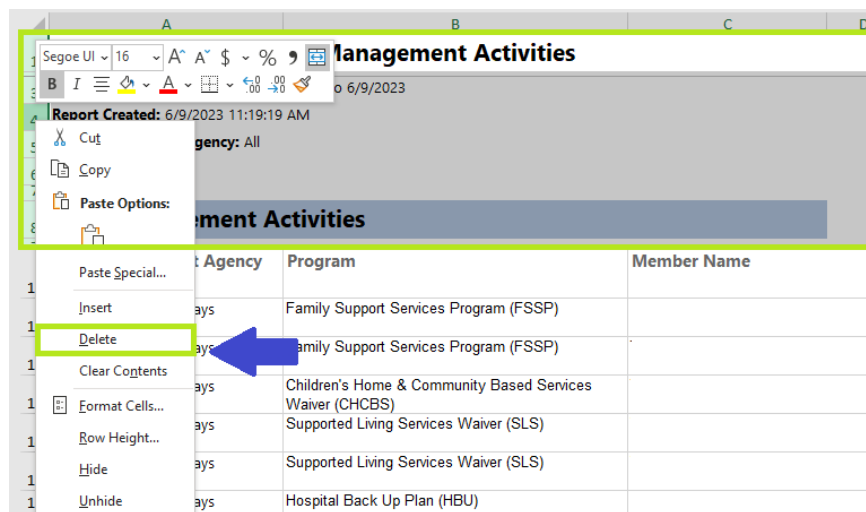
4. The data will generate on the same screen below.
 - a. Some of the reports have a summary of the data ran
 - b. The reports will also have the raw data
5. The report can also be exported into Excel by selecting the "Export" button and selecting "Excel" from the dropdown.



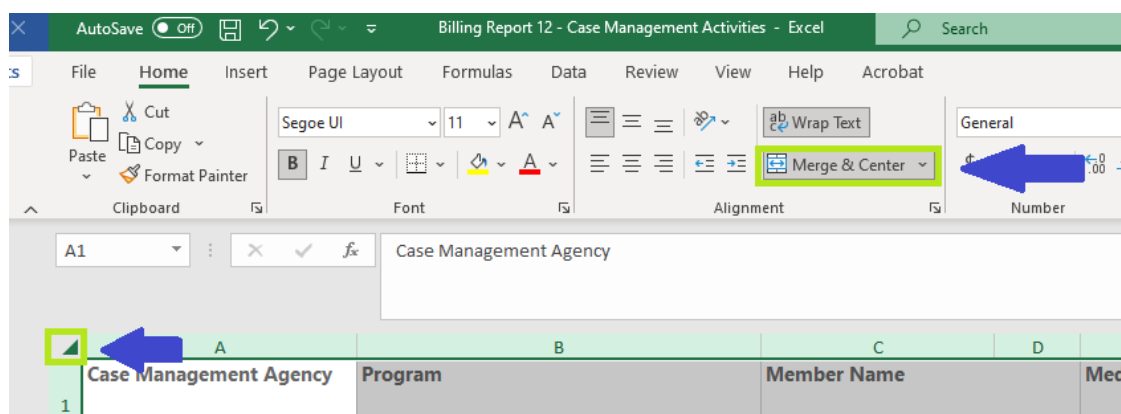
6. Once the file finishes downloading, the file will pop up at the bottom of your screen and within your downloads to open and use as needed.
7. Once you have exported the file to Excel, users may need to adjust the report in order to sort and filter and get to the data in the way that works best for 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 worksheet 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.

Contact Information

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

- Contract, Deliverable, Payment, Payment Corrections, and Payment Report Questions: Sarah.McDonnell@state.co.us
- Case Management Questions: hcpf_hcbs_casemanagement@state.co.us