2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Colorado Rocky Mountain Health Plans

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Welcome

Welcome to the Colorado Rocky Mountain Health Plans® care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites on the How to Contact Us section.

Click to access different manuals:

- **Administrative Guide – UHCprovider.com/guides**
  Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **Community Plan manuals – UHCprovider.com/guides**
  Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your State**

Easily find information in this manual using the following steps:

1. Select CTRL+F
2. Type in the key word
3. Press Enter

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services**.

Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using this manual

This provider manual is a resource of information designed to assist provider offices in successfully delivering health care services to patients covered by Rocky Mountain Health Plans (RMHP). This provider manual includes:

- Information about our products
- Credentialing and recredentialing guidance
- Member ID card samples
- Claim submissions/status
- Inquiry/explanation of the benefit review
- General claim-based questions
- Appeal submissions/updates
- Details on proper continuity of care for members
- Patient and provider rights and responsibilities
- An array of web-based tools

The information in this manual applies to all health plans offered by RMHP unless otherwise noted.

When we make changes to our procedures, we notify you by a special mailing or alerts on the portal located on our website.

This manual is not a contract. It is an extension of the participating provider's Agreement. This manual does not change the terms of any contract between RMHP and any participating provider. However, each participating provider agrees to comply with the policies and procedures in this manual as part of the participating provider's contract to provide services.

If there is a conflict between your Agreement and this care provider manual, use this manual, unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control. UnitedHealthcare reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

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Participation Agreement

Terms and definitions as used in this manual:

- “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- “You,” “your” or “care provider” refers to any health care provider subject to this manual. This includes physicians, clinicians, facilities and ancillary providers, except when indicated
- “RMHP” refers to Rocky Mountain Health Plans
- “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us
- “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to “ID card” includes a physical or digital card

Thank you for your participation in our program and the care you offer our members.

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Chapter 1: Introduction

Rocky Mountain Health Plans (RMHP) is Colorado-based and Colorado-focused. We were founded in Grand Junction more than 45 years ago to provide Coloradans access to high-quality health care. We continue this commitment and combine the personalized attention, quality care and comprehensive coverage that our members deserve and have come to expect from their local health insurance carrier.

RMHP is part of the UnitedHealthcare® family. The 2 organizations share a commitment to helping members live healthy. This relationship gives RMHP members access to national resources, such as a national provider network for Individual and Family Plan members and UnitedHealthcare's Medicare Part D prescription drug plans. The heart of our success lies with our commitment to that mission and our relationship with providers to provide that high standard of care. We make decisions based on the well-being of our members, and we honor the rights of physicians and patients in medical decision-making.

RMHP is dedicated to the good health of the communities we serve. We continue our commitment to doing the right thing and are deeply committed to our social responsibility and community involvement. We work diligently toward affecting change that results in positive health outcomes.

About our plans

RMHP proudly serves individual, family, Medicare and Health First Colorado (Colorado's Medicaid program) beneficiaries, and children covered by Colorado's Child Health Plan Plus (CHP+) program. RMHP is a qualified health plan with Connect for Health Colorado, the state's health insurance exchange.

Through contracts with participating providers, RMHP offers Individual and Family Plan health care plans to private individuals and families throughout Colorado. RMHP also contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage Plans and Dual Special Needs Plans (D-SNP). RMHP also manages plans in partnership with the Colorado Department of Health Care Policy and Financing (HCPF) to administer RMHP PRIME health care benefits to members in western Colorado counties. In addition, RMHP services as the Regional Accountable Entity (RAE) for Health First Colorado's Accountable Care Collaborative (ACC) in Region 1. RMHP also administers the CHP+ program in the Western Slope counties.

Our mission

With RMHP, your patients don't just get health insurance – they get more than a health plan. We offer:

- Supplemental coverage options
- Online tools and services to help make health care choices easier
- A care management team dedicated to members' good health
- A commitment to helping your patients navigate health care coverage decisions

Philosophy of care

RMHP believes in developing long-term partnerships in health care — with our members and our providers. We believe in:

- The physician-patient partnership and shared responsibility for decisions
- Providing appropriate levels of care for patients, whether preventive, inpatient or outpatient
- Holding health care providers accountable for the quality of their service
- Offering choices for obtaining services within our health plans
- Using providers who meet high standards of training and professional conduct
- Prevention as a key component of any health care program
- Access to affordable, comprehensive care for all Coloradans

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Because of Colorado's diverse nature, rural and urban issues affecting provider practice, patterns are considered. Care management is conducted with physician input on a local or regional basis.

Nondiscrimination in providing services

Providers shall not discriminate, with respect to the provision of medically necessary health care services, against any covered person who is a participant in a publicly financed program, including the limiting of hours of operation in a manner, which is less than is offered to members of nonpublicly financed programs.

Objections to providing services based on moral or religious grounds

RMHP does not have any moral or religious objections to contracted providers rendering medically necessary services. If you will not provide certain medically necessary services based on moral or religious grounds you must notify the member and RMHP. Our care management department will assist the member in finding a provider in our network that will provide the covered and medically necessary services.

Affirmative statement

RMHP encourages open communication between our providers and members in discussing appropriate treatment alternatives for medically necessary health care services, including medication treatment options, regardless of benefit coverage limitations. Contracted providers are not prohibited or discouraged from protesting or expressing disagreement with a medical decision, medical policy, or medical practice, including, without limitation, medication treatment options made by RMHP or an entity representing or working for RMHP (e.g. a utilization review company).

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Contact us

Topic	Contact	Information
RMHP Member Services	• Individual and Family Plans (IFP) **1-888-809-6539** • RMHP PRIME and RAE **1-800-421-6204** • CHP+ **1-877-668-5947** • D-SNP **1-800-701-9054** • Medicare **1-800-980-5195**	Individual and Family, RMHP PRIME and RAE, and CHP+ available Monday through Friday from 8 a.m.-5 p.m. Medicare available Monday through Friday from 8 a.m. to 8 p.m. April 1-September 30; 7 days a week from 8 a.m. to 8 p.m. October 1-March 31. Call for information about: • General claims • Prior authorization status • Eligibility, benefit and copay • Provider participation status • Remittance • Coordination of benefits
Behavioral Health	• RMHP MHSA **1-855-886-2832** • Facility admissions prior authorizations **1-855-886-2832**	Available any time.
Care Management	• Case management referrals **1-970-248-8718** or **1-800-793-1339** • Disease management referrals 1-888-847-6466	
Credentialing	**1-970-244-7798** or **1-888-286-3113**	For questions about credentialing, contact your provider relations representative.
Pharmacy (OptumRx®)	• CHP **1-877-305-8952** • D-SNP **1-877-889-6510** • IFP **1-844-569-4143** • Medicare **1-877-889-6510** • Prime/Rae **1-877-305-8952**	
Provider Services	• IFP **1-888-478-4760** • RMHP PRIME and RAE **1-800-421-6204** • CHP+ **1-877-668-5947** • Medicare **1-877-842-3210**	Available Monday through Friday from 8 a.m. to 5 p.m. Chat support is available 7 a.m.–7 p.m. CT, Monday–Friday on the **UnitedHealthcare Provider Portal**.

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2024 holiday calendar

RMHP offices will be closed on the following holidays:

- January 1 – New Year's Day
- January 15 – Martin Luther King, Jr. Day
- May 27 – Memorial Day
- July 4 – Independence Day
- September 2 – Labor Day
- November 28 and 29 – Thanksgiving Break
- December 25 – Christmas

Assistance for providers and sources of information

- **Member service representatives**
  RMHP Member Services representatives are highly knowledgeable about our operations and trained to provide assistance with claims status, payment explanations, eligibility, benefit and copay information, provider status, check amounts, remittance inquiries, and primary care provider (PCP) information.
- **Provider relations representatives**
  Provider relations representatives are responsible for educating providers about RMHP's philosophy, functions and requirements. Education comes in many forms, including virtual or onsite orientations, workshops, management seminars, office presentations and through information found in this provider manual, which is updated periodically throughout the year.
- **Join our network**
  For instructions on joining the UnitedHealthcare provider network, go to UHCprovider.com/join. There you will find guidance on our credentialing process, how to sign up for online tools and other helpful information.
- **Changes in physician status**
  Contact your provider relations representative immediately with the following information if there has been a change in the status of your practice.
  - Your address and/or telephone number have changed
  - You have added an additional practice location and/or phone number
  - Your federal tax identification number has changed
  - You are planning to leave your practice. RMHP requires a minimum of a 60-day advance notification of your intent to terminate your contract. This allows RMHP to notify members of your change in status.
  - You have changes in your physician group
  - You plan to close your practice to "new patients", as that term is defined in Colorado law, C.R.S. 25-37-101
- **Orientation in your office**
  An RMHP provider relations representative is available to assist you and your staff with RMHP procedures. If you need training assistance or would like to schedule a virtual or onsite office site visit, please call your provider relations representative.
  - Filing claims with RMHP
  - Contracts
  - Prior authorization process
  - Electronic claims submission
  - Website tools
- **UnitedHealthcare Provider Portal**
  This secure portal is available at UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such as submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

  Available benefit plan information varies for each of our UnitedHealthcare Provider Portal tools. Here are the most frequently used tools:
  - **Eligibility and benefits —** View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
  - **Claims —** Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
  - **Prior authorization and notification —** Submit notification and prior authorization requests. For more information, go to UHCprovider.com/paan.
  - **Specialty pharmacy transactions —** Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization drop-down in the UnitedHealthcare Provider Portal landing page.

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You will be directed to Prior Authorization and Notification capability to complete your requests.

- **My Practice Profile —** View and update your health care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mpp.
- **Document Library —** Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to [UHCprovider.com/documentlibrary.](UHCprovider.com/documentlibrary)
- **Paperless delivery options —** Eliminate paper mail correspondence. In Document Library, you can set up daily or weekly email notifications to alert you when we add new letters to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of correspondence. This tool is available to One Healthcare ID Primary Access Administrators only.
- **Chat support now available —** Have a question? Skip the phone and chat with a live service advocate when you **sign in** to the UnitedHealthcare Provider Portal. Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.

Service map

RMHP has covered Colorado — and only Colorado — for more than 40 years. We know what makes our state unique, including what our members need to remain healthy, happy and secure. We've helped Coloradans find plans that fit their Colorado lifestyle, and we've worked with amazing providers to help our members get the care they deserve. Following are our service areas by line of business so you better understand who we serve and in what parts of our beautiful state.

RMHP DualCare Plus service area

RMHP DualCare Plus current network counties include:

- Archuleta
- Delta
- Delores
- Eagle
- Garfield
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Mesa
- Mineral
- Moffat
- Montrose
- Montezuma
- Ouray
- Pitkin
- Rio Blanco
- Rio Grande
- Routt
- Saguache
- San Juan
- San Miguel
- Summit

RMHP Medicare Colorado service area

RMHP Medicare Advantage Plans current network counties include:

- Delta
- Delores
- Garfield
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Mesa
- Mineral
- Moffat
- Montrose
- Montezuma
- Ouray
- Pitkin
- Rio Blanco
- Rio Grande
- Routt
- Saguache
- San Juan
- San Miguel

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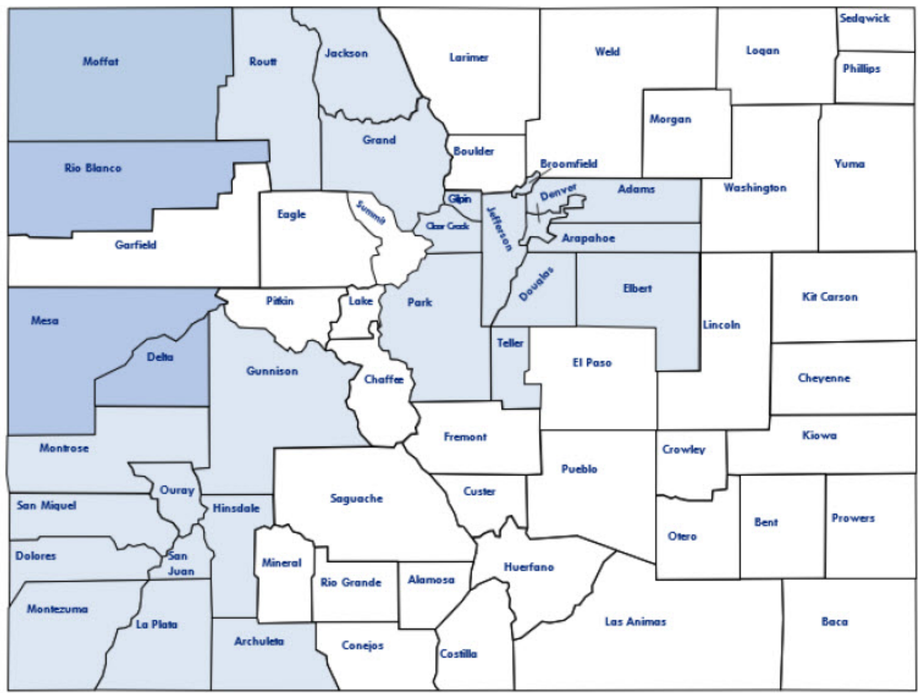
Monument Health HMO Network

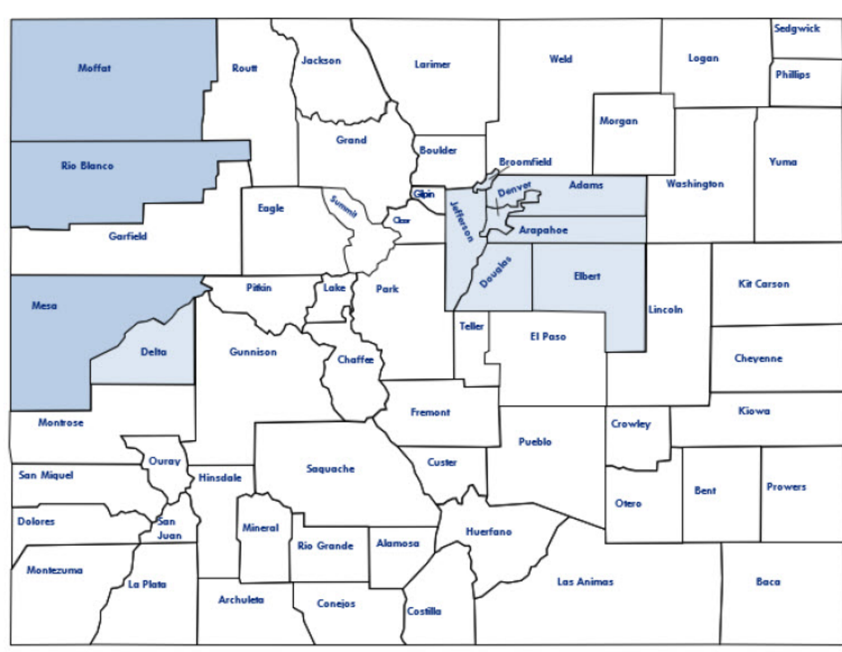


Available to Residents for Enrollment

Access to the RMHP Provider Network

Enrollment is not available, however, all RMHP participating physicians and facilities in these counties are in-network

Monument Health ONE Network Access



Available to Residents for Enrollment

Access to the RMHP Provider Network

Enrollment is not available, however, select provider access includes: University Hospital, Children's Hospital, and SCL Health providers and facilities

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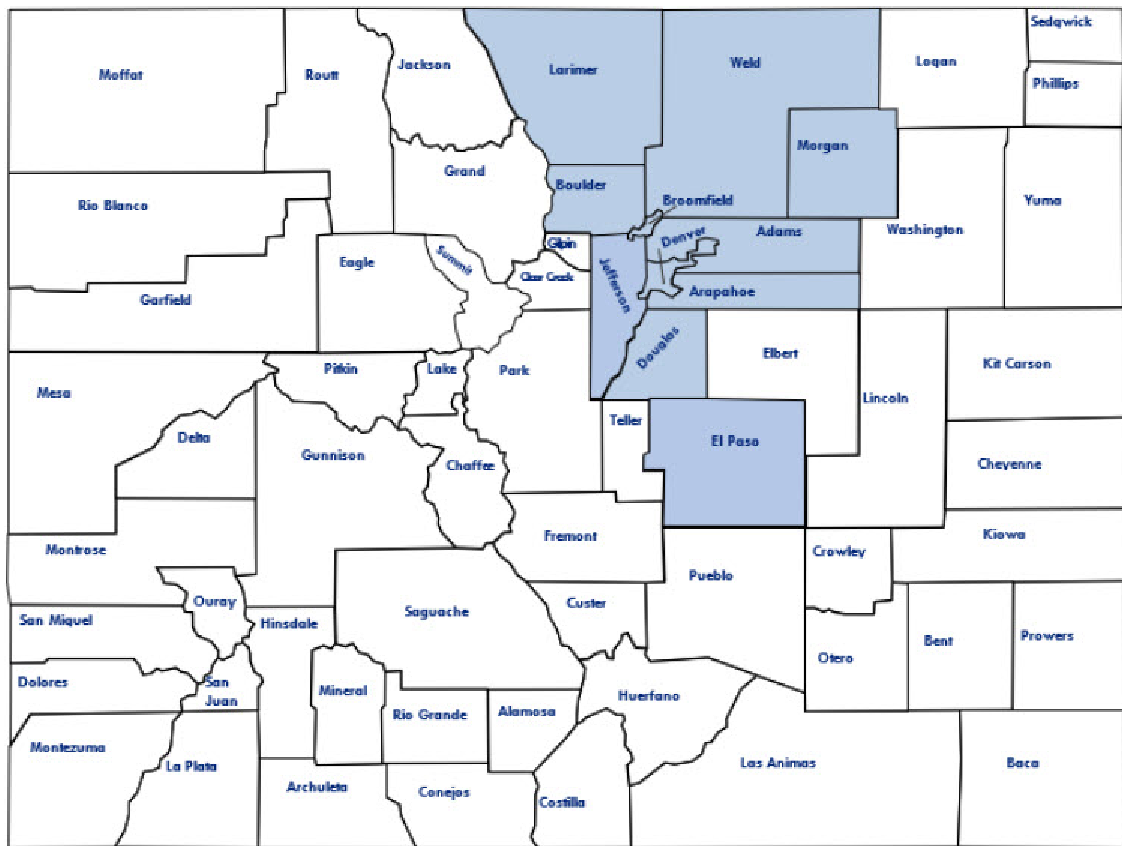
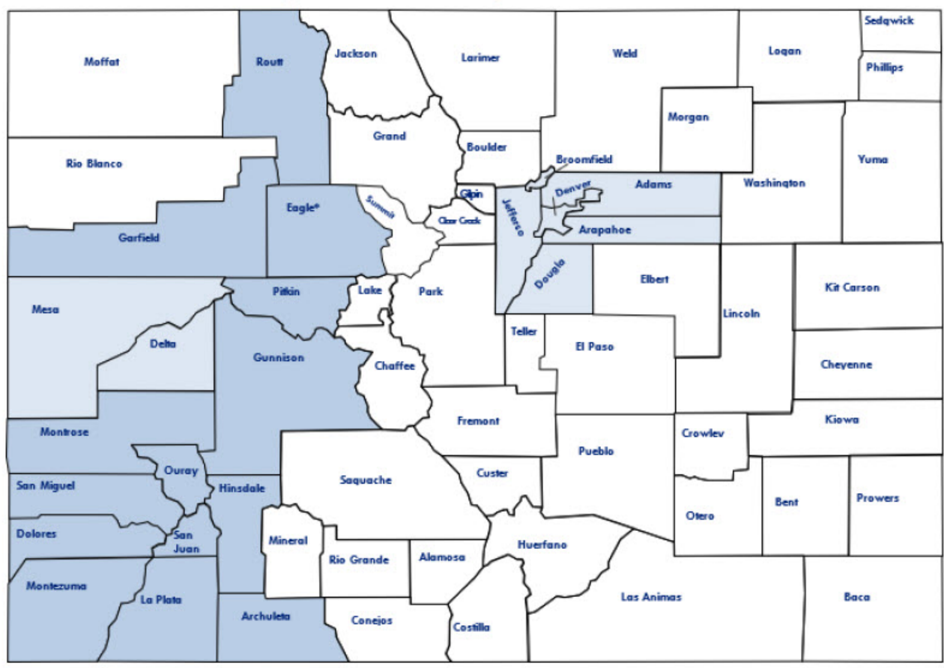
Colorado Doctors Plan



Available to Residents for Enrollment

Rocky Mountain Valley HMO Network Access



*Plans available in these Eagle County zip codes: 81621 and 81623

Available to Residents for Enrollment

Access to the RMHP Provider Network

Enrollment is not available, however, all RMHP participating physicians and facilities in these counties are in-network

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Rocky Mountain Sky HMO Network Access

*Plans available in these Eagle County zip codes: 80423, 80426, 80463, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658

Available to Residents for Enrollment

Access to the RMHP Provider Network

Enrollment is not available, however, select provider access includes: University Hospital, Children's Hospital, and SCL Health providers and facilities

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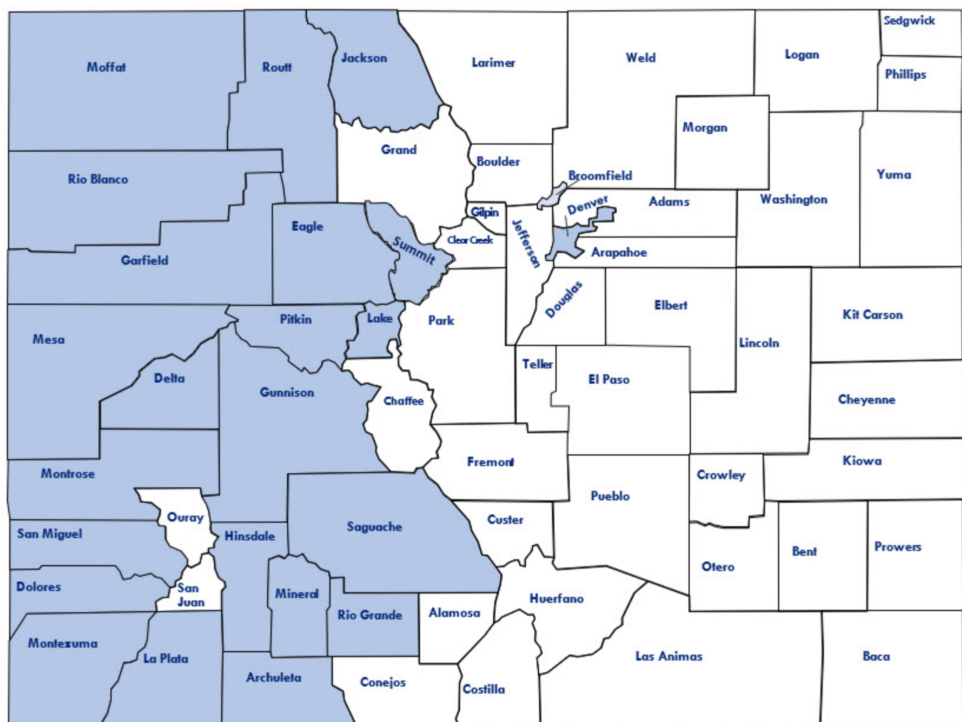
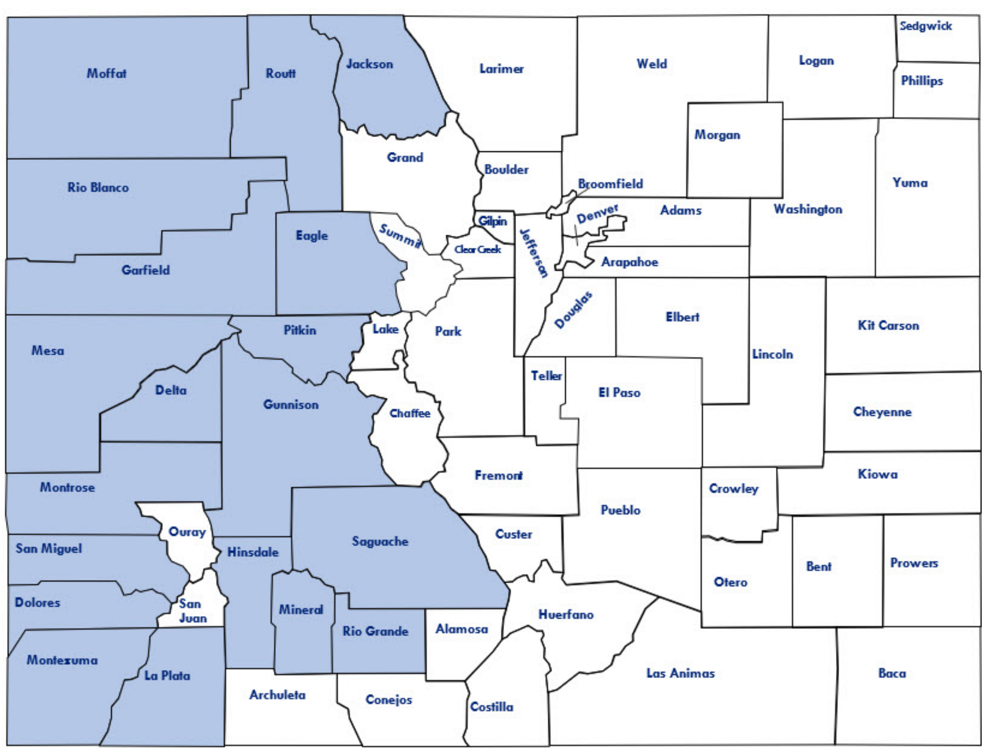
Dual Eligible Special Needs Plan



Medicare Advantage



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Access to care

Network of acute care hospitals, PCPs and specialists

RMHP contracts with all area providers who meet our credentialing guidelines, are willing to negotiate in good faith, and are willing to participate with RMHP under our general and customary contractual terms. There is no specific criteria for selection.

In establishing and maintaining our provider network, RMHP strives to provide care within a reasonable travel time and distance to members. To achieve this, RMHP contracts with all willing acute care hospitals, PCPs, specialists and sub-specialists in the service area who meet RMHP's credentialing and quality standards.

For those plans with a pharmacy benefit, OptumRx offers a network of participating pharmacies. Our policy is to offer contracts to any willing pharmacy provider who meets our licensure and credentialing standards, is willing to provide services to members at reasonable rates for the services provided and is willing to negotiate in good faith. OptumRx may also contract with mail-order pharmacies whenever access to service is limited or there is no physical location for members to access pharmacy services.

RMHP uses an "any willing provider" policy in establishing and maintaining our network.

RMHP maintains quality standards to identify, evaluate and remedy problems relating to access of care. Following are RMHP's targets (goals), for availability (provider/member ratios), geographic access and appointment availability standards; by network for each specific area served established by such agencies the DOI and/or HCPF, CMS and other accrediting agencies such as National Committee for Quality Assurance (NCQA). RMHP annually reviews access to care for our members, considering the relative availability of PCPs, specialists and sub-specialists, and acute care hospitals in the area based on location, number and types of providers, cost and suitability of care, and whether the provider meets RMHP's credentialing requirements.

An annual analysis is also performed on provider availability using geo analysis data. Provider-to-member ratios and time and distance Drive Band criteria are measured for all provider types and counties. The analysis is reviewed, and a corrective action plan established if inadequacies are identified. In addition, this organization assesses the cultural, ethnic, racial and linguistic characteristics of network practitioners to evaluate whether they meet members' needs.

RMHP educates members about how to access the care they need. Directions on how to obtain primary care, specialty care, after-hours and emergency care, and ancillary and hospital services is given in our provider directories and RMHP Member Handbooks.

Process for monitoring and assuring network sufficiency

In many communities, and particularly in rural areas, RMHP's philosophy is to contract with all available physicians, pharmacies, essential community providers and hospitals that meet RMHP's credentialing and quality standards. This inclusive concept results in high provider participation levels in most of RMHP's marketing area, thereby resulting in a large enough provider base to ensure accessibility and range of services for all our members. In areas where most available physicians, hospitals, pharmacies, essential community providers and ancillary providers who meet RMHP's credentialing and quality standards are not under contract, the number of such providers contracted in the area is based on membership size.

However, in all areas, RMHP maintains an appropriate number of providers to helps ensure accessibility and range of services. When feasible, contracts are negotiated with ancillary providers who have multiple statewide locations to help ensure coverage.

The need for additional access to physicians, ancillaries and facilities is based on the following factors:

- A specific need identified by RMHP's Quality Improvement Committee
- Requests from members
- Expansion of RMHP's service area
- When RMHP determines more providers are needed for providing enrolled members and projected enrollment with adequate access to care. If the enrolled membership size in an area is stable, providers leaving a specified panel will be replaced.

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Service coverage

RMHP highly encourages all providers to have the following service coverage standards to meet the needs of our members:

- Minimum hours of provider operation, including service coverage from 8 a.m.–5 p.m. Mountain Time, Monday through Friday
- Extended hours, outside the hours from 8 a.m.–5 p.m. on evenings and weekends and alternatives for emergency room visits for after-hours urgent care
- Evening and weekend support services for members and families shall include access to clinical staff, not just an answering service or referral service staff

County designations

CMS designates Colorado counties by type based on the county's population. This method is also used by the Department of Insurance (DOI) for Individual and Family Plans per Colorado Insurance Regulation 4-2-53.

Individual and Family Plan Network		
Classification	**County**	
Large Metro	Denver	
Metro	Adams Arapahoe Boulder Broomfield	Douglas El Paso Jefferson Larimer Weld
Micro	Eagle Garfield La Plata	Mesa Pueblo
Rural	Alamosa Chaffee Clear Creek Delta Elbert Fremont Gilpin Lake	Logan Montezuma Montrose Morgan Otero Pitkin Rio Grande Summit Teller

Individual and Family Plan Network		
Classification	**County**	
CEAC	Archuleta Baca Bent Cheyenne Conejos Costilla Crowley Custer Dolores Grand Gunnison Hinsdale Huerfano Jackson Kiowa Kit Carson	Las Animas Lincoln Mineral Moffat Ouray Park Phillips Prowers Rio Blanco Routt Saguache San Juan San Miguel Sedgwick Washington Yuma

PRIME, RAE and CHP+				
Classification	**County**	**Network**		
		Prime	RAE	CHP+
Rural	Larimer		X	
	Mesa	X	X	X
	Archuleta		X	X
	Delta	X	X	X
	Eagle		X	X
	Garfield	X	X	X
	Grand		X	X
	La Plata		X	X
	Lake			X
	Montezuma		X	X
	Montrose	X	X	X
	Ouray	X	X	X
	Pitkin	X	X	X
	Routt		X	X
	Summit		X	X
	Dolores		X	X
	Gunnison	X	X	X
	Hinsdale		X	X
	Jackson		X	X
Frontier	Moffat		X	X
	Rio Blanco	X	X	X
	San Juan		X	X
	San Miguel	X	X	X

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Availability standards

Individual and Family Plan Network			
Provider/Facility Type	**Large Metro**	**Metro**	**Micro**
Primary care	1:1,000	1:1,000	1:1,000
Pediatrics	1:1,000	1:1,000	1:1,000
OB/GYN	1:1,000	1:1,000	1:1,000
Mental health, behavioral health and substance use disorder care providers	1:1,000	1:1,000	1:1,000

PRIME, RAE and CHP+ Networks			
Provider/Facility Type	**Prime**	**RAE**	**CHP+**
Adult primary care	1:1,800	1:1,800	N/A
Mid-level adult primary care	1:1,200	1:1,200	N/A
Pediatric primary care	1:1,800	1:1,800	1:1,800
Specialists	1:1,800	N/A	1:1,800
Adult mental health	1:1,800	1:1,800	N/A
Pediatric mental health	1:1,800	1:1,800	1:1,800
Substance use disorder	1:1,800	1:1,800	1:1,800

Geographic access standards

Individual and Family Plan Network					
Specialty	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (miles)				
Primary care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - routine/ primary care	5	10	20	30	60
Allergy and immunology	15	30	60	75	110
Cardiothoracic surgery	15	40	75	90	130
Cardiovascular disease	10	20	35	60	85
Chiropractic	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/ Otolaryngology	15	30	60	75	110

Individual and Family Plan Network					
Specialty	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (miles)				
Gastro-enterology	10	30	45	60	100
General surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious diseases	15	40	75	90	130
Licensed clinical social worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological surgery	15	40	75	90	130
Oncology - medical, surgery	10	30	45	60	100
Oncology - radiation, oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine pediatric vision services	15	30	60	75	110
Orthopedic surgery	10	20	35	60	85
Physiatry, rehabilitative medicine	15	30	60	75	110
Plastic surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular surgery	15	40	75	90	130

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Individual and Family Plan Network					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum Distance (miles)				
Other medical provider	15	40	75	90	130
Dentist	15	30	60	75	110
Pharmacy	5	10	20	30	60
Acute inpatient hospital	10	30	60	60	100
Cardiac surgery program	15	40	120	120	140
Cardiac catheterization services	15	40	120	120	140
Critical care services	10	30	120	120	140
Outpatient dialysis	10	30	50	50	90
Surgical services (outpatient or ASC)	10	30	60	60	100
Skilled nursing facilities	10	30	60	60	85
Diagnostic radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical therapy	10	30	60	60	100
Occupational therapy	10	30	60	60	100
Speech therapy	10	30	60	60	100
Inpatient psychiatric facilities	15	45	75	75	140
Orthotics and prosthetics	15	30	120	120	140
Outpatient infusion/ chemotherapy	10	30	60	60	100
Other facilities	15	40	120	120	140

PRIME Network						
Specialty	Urban County		Rural County		Frontier County	
	Max Min.	Max Miles	Max Min.	Max Miles	Max Min.	Max Miles
Adult primary care	30	30	45	45	60	60
Pediatric primary care	30	30	45	45	60	60
Gynecology OB/GYN	30	30	45	45	60	60
Specialist (adult)	30	30	60	60	100	100
Specialist (pediatric)	30	30	60	60	100	100
Hospitals (acute care)	20	20	30	30	60	60
Pharmacy	10	10	30	30	60	60
Behavioral Health Network						
Hospitals (acute care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers - adult	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers - Pediatric	30	30	60	60	90	90
Mental health provider - adult	30	30	60	60	90	90
Mental health provider - pediatric	30	30	60	60	90	90
Substance use disorder provider - adult	30	30	60	60	90	90

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PRIME Network						
Specialty	**Urban County**		**Rural County**		**Frontier County**	
	Max Min.	**Max Miles**	**Max Min.**	**Max Miles**	**Max Min.**	**Max Miles**
Substance use disorder provider - pediatric	30	30	60	60	90	90

CHP+ Network						
Specialty	**Urban County**		**Rural County**		**Frontier County**	
	Max Min.	**Max Miles**	**Max Min.**	**Max Miles**	**Max Min.**	**Max Miles**
Pediatric primary care	30	30	45	45	60	60
Pediatric specialty care, including PT, OT, ST	30	30	45	45	100	100
Gynecology OB/GYN	30	30	45	45	60	60
Pharmacy	10	10	30	30	60	60
Hospital (acute care)	10	10	30	30	60	60
Behavioral Health Network						
Hospitals (Acute Care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers - adult	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers - pediatric	30	30	60	60	90	90
Substance use disorder provider - adult	30	30	60	60	90	90
Substance use disorder provider - pediatric	30	30	60	60	90	90

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Appointment availability

RMHP annually monitors to ensure primary care, specialty and behavioral health care practitioners meet the needs of our members based on internal/external Appointment Availability standards set forth by the Colorado Division of Insurance, NCQA, as well as governmental programs such agencies the DOI and/or HCPF, CMS and other accrediting agencies such as NCQA.

To do so, RMHP enlists the assistance from our members in the form of survey's which are distributed throughout all lines of business and plans. Each survey contains questions pertaining to time frames to be seen for particular service types. The returned data is then compiled into a quantitative/qualitative analysis, which is presented to RMHP's Network Advisory Committee.

Appointment standards

Individual and Family Plan Network

Service type	Standard	Time Frame Goal
Emergency care - medical, behavioral and substance use	24 hours a day, 7 days a week	Met 100% of the time
Urgent care - medical, behavioral and substance use	Within 24 hours	Met 100% of the time
Primary care - Routine and nonurgent symptoms	Within 7 calendar days	Met ≤90% of the time
Behavioral health, mental health and substance use disorder care - initial and follow-up appointments (routine, nonurgent, nonemergency)	Within 7 calendar days	Met ≤90% of the time
Prenatal care	Within 7 calendar days	Met ≤90% of the time
Primary care access to after-hours care	Office number answered 24 hours a day, 7 days a week by answering service or instructions on how to reach a physician	Met ≤90% of the time
Preventive visit/well visit	Within 30 calendar days	Met ≤90% of the time
Specialty care, nonurgent	Within 60 calendar days	Met ≤90% of the time

PRIME Network

Service type	Standard
Urgent care	Within 24 hours after initial identification of need
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization
Nonurgent, symptomatic care visit	Within 7 days after the request
Well care visit	Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the department's accepted EPSDT schedules
Behavioral Health	
Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility Urban, in person: within 1 hour of contact Rural and Frontier, in person: within 2 hours after contact
Nonurgent, symptomatic behavioral health services	Within 7 days after member's request * Provider shall not consider administrative intake appointments or group intake processes as a treatment.
* Provider shall not place members on waiting lists for initial routine service requests.	

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RAE Network	
Service type	**Standard**
Urgent care	Within 24 hours after initial identification of need
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization
Nonurgent, symptomatic care visit	Within 7 days after the request
Well care visit	Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the department's accepted EPSDT schedules
Behavioral Health	
Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility Urban, in person: within 1 hour of contact Rural and Frontier, in person: within 2 hours after contact
Nonurgent, symptomatic behavioral health services	Within 7 days after member's request * Provider shall not consider administrative intake appointments or group intake processes as a treatment.
* Provider shall not place members on waiting lists for initial routine service requests.	

CHP+ Network	
Service type	**Standard**
Urgently needed services	Within 24 hours of notification of the member's need for those services to the member's PCP
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization
Nonemergent, nonurgent medical	Within 30 calendar days * Does not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 calendar days
Nonurgent, symptomatic care	Within 7 calendar days of the member's request for services
Nonsymptomatic well care physical exams	Within 30 calendar days month after the request; unless appointment is required sooner to ensure the recommended screenings in accordance with the Academy of Pediatrics (AAP) accepted Bright Futures schedule
Behavioral Health	
Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility Urban, in person: within 1 hour of contact Rural and Frontier, in person: within 2 hours after contact
Nonurgent, symptomatic behavioral health services	Within 7 days after member's request *Provider shall not consider administrative intake appointments or group intake processes as a treatment. * Provider shall not place members on waiting lists for initial routine service requests

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Products and networks

RMHP has covered Colorado — and only Colorado — for more than 45 years. We know what makes our state unique, including what our members need to remain healthy, happy and secure. We continue to help Coloradans find plans that fit their Colorado lifestyle.

When you work with us, you are working with a Colorado company that understands the importance of promoting our local economy. When you, your staff or your patients call us with a question, someone who lives here and understands your needs answers.

Access to care

HMO Individual Plans, Medicare, RMHP PRIME, CHP+

For most care, members must receive covered services from participating providers. If a member is temporarily out of the service area and needs urgent or emergency care, they are able to see any provider. Members are also able to see nonparticipating providers within the RMHP service area for urgent and emergent services. In limited circumstances, RMHP will prior authorize services for nonparticipating providers when there is not a participating provider for the covered service. In these limited cases, members do not pay any more for these services than they would if they saw a participating provider for the same service. Participating providers are responsible for obtaining prior authorization for services.

Urgent and emergent, life and limb-threatening care is available, without prior authorization, for all members 24 hours a day, 7 days a week. Additionally, members may receive emergency services and urgently needed services while temporarily outside the service area. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services.

When possible, members should contact their PCP, who can provide guidance for the urgent care needs. Urgent care centers are available for members within certain communities.

Members may obtain emergency care by dialing 911 or going to the nearest hospital emergency room. Treatment of life- and limb-threatening emergencies is covered whether received from a participating or nonparticipating facility.

Types of products and programs

Individual and Family Plan products

RMHP markets a variety of benefit plans with varying levels of coverage and flexibility. Plans are marketed throughout Colorado and include many Individual and Family plan selections, including high-deductible health plans used with health savings accounts. United Medical Resources (UMR), a division of UnitedHealthcare, provides third-party administration to self-funded groups. Some of the self-funded groups use the RMHP Administrative Services Only (ASO) Network.

Government programs

Government program plans include RMHP PRIME, RAE, CHP+ and Medicare. RMHP works with various governmental agencies to assist beneficiaries of these plans.

Plan information and details

PCP selection
Members in a gated plan choose a network PCP at the time of the enrollment. If not, we assign one. Please visit UHCprovider.com for more information.

PCP referrals
No referrals from PCPs to participating specialists are required for any RMHP health plan unless the member is in a gated plan. In most cases, members pay a lower copayment for services obtained from a PCP type than for services obtained from a specialist.

Prior authorization
Obtaining prior authorization for certain services is the responsibility of the participating provider. The participating provider cannot bill the member for services requiring prior authorization if the provider

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failed to obtain such prior authorization from RMHP for those services. RMHP will periodically issue updated lists of covered services requiring prior authorization to participating providers. The provider may obtain a current prior authorization list at UHCprovider.com, or a provider may call Member Services at any time to check which services are on the list.

Covered services
Covered services, limited services and noncovered services (exclusions) may be identified by calling RMHP member service or logging into UHCprovider.com.

Individual plans

- **Colorado Doctors Plan**
  Offered in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Larimer, Jefferson and Weld counties
- **Monument Health HMO**
  Offered in Mesa, Delta, Rio Blanco and Moffat counties
- **Monument ONE**
  Offered in Mesa, Rio Blanco and Moffat counties
- **Rocky Mountain Valley**
  Offered in Archuleta, Dolores, Eagle (Basalt), Garfield, Gunnison, Hinsdale, La Plata, Montezuma, Montrose, Ouray, Routt, Pitkin, San Juan and San Miguel counties
- **Rocky Mountain Sky**
  Eagle (Basalt), Grand, Lake and Summit counties

Member eligibility

Providers must verify eligibility with each patient encounter. If a member requests services at your office but does not have their card, you should check the person's eligibility by checking UHCprovider.com, the Medicaid Provider Portal, or call Member Services to verify eligibility.

RMHP may not receive eligibility data before a member's effective date (i.e. newborn babies). No claims will be processed for these members until RMHP receives eligibility information.

Understanding ID cards

Pictured are sample membership ID cards for several plans offered by RMHP; this is not a complete depiction of all plans available through us. The ID card has key information the provider office needs to file a claim with RMHP and to collect copayment and deductible amounts from members, when applicable. This card includes the member number, PCP name (if the plan requires a PCP) and several copayment amounts.

- The plan description will always contain "HMO" if the plan is an Individual and Family Plan or CHP+
- The plan description will always contain "Medicare" if the plan is a Medicare plan
- The in-network deductible amount (if any) is always shown in the plan description
- If the plan has coinsurance after deductible, the RMHP in- and out-of-network coinsurance amount is shown at the end of the plan description

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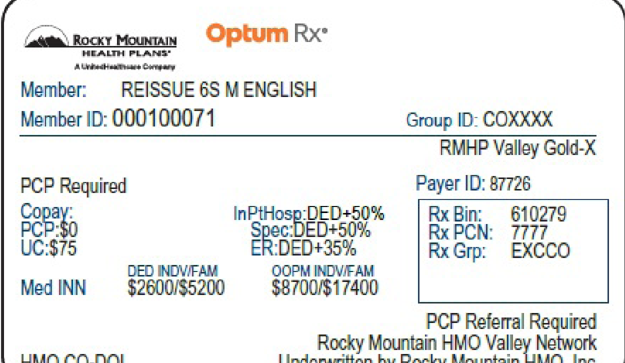

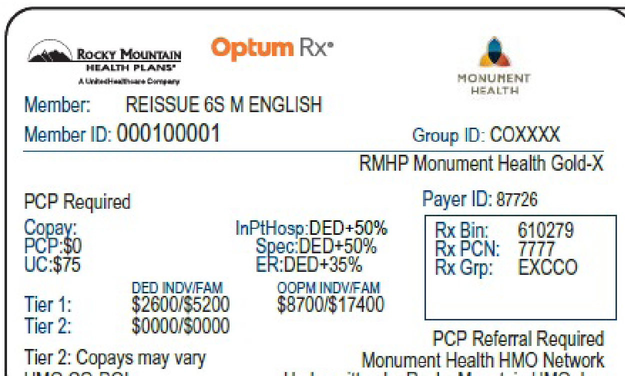

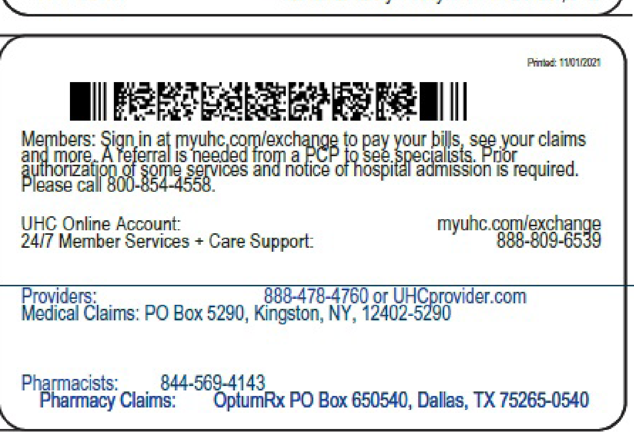

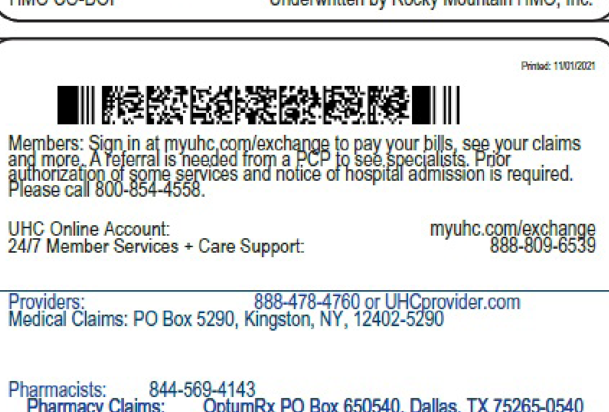

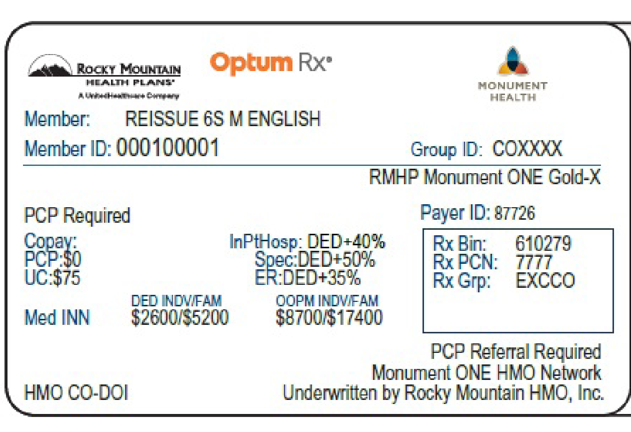

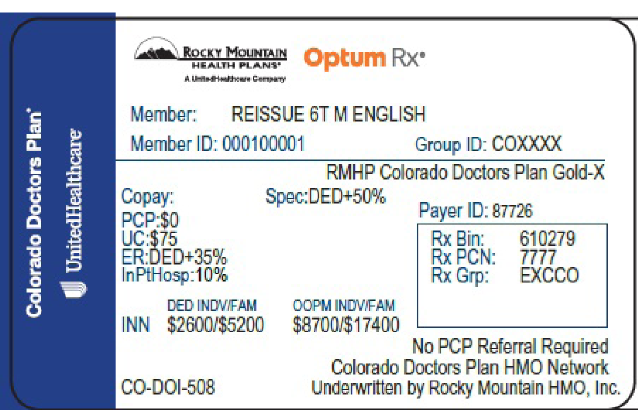

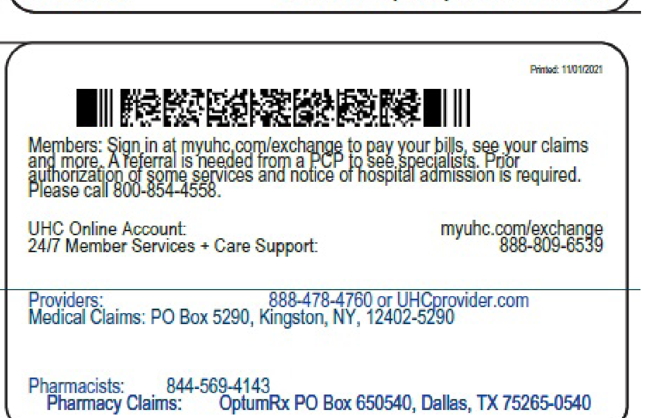

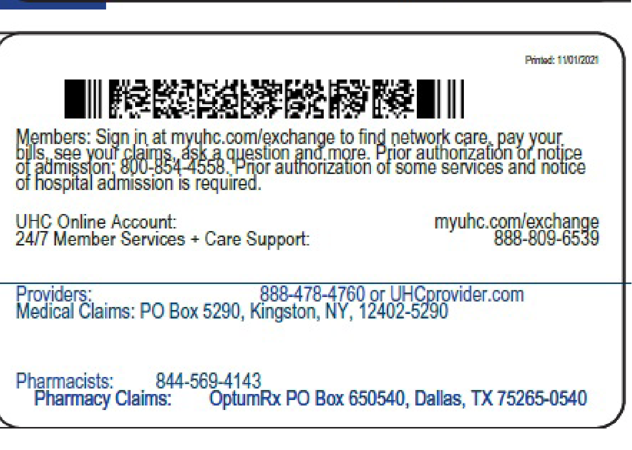

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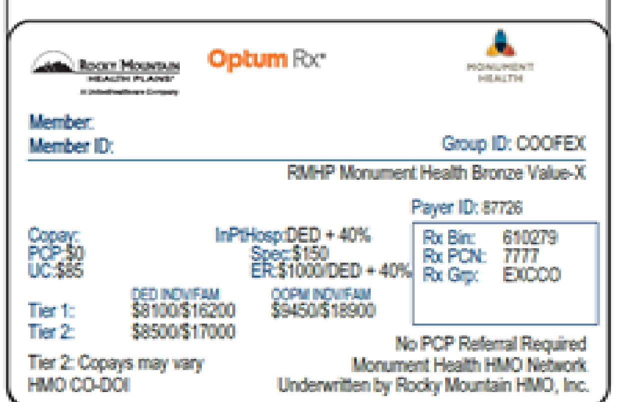

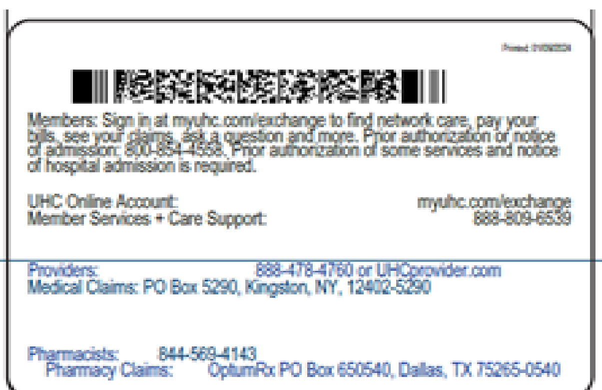

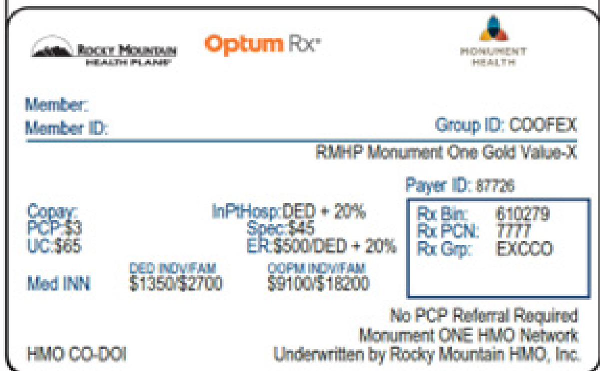

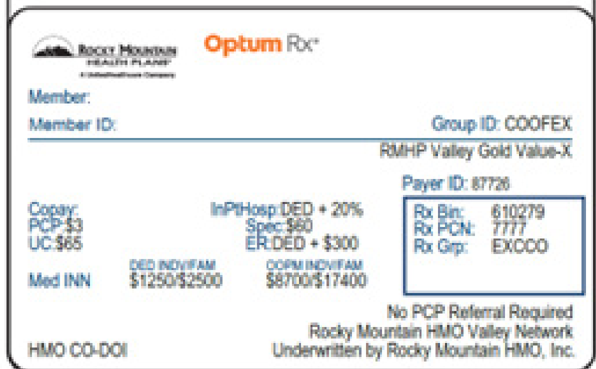

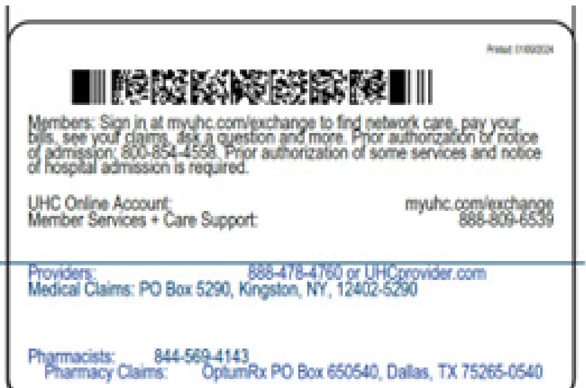

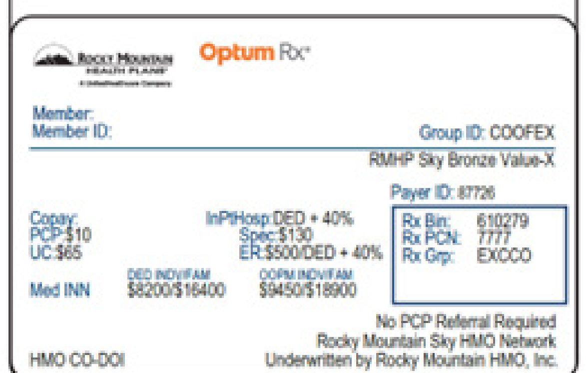

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Medicare and D-SNP plans

RMHP is a Medicare-approved Medicare Advantage plan and is authorized by CMS to process claims for most Part A and Part B covered services and Part D prescription drugs. RMHP Medicare and D-SNP members must use participating providers except for urgent/emergent care or when out-of-network services have been approved by the plan in advance.

D-SNP counties:

- Archuleta
- Delta
- Delores
- Eagle
- Garfield
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Mesa
- Mineral
- Moffat
- Montrose
- Montezuma
- Ouray
- Pitkin
- Rio Blanco
- Rio Grande
- Routt
- Saguache
- San Juan
- San Miguel
- Summit

Medicare Advantage counties:

- Delta
- Dolores
- Garfield
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Mesa
- Mineral
- Moffat
- Montrose
- Montezuma
- Ouray
- Pitkin
- Rio Blanco
- Rio Grande
- Routt
- Sagauche
- San Juan
- San Miguel

RMHP PRIME, RAE and CHP+ plans

RMHP works closely with the state of Colorado and with local private and government organizations to provide or coordinate the delivery of publicly funded Health First Colorado and CHP+ benefits.

RMHP PRIME counties
RMHP services RMHP PRIME members living in the following counties under its RMHP PRIME plan:

- Garfield
- Gunnison
- Mesa
- Montrose
- Pitkin
- Rio Blanco
- Ouray
- Delta
- San Miguel

RMHP PRIME member eligibility
All RMHP PRIME members receive a member identification card that clearly indicates that they are enrolled in RMHP PRIME. Members are advised to show this card to all health care providers when they receive services.

Please verify eligibility using the **department's eligibility system**. This system is updated frequently in real time and serves as the most accurate method for determining eligibility. Please retain all documents related to eligibility verification, as they will be required if a claim is denied and appealed. Please note if the department retroactively adjusts eligibility, claims payment may also be retracted if you are unable to demonstrate eligibility was verified at the time of service. Providers must use a member's

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Medicaid ID Letter followed by 6 digits to verify eligibility in the Medicaid Provider Portal.

Claims for a RMHP PRIME member who may be eligible for Medicare because of age or disability need to be billed to Medicare first. It is essential you call RMHP Member Services to verify eligibility before billing.

CHP+

CHP+ is public low-cost health insurance for certain pregnant members and children whose families earn too much to qualify for Health First Colorado (Colorado's Medicaid program) but not enough to pay for private health insurance. RMHP serves those members residing in Western Slope counties. Please refer to the CHP+ Service Area Map for a list of all CHP+ counties.

Eligibility is based primarily on age and income. Pregnant members and children are enrolled by applying at a local county office or application assistance site or online at **peak–coloradopeak.force.com**.

CHP+ counties

- Archuleta
- Delta
- Dolores
- Eagle
- Garfield
- Grand
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Lake
- Mesa
- Moffat
- Montezuma
- Montrose
- Ouray
- Pitkin
- Rio Blanco
- San Juan
- San Miguel
- Summit

Colorado's Accountable Care Collaborative program

The goal of the Accountable Care Collaborative (ACC) program is to improve health outcomes of members of Health First Colorado through a coordinated, member-/family-centered system that proactively addresses members' health needs. RMHP serves members in Western Colorado and Larimer counties.

RMHP coordinates care and partners with Health First Colorado to ensure access for the ACC members. Providers are to bill Health First Colorado for all Physical Health services rendered. You can verify eligibility through the Medicaid Provider Portal or by calling Provider Portal Member Services at 1-844-235-2387. Follow the prompts for verification of member eligibility. Additionally, members receive a letter from the department confirming their participation in the program.

ACC member physical health and some behavioral health claims must be billed to the state of Colorado Fee-for-Service program. Enrollee benefits and prior authorization requirements follow the department rules and processes. RMHP provides member service and care coordination for this member population. Behavioral health claims are billed to the RAE that a member is assigned.

ACC/RAE counties

- Archuleta
- Delta
- Dolores
- Eagle
- Garfield
- Grand
- Gunnison
- Hinsdale
- Jackson
- La Plata
- Larimer
- Mesa
- Moffat
- Montezuma
- Montrose
- Ouray
- Pitkin
- Rio Blanco

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- Routt
- San Juan
- San Miguel
- Summit

Cost-share collection

All members make their cost-sharing payments (deductibles, copays, and/or coinsurance) to the provider. Your office will be responsible for collecting any applicable cost-sharing at the time of service directly from all RMHP members.

Colorado law (C.R.S. 25.5-4-301(1)) states that no Medicaid member shall be liable for the cost–or the cost remaining after payment by Medicaid, Medicare or a private insurer–of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Medicaid has reimbursed the provider, whether claims are rejected or denied by Medicaid due to provider error, and whether or not the provider is enrolled in the Colorado Medical Assistance Program. This law applies even if a Medicaid member agrees to pay for part or all of a covered service.

For CHP+ members, this law is not fully applicable, as CHP+ members may have a copay or out-of-network liability for services that did not obtain a pre-authorization or for noncovered services.

RMHP CHP+ members

All RMHP CHP+ members will pay any applicable copayments directly to the provider at the time of service. As a provider, you can choose to waive copayments, but you cannot deny care if a member is unable to pay. The member may not be billed for any costs that are not covered by either RMHP or CHP+. The member should never pay more than their minimal CHP+ copay, if any. Please see the **RMHP CHP+ section** for additional information on RMHP CHP+, including copay summary.

Payment for services may be collected from or billed to a CHP+ member only if the specific service rendered is a noncovered service by the CHP+ benefit. In this situation, CHP+ requires that provider obtain a statement prior to service, signed by the CHP+ member, acknowledging that the specific services is not a CHP+-covered benefit and agreeing to pay.

Following federal rules, CHP+ members who are American Indians or Alaskan Natives do not have to pay any copays or cost-sharing. American Indians are members of a federally recognized Indian tribe, band or group, or a descendant in the first or second degree of any such member. Alaskan Natives are an Eskimo, Aleut or other Alaska Native enrolled by the Secretary of the Interior. In addition, prenatal members do not have a copay.

The standard CHP+ copayments range from $0 to $20 per visit. CHP+ program copayments are based on family size and income. There are no copayments for preventive visits. In addition, there are no copayments for family planning services or prenatal care services.

RMHP PRIME members

All RMHP PRIME members do not have a copay for medical/behavioral services. The member may not be billed for any costs that are not covered by either RMHP or Health First Colorado. Please see the RMHP PRIME section for additional information on RMHP PRIME.

Payment for services may be collected from or billed to a Medicaid member only if the specific service rendered is not covered by Medicaid. In this situation, the department requires that providers obtain a statement prior to service, signed by the Medicaid member, acknowledging that the specific service is not a Medicaid-covered benefit and agreeing to pay.

Statewide providers

Statewide providers for services such as oxygen and DME collect the copayment or deductible at the time of service. The member pays the provider any applicable copayment or deductible at the time of service. RMHP sends the member an Explanation of Benefits (EOB) that shows the portion of the bill that RMHP will pay and any amounts that are member responsibility.

Balance billing

The member may not be billed for any amount more than RMHP's allowed amount for services from participating providers. If a member has an IFP plan and chooses to receive services from a nonparticipating provider, the member is responsible for paying any amount billed by the provider that exceeds the RMHP allowed charges.

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Supplemental networks

Chiropractic coverage
Optum Physical Health manages plans that have Chiropractic benefits on behalf of Rocky Mountain Health Plans. Please visit **providerexpress.com** for more information.

Behavioral and/or mental health

- Effective Jan. 1, 2021, the Department of HCPF ensured a full continuum of Substance Use Disorder (SUD) benefits for Health First Colorado RAE and RAE PRIME members. Residential and inpatient SUD treatment and withdrawal management services were added to the SUD benefit.
- The treatment provider will conduct an assessment and determine the appropriate level of care for the member based on American Society of Addiction Medicine (ASAM) Criteria. The provider will then submit a request for prior authorization to RMHP. RMHP will review the recommendation for treatment and ensure that it is consistent with ASAM criteria.
- Services will be covered as long as they are medically necessary. Medical necessity will be based on the ASAM criteria. Length of stay will be determined by progress in treatment and continued medical necessity. There will be no limit on length of stay.
- Partial hospitalization will not be a covered service. Intensive outpatient is the Level 2 service covered by Medicaid
- If a member receives a denial of their prior authorization request for a level of treatment from RMHP, they have the right to appeal the decision. See Appeals and Grievance Processes – RAE, RMHP PRIME, CHP+
- Special Connections (a program for pregnant members on Colorado Medicaid who have alcohol and/or drug use problems) is part of the capitated behavioral health benefit managed by RMHP. The Office of Behavioral Health will continue to certify those programs.

Benefit exclusions

Contact Member Services for a complete list of exclusions per member's Evidence of Coverage.

Guidelines

- The diagnosis must be coded according to DSM IV guidelines and substantiated by the record
- Documentation in the patient record and interpretation of psychological testing when performed is required
- Office or hospital follow-up must be timely and documented appropriately
- After the second visit, the provider of psychological services must indicate in a written report to the PCP the diagnosis and treatment plan anticipated
- Periodic reports should be sent to the PCP as a courtesy and summarize the therapy that has been administered and indicating the diagnosis and treatment. See Appeals and Grievance Processes – RAE, PRIME, CHP+

Codes

The following list of codes is from Colorado Department of Health Care Policy and Financing website at **hcpf.colorado.gov/sbhs-billing-manual**. Please reference their website for the most up to date codes.

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SUD Residential Treatment – Clinically Managed Low-Intensity Residential Services: ASAM level 3.1	
CPT/HCPCS Procedure Code: H2036	Procedure code description: Alcohol and/or other drug treatment program, per diem
Service description: Structured alcohol and/or drug treatment program to provide therapy and treatment toward rehabilitation. A planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and/or drug addiction disorders.	**Minimum Documentation Requirements** Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing (HCPF) Service Content: Shift Notes or Daily Note (summary of shift notes) 1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status 2. Participating in treatment 3. Pertinent physical health status information 4. Progress toward treatment/service plan goals and/or discharge 5. Any other patient activities or patient general behaviors in milieu 6. The therapeutic intervention(s) used and the individual's response to the intervention(s) All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

SUD Residential Treatment – Clinically Managed Low-Intensity Residential Services: ASAM level 3.1	
Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.1 services are as follows: • First position: HF • Second position: U1 Special Connection services use an additional modifier • Third position: HD Room and board is billed separately to the Office of Behavioral Health or their designee	Example activities This per diem could include services such as: 1. SUD assessment 2. Individual and family therapy 3. Group therapy 4. Alcohol/drug screening counseling 5. Service planning 6. Discharge planning
Applicable population: • Child (0-11) • Adolescent (12-17) • Young adult (18-20) • Adult (21-64) • Geriatric (65+)	Unit: Day Duration: • Min: N/A • Max: 24 hours
Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.1 Specialty Provider Type (871) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: • HF (SUD) (First position) • U1 (Second position) For Special Connections ONLY: HD (Third position)
Place of service: RSATF (55)	

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SUD Residential Treatment – Clinically Managed Population - Specific High-Intensity Residential Services: ASAM level 3.3	
CPT/HCPCS Procedure Code: H2036	Procedure code description: Alcohol and/or other drug treatment program, per diem
Service description: Structured alcohol and/or drug treatment program specifically tailored to meet the needs of individuals who are unable to participate in other levels of care due to cognitive limitations. The recovery environment is combined with high-intensity clinical services in a manner that meets the functional limitations of the individual. If the limitation is temporary, the individual may be transferred to another level of care when they are no longer impaired. A planned program of professionally directed evaluation, care and treatment for persons with alcohol and/or drug addiction disorders.	**Minimum Documentation Requirements** Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF Service Content: Shift Notes or Daily Note (summary of shift notes) 1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status 2. Participating in treatment 3. Pertinent physical health status information 4. Progress toward treatment/service plan goals and/or discharge 5. Any other patient activities or patient general behaviors in milieu 6. The therapeutic intervention(s) used and the individual's response to the intervention(s) All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

SUD Residential Treatment – Clinically Managed Population - Specific High-Intensity Residential Services: ASAM level 3.3	
Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.3 services are as follows: • First position: HF • Second position: U3 Special Connection services use an additional modifier • Third position: HD Room and board is billed separately to the Office of Behavioral Health or their designee	Example activities This per diem could include services such as: 1. SUD assessment 2. Individual and family therapy 3. Group therapy 4. Alcohol/drug screening counseling 5. Service planning 6. Discharge planning
Applicable population: • Child (0-11) • Adolescent (12-17) • Young adult (18-20) • Adult (21-64) • Geriatric (65+)	Unit: Day Duration: • Min: N/A • Max: 24 hours
Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.3 Specialty Provider Type (872) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: • HF (SUD) (First position) • U3 (Second position) For Special Connections ONLY: HD (Third position)
Place of service: RSATF (55)	

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SUD Residential Treatment – Clinically Managed High-Intensity Residential Services: ASAM level 3.5	
CPT/HCPCS Procedure Code: H2036	Procedure code description: Alcohol and/or other drug treatment program, per diem
Service description: 24-hour supportive treatment environment to assist with the initiation or continuation of a patient's recovery process. Daily clinical services are provided as outlined in an individualized treatment plan to address the member's needs.	**Minimum Documentation Requirements** Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF Service Content: Shift Notes or Daily Note (summary of shift notes) 1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status 2. Participating in treatment 3. Pertinent physical health status information 4. Progress toward treatment/service plan goals and/or discharge 5. Any other patient activities or patient general behaviors in milieu 6. The therapeutic intervention(s) used and the individual's response to the intervention(s) All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

SUD Residential Treatment – Clinically Managed High-Intensity Residential Services: ASAM level 3.5	
Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.5 services are as follows: • First position: HF • Second position: U5 Special Connection services use an additional modifier • Third position: HD Room and board is billed separately to the Office of Behavioral Health or their designee	Example activities This per diem could include services such as: 1. SUD 2. Individual and family therapy 3. Group therapy 4. Alcohol/drug screening counseling 5. Occupational therapy 6. Recreational therapy 7. Vocational therapy 8. Service planning 9. Discharge planning
Applicable population: • Child (0-11) • Adolescent (12-17) • Young adult (18-20) • Adult (21-64) • Geriatric (65+)	Unit: Day Duration: • Min: N/A • Max: 24 hours
Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.5 Specialty Provider Type (873) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: • HF (SUD) (First position) • U5 (Second position) For Special Connections ONLY: HD (Third position)
Place of service: RSATF (55)	

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SUD Residential Treatment – Medically Monitored-Intensive Inpatient Services: ASAM level 3.7	
CPT/HCPCS Procedure Code: H2036 These services will also be billed using revenue code 1000 by hospitals (general or specialty).	Procedure code description: Alcohol and/or other drug treatment program, per diem
Service description: Inpatient services for patients whose medical, cognitive or psychiatric problems are so severe that they require inpatient care but do not require the full resources of an acute care general hospital. Services offered include physician monitoring, nursing care and observation. 24-hour professionally directed evaluation, care and treatment services are available.	**Minimum Documentation Requirements** Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF Service Content: Shift Notes or Daily Note (summary of shift notes) 1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status 2. Participating in treatment 3. Pertinent physical health status information 4. Progress toward treatment/service plan goals and/or discharge 5. Any other patient activities or patient general behaviors in milieu 6. The therapeutic intervention(s) used and the individual's response to the intervention(s) All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

SUD Residential Treatment – Medically Monitored-Intensive Inpatient Services: ASAM level 3.7	
Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.5 services are as follows: • First position: HF • Second position: U7 Special Connection services use an additional modifier • Third position: HD Room and board is billed separately to the Office of Behavioral Health or their designee	Example activities This per diem could include services such as: 1. SUD assessment 2. Individual and family therapy 3. Group therapy 4. Alcohol/drug screening counseling 5. Occupational therapy 6. Recreational therapy 7. Vocational therapy 8. Service planning 9. Discharge planning 10. Medical or nursing services
Applicable population: • Child (0-11) • Adolescent (12-17) • Young adult (18-20) • Adult (21-64) • Geriatric (65+)	Unit: Day Duration: • Min: N/A • Max: 24 hours
Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.7 Specialty Provider Type (874) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: • HF (SUD) (First position) • U7 (Second position) For Special Connections ONLY: HD (Third position)
Place of service: • RSATF (55) • Inpt Hosp (21) • Inpt PF (51)	

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SUD Residential Treatment – Clinically Managed Residential Withdrawal Management: ASAM level 3.2WM (Formerly referred to as Social Detox)	
CPT/HCPCS Procedure Code: H0010	Alcohol and/or drug services, acute detoxification (residential addiction program inpatient)
Service description: An organized clinical service that provides 24-hour structure, support and supervision for patients who are intoxicated or experiencing withdrawal symptoms. Services are supervised by a qualified medical professional who must be available by telephone or in person 24 hours per day.	**Minimum Documentation Requirements** Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF Service Content: Shift Notes or Daily Note (summary of shift notes) 1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status 2. Participating in treatment 3. Pertinent physical health status information 4. Progress toward treatment/service plan goals and/or discharge 5. Any other patient activities or patient general behaviors in milieu 6. The therapeutic intervention(s) used and the individual's response to the intervention(s) All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

SUD Residential Treatment – Clinically Managed Residential Withdrawal Management: ASAM level 3.2WM (Formerly referred to as Social Detox)	
Notes: Procedure code H0010 should be used with the HF modifier. First position: HF Room and board is billed separately to the Office of Behavioral Health or their designee.	Example activities This per diem could include services such as: 1. SUD assessment 2. Physical examination 3. Individual and group therapy 4. Peer recovery support services 5. Medical and nursing care, including daily medical evaluation 6. Medication management and administration 7. Health education 8. Service planning 9. Discharge planning
Applicable population: • Child (0-11) • Adolescent (12-17) • Young adult (18-20) • Adult (21-64) • Geriatric (65+)	Unit: Day Duration: • Min: N/A • Max: 24 hours
Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid as under the 3.2WM Specialty Provider Type (875) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: HF (SUD) (First position)
Place of service: • CMHC (53) • Outp Hospital (22) • Independent Clinic (49)	

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<table>
<tr><th colspan="2">SUD Residential Treatment – Medically Monitored Inpatient Withdrawal Management: ASAM level 3.7WM</th></tr>
<tr><td>CPT/HCPCS Procedure Code: H0011

These services will be billed as revenue code 1002 by hospitals (general or specialty).</td><td>Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)</td></tr>
<tr><td>Service description: Inpatient care in which services are delivered by medical and nursing staff to address a patient's withdrawal from substances. 24-hour observation, monitoring and treatment are available.</td><td>Minimum Documentation Requirements

Technical Documentation Requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF

Service Content: Shift Notes or Daily Note (summary of shift notes)
1. Patient's current clinical status, e.g. symptoms or pertinent mental status and functioning status
2. Participating in treatment
3. Pertinent physical health status information
4. Progress toward treatment/service plan goals and/or discharge
5. Any other patient activities or patient general behaviors in milieu
6. The therapeutic intervention(s) used and the individual's response to the intervention(s)

All individual and group services, provided by residential staff, e.g. skills training group, individual therapy, med administration services should be identified separately. These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.</td></tr>
</table>

<table>
<tr><th colspan="2">SUD Residential Treatment – Medically Monitored Inpatient Withdrawal Management: ASAM level 3.7WM</th></tr>
<tr><td>Notes: Procedure code H0011 should be used with the HF modifier.

First position: HF

Room and board is billed separately to the Office of Behavioral Health or their designee</td><td>Example activities

This per diem could include services such as:
1. SUD assessment
2. Physical examination
3. Individual and group therapy
4. Peer recovery support services
5. Medical and nursing care, including daily medical evaluation
6. Medication management and administration
7. Health education
8. Service planning
9. Discharge planning</td></tr>
<tr><td>Applicable population:
• Child (0-11)
• Adolescent (12-17)
• Young adult (18-20)
• Adult (21-64)
• Geriatric (65+)</td><td>Unit: Day

Duration:
• Min: N/A
• Max: 24 hours</td></tr>
<tr><td>Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid as under the 3.7WM Specialty Provider Type (876) and SUD Clinic Provider Type (64) or as a hospital (general or specialty). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.</td><td>Program service categories: HF (SUD) (First position)</td></tr>
<tr><td>Place of service:
• RSATF (55)
• Inpt Hospital (21)
• Inpt PF (51)</td><td></td></tr>
</table>

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Physical, occupational and speech therapy

RMHP Individual and Family Plan PT/OT/ST

Services are limited to 20 visits per calendar year. A request for authorization is needed for members to receive PT, OT or ST beyond 20 units.

Medicare and D-SNP PT/OT/ST

Benefits are payable according to CMS guidelines.

RMHP PRIME PT/OT/ST

Services are limited to 48 units annually. A request for authorization is needed for RMHP PRIME members to receive PT, OT, or ST beyond 48 units (1 unit equals 15 minutes) as determined by RMHP and specified on the RMHP Prior Authorization List.

CHP+ PT/OT/ST

Services are limited to 30 visits per calendar year per diagnoses, beginning with the date of the first treatment. For children ages 0-3, the benefit is unlimited through the Early Services Prevention program, to those members who qualify for the program.

Home health services

Individual and Family Plan/Medicare/CHP+

Depending on a member's plan, intermittent skilled home health care may be a benefit. A patient may receive the services of a skilled nurse; a certified aide or a medical social worker; as well as physical, occupational, pulmonary and/or speech therapy in their place of residence. Custodial (nonskilled nursing) care and homemaking services are not a RMHP benefit. Medicare members must meet certain homebound requirements.

Examples of home health services benefits include but are not limited to:

- Teaching the self-administration of injectable or IV medications
- Assessment and monitoring of unstable medical conditions
- Tracheotomy care and teaching
- Diabetic care and teaching
- Newborn assessment and postpartum care and teaching
- Teaching complex wound care and management
- Ostomy training
- Teaching self-catheterization
- Skilled services to avoid hospital or SNF admission
- Teaching safe provision of skilled services to an able and willing caregiver
- Provision of skilled services in the absence of a willing or able caregiver
- Provision of skilled services to ensure safety of the member in the home
- Rehabilitative services to achieve maximum functional capacity in the home

Patients may be referred directly to a contracted home health agency in the member's area. Home care agencies must have specific doctor orders to initiate care and establish an ongoing home care plan. Please refer to the Provider Directory online at UHCprovider.com for the most current listing of RMHP participating home health agencies.

After receiving an authorization for home health services, the home care agency will contact RMHP for appropriate prior authorization and approval of home visits.

RMHP PRIME – What is covered?

RMHP PRIME home health services are covered without prior authorization.

Home health services are limited to 60 days per episode per contract year for acute skilled home health care. (An episode is an incident or event that stands out from the continuity of everyday life, such as an episode of illness or a traumatic event). Short-term nursing home stays at a skilled nursing facility are not a benefit.

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Skilled home health services are intermittent services from nurse/pulmonary therapist/PT/OT/ST/HHA/MSW /dietitian – done to avoid placing the member at risk for medical complications.

When is it covered?

- There is an unexpected onset of an illness or condition or an exacerbation of a chronic condition
- The member is expected to make significant improvement in 60 days
- When there is a physician order for the service
- When the services are reasonable and necessary
- When the member resides in the home and agrees to the plan of care

How long is it covered?

- The maximum length of time is up to 60 days
- Home health is covered for up to 60 days OR until the member ceases to make significant improvement
- Home health services after 60 consecutive days are not covered services but are available to members under FFS and require prior authorization. If home health services after 60 consecutive days are anticipated, at least 30 days prior to the 60th day of home health services, the home health services provider should coordinate prior authorization with the single entry point agency for adult members and with the Medicaid fiscal agent for children.

What is the required documentation?

To obtain prior authorization you will need to submit physician orders for all services. The services must be reasonable and medically necessary.

To continue or extend the date of service up to the 60-day limit you may be asked to provide documentation demonstrating significant improvement.

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Chapter 2: Claims

Forms and filing requirements

Claim forms

Providers are responsible for submitting claims to UnitedHealthcare for payment. Please call Provider Relations if you have questions or need assistance with billing. UnitedHealthcare encourages providers to submit claims electronically. UnitedHealthcare works with multiple clearinghouses that will transmit your claims electronically. For more information, please refer to our website at **UHCprovider.com**.

If claims are submitted on paper, they must be submitted on a CMS 1500 or UB-04/CMS 1450. If your claims are prepared by a computerized billing service, be sure the staff is familiar with and understands UnitedHealthcare claim submission requirements.

Mail claims to:

UnitedHealthcare Individual and Family Plans
P.O. Box 5290
Kingston, NY 12402-5290

UnitedHealthcare® Medicare Advantage
P.O. Box 31362
Salt Lake City, UT 84131-0362

UnitedHealthcare D-SNP
UnitedHealthcare Community Health
UnitedHealthcare Regional Accountable Entities (RAE)
UnitedHealthcare PRIME
P.O. Box 5260
Kingston, NY 12402-5260

Claim filing requirements

How to file a claim

All participating providers must submit claims in accordance with their contractual requirements. Please refer to the Medicare section of the Provider Manual for information specific to the claims filing process for Medicare Part A and Medicare Part B claims.

Clean claims shall be submitted in the appropriate format (electronic or paper) as required, must utilize the appropriate form (the American Dental Association Dental Claim Form, the CMS 1500 Form, or the CMS 1450 (UB-04) Form) or electronic equivalent and shall include all essential fields necessary for the carrier to determine its liability and resolve the claim. In the case of a dispute over the status of a claim as clean or unclean, the Division shall make the final determination as to what fields are essential.

If the required filing information is not submitted, it may delay the processing of the claim. Please be aware that even when you submit a completed claim form, RMHP may request additional information consistent with Colorado Division of Insurance Regulation 4-2-24.

Payment and reimbursement policies

Payment and reimbursement policies are managed by UnitedHealthcare in conjunction with Colorado laws, regulations and contractual requirements. They can be found at **UHCprovider.com/en/policies-protocols.html**.

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Electronic submission

Visit **UHCprovider.com** for information on submitting claims using electronic data interchange (EDI). You should use the EDI payer ID 87726 for all plan types.

Advantages of transmitting claims electronically:

- Improve cash flow by reducing the time it takes to receive payment in comparison with paper claims
- Reduces postage costs as well as costs of claim forms, printing and staff expenses
- User-friendly and easier than using paper claims
- Transmission report confirms your claim was received
- If rejected, the report provides information about how to correct the claim for resubmission

Hospital/OB claims

Please bill obstetric claims for all RMHP members (with the exception of PRIME) as 2 separate claims: the member's claim(s), and the baby's claim(s). Please bill the member and baby on the same claim for PRIME only.

We will adjudicate both claims under the member's member ID number. If the member is discharged, and the baby remains an inpatient, submit a new claim for the baby's entire stay under the baby's member number. The admission date on the baby's claim should be the baby's date of birth.

Lab charges – billing guidelines

Only physicians whose contractual agreement allow may bill for limited laboratory tests performed in their offices. All other lab tests must be performed at a contracting reference lab.

The RMHP in-office lab fee schedule is used to determine reimbursement for physicians who perform limited lab work in their offices. The in-office lab must be CLIA-certified and the certification number and the test level for which you are certified (e.g. waiver, moderate, high), should be submitted to the RMHP Provider Relations department. If you have questions, please call your provider relations representative.

See CLIA Regulations for additional information or visit their website at **fda.gov/medical-devices/ivd-regulatory-assistance/clinical-laboratory-improvement-amendments-clia**.

Payments for medical services

RMHP contracting providers will accept the amount of reimbursement agreed to in the contract for each procedure or service as full payment. The RMHP member cannot be billed for the difference, if any, between the billed amount and the amount allowed. The provider may bill the RMHP member for noncovered services or specialty services such as personal convenience items. Payment for services may be collected from or billed to RMHP PRIME member only if the specific service rendered is not covered by Medicaid. In this situation, the department requires that providers obtain a statement prior to service, signed by the Medicaid member, acknowledging that the specific service is not a Medicaid-covered benefit and agreeing to pay.

Payment errors

Duplicate payments and/or payment errors should be reported to Member Services immediately, at **UHCprovider.com**. It is the policy of RMHP to retract credited amounts from the provider remittance.

Provider remittance

Electronic funds transfer registration

Payments are administered through Optum Pay®. To learn more about Optum Pay visit **Providerexpress.com** > About Us > Navigating Optum > Billing and Claims > Get Paid Faster

Please Note: Individuals who are dually eligible for both Medicare and RMHP PRIME coverage with RMHP will report 2 individual claims — Medicare and RMHP PRIME. RMHP PRIME claims for Medicare denied, non -covered or exhausted benefits are not considered Medicare crossover claims and must be filed within 120 days of the date of service or 60 days after the Medicare denial.

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In some instances, there may be enrollees with dual coverage under RMHP PRIME and an Individual and Family Plan plan. Those claims will also be coordinated and be reported as 2 claims.

Claims in process report

In compliance with CRS 10-16-106.5, RMHP will request additional information prior to immediately denying certain claims, offering the office or facility the opportunity to supply the documentation needed to process such claims. This is how the process works:

- The Claims in Process report is marked by a header giving you specific instructions regarding the claims within that section
- The report lists claims that require immediate action on your part to complete the claim. You are instructed on what to send for the claim to process. Some examples of the documentation that might be requested include copies of invoices, chart notes and itemizations.

You will have 30 days to fax or mail the requested documentation to RMHP. If the requested documentation is not received, the claim will deny. A sample fax form can be found online at UHCprovider.com.

Please send only the documentation specifically requested. If you need clarification, please call Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP. HIPAA regulations direct carriers and providers to exchange only the specific information needed to process the claim. In other words, please do not copy all notes in a patient's chart if we only ask for notes for 1 date of service.

Surgery guidelines

Following clinical edits, RMHP will reimburse for bilateral or multiple surgical procedures.

Bilateral procedures will be reimbursed 100% of allowable for the first procedure and 50% for the second procedure.

Multiple procedures will be reimbursed at 100% of the allowable for the procedure deemed primary and 50% for each subsequent procedure. The primary procedure will be automatically ranked by RMHP as the procedure with the highest allowable, regardless of the order in which the procedures are submitted.

Bill your usual fee for each procedure and RMHP will make the reduction.

For Medicare members, RMHP will follow Medicare guidelines to determine if a surgical assist is allowed. For all other members, RMHP will follow guidelines within the clinical editing program. These are based on a combination of Medicare guidelines and recommendations by the American College of Surgeons.

Physician and nonphysician surgical assistants will be reimbursed at a percentage of the allowable of the primary surgeon as indicated in your contract.

Nonphysician surgical assistants will be reimbursed at 12% of the surgeon's allowable.

Nonphysician surgical assistants must be participating, credentialed providers with RMHP. It is the surgeon's responsibility to arrange for a participating surgical assistant. In most cases, no more than 1 surgical assistant will be reimbursed per surgical session.

RMHP will not reimburse for the services provided to a Medicare or Medicare/Medicaid member by a surgical assistant who is not enrolled in Medicare.

RMHP will not reimburse nonphysician surgical assistants for RMHP PRIME members with the exception of nurse midwives who assist with a Cesarean section delivery.

Spanning year end

Claims that span the calendar year should be split accordingly. Please do not submit a claim that includes both December and January dates-of-service. Claims for RMHP PRIME members must be split per the RMHP PRIME benefit year, which begins on July 1. Do not include June and July dates of service on 1 claim.

Timely filing limit

RMHP requires providers to submit claims within 120 days of the date of service (or as otherwise indicated in your contract). We recommend you submit claims as close to the date of service as possible to help ensure you receive prompt payment. The member cannot be billed for claims denied for being out of the timely filing limit.

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RMHP PRIME timely filing limit

Based on RMHP's PRIME contract with the department, the following claim submission deadlines now apply:

- Standard RMHP PRIME claims – 120 days
- Third-party primary payment – 60 days from date of third-party payment/denial, including Medicare
- If a member's eligibility is backdated, timely filing is 120 days from the date the enrollee is added to the eligibility system. Eligibility must be verified using the department's website. A letter from the county Department of Human Services or Single Entry Point verifying backdating must accompany the claim.

Claim corrections

Late charges

If you submit a claim to RMHP for correction, complete a Claims Action Request form and attach it to the corrected claim. If you are submitting only late charges and are within the timely filing period, you can submit the charges as a new claim. If you are correcting a paid claim and submitting late charges, complete the Claims Action Request form and attach it to the claim.

Electronic process for claim correction

- Submit corrected claims electronically as an EDI 837 transaction with the appropriate frequency code. For more details, go to UHCprovider.com/ediclaimtips > Corrected Claims.
- Use the claims tool in the UnitedHealthcare Provider Portal to resubmit corrected claims that have been paid or denied
- If you received a letter asking for additional information, submit it using the Claims tool in the UnitedHealthcare Provider Portal
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim
- When correcting or submitting late charges on a 1500 professional claim, use the following frequency code in Box 22 and use left justified to enter the code. Include the 12-digit original claim number under the Original Reference Number in this box.
  - Frequency code 7 Replacement of Prior Claim: Corrects a previously submitted claim
  - Frequency code 8 Void/Cancel of Prior Claim: Indicates this bill is an exact duplicate of an incorrect bill previously submitted. This code will void the original submitted claims.

Refunding RMHPs

Please report and return to RMHP any funds received, retained, or derived from payments to which you are not entitled no later than 60 days after the overpayment is identified. The report to RMHP must include a written statement of the reason for the overpayment.

When refunding RMHP for claims overpayments, please submit the full overpayment stated on the Account Balance section of your voucher or in the Refund Request letter. RMHP does not accept partial refunds. When sending a refund check, please attach the voucher or letter that relates to the refund. If you have questions regarding the refund amount please call RMHP Member Services, and a representative will assist you.

Request for reconsideration

Request for reconsideration is the first level in the inquiry process. Claims at this level may be corrected by providing additional information. The following examples are adjudicating codes that may be reconsidered and are not an all-inclusive list.

There are other denials that fall into the Request for reconsideration category. An RMHP Member Services representative can tell you if your denial is a candidate for reconsideration at this level. If you prefer to send your request for reconsideration in writing, please use the request form located at **UHCprovider.com**.

Claims involving other insurance

Coordination of benefits

Sometimes an RMHP member may have other insurance coverage. Regarding coordination of benefits (COB),

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examples include a group policy through their spouse's employer. Examples for third-party liability (TPL) include on-the-job injuries that may be covered by workers' compensation, and auto-related injuries covered by automobile insurance. The RMHP COB and TPL teams can help you file claims properly if more than 1 insurance carrier is involved.

Double coverage

If the payment amounts made by RMHP are more than they should have been after applying COB, RMHP may recover the excess from:

- 1 or of more of the person it has paid or for whom it has paid or
- Any other person or organization that may be responsible for the benefits or services provided for the member

The payment amounts made includes the reasonable cash value of any benefits provided in the form of services. If RMHP has been determined to be the secondary plan but pays on behalf of a member benefits that should have been paid by the member's primary plan, the member becomes responsible to submit to RMHP requested documents that will enable RMHP to obtain reimbursement from the primary plan.

As secondary, RMHP is responsible for coinsurance and deductible. All other out-of-pocket expenses or ineligible charges may be the member's responsibility. Secondary claims should be submitted by paper with a copy of the primary payer's voucher. Timely filling for secondary claims is 120 days from the printed date on the primary payer's voucher. When primary insurance denies as not a benefit or benefits have reached the maximum benefit limit, RMHP becomes primary and applies prior authorization requirements. In the instances you are required to bill Medicare primary, the timely limit for secondary claim submission to RMHP is 1 year from the date of the EOMB.

Injuries – auto-related

RMHP will coordinate benefits against any "medical payments" and uninsured/underinsured coverage that may be available to our members for claims sustained as a result of an automobile accident. With respect to "medical payments" coverage, RMHP will pay benefits only after such coverage has been exhausted. If no coverage is available through our members' own automobile insurance, and if "no-fault" insurance is also unavailable, ("No-fault" insurance could be available to a RMHP member injured out of state.) RMHP will generally be primary, not secondary. For all automobile accident-related claims, RMHP requires automobile insurance and accident information from our members.

Injuries – on-the-job

Colorado employers must provide workers' compensation coverage. RMHP cannot consider claims for services related to on-the-job illness or injuries. This includes aggravation of existing conditions as a result of working, unless they are denied by workers' compensation. If you have any doubt about whether the claim may be work -related, please notify our TPL team so additional research can be performed.

Injury – other accidents

All claims for injury-related accidents/diagnoses (e.g. broken bones, lacerations, back pain) must include information concerning other insurance, if available. Note on the claim when, where, and how the injury occurred. If no accident is involved, simply specify "NO ACCIDENT."

Occasionally there may be a lawsuit filed in these cases resulting in a member being compensated for their injuries and being reimbursed for medical expenses. If you are aware the member has contacted an attorney and plans to file suit, please notify RMHP so we can contact the insurance company and the attorneys involved as soon as possible. A sample of the Injury Information Form is available at UHCprovider.com.

Other coverage

Please notify RMHP if you are aware of any other health insurance for the member. This information should be included on the claim(s). However, if it comes to your attention after the claim has been filed, please call RMHP Member Services. The primary insurance must be billed first. Once you receive payment and EOB from the primary carrier, you may bill RMHP. Include a copy of the EOB with your claim(s).

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Chapter 3: Appeals and grievances

Individual and Family Plans

All IFP appeals must be submitted in writing unless urgent by using any of the following methods:

- Member Portal
- Phone (urgent only): **1-888-478-4760**
- Fax (standard): 1-888-404-0949
- Fax (urgent): 1-888-808-9123
- Mail: P.O. Box 6111
  MS CA-0197
  Cypress, CA 90630

For additional appeals information, please refer to UHCprovider.com.

PRIME, RAE and CHP+

RMHP RAE, PRIME and CHP+ members have many rights. Providers should be aware of these rights as members may ask for your assistance in exercising some of them. Members have the right to complain about RMHP. They have the right to complain about provider care. The member or a designated client representative (DCR) may complain about anything the member is unhappy about or has a problem with. A DCR is someone (including a provider) the member chooses to help them with an appeal or a grievance.

The member must sign a form to give their DCR permission to act on their behalf. The form must have the DCR's name, address, and telephone number. If the complaint is about medical care, the DCR will have access to the member's medical records and specific details about the member's medical care. The member has the right to "Appeal a Decision." This means the member can ask for a review of something RMHP has done. Decisions are just those things listed in Section A. The member has the right to "File a Grievance." This means the member can complain about any matter other than a decision (see Section A). Grievances are the kinds of things listed in Section B.

If a member needs help filing an appeal or grievance, they can also call the Managed Care Ombudsman at 1-877-HELP-123 (1-877-435-7123), TTY users call 711. The member can email them at **help123@maximus.com**.

RMHP RAE, PRIME, and CHP+ members have the right to file a complaint about access to behavioral health care. The member's health plan is subject to the Mental Health Parity Addiction Equity Act of 2008. This means that the member's covered behavioral health benefits cannot be more difficult to access than physical health benefits. A denial, restriction, or withholding of behavioral health services could be a potential violation of the parity act. To file a complaint with the Behavioral Health Ombudsman Office of Colorado with a parity concern, please contact Behavioral Health Ombudsman Office of Colorado:

- Phone – 1-303-866-2789
- Email – **ombuds@bhoco.org**
- Online – **behavioralhealthombudsman.colorado.gov**

In addition to filing an appeal or grievance with RMHP, the member may file for a state fair hearing/state review with the state of Colorado. The state fair hearing/state review process is described in Section C.

Section A. Appeal a decision

RMHP may do something ("make a decision") that the member is not happy with. The member or the DCR may ask for an appeal. An appeal is a review of an RMHP decision. For example, the doctor may order a medication or service that RMHP must okay. If it is approved, the member will receive what the doctor ordered. If RMHP does not approve the request, then the request by the doctor has been denied by RMHP. The decision RMHP made is to deny the request.

Once RMHP has made a decision, the member always has the right to appeal. This means the member asks that RMHP take a second look. These are the decisions that a member may appeal:

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- RMHP denies services the doctor requested
- RMHP denies payment for services received
- RMHP shortens or ends a service we had agreed to provide the member
- RMHP does not provide services in a timely way
- RMHP does not act within the amount of time it say it will. This includes answering appeals, grievances, and fast reviews in the number of days listed.
- RMHP denies certain services if the member lives in a rural area. This means the rights a member has to use a provider, even if the provider is not in RMHP's network when the member lives in a rural area.

There are 2 types of reviews that can happen: first level review and expedited review.

First level review

The member or DCR must call or write to complain within 60 calendar days of the day RMHP notifies the member about the decision RMHP has made. If the member would like RMHP to assist them in filing the appeal, the member can call Member Services.

Expedited (fast or quick) review

Expedited or fast/quick appeals are used when RMHP's decision puts the member health in danger. The member or DCR can ask for an expedited or fast appeal. RMHP must complete the fast/quick appeal review within 72 hours of the request. Because of this short time frame, it is recommended that all medical records and any other pertinent information be provided to RMHP with the request for the expedited appeal.

State fair hearing/state review

The member may not like the decision RMHP makes about their appeal, therefore the member has the right to ask for a state fair hearing about their appeal. The member or DCR cannot ask for the state fair hearing/ state review before RMHP makes a decision. A state fair hearing/state review must be requested within 120 calendar days of the date of RMHP's final decision.

Continuing the member's benefits (only applicable to PRIME and RAE members)

For any type of an appeal, the member may still receive services when the member asks the plan to take a second look at a decision. The same is true when the member has asked for a state fair hearing, (see section C). To receive continued benefits while the appeal is being reviewed, the following must occur:

- The appeal must involve termination, suspension or reduction of a previously approved course of treatment
- The original approval must not have expired. This does not apply to when a member asks for a state fair hearing
- The member or the DCR must tell RMHP if they want to keep getting already covered services within 10 calendar days of the notice of the adverse decision letter. Providers may not ask to have benefits continued while the appeal is being reviewed.
- An RMHP provider must have ordered the services. The member or DCR must tell RMHP if they want to keep getting services within 10 days of the notice of the appeal decision. Providers may not ask to have benefits continued while the state fair hearing is being reviewed.
- If the member loses the appeal, the member will have to pay for the care they received

To get more information about grievances, appeals, or any other subject, the member should call RMHP member service.

Section B. File a grievance

The member may have a problem or be unhappy with RMHP and/or the care they receive about something other than a decision (see Section A). To complain about something other than a decision, the member or DCR may "file a grievance." This means a complaint is sent to RMHP. Please advise the member to call RMHP if they wish to lodge a complaint. RMHP can help the member file a grievance.

A grievance is a verbal or written statement that says the member is unhappy. The member will not lose their coverage because of the complaint. The member will be treated the same as any other member. All grievances must be in writing and may be filed using any of the following methods:

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- Member Portal
- Fax: 1-888-404-0949
- Mail: P.O. Box 6111
  MS CA-0197
  Cypress, CA 90630

Here are some things a member can complain about:

- The member is unhappy with their doctor, clinic, or any RMHP provider
- The member cannot find a doctor or get in to see their doctor
- The member has a problem with RMHP Member Services
- The member is unhappy with how their doctor took care of them
- The member feels they have been treated in a different way by RMHP or one of its providers. This could be because of race, color, national origin, disability, sex, sexual orientation or gender identity.
- The member is unhappy because a provider or RMHP employee was rude to them

How grievances are handled

The member or DCR may call or write to file the grievance at any time. There is no deadline to file a grievance. In 2 working days, RMHP will notify the member in writing acknowledging RMHP received the member's grievance. RMHP will review the grievance and send a response within 15 working days of the day the grievance was received. RMHP may respond to the grievance sooner than 2 working days. If this happens, the member will not receive a separate letter telling them that RMHP received the grievance.

If the response is not satisfactory, the member or DCR may call or write the health plan manager at:

Colorado Department of Health Care Policy and Financing Health First Colorado Managed Care
Contract Manager
1570 Grant Street
Denver, CO 80203

The member may also call 1-303-866-4623 or send an email to HCPF.MCOS@state.co.us. The department will inform the member they received the member's request. The department will look into the complaint and send the member a response.

Section C. State fair hearing/ state review

A state fair hearing/state review is a chance for the member to make a case to a judge that a denied service should have been approved, or that a denied claim should have been paid. The member must wait for an answer to an appeal from RMHP before they file. To file a state fair hearing/state review the member, provider or DCR must:

- Write a request for a hearing within 120 calendar days from the date of RMHP's final decision
- If needed, RMHP Member Services of the Office of Administrative Courts will be able to provide assistance to the member in writing the request for the hearing. Include the member's name, address, and the Health First Colorado ID in the request for a hearing.
- Write what RMHP did or did not do that has caused the problem with the care
- Explain in writing what actions should be taken to solve the problem

The request for a hearing should be mailed or faxed to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Phone: 1-303-866-2000 or 1-303-866-5909

The member, provider or DCR may file for a state fair hearing on the member's behalf. The provider of DCR must have the member's written permission to file. If the state fair hearing is lost, the member may have to pay for the care received while the appeal is pending.

The member has the right to:

- Represent themselves at the state fair hearing
- Choose someone to represent them at the state fair hearing
- Present information or evidence to the administrative judge during the hearing
- Read or examine all RMHP documents related to the appeal before and during the hearing

For help from RMHP in writing and submitting a request for a state fair hearing, members should call RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP.

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Representatives filing appeals for enrollees – Medicare

Individuals who represent enrollees may either be appointed or authorized (for purposes of this manual [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as "representatives"). An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney or any physician) to act as their representative and file an appeal on their behalf. Also, a representative (surrogate) may be authorized by the court or act in accordance with state law to file an appeal for an enrollee. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has durable power of attorney, a health care proxy or a person designated under a health care consent statute.

To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment (including attorneys) must sign, date and complete a representative form (for purposes of this section, "representative form" means a Form CMS-1696 Appointment of Representative or other conforming instrument). Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate is not required to produce a representative form. Instead, they must produce other appropriate legal papers supporting their status as the enrollee's authorized representative.

Either the signed representative form for a representative appointed by an enrollee, or other appropriate legal papers supporting an authorized representative's status, must be included with each appeal. Regarding a representative appointed by an enrollee, unless revoked, an appointment is considered valid for 1 year from the date the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of the appeal. A photocopy of the signed representative form must be submitted with future appeals on behalf of the enrollee to continue representation. However, the photocopied form is only good for 1 year after the date of the enrollee's signature.

Any appeal received with a photocopied representative from more than 1 year old is invalid to appoint that person as a representative and a new form must be executed by the enrollee. Please note that the OMB-approved Form CMS-1696, Appointment of Representative (AOR) form, contains the necessary elements and conforms to the Privacy Act requirements, and is preferred. The prior versions of Form CMS-1696 are obsolete. However, if another representative form is used, it must contain at least the applicable elements included in the AOR form.

Notification of hospital discharge appeal rights

Consistent with 42 CFR 422.620 and 422.622, Medicare enrollees who are hospital inpatients have a statutory right to appeal to a Quality Improvement Organization (QIO) for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary. RMHP contracting hospitals must notify a Medicare enrollee (or their representative) about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) to explain the enrollee's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the enrollee (or representative) and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible but not more than 2 calendar days before discharge. Please note a new OMB-approved form must be used. The most current forms are available at **cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices**.

Notice of Medicare Non-Coverage

RMHP members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with the decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. The member must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 calendar days in advance of the services ending. The facility is responsible for delivering the NOMNC on behalf of RMHP to all Medicare members no later than 2 days before their covered services end. All members must receive a NOMNC, even if they agree services should end.

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RMHP providers must use the Office of Management and Budget (OMB)-approved standardized notice which can be found by visiting CMS.gov. Under Medicare – General Information select Beneficiary Notices Initiative (BNI). Scroll down to Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123). Links include forms and form instructions. If you have any questions or concerns accessing the correct form, please contact RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP.

Provider appeal

A provider appeal is a request for a review of an administrative payment or other dispute between a participating provider or carrier.

Examples of provider appeals: (Please note this is not an exclusive list.)

- Timely filing denials
- No prior authorization
- Clinical edits
- No admission notification
- Denied inpatient days
- COB/Third-party liability

How to request a provider appeal

Pursuant to Colorado Division of Insurance regulation 4-2-23, any request for a provider appeal must begin with a written request from the provider. Providers can submit their appeal electronically using the claims tool in the UnitedHealthcare Provider Portal.

The request should contain the necessary information located on the form to process the appeal. Necessary information consists of the following:

- Each applicable date of service
- Subscriber or member name
- Subscriber or member ID number
- Provider name
- Provider tax ID number
- Dollar amount in dispute
- Statement explaining the nature of the dispute
- Supporting documentation where necessary, e.g. medical records, proof of timely filing

Any request received from the provider that is not a written request will be returned to the provider with a request to complete the Provider Dispute Resolution form.

A provider cannot request a provider appeal for a claim that has not been processed by RMHP yet. If a provider appeal is received for a claim that has not been processed, the claim will be sent for processing. The provider may request an appeal once the claim as processed and the provider has received a denial.

Provider notification

Provider appeals shall make a determination of a provider dispute resolution request within 30 calendar days of receipt of all necessary information. If all necessary information is not received the provider dispute coordinator will send a written request for the necessary information. RMHP will allow 30 days from the date of the request to receive the requested information. If the provider does not respond within the 30-day time frame, RMHP will close the request without further review. Reconsideration of the closed provider dispute resolution must begin with a new request by the provider.

In the event the determination is not in favor of the provider, written notification will be sent to the provider. The notification shall include the principal reasons for the determination.

In the event the determination is favorable to the provider, the claim will be reprocessed. The provider voucher will serve as notification to the provider the decision was overturned.

Filing an appeal – Individual and Family Plan, Medicaid, Medicare and CHP+ members

Appeals must be received within 180 days from the date of the original remittance advice, or such other time frame as indicated in your provider contract.

If the disagreement concerns claims related to coordination of benefits with federally funded health benefit plans, including Medicare, the notice of disagreement and the adjustment of the claim shall be made within 36 months from the date of service.

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Levels of appeal

First level – informal review
Upon receipt of a written request for review research is done based on the type of dispute. After review a decision is made utilizing the expertise of appropriate personnel as needed. If the claim is overturned the claim will be sent for payment or adjustment. Notification of a decision to overturn a previous denial will be sent to the provider in the form of a provider voucher. If the decision is not overturned a letter of determination will be sent to the provider.

Second level – review appeal
The request for a second level appeal must be received within 30 days from the date of the denial letter. Additional information must be submitted with the request for a second level appeal in order for the second level appeal to be considered. If additional information is not received with the request the appeal will not be reviewed. A letter will be sent to the provider.

Arbitration

Arbitration is provided for in the provider contracts as the mandatory dispute resolution process. Arbitration is the final step of RMHP mandatory dispute process. The request for arbitration must begin with a written request from the provider.

Face-to-face

If a provider requests to present their rationale for the dispute resolution in person, the provider must contact the provider dispute resolution coordinator to initiate the process. The provider dispute resolution coordinator will coordinate with the Provider Relations department manager and based on the nature of the appeal, the appropriate departments and representatives will be selected to participate in the dispute process.

Medicare plan members

The following is a summary of RMHP member appeals procedures.

General information on Medicare appeals procedures

RMHP members have the right to appeal any decision that is an organization determination. An organization determination is a decision by RMHP with respect to:

- Payment for emergency services or urgent care services
- Payment for any health services furnished by a nonparticipating provider that the member believes are covered under Medicare and should have been arranged for, furnished, or reimbursed by RMHP
- Services the member has not received but which the member feels RMHP is responsible to pay for or arrange
- Discontinuation of a service the member believes is still medically necessary

Members can ask for an appeal or can name someone to do it for them (appointed representative). The appointed representative can be a relative, friend, advocate, doctor or someone else.

Members have the right to appeal if RMHP fails to approve, furnish, arrange for or provide payment for services in the time frames allowed or to provide notice in the following time frames discussed of the decision to approve, furnish, arrange, continue or pay for such services such that a delay would adversely affect the member's health. Upon request, members have a right to access their case file as part of the appeals process.

Important–Regardless of who should pay a Part A or Part B claim, if a member has received services through the RMHP contracted network, out-of-network at the direction/authorization of RMHP, through a referral by a network provider, or because of an emergency or urgently needed care, appeals concerning a denial of payment of such services are processed by RMHP.

If a member or an appointed representative asks for an expedited appeal or supports the member in asking for one, RMHP will automatically make a decision on the appeal on an expedited/72-hour basis. If an expedited appeal is requested without support from a physician, RMHP will decide if the member's health condition requires the plan to make a decision on the appeal on an expedited basis. If RMHP does not give an expedited appeal, RMHP will give the member prompt verbal notice followed by written confirmation within 3 calendar days that the appeal will be decided within the time frame for a standard appeal (30 calendar days).

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To request an appeal: the member, any physician or the member's appointed representative may call, write or fax.

Medicare Advantage
Attn: Member Appeals Department
P.O. Box 6111
MS CA 124-0157
Cypress, CA. 90630-0016

Phone – **1-877-842-3210**

Fax (standard) - 1-888-517-7113

Fax (urgent) - 1-866-373-1081

D-SNP
Attn: Member Appeals Department
P.O. Box 6103
MS CA 124-0187
Cypress, CA. 90630-0023

Phone – **1-800-701-9054**

Fax – 1-844-226-0356

Medicare

Medicare Part A and B charges

Participating providers should bill RMHP for Part A and B services, with certain exceptions, so we can pay all the benefits for which the member is entitled, including any additional benefits not covered by Medicare.

ABN vs. organization determination

Per the May 5, 2014, CMS memo titled "Improper Use of Advance Notices of Noncoverage," the Advanced Beneficiary Notice of Noncoverage (ABN) is intended for use only for beneficiaries covered under Medicare. The ABN is not appropriate for use by RMHP providers with respect to our members and should not be used under any circumstances.

In the event that a RMHP provider intends to provide services that are known to be noncoverable by Medicare, or if there is any question whether or not RMHP will cover an item or service, the RMHP provider must request a pre-service organization determination.

If coverage is denied, RMHP must provide the member with a standardized written denial notice that states the specific reasons for the denial and informs the member of their appeal rights. For more information on the organization determination process, go to go.cms.gov/1JWmDQ7.

How to handle duplicate payments

If you bill both Medicare and RMHP and receive duplicate payment, RMHP will retract its payment. When you or RMHP identify that you have received duplicate payment:

- Return the amount of the plan's payment to RMHP. Do not return payment to Medicare.
- Send the Medicare Explanation of Medicare Benefits (EOMB) to RMHP
- RMHP will then pay the applicable Medicare coinsurance and deductible

How to handle claims inadvertently submitted to Medicare that have not been submitted to RMHP

- If you inadvertently bill Medicare first and receive payment from them, you will need to refund the Medicare payment before you can bill RMHP for Part A or B services
  - To determine if you can refund the Medicare payment, contact the Medicare AB MAC (i.e. Medicare contracted claims payer) to determine the process for returning payments to Medicare.
  - The AB MAC may or may not consider the payment of services performed for a member of an Option 1 Cost plan to have been made in error.
- The AB MAC (Medicare payer) for Jurisdiction H, which includes Colorado, is Novitas Solutions novitas-solutions.com/webcenter/portal/NovitasSolutions
- If you successfully refund the Medicare payment, you can bill RMHP
- If you are unsuccessful in refunding the Medicare payment, you may not bill RMHP
  - Submitting a claim for payment would result in duplicate payment

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Medicare Part D charges

Your office cannot bill Medicare Part D-covered vaccines to RMHP. The cost of these vaccines includes the administration fees which must accrue toward the member's true out of pocket. Prescription drug claims for Medicare Part D-covered vaccines can be submitted online by participating providers.

- **Option 1 preferred**
  Send the member to a local pharmacy that administers vaccines, with a prescription for the vaccine. The pharmacist will administer the vaccine and bill the service to OptumRx using their real-time electronic adjudication system. The member would pay any applicable copays at the time of service. Contact RMHP Member Services for a list of pharmacies that administer vaccines.
- **Option 2 nonpreferred**
  Administer the vaccine(s) to the member and collect the full amount from the member at the time of service. Supply the member with an invoice showing the vaccine name, price, date given and NDC code (if available). The member can obtain a **Medicare Part D Prescription Claim Form** from UHCprovider.com. They will complete the claim form and attach the invoice. The member may then be reimbursed by the PBM, OptumRx. The member must have an RMHP prescription drug plan to receive reimbursement.

For more information contact OptumRx at **1-888-290-5416**.

Provider marketing

As a contracted provider with RMHP, certain rules on allowable provider activities must be observed to ensure communication with Medicare beneficiaries regarding enrollment decisions are in the best interest of the beneficiary. Providers should remain neutral parties in assisting contracted health plans (contracted plans) with marketing to beneficiaries or assisting with enrollment decisions. Please review 42 CFR 422.2266 – Activities with health care providers or in the health care setting, for more information regarding marketing activities that are allowed and disallowed. RMHP must approve all marketing materials and activities in advance.

Benefits questions

Address all benefits questions to RMHP Member Services by calling **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP. Please DO NOT quote our benefits to members or attempt to interpret them. The information on all RMHP plan benefits in this manual is in summary form only. Complete details are available in the appropriate member evidence of coverage (EOC) and through Member Services.

Representatives filing appeals for enrollees

Individuals who represent enrollees may either be appointed or authorized. (For purposes of this manual [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as "representatives.") An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney or any physician) to act as their representative and file an appeal on their behalf. Also, a representative (surrogate) may be authorized by the court or act in accordance with state law to file an appeal for an enrollee. A surrogate could include, but is not limited to, a court-appointed guardian, an individual who has durable power of attorney, a health care proxy or a person designated under a health care consent statute.

To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment (including attorneys) must sign, date and complete a representative form. For purposes of this section, "representative form" means a Form CMS-1696 Appointment of Representative or other conforming instrument. Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate is not required to produce a representative form. Instead, they must produce other appropriate legal papers supporting their status as the enrollee's authorized representative.

Either the signed representative form for a representative appointed by an enrollee, or other appropriate legal papers supporting an authorized representative's status, must be included with each appeal. Regarding a representative appointed by an enrollee, unless revoked, an appointment is considered valid for 1 year

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from the date the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of the appeal. A photocopy of the signed representative form must be submitted with future appeals on behalf of the enrollee to continue representation. However, the photocopied form is only good for 1 year after the date of the enrollee's signature.

Any appeal received with a photocopied representative from more than 1 year old is invalid to appoint that person as a representative and a new form must be executed by the enrollee. Please note that the OMB-approved Form CMS-1696, Appointment of Representative (AOR) form, contains the necessary elements and conforms to the Privacy Act requirements, and is preferred. The prior versions of Form CMS-1696 are obsolete. However, if another representative form is used, it must contain at least the applicable elements included in the AOR form.

Notification of hospital discharge appeal rights

Consistent with 42 CFR 422.620 and 422.622, Medicare enrollees who are hospital inpatients have a statutory right to appeal to a Quality Improvement Organization (QIO) for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary. RMHP-contracting hospitals must notify a Medicare enrollee (or their representative) about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) to explain the enrollee's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the enrollee (or representative) and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible but not more than 2 calendar days before discharge. Please note a new OMB-approved form must be used. The most current forms are available at [cms.gov.](https://cms.gov)

Providers shall not discriminate, with respect to the provision of medically necessary health care services against any covered person who is a participant in a publicly financed program, including the limiting of hours of operation in a manner which is less than is offered to members of nonpublicly financed programs.

RMHP highly recommends the minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday.

"Medically Necessary" - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that RMHP solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury
- Obtained from a licensed, certified or registered provider
- Provided in accordance with applicable medical and/or professional standards
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes
- The most appropriate supply, setting or level of service that can safely be provided to the patient and which cannot be omitted, and is consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient)
- Cost-effective compared to alternative interventions, including no intervention. ("Cost effective" does not mean lowest cost.) Not experimental/investigational.
- Not primarily for the convenience of the patient, the patient's family or the provider
- Not otherwise subject to an exclusion under the PRIME Member Handbook
- The fact that a provider may prescribe, order, recommend or approve care, treatment, services or supplies does not itself make such care, treatment, services or supplies medically necessary

The fact that a participating physician or other health care professional may prescribe, order, recommend or approve a service or supply does not make such service or supply medically necessary. If standards regarding whether health care services are medically necessary are subject to dispute, such standards shall be as determined solely by the medical director.

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Chapter 4: RMHP PRIME, RAE and CHP+

RMHP PRIME

All PRIME members receive an initial screening for special heath care needs following enrollment.

Members who are women have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of postpartum care directly related to the delivery only if the practitioner agrees to terms as specified in Section 26 -4-117, C.R.S. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with RMHP PRIME toward a transition. Persons with special health care needs who use specialists frequently for their health care may maintain these types of specialists as their PCP or will be allowed access without referral to specialists for the needed care.

In-network services

All members should select a PCMP/PCP as their medical home. Members of the RMHP PRIME network are able to obtain consultation and treatment from in-network specialist physicians and mid-level providers without a referral from the PCMP/PCP. The member must be eligible to receive services through RMHP at the time services are provided and the services that the member receives must be covered services as specified in the RMHP PRIME Member Handbook.

Out-of-network/out-of-plan services

Members may obtain covered services from out-of-network/out-of-plan providers at the in-network benefit level, subject to obtaining RMHP's approval. Such approval shall be in a timely manner relative to the member's condition. Such services include those in which:

- RMHP has no participating providers who can provide a specific, medically necessary covered service
- Members do not have reasonable access to a participating provider due to distance or travel time
- Continuity of care when a new member is receiving frequent and current care from a non participating provider for a special condition, such as chemotherapy, high-risk pregnancy or pregnancy beyond the first trimester. In each of these cases, RMHP will arrange for authorization of services from a provider with the necessary expertise and ensure that the member obtains the same benefit level as if the benefit was obtained from a plan provider. Refer to the Continuity of Care section for specific parameters.

Any such requests must be approved in advance by RMHP prior to the member obtaining the health care services. Any authorized care is subject to the conditions and restrictions of the authorization.

Early and Periodic Screening, Diagnostic and Treatment

Through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program RMHP works closely with the state of Colorado to ensure all RMHP PRIME and RAE enrolled children and youth, from birth through age 20 and adults who are pregnant receive the appropriate screening, diagnosis, treatment and immunizations needed to develop or maintain a healthy life. This is a benefit program designed to enhance primary care, with emphasis on prevention, diagnosis and timely treatment. The program includes periodic screenings for children and youth, which are often included in "well-child exams." These exams are the foundation of the EPSDT program, and RMHP encourages all PCMP providers for RMHP PRIME and RAE enrolled children and youth to participate in the program.

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EPSDT coverage ends with the member's 21st birthday (coverage is through age 20). EPSDT visits must occur within 2 weeks of the date the visit is requested by the member.

RMHP has developed and annually updates the EPSDT Guidebook for providers. This annual publication is distributed each fall but is available on the RMHP website for reference at any time.

Colorado has adopted the American Academy of Pediatrics Bright Futures periodicity schedule for screening services. The frequency of the periodic screening is as follows:

Infancy periodicity schedule

- Initial visit
- Newborn
- Within the first week
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months

Early childhood periodicity schedule

- 1 year
- 15 months
- 18 months
- 2 years
- 3 years
- 4 years

Middle childhood periodicity schedule

- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years

Adolescence periodicity schedule

- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years

Comprehensive screening must include:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Appropriate vision testing
- Appropriate hearing testing
- Appropriate laboratory tests
- Lead toxicity blood screening between 36 and 72 months of age if not previously tested
- Dental screening services, including an assessment of mouth, oral cavity and teeth; and referral to a dentist for children by 1 year of age or at the eruption of the first tooth
- Developmental screening to determine whether a child's emotional and developmental processes fall within a benchmarked range according to the child's age group and cultural background. Includes self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills and appropriate mental/behavioral health screening
- Immunizations should be provided at the time of screening if the need for immunization is identified at the time of screening, and it is medically appropriate to provide the immunization at that time
- Health education and anticipatory guidance

It is imperative that EPSDT screenings are coded properly to reflect accurately the services delivered. RMHP captures and reports data based on your accurate coding. If you have any questions, please refer to the Health First Colorado website to locate the EPSDT Billing Manual. Once in the state's website:

- Select "For Our Providers" from the horizontal tool bar at the top of the page
- Select "Provider Services"

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- Select “Billing Manuals”
- Once in “Billing Manuals” select CMS 1500 and scroll down to EPSDT
- Click on the hyperlink to allow popups in your browser, if needed
- The complete EPSDT Manual will appear

Screenings should be performed by providers qualified to furnish primary medical and/or mental health services. They should be performed in a culturally and linguistically sensitive manner. Diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure are covered. The results of screenings and examinations should be recorded in the child’s medical record. Documentation shall include, at a minimum, identified problems and negative findings and further diagnostic studies and/or treatments needed, and the date ordered. If further diagnosis and treatment is necessary as the result of a screening, these services may be rendered by the PCMP. If the PCMP is not equipped or licensed to provide the additional diagnosis or treatment, a referral should be made to the appropriate practitioner or facility or to RMHP for assistance in finding a provider.

Medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by Health First Colorado — may under certain circumstances be covered by RMHP as EPSDT exceptions. A provider can request an EPSDT exception by submitting a prior authorization request in accordance with the instructions in this manual. The request will be reviewed based on EPSDT and approved or denied.

Please direct any questions about medically necessary EPSDT services that are not covered by RMHP but are covered by Health First Colorado (wrap-around services) to RMHP’s Care Management department.

Vaccines for Children program

RMHP does not reimburse for PRIME member (ages 18 and under) vaccines as they are available through the Vaccines for Children (VFC) program. The state of Colorado, Department of Public Health and Environment, supplies providers with free vaccine for their Medicaid patients. This program is open to all providers who have completed the necessary paperwork. RMHP reimburses providers for the administration of each state-supplied vaccine.

Use the following codes for VFC vaccine administration, to patients 18 and under, with face -to-face counseling of the patient/family during the vaccine administration: 90460, 90461, 90471, 90472, 90473 and 90474. Report these codes in addition to the vaccine and toxoid code(s).

If you have questions, contact RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP.

Health First Colorado sterilization consent

RMHP PRIME members seeking service for sterilization must submit a copy of the Health First Colorado Sterilization Consent form (MED 178) with a CMS 1500. If the consent form is required but not submitted, RMHP will not pay for the procedure, and the provider may not bill the member. A consent form is required if a woman can have a baby and has dual coverage (Medicare/Medicaid) with RMHP PRIME as secondary.

To receive sterilization services, the following criteria must be met:

- The member must be at least 21 years of age
- The member may not be currently institutionalized for the care and treatment of mental illness
- They must be mentally competent

The MED 178 consent form must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and:

- In the case of premature delivery, must state the expected date of delivery, or
- In the case of abdominal surgery, must describe the emergency

A copy of this form is available at our website, UHCprovider.com, as well as colorado.gov/pacific/hcpf/provider-forms.

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RMHP PRIME copay

Effective July 1, 2022, RMHP PRIME members do not have copays for any medical or behavioral health services. RMHP PRIME members will only have copayments required for prescriptions that will need to be paid at the pharmacy unless they are exempt per the following listing. See summary chart for applicable copay amounts.

Members who are copay-exempt for prescriptions ($0 copay):

- Children 18 and younger
- Pregnant members
- American Indian or Alaska Native
- Live in a skilled nursing facility
- Live in a traditional care facility or mental institution
- Former foster care children ages 18 through 26
- Household has paid more than 5% of household income in copays for the month

RMHP PRIME copay summary

Service	Copayment
Physician office visit	No copay
Hospital	
Emergency room	
Lab work	
X-ray	
Durable medical equipment	
Second opinions	
Mental health and substance use disorder services	
Pharmacy - generic drugs	$1 generic, including injectables (31-day supply) $1 for up to a 31-day supply from a retail pharmacy $2 for a 90-day supply from a mail-order pharmacy
Pharmacy - brand-name drugs	$3 for up to a 31-day supply from a retail pharmacy $6 for a 90-day supply from a mail order pharmacy

Service	Copayment
*** If the member has Medicare and Colorado Medicaid, their Medicare drug plan should cover their drugs.**	Member pays more if they buy a brand-name drug when they could buy the same drug in a generic form. If physician can provide evidence that the generic drug does not work for the member, or can provide records that show the member must have the brand-name drug, RMHP may approve for the member to pay the brand-name copayment only without having to pay more.

* You or the member will need to call RMHP Member Services prior to billing for the second opinion to ensure that the member will be covered with no copayment.

Please Note: If member is eligible for Medicare and Colorado Medicaid, most drugs are covered by Medicare Part D. RMHP PRIME will only cover some drugs that Medicare does not cover. There is no coordination of drug benefits.

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Wrap-around services

Colorado Medicaid Services covered by Health First Colorado Medicaid, not RMHP PRIME

Health First Colorado Medicaid covers some additional services that are not offered by RMHP. These are called wrap-around services. Wrap-around services may include, but are not limited to:

- Hospice care, however member may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested
- Private duty nursing
- Extraordinary home health
- Skilled nursing facility services
- Auditory services for children: HMO covered services include screening and medically necessary ear exams and audiological testing. Wrap-around benefits include hearing aids, auditory training, audiological assessment and hearing evaluation
- Limited case management services
- Hearing aids and batteries, auditory training, audiological assessment and hearing evaluation. Comprehensive dental assessment, care, and treatment for children
- Adult dental services consisting of diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment and oral surgery
- Cochlear implants, batteries and supplies for children, and for adults under limited circumstances
- HCBS services including case management (for Model 200 children); home modification, electronic monitoring, personal care and nonmedical transportation
- Personal care benefit for children
- Nonemergent medical transportation (NEMT)
- Inpatient substance abuse rehabilitation treatment for individuals aged 20 and younger

More information about these wrap-around services can be found in the **PRIME Member Handbook** and in Colorado Medicaid Rules and Regulations. The Member Handbook also includes information about how to access these services. Wrap-around services include, but not limited to the following:

Service/procedure	RMHP benefit	Health First Colorado wrap-around benefit	Comments
Auditory services - children **Hearing aids** **Auditory training** **Audiological assessment and evaluation**	See comments	Yes - See comments	RMHP covers screening and medically necessary ear exam and audiological testing. Wrap-around services include hearing aids, auditory training, audiological assessment and hearing evaluation. Wrap-around services also include Cochlear implants, batteries and supplies for children, and for adults under limited circumstances.

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Service/procedure	RMHP benefit	Health First Colorado wrap-around benefit	Comments
Dental services - children	No	Yes	RMHP covers a dental evaluation by a doctor. All other routine dental care and treatment by a dentist are wrap-around services. Referral to a dentist begins at 1 year of age or earlier.
Dental services - adults	No	Yes	Dental care including exams, cleanings, X- rays and some restorative services covered as a wrap-around benefit. Limited to $1,500 each benefit year.
Extraordinary home health services - expanded EPSDT	No	Yes	Expanded EPSDT, which includes any combination of necessary home health services that exceed the maximum allowable per day and services that must, for medical reasons, be provided at locations other than the child's place of residence
HCBS services	No	Yes	Included: case management (for Model 200 children), home modification, electronic monitoring, personal care and nonmedical transportation
Home health care	Yes	Yes	RMHP does not cover private-duty nursing, but state Medicaid may cover it
Hospice	No	Yes	Member may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested
Intestinal transplants	Immunosuppressive medications only	Yes	Intestinal transplants (excluding immunosuppressive medications, which are a covered RMHP benefit) covered alone or with other simultaneous organ transplants (i.e. liver), coordinated by department and RMHP case manager
Private duty nursing (PDN)	No	Yes	Nursing services only
Skilled nursing facility – skilled nursing and rehabilitation services	Not a covered benefit	31 plus days	Skilled nursing facility charges (skilled nursing and rehabilitation services) beginning on day 31 of member meets level of care certification

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You can find out more about services offered through Colorado's Medicaid program by calling the county Department of Health and Human Services in the county where the member resides. These services are not covered by RMHP.

- Delta – 1-970-874-2030
- Garfield – 1-970-625-5282
- Gunnison – 1-970-641-3244
- Mesa – 1-970-241-8480
- Montrose – 1-970-252-5000
- Ouray – 1-970-626-2299
- Pitkin – 1-970-920-5235
- Rio Blanco – 1-970-878-9640
- San Miguel – 1-970-728-4411

RMHP timely filing limit

Based on RMHP's PRIME contract with the department, the following claim submission deadlines now apply:

- Standard RMHP PRIME claims
  - 120 days from the date of service
- Medicare Crossover claims
  - 120 days from the Medicare processing date
- Third-party primary payment
  - 60 days from the date of third-party payment/ denial or within 365 days from the date of service, whichever occurs first

If a member's eligibility is backdated, timely filing is 120 days from the date the enrollee is added to the eligibility system. Eligibility must be verified using Health First Colorado's Medicaid Provider Portal. A letter from the county Department of Human Services or Single Entry Point verifying backdating must accompany the claim.

CHP+

CHP+ members receive an initial screening for special heath care needs following enrollment when they are able to be reached through a welcome call.

Members who are women have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of postpartum care directly related to the delivery only if the practitioner agrees to terms as specified in Section 25.5 -5-406(g)(II), C.R.S. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with RMHP toward a transition. Persons with special health care needs who use specialists frequently for their health care may maintain these types of specialists as their PCP or will be allowed access without referral to specialists for the needed care.

In-network services

All members should select a PCP. If a PCP is not selected, one will be assigned to the member and a letter will be sent to the member notifying them of their assigned PCP. Members of the RMHP CHP+ network are able to obtain consultation and treatment from in-network specialist physicians and mid-level providers without a referral from the PCP. The member must be eligible to receive services through RMHP at the time services are provided and the services that the member receives must be covered services as specified in the RMHP CHP+ Member Handbook.

Out-of-network/out-of-plan services

Members may obtain covered services from out-of-network/out-of-plan providers at the in-network benefit level, subject to obtaining RMHP's approval. Such approval shall be in a timely manner relative to the member's condition. Such services include those in which:

- RMHP has no participating providers who can provide a specific, medically necessary covered service
- Members do not have reasonable access to a participating provider due to distance or travel time
- Continuity of care when a new member is in an active course of treatment, as defined in the Definitions section

In each of these cases, RMHP will arrange for authorization of services from a provider with the necessary expertise and ensure that the member

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obtains the same benefit level as if the benefit was obtained from a plan provider. Refer to the **Continuity of Care section** for specific parameters.

Any such requests must be approved in advance by RMHP prior to the member obtaining the health care services. Any authorized care is subject to the conditions and restrictions of the authorization.

CHP+ copay summary

There are 3 copay levels for RMHP CHP+ children based on family income. Provider offices will collect copays for medical services applicable to the member's copay level. Native Americans, Alaskan Natives and prenatal members do not have to pay copayments.

Service	RMHP copay/no copay	RMHP copay level L	RMHP copay level H
Annual deductible (Individual/ Family)	None	None	None
Out-of-pocket limit (Individual/ Family)	None	None	5% of annual family income adjusted for family size
Routine medical office visits	$0	$0	$5
Hospital/other facility services:			
• **Inpatient**	$0	$0	$20
• **Physician**	$0	$0	$5
• **Outpatient/ambulatory**	$0	$0	$5
Emergency room	$3	$3	$30
Laboratory and X-ray	$0	$0	$5
Durable medical equipment	$0	$0	$0
Mental disorders/mental illness care	$0	$0	$5/office visit $20/admission
Outpatient substance abuse treatment services	$0	$0	$5
Prescription drugs	$0	$0	$3/generic $10/brand name

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RAE behavioral health telemedicine

In alignment with the Colorado Department of HCPF, RMHP adopted an expanded allowance of telemedicine for most services covered under the Medicaid Regional Accountable Entity Behavioral Health Benefit (see Telemedicine Services Exception Codes) not previously allowed to be delivered by telemedicine for RAE members.

RMHP behavioral health telemedicine guidelines:

1. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.
2. All other general requirements for telemedicine services–such as documentation, time frames and standard of care–must be met
3. The availability of services through telemedicine does not alter the scope of practice of any health care provider; nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law
4. The use of telemedicine does not change RMHP prior authorization requirements that have been established for the services being provided

Provider requirements

1. Practitioners using intensive outpatient psychiatric services (IOP) to treat substance use disorders or eating disorders through telemedicine must continue to employ accountability measures to safeguard that members are benefiting from programming. These measures includes adjunctive practices such as urinalysis testing (UAs), breathalyzers, vital signs, laboratory testing and/or weight measurements monitored by a professional.
2. Providers are responsible to provide telemedicine services in accordance with **Office for Civil Rights (OCR) Notice**.

In addition, providers should:

- Be consistent with directives from the Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMSHA), health services that are not urgent should be postponed where possible. Providers should weigh potential benefits from rendering needed care against the potential weakened validity and reliability of assessment results if choosing to conduct testing by telemedicine or virtual visit care.
- Ensure the integrity of the psychometric properties of the tests or assessment procedures used to include:
  - Modifying the test environment as necessary to prevent access to cell phones, the internet or coaching from other persons during administration
  - Minimizing any potential distractions which could affect performance
- Ensure that additional consideration is given to issues that arise with testing diverse populations that could further lower reliability and validity of scores due to changes in administration procedures and the test environment
- Ensure the quality of the technologies being used and the hardware requirements needed are considered prior to starting testing–consideration should be given to the availability of backup technologies should technical problems be encountered during administration
- Use HIPAA-approved telemedicine technologies as well as temporarily allowed popular applications that allow for video chats to provide telemedicine in accordance with the OCR Notice. Notify patients that telemedicine applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
- Ensure that documentation of the following issues are included in the member record:
  - Potential difference in obtained scores due to telemedicine administration
  - Any accommodations or modifications that were made to standard administration procedures, and
  - Potential limitations of all assessment results or conclusions when test norms used for interpretation are not based on a telemedicine administration

Providers are responsible for using a HIPAA-approved telemedicine technology platform that allows asynchronous communication with video. Providers will continue to be responsible for ensuring compliance with all local, state and federal regulations for the delivery of services through a telemedicine modality (including but not limited to rules and regulations from HCPF, Office of

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Behavioral Health, Colorado Division of Insurance, CDC, SAMSHA and CMS).

1. Billing and coding guidance:
   - Providers are required to abide by all Medicaid billing and coding policy as outlines in the state Uniform Service Coding Standards (USCS) manual and requires all services billed in accordance with the USCS, including services delivered through telemedicine
   - In addition, the following claim guidance must be followed to receive a reimbursement and to allow identification of services as provided through telemedicine during the COVID-19 State of Emergency:
     1. CMS 1500 Professional Claims: Place of Service code 02 must be indicated on all CMS 1500 professional claims for telemedicine; All codes outlined in the USCS are allowed with the exception of those codes listed as follows in the Telemedicine Services Exception Code table
     2. UB-04 Institutional Claims: The GT modifier must be appended to the UB-04 institutional claim form with the service's procedure code
   - Providers may only bill procedure codes which they are already eligible to bill per their contract and not outlined in the below Telemedicine Services Exception Code table
2. Medical record standards and documentation:
   - Providers must obtain and document the member's consent to receive services through telemedicine prior to rendering services
   - Clinical records must be maintained in a timely and accurate manner, ensuring effective and confidential member care and quality review. RMHP will continue to monitor medical records, claim submissions and compliance to policies and procedures to ensure patient is achieved through behavioral health services.

Telemedicine services exception codes

Code	Description
90870	Electroconvulsive therapy
99217	Observation care discharge day management
99218	Initial observation care, per day, for the evaluation and management of a patient
99219	Initial observation care, per day, for the evaluation and management of a patient
99220	Initial observation care, per day, for the evaluation and management of a patient
99221	Initial hospital care (30 min.)
99222	Initial hospital care (50 min.)
99223	Initial hospital care (70 min.)
99224	Subsequent observation care (15 min.)
99225	Subsequent observation care (25 min.)
99226	Subsequent observation care (35 min.)
99233	Subsequent hospital care (35 min.)
99234	Observation or inpatient hospital care, low complexity (40 min.)
99235	Observation or inpatient hospital care, moderate complexity (50 min.)
99236	Observation or inpatient hospital care, high complexity (55 min.)
99238	Hospital discharge day management: 30m or Less
99239	Hospital discharge day management: more than 30m
99242	Office consultation for new or established patient (30 min.)
99251	Inpatient consultation for new or established patient (20 min.)
99252	Inpatient consultation for new or established patient (40 min.)
99253	Inpatient consultation for new or established patient (55 min.)
99254	Inpatient consultation for new or established patient (80 min.)

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Code	Description
99255	Inpatient consultation for new or established patient (110 min.)
99281	Emergency department visit, focused
99282	Emergency department visit, expanded, low complexity
99283	Emergency department visit, expanded, moderate complexity
99284	Emergency department visit, detailed
99285	Emergency department visit, comprehensive
G0176	Activity therapy, such as music, dance, art or play therapies 45 min or more
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems
H0017	BH residential without room/board
H0018	BH short term res without room/board
H0019	BH long term res without room/board
H0020	Methadone admin/service
H0033	Oral med admin direct observation
H0035	MH partial hospitalization less than 24 hr.
H0036	Community psychiatric supportive treatment, face to face, per 15 min
H0037	Community psychiatric treatment, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H2001	Rehab program 1/2 day
H2030	Mental health clubhouse per 15 min
H2031	Mental health clubhouse per diem
H2032	Activity therapy per 15 min
S3005	Performance measurement, depression
S5150	Unskilled respite care, not hospice; per 15m
S5151	Unskilled respite care, not hospice; per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care service 15 minutes
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification
T1019	Personal care services per 15 min

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Chapter 5: Utilization and care management

About utilization and care management — philosophy and purpose

The RMHP utilization management (UM) and care management (CM) programs are essential for medical management of all lines of business including Individual and Family Plan, CHP+, RAE and RMHP PRIME, D-SNP and Medicare members. The program is designed to facilitate access to care, improve health care outcomes, and address patterns of under- and over-utilization of services related to both physical and behavioral health. The UM and CM teams work effectively to support the delivery of high-quality care while evaluating cost-effective alternatives as appropriate. The team also collaborates with providers and members to provide education related to processes and facilitate appropriate changes in care patterns.

RMHP members may obtain services from contracted providers and facilities or choose to seek services with noncontracted providers if their plan design supports that feature. Using contracted providers ensures licensed and credentialed providers deliver quality care. RMHP strives to provide members and providers access to effective management across the continuum of care.

Annual evaluation

The UM and CM programs are evaluated annually. The principal focus of the annual evaluation is to document the contribution of UM and CM towards the efficiency and appropriateness of care within the delivery system. Program objectives for the following year are identified and implemented.

Staff availability

RMHP staff is available during normal business hours Monday through Friday, 8 a.m. to 5 p.m. for calls, faxes and secure emails including UM and CM issues.

Behavioral health UM and CM staff are available after hours 24/7, please call **1-888-282-8801**. You may also make arrangements in advance to speak to CM staff after normal business hours by calling your provider relations representative at **1-970-244-7798**.

RMHP UM and CM staff have password-protected, confidential voicemail to receive inbound calls after normal business hours. Calls will be returned as soon as possible but no later than 1 business day.

Additionally, you can refer a patient to case management by completing the RMHP online Provider Referral form on our website at **UHCprovider.com**.

Confidentiality

Any data or information pertaining to the diagnosis, treatment, or health of any RMHP member obtained from the member, family or provider will be held in confidence and will not be disclosed to any person except consistent with HIPAA and to the extent it may be necessary to perform UM and CM services. All minutes, records, reports, worksheets, studies or other materials collected as part of the UM and CM program shall be considered strictly confidential and processed in a manner designed to ensure confidentiality. Access to UM and CM information (e.g. clinical information and patient history) shall be restricted to those individuals and/or committees charged with the responsibility and accountability for various aspects of the program. All RMHP employees sign a confidentiality statement annually.

RMHP complies with all applicable HIPAA regulations including the privacy, security, breach notification, transactions and code set regulations. The RMHP Notice of Privacy Practices, which further explains our members' privacy rights distributed to all subscribers upon enrollment and thereafter, as required by HIPAA. It is also available for review on our website. Similarly, providers who are "covered entities" under HIPAA must comply with all applicable regulations.

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Goals and objectives

The UM and CM program goals and objectives are as follows:

- To support and augment the Rocky Mountain Health Management Corporation's objectives
- To promote quality of care for all RMHP
- To facilitate access and delivery of care at the appropriate level, using resources relevant to the individual needs of members
- To identify over-/underutilization of health care resources
- To establish an environment of cooperation, communication and education between the member, providers and RMHP that will result in the most effective use of all levels of care
- To meet or exceed relevant state and federal regulatory requirements
- To ensure all RMHP members receive high-quality care and to facilitate access to care obtained from participating providers
- To ensure member and provider satisfaction through use of satisfaction surveys, complaint processes and audits with appropriate committee oversight and feedback
- To review and monitor all applicable health care services provided by physicians, facilities, and ancillary personnel
- To facilitate effective access to behavioral health providers and coordinate services as necessary
- To evaluate and monitor appropriateness of authorizations to specialists, prior authorization requests, and confinements
- To evaluate pharmacy service utilization related to case management issues and to prior authorize medications as indicated
- To identify potential case management patients and effectively manage those cases to facilitate quality outcomes in a cost-effective manner
- To coordinate health care services for members with special health care needs and collaborate with family members, caregivers, advocates, and outside agencies as necessary

Liability

Physicians who serve at the request of RMHP to review practice patterns and utilization data or perform peer review of clinical performance are indemnified by RMHP and must hold active, unrestricted licenses in the state of Colorado. The United States Congress and the Colorado state legislature acknowledge the overriding national and state need to provide incentive and protection for physicians and persons assisting them who are engaged in professional peer review. All medical directors for RMHP hold unrestricted licenses in the state of Colorado.

Medical records

All RMHP member medical records shall be archived and maintained by providers for a minimum of 7 years, unless a longer time frame for retention of records is required by legal requirements applicable to RMHP. Generally, longer time frames apply for medical records of RMHP PRIME recipients, Medicare beneficiaries, RAE and CHP+ members.

Delegated activities

In circumstances where it is appropriate to delegate utilization management responsibilities, RHMP remains accountable for the requirements of the UM process.

In the event UM activities are delegated, a written description outlining responsibilities of RMHP and the delegated agency, including delegated UM activities, frequency of reporting, performance evaluations and appropriate action plans, are addressed in the contract of any entity to which UM activities are formally delegated. Such contracts include a list of key performance indicators, designation of specific delegated activities, and reporting and monitoring requirements. Intervention will occur when warranted as outlined in the contract. Such interventions may include education, chief medical officer (CMO), consultation and involvement, contract alterations, or revocation of delegation. Any compensation which may be paid for UM services do not provide incentives for the entity to deny, limit, or discontinue medic ally necessary services to the member.

An evaluation of the delegated UM activities is performed prior to delegation and the signing of the

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contract and then at least annually by reviewing and approving the delegated agency's UM program. Reports with specific UM data will be analyzed at least semi-annually. All other necessary data for tracking purposes will be extracted from the RMHP database as needed.

By executing an agreement, the delegated entity agrees to abide by RMHP's policies and procedures regarding delegated UM and the philosophies as outlined in the RMHP UM program description.

Collaboration with quality improvement

RMHP maintains its tradition and commitment to constantly seeking improvement for the quality of care and level of services for our members. To request a copy of the quality improvement program description, the quality improvement work plan, as well as performance of the quality improvement program, please contact the RMHP Quality Improvement Team by calling **1-970-263-5552** or **1-855-830-1565**.

The practitioners/providers cooperate with the RMHP QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs.

The practitioners/providers allow RMHP to use their performance data for quality improvement activities.

Use of clinical practice guidelines

To promote the use of nationally recognized and accepted practices for providing care, RMHP develops and adopts clinical practice guidelines (CPG) and preventive health recommendations (PHR). The guidelines are based upon professionally recognized standards of practice and address the provision of acute, chronic, behavioral, and preventive health care. These CPG are based on National Professional Societies guidelines and scientific peer-reviewed literature. PHR are based on National and Governmental Organizational Guidelines for prevention or interventions, as appropriated for specific age, gender and/or risk factor. All guidelines are distributed annually in a network newsletter and published on the Provider Portal. When evidence-based guidelines are not available, consensus guidelines are used with an appropriate specialist review required. Evidence-based clinical and preventive health guidelines from nationally recognized sources guide the quality and health management programs at RMHP.

The RMHP quality improvement program includes monitoring activities to assess the quality and appropriateness of services provided to enrollees. The RMHP Medical Advisory Committee (MAC) reviews monitoring activities and provides recommendations for quality management activities.

There are several processes in place to assess provider utilization of CPG, including but not limited to annual assessment of performance of HEDIS data, occurrence of adverse events, quality assurance case review processes, other quality improvement review activities, and routine medical record audits to determine if medical record review standards and preventive care guidelines are met.

CPG are reviewed annually, updated as necessary and posted on the RMHP website.

Review activities

Prospective review consists of prior authorization of select in-network services as well as all out-of-plan services for members whose coverage requires use of a specific network. Examples may include but are not limited to:

- Selected inpatient and outpatient surgery/treatment
- Durable medical equipment
- Home health, home IV therapy services
- Skilled nursing facility admissions
- Selected prescription drugs
- Out-of-plan services for HMO members
- Transplant services
- Selected diagnostic testing
- Outpatient rehabilitation services

Failure to obtain the requested prior authorization necessitates member and provider education and will result in delayed or denied claims payment. Potential cases for case management can be identified and referred during the prospective review process using the CM selection criteria policies. Urgent/emergent services do not require prior authorization and may be reviewed retrospectively. Continuity of care and network adequacy and access are considered in the prior authorization process.

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"Continuity of care" is continuity and coordination of medical care is evaluated based upon whether a member is undergoing an active course of treatment.

A member must have been undergoing treatment, or have been seen at least once in the last 12 months, by the provider being removed or leaving the network for that member to be considered in an active course of treatment.

Subject to the terms of a member's contract, emergency services will be approved for payment without prior authorization when they are necessary to screen and stabilize a covered person if a prudent layperson having average knowledge of health services and medicine, acting reasonably, believes that a delay or failure to obtain services would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place the person's health (or, with respect to a pregnant member or their unborn child) in serious jeopardy.

RMHP may require claims for emergency or urgent care be accompanied by sufficient documentation to verify the nature of the services. Services for urgent/emergent services will not be denied for treatment of conditions which a prudent layperson would perceive as urgent/emergent based on the previous description. These emergency services will be covered when a primary medical diagnosis with psychiatric conditions or procedures, or a primary psychiatric diagnosis including medical treatment, are present. Furthermore, RMHP will not limit these services based on a list of diagnoses or symptoms.

A prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

Subject to the terms of a member's contract, urgent care services will be approved for payment without prior authorization when delay in treatment could seriously jeopardize the life or health of the member or the member' s ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment.

RMHP may require claims for emergency or urgent care be accompanied by sufficient documentation to verify the nature of the services.

Concurrent review is the ongoing assessment during a course of treatment. The assessment ensures the continued care is high-quality, medically appropriate, provided effectively and efficiently, and performed at the appropriate level of care. Concurrent review is conducted daily during business hours by on-site chart review or by telephonic review. Discharge planning is incorporated within the concurrent review process.

Concurrent review is performed on all notified admissions with a focus on the following categories:

- Admission and continued stay review for medical necessity
- Appropriateness of setting, severity of illness/ intensity of service
- Potential case management referrals
- Identified quality management issues
- Medical appropriateness of services
- Extended lengths of stay
- Behavioral health services and admissions
- Potential quality of care issues, e.g. adverse advents, are referred to an investigated thoroughly by the quality improvement process

Retrospective review is conducted on all admissions where notification did not occur, such as services occurring over a weekend or holiday. Retrospective review prompted by late notification, receipt of claims or other reasons is handled as outlined in the claims and UM policies and procedures.

Discharge planning is initiated by the attending physician, hospital staff and/or care manager coordination staff upon the patient's admission. This process is performed through the identification of patient/family needs, distribution of community resource information and recommendation to the attending physician of specific resources available to meet the patient/family needs. A physician's order is required for discharge. The discharge planning process is more completely detailed in the CM policies and procedures.

UM provides a framework for managing and monitoring the utilization of resources to maximize the effectiveness of care provided to our members. The UM program includes prospective review, concurrent and retrospective review, case management, quality improvement and disease state management referral, and monitoring of physician under-/over-utilization.

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The program consists of those activities that focus on ensuring quality of care, evaluation of appropriateness and efficacy of health care services, and evaluation of appropriate level of services. All UM processes are performed to evaluate the medical necessity and medical appropriateness of health services, procedures, quality of care and level of care.

Pharmacy/drug care review is a mechanism of identifying cases requiring further review and may be identified by claims analysis, provider/member telephone call, or the care review process. Cases reviewed and referred by the pharmacist may require direct communication with the provider, case management intervention, or referral to the medical officer and/or MPRC for quality-of-care review.

Review criteria

Professional medical judgment is required in all phases of the health care delivery and management process. RMHP's UM and CM staff are comprised of registered nurses and behavioral health practitioners supported by the CMO and associate medical directors to perform comprehensive utilization review of primary, ancillary, specialty, inpatient and outpatient care. All RMHP medical directors and the CMO hold an unrestricted license in the state of Colorado.

The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally recognized standards of practice for medical services and are applied on an individual needs basis. RMHP's UM program bases decisions on utilization of the most current edition of MCG (formerly Milliman Care Guidelines®), approved RMHP guidelines and the ASAM (American Society of Addiction Medicine) criteria.

If MCG or other evidence-based criteria do not address a particular area, RMHP utilizes other nationally established criteria in making determinations. Other criteria utilized include the American Academy of Obstetrics, Gynecology, or Pediatrics and other nationally recognized guidelines approved by the CMO, associate medical directors, and MAC. Determinations set forth by Medicare by way of national coverage determinations (NCDs) or local coverage determinations (LCDs) that are prepared by CMS, fiscal intermediary, or DME Medicare Administrative Contractor (DME MAC) may be used. If no nationally established criteria are available, RMHP develops internal UM guidelines or policies through the New Technology Assessment and Guideline Physician Advisory Committee (NTAG).

UM guidelines align with the Dual Special Needs Plan and the Medicare Advantage plan. Provider/practice performance for adherence to 10 is monitored through multiple mechanisms. If providers are identified as requiring further analysis, RMHP will conduct a provider specific medical record review to include an assessment of adherence to specified clinical practice guidelines. The primary function of NTAG is to utilize a systematic approach in the review of new health care technologies and the new application of existing technology, including medical procedures, behavioral health procedures and devices for inclusion in benefit plans.

The local delivery system is evaluated to determine availability of services at sub-acute facilities and home care to support the patient after discharge, the ability of the local acute hospitals to provide all recommended services within the estimated length of stay and availability of behavioral health services and community resources. The local delivery system and practitioner practice patterns also are considered in the adoption of criteria for procedures performed in the outpatient setting.

The MCG criteria, RMHP guidelines/policies and ASAM criteria are reviewed and updated at least annually by the CMO and associate medical directors. RMHP involves appropriate, licensed practitioners with professional knowledge of clinical expertise in the relevant area when developing, adopting and reviewing clinical policies used by RMHP or delegated entities in UM decision-making. The criteria and updates (purchased or developed by RMHP) are reviewed annually by the NTAG Committee, and recommendations are provided to the UM department.

Criteria used in decision-making are available, free of charge, to physicians, practitioners, facilities and members upon request to RMHP. A copy of specific criteria may be obtained by emailing rmhpcmresearchteam@uhc.com by calling **1-970-248-8718** or **1-800-793-1339**, or by sending a written request to:

Rocky Mountain Health Plans
Attn: Care Management
P.O. Box 10600
Grand Junction, CO 81502-5600

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Utilization management

The UM program is designed to ensure that medical services rendered to members are medically necessary and/or appropriate, as well as in conformance with the benefits of the plan. The program encompasses services rendered in ambulatory, impatient, and transitional settings. The UM program is designed to assist members, practitioners and providers with tools and services to get the right care at the right time by the right provider in the right place for the best value.

The RMHP CMO and associate medical directors are responsible for oversight of the UM program and all clinical decisions. Physicians, registered nurses, licensed practical nurses, behavioral health practitioners and administrative staff accountable to the RMHP CMO perform the UM functions. The CMO is accountable to the RMHP board of directors for the overall development, implementation and direction of the UM Program. The associate medical directors review and determine the appropriateness of all denials when those decisions bring into question medical necessity and/or appropriateness of care.

When the CMO or an associate medical director do not have expertise in the same or similar specialty area as the requesting provider, they consult a provider with professional knowledge or clinical expertise in the area being reviewed. In all decisions that result in approval or denial of services, RMHP strives to make decisions within regulatory time frames and take into consideration the health status of the member.

Examples of specific components of the evaluation process include:

- Appropriate provider type
- Appropriate setting
- Appropriate diagnostic evaluations
- Appropriate case management by the provider
- Potential adverse events
- Appropriate discharge plans
- Case management opportunities

RMHP considers the following factors when applying criteria to an individual:

- Age
- Co-morbidities
- Complication
- Progress of treatment
- Psychosocial situation
- Home environment
- Cultural diversity

Characteristics of the local delivery system are considered as well, such as:

- Availability of skilled nursing facilities, sub-acute care, or home care in the service area
- Benefit coverage for skilled nursing facilities, sub-acute care, or home care
- Ability of local hospitals to provide all recommended services within the estimated length of stay

Ensuring quality of care is being provided to RMHP members is the founding principle of the medical management program. Professional medical assessment applied to each individual case is the basis of all UM decisions. Consistency among RMHP UM nurses and practitioners is facilitated by utilizing explicit written criteria and other guidelines developed with physician input and based on reasonable medical evidence.

Inter-rater reliability testing in applying criteria is tested at least annually for the nurses, practitioners, and medical directors. Audits are conducted at least annually to measure consistency in application of criteria for all clinical reviewers. Any potential qualities of care issues identified are addressed immediately with a medical director. Utilization clinical rounds (extended-length-of-stay reviews) are conducted as needed, on a case-by-case basis with the UM nurses, behavioral health practitioners, clinical manager, UM director and an associate medical director to evaluate patient care plans, discharge planning needs and family support, appropriate levels of care, potential alternative levels of care and facilitate quality of care.

Utilization management decision-making

Medical necessity decision-making includes the examination of contributory history and clinical information received from the PCP, treating specialist or other clinicians, onsite chart review, and the RMHP database to document appropriateness and level of services. Collection of necessary information may also include discussions between the PCP and/or other treating clinicians (peer-to-peer) and the RMHP medical director(s).

Medical necessity is determined by examining contributing history with sufficient clinical information

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to support appropriateness and level of services proposed for the individual member. If existing criteria do not support the case for medical necessity of services, cases are reviewed with the RMHP medical director for a determination. If a denial of services is warranted, notification of denial is made by following the parameters of regulations that outline the appropriate time frames for decisions.

UM decision-making is based only on the benefit structure and appropriateness of care and services. RMHP does not offer incentives to encourage inappropriate under-utilization or reward providers for issuing denials.

RMHP standards for UM decisions and notifications are based on the timing of the request (e.g. prospective, concurrent, or retrospective). RMHP does not require prospective authorization of emergency care. Decisions regarding approval for prospective reviews and prior authorizations of care are also made and notifications done within established timelines.

Scope of activities

The UM program uses standardized criteria, policies and procedures to perform consistent and timely prospective, concurrent and retrospective care review and to monitor the provision of all medical services, including behavioral health services by all types of participating providers. The RMHP UM program applies to all RMHP members (all individuals in all age groups and in all lines of business).

Unfair discrimination

RMHP UM and CM practices do not unfairly discriminate against any enrollee on the basis of age, sex, race, color, creed, national origin, ancestry, religion or marital status.

Affirmative statement

When RMHP and the UM department make benefit and medical necessity decisions that affect our members:

- We only make our decision on appropriateness of care and services and existence of coverage
- We do not reward our decision makers for issuing denials of coverage

Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Care management

RMHP offers a comprehensive CM program for its eligible members to promote enhanced coordination of care by meeting the needs of members across a continuum of settings. Case management focuses on enhancing and coordinating care across an episode of establishing a continuum of care. These interactions will promote the best overall health care results and quality of life for the member.

At no additional cost, RMHP offers registered nurses, certified case managers and care coordinators to work 1:1 with your patients to help them in:

- Following their treatment plan
- Understanding their diagnosis and treatment options
- Managing their chronic conditions
- Coordinating their health care services
- Understanding their RMHP benefits

In addition, we offer:

- Consistent support to change behaviors necessary to better accomplish the treatment plan you and the patient have devised
- Timely reminders encouraging proactive self-care activities to help your patients manage their chronic conditions according to your treatment plan
- Reinforced understanding of the meaning and significance of the treatment goals you have established
- Encouragement to get the medicines and stay on the medication regimen prescribed for them
- Accurate information about nutrition, stress, depression and available community services

RMHP offers formal CM programs in the following areas:

- **Oncology case management**
  A specially trained nurse provides support and coordinates services that help your patients better understand their treatment plans
- **Special needs case management**
  Our nurse case manager’s help your RMHP PRIME patients and their families negotiate the health care system by improving continuity of care and facilitate communication

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- **Catastrophic case management**
  Patients experiencing a catastrophic event can become overwhelmed. Our nurse case managers will work with you and your members to develop a comprehensive and coordinated approach to their care
- **High-risk OB case management**
  Qualified RNs assist you with coordination of care to ensure member receives adequate support, education and resources to minimize risk during pregnancy and the postpartum period
- **Transplant case management**
  The program is designed to reinforce the care and treatment you provide to your patients. The focus of this program is to educate and help your patients take a more active and responsible role in managing their health.

Additional coordination and continuity of care

RMHP allows continuation of treatment for members undergoing an active course of treatment.

A member must have been undergoing treatment or have been seen at least once in the last 12 months, by the provider being removed or leaving the network for that member to be considered in an active course of treatment. Prior authorization is required, benefit limitations apply, and treatment may be extended upon approval by RMHP's medical director.

The continuity of care period in the event of provider removal or leaving of the network or a member undergoing an active course of treatment shall extend to the earlier of:

1. The termination of the course of treatment by the member or the treating provider
2. 90 days after the effective date of the provider's departure or termination, unless RMHP's medical director determines that a longer period is necessary
3. The date that care is successfully transitioned to a participating provider
4. Benefit limitations under the plan are met or exceeded
5. Care is no longer medically necessary. The continuity of care period for members who are in their second or third trimester of pregnancy shall extend through the postpartum period.

RMHP shall make a good faith effort to provide written notice within 15 working days of the provider being removed or leaving the network to members who are in an active course of treatment. If RMHP becomes insolvent or unable to continue operations for any reason, all members will be given written notice within 15 days of such an event. RMHP participating providers will continue to provide benefits to members through the date of termination of RMHP's contract with the department to provide services and will continue care for members confined in an inpatient facility until their discharge. RMHP providers cannot seek reimbursement from RMHP members for covered services received during this period, except for any applicable copayments, coinsurance, or deductibles.

A continuity of care request can only be granted when:

1. The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to RMHP for that member as provided in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and RMHP
2. The provider agrees in writing not to seek any payment from the member for any amount for which the member would not have been responsible if the provider were still a participating provider
3. Any decisions regarding continuity of care are subject to the internal and external member appeal procedures as set forth in the evidences of coverage

To request case management for a member:

Call RMHP Case Management referral line at **1-970-248-8718** or **1-800-793-1339**. You may also call Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP and ask for a case manager.

Finally, you may also complete the online Case Management Referral Form available on the RMHP website.

Disease management programs

RMHP offers comprehensive disease management (DM) program for its members to promote self-management skills, provide disease-specific education,

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and encourage communication between member and provider. RMHP currently offers a Diabetes Disease Management programs targeting all RMHP members with diabetes who are referred in to the program. RMHP actively outreaches members with newly diagnosed diabetes to offer the program.

Each member identified for a DM program is stratified into a level of care based on available clinical data. A comprehensive assessment is completed on high-risk members in the DM program including a depression screen. This helps the DM RN health educators assess the member's understanding of their disease, their level of self-management and adherence to their physician's treatment plan. Members are stratified into different levels of interventions based on clinical criteria.

Program content is developed and based on the RMHP CPG, which are reviewed and approved annually. Program content and materials are reviewed annually to ensure they meet the purpose of the DM program and comply with current guidelines and standards of care.

Goals of disease management program

- Reduce complications of disease through education and promoting lifestyle changes
- Support member's optimal treatment plan as directed by their physician using evidence -based guidelines
- Increase knowledge of disease process to promote self-management of condition
- Facilitate member's understanding and responsibility of the disease process
- Coordinate between the member/caregiver and the provider

Measurement and reporting

RMHP routinely measures the results of its DM programs by establishing key measures in the domains of utilization, process improvement and clinical outcomes. These annual measurements are analyzed for the purpose of developing new intervention strategies and for ongoing improvement efforts.

Clinical guidelines and tools are available on the RMHP website.

Member outreach

All members who are targeted for the program are sent initial mailings to include introductory letter and brochure with information on the guidelines specific to their condition, along with contact information for the RMHP RN health educators. Those members who have requested further follow-up, or whose status has indicated they need additional follow-up based on stratification are contacted more frequently by phone calls, mailings, or email. Examples of materials mailed or emailed include health assessment tools when indicated, a copy of UM guidelines pertinent to their care, tools to guide them in self-management and adherence, various condition specific pieces, reminders to have needed lab work and information regarding how to access RMHP RN health educators.

Communication with providers

During each intervention with the member the RN health educator reinforces the importance of regular and appropriate communication with their health care provider. The RN health educator will specifically discuss treatment plans prescribed by provider, self-management goals and the importance of following their health care provider's recommendations. The RN health educator will suggest methods of effective communication between patients and practitioners such as reminder notes, lists of questions and concerns, having a third party in attendance to hear provider's comments/instructions, etc.

Guidelines for communicating with treating provider:

- Any instance when recommended treatment varies from the clinical practice
- DM RN will refer the clinical questions back to the specific treating provider which are outside the DM's scope of practice
- If DM RN is notified of urgent situation affecting member's health status
- Member will be instructed to contact provider directly and/or advised to call 911 in emergent situations
- Providers have the right to request program information including, but not limited to, clinical practice guidelines, evidence-based reports, and educational material as it pertains to the individual member's primary and co-morbid condition(s)

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Notification of admission

RMHP must be notified of all admissions of a member within 24 hours unless the admission falls on a weekend or holiday. In those instances, you must notify RMHP within 72 hours of admission. Please phone or fax your admission notices to UM. Notification is required for inpatient admission only; notification is not required for observation or emergency services.

Out-of-network or out-of-plan services

A written request from the member's PCP or a participating physician and RMHP authorization are required for out-of-network services that are a benefit of the member's EOC and are medically necessary for RMHP PRIME, CHP+, Medicare and RMHP Individual and Family Plans. Out-of-network providers are physicians, facilities, ancillary providers and mental health providers who do not contract services to members.

Please use the prior authorization form to submit your request. The following information is required to process the request:

- The complete name and address of the specialist, lab, or ancillary provider
- The patient's diagnosis
- The name of the provider recommending the out-of-network service, if applicable
- The effective date, place of service, and type of services requested
- The name and address of the out-of-network provider or facility

To expedite the review process, please include medical records to justify the reason for requesting approval to obtain services from a nonparticipating provider. The out-of-network prior authorization is valid only for the services specified by the UM nurse(s) on the prior authorization form.

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Chapter 6: Prior authorization

Prior authorization policies and procedures

DME/surgery approval process

The physician's staff may request prior authorization online by answering a few questions regarding your patient's condition and obtain an immediate response regarding approval or denial. Submit requests online at UHCprovider.com, our Provider Portal. If you haven't received training, log in to learn how to sign up.

RMHP has partnered with Essette Inc. and MCG, formerly Milliman Care Guidelines, to create a tool for providers to submit prior authorization requests online through the UHCprovider.com Provider Portal.

All providers are required to request all prior authorizations through RMHP's Provider Portal. You will be able to request authorization online and, by answering a few questions, receive a determination. We no longer accept faxes for prior authorization, with the exception of specific behavioral health procedures.

To gain access to submit prior authorization requests through the Provider Portal, send an email to RMHPEssetteSupport@rmhp.org.

Approximately 60% of the requests are approved when submitted. This reduces the wait time for you and the member, decreases the volume of requests RMHP receives, and lessens overall turnaround on cases pended.

If you currently do not have access to the UHCprovider.com Provider Portal, please contact your provider relations rep. Once you have access, you can submit authorizations online.

Your prior authorization request will then be reviewed for eligibility, benefit determination, medical necessity and network status. If the requested service is approved, an approval letter will be sent. If the requested service cannot be approved by the RMHP medical director, a denial letter will be sent to the provider and member.

RMHP will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type or illness, or condition of the member. RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and the limits are in accordance with the state plan. The decision to deny or reduce the services requested will be made by a health care professional with the appropriate clinical experience in treating the member's condition.

Prior authorization policies and procedures are subject to change. Criteria used in decision-making are available, free of charge, to physicians, practitioners, facilities and members upon request to RMHP by calling Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP. Call a CM nurse with any questions regarding clinical criteria.

Please Note: RMHP will not be financially responsible for services if the patient is not eligible on the treatment date or if the member has not been properly prior authorized for the services. RMHP will make reasonable effort to verify a member's eligibility in advance of the treatment date. To submit requests to eviCore healthcare:

- Advanced imaging procedures performed outside of Delta, Montezuma or Montrose counties and within Colorado, must be made through eviCore online at evicore.com or by telephone at 1-800-792-8750.
- Genetic testing must be submitted through eviCore online at evicore.com or by telephone 1-800-792-8750

To submit a behavioral health service prior authorization request for RMHP Individual and Family Plan, Medicare and CHP+ members:

- Access the secure Provider Portal, UHCprovider.com, for outpatient authorization requests
- Specific behavioral health requests require completion of specific behavioral health prior authorization form. Please see Commonly Used Forms For Providers at UHCprovider.com.
- Contact RMHP at **1-855-886-2832** for hospital notification

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Guidelines and responsibilities of providers

Providers must follow the prior authorization guidelines. All out-of-plan services that are nonemergent must be authorized by RMHP prior to service being rendered for Medicare, RMHP PRIME, CHP+ and HMO members. PPO members have an out-of-network benefit the member can choose to access. It is the responsibility of the provider to verify eligibility and limitation of benefits. (Call RMHP Member Services.) The provider must also verify coordination of benefits for members with other insurance.

RMHP must be notified of all inpatient admissions by the hospital in accordance with the contract. Failure to do so may result in reduced payment or nonpayment of services.

These policies allow RMHP to appropriately administer benefits provided in the member's RMHP EOC.

Helpful hints for the prior authorization process – office staff

Please use the Provider Portal at UHCprovider.com. If you haven't received training, log in to learn how to sign up.

If you do not have access to the prior authorization portal, please see access process. You can contact the Member Services department and they will work with you to obtain access.

By submitting complete and detailed information, you protect your practice, your patient, and RMHP from assumption or misinterpretation. To avoid delay in processing, always complete ALL sections on the prior authorization request:

- **Use of a surgical assist**
  Specify if an M.D. or non M.D. assist will be used and provide the assist's name or group affiliation and tax ID
- **Use of intraoperative neuromonitoring**
  Specify both the physician and the technician who will perform this service, including tax ID
- **Clinical information**
  Submit clinical information with every prior authorization request if your request is not automatically approved: include what treatment has been provided to the member including medications, lab results, radiology imaging reports and/or past and current therapies in progress, and the proposed plan for the member. When requesting prior authorization for a diagnostic procedure, please include current notes to facilitate the review process. Requests submitted without clinical information will result in a delay in the prior authorization determination.
- **Contact person and phone number**
  Please provide this information in the event additional information is necessary or questions arise. Please add this information in the additional notes field when submitting your prior authorization online.

Also:

- Please include diagnosis codes that accurately describe what you are requesting and the name of the provider, facility or organization that will be billing for the services
- Expedited requests are reviewed with priority status. Expedited requests should only be used for medically urgent or life-threatening conditions. Please use the expedited designation appropriately.

Please note: When adequate information is submitted, notification of prior authorization determination will be done in the following time frames:

Standard pre-service review time frames:

- Individual and Family Plan members: 5 calendar days
- RMHP PRIME & CHP+ members: 10 calendar days
- Medicare members: 14 calendar days

Expedited review time frames:

- Individual and Family Plan members: 24 hours
- RMHP PRIME & CHP+ members: 72 hours
- Medicare members: 72 hours
- Part D appeals: 72 hours

Any request RMHP makes of you as a provider for additional information will be outlined in a letter and or fax along with the date the information is due.

Please note: following the instruction on the letter or facsimile will result in better service. If the requested information is not received by the date stated in the fax or letter, the request may be denied for lack of information.

Please submit all information well in advance of the scheduled procedure to ensure the services have been approved by RMHP prior to the member receiving services. You — and not the member — are responsible for obtaining prior authorizations.

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DME and supplies

A written order for durable medical equipment (DME) equipment and supplies must be provided to the DME vendor by the PCP or the specialist. A telephone order to the DME vendor, followed by written documentation, is acceptable. This information must be included in the documentation:

- Member name and RMHP subscriber number
- Diagnosis
- Equipment needed
- Length of need

The DME vendor is responsible for obtaining the required approvals from RMHP according to their contract requirements. A list of DME and supplies that require authorization can be requested through your provider relations representative or by visiting the RMHP website at **UHCprovider.com**.

Please contact the provider relations representative for your area if you have questions.

For pharmacy information, please go to OptumRx, at **OptumRx.com** or by calling **1-844-569-4143**.

Formulary – copay tiers

RMHP has a tiered Formulary pharmacy benefit for most Individual and Family Plan members and Medicare members. Members and their physicians can make drug selection choices together and members share in the savings achieved through the use of generic and preferred brand drugs. The specific copay amounts vary with the plan selected by the member.

The RMHP outpatient drug Formulary offers comprehensive drug coverage to allow for shared decision making between the members and their prescribers.

The Medicare Formularies are CareAdvantage for Medicare Advantage members and Dual Care Plus Formulary for Dual Special Needs population members. Both formularies include comprehensive, pharmacoeconomically and clinically sound coverage of Part D drugs.

Individual and Family Plan Formularies are named the Essential Plus Six-Tier and Colorado Options Plan. Self-administrable injectables are a prescription drug benefit. Since these injectables are considered a prescription drug benefit, they will not be covered if billed through a physician's office. Nonself-administered injectables (also known as physician-administered drugs) billed through a physician's office will be subject to the medical benefit cost-sharing.

The formularies are managed through the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee, which actively participate in the management of the Formulary and applies principles of evidence-based medicine in its development. Drug coverage decisions are based on various factors including comparative efficacy, safety, side-effects, indications, pharmacokinetics, contraindications and cost. Evaluations are based on information from medical references, primary literature and practice guidelines.

The outpatient drug formularies are updated periodically and are available online at **UHCprovider.com**, or by calling **1-800-843-0719,** ext. 5186. Please check the RMHP website for recent changes to the RMHP formularies.

Download ePocrates onto your PDA device to access extensive drug information including dosing, interactions, cost and Formulary coverage for Medicare Part D Formularies. If you want additional information about ePocrates, contact 1-800-843-0719, ext. 5182.

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Chapter 7: Referrals

Colorado Doctors Plan, Monument Heath HMO, Monument ONE HMO, Rocky Mountain HMO Valley and Rocky Mountain Sky benefit plans offer UnitedHealthcare Exchange members a customized, focused network of health care professionals. Some plans require referrals.

Plans overview

Plan	Primary care physician (PCP) required?	In-network benefits	In-network without referral	Out-of-network benefits
Colorado Doctors Plan	Yes	No referral needed	No referral needed	No coverage without prior authorization for nonemergent services
Monument Health HMO	Yes	Referral needed	No referral needed	No coverage without prior authorization for nonemergent services
Monument ONE HMO	Yes	Referral needed for Colorado Public Option Plans only	Referral needed for Colorado Public Option Plans only	No coverage without prior authorization for nonemergent services
Rocky Mountain HMO Valley	Yes	Referral needed for Colorado Public Option Plans only	Referral needed for Colorado Public Option Plans only	No coverage without prior authorization for nonemergent services
Rocky Mountain Sky	Yes	Referral needed for Colorado Public Option Plans only	Referral needed for Colorado Public Option Plans only*	No coverage without prior authorization for nonemergent services

*Please refer to the “Services that don’t require referrals” section of this guide for more information on services that do not require referrals.

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Understanding referrals and prior authorization/notification

Referral requests are different from prior authorization requests.

A referral request is entered by the member's primary care physician for the member to see a specialist.

A prior authorization request is for a provider (PCP or specialist) to perform a specific service that's on our prior authorization list. We must approve the prior authorization request for you to perform the service.

A prior notification request informs us that you've scheduled a specific service that'll be performed in the future. You don't need our approval to perform the service.

These plans may require both referrals and prior authorizations/notifications. We may reduce or deny coverage if you don't submit these requests to us.

Referral requirements

All the plans in the table above require a referral for a member to see most network specialty care providers. Certain services don't require referrals.

- We require a referral for a member to see most network specialty care providers
- Unless otherwise allowed by law, you must submit referrals electronically by using the UnitedHealthcare Provider Portal
- Referrals to network physicians must be submitted electronically by the member's assigned PCP or a PCP within the same provider network
- You can backdate referrals up to 5 calendar days prior to the date of entry
- Referrals are valid for 6 months or 6 visits, whichever is met first (unless they meet the chronic conditions listed below)
- Referrals must be submitted before the services are rendered
- Members without valid referral on file with the admitting physician for planned inpatient or outpatient services won't have coverage for both the admitting physician's claim and the hospital claim
- We require referrals for members to see nurse practitioners or physician assistants who practice as specialists
- The diagnosis you indicate in the claim must be the same or similar to the diagnosis in the approved referral request

When to submit a new referral request

Please submit a new referral when a member:

- Needs to see another specialist
- Needs additional visits after the referral expires
- Needs additional visits after using all the initial approved visits

We don't need you to request a new referral if a member sees a covering physician with the same specialty within the same TIN for the same diagnosis.

How to submit referral requests

To submit and view your referral requests, please use the UnitedHealthcare Provider Portal. To sign in to the portal, visit UHCprovider.com and click the sign in button at the top right of the screen. This secure online portal gives you access to patient information and more. To use the portal, you will first need to register for a One Healthcare ID, if you don't already have one. Visit UHCprovider.com/access for detailed instructions and training.

By accessing the referrals tool in the provider portal, you can:

- See if you need to submit a referral for your patient
- Submit a referral request and receive a confirmation number
- Check the status of a referral request
- View, print or save confirmation numbers and timelines for submitted referrals

Services that don't require referrals

- Any services from a network physician who shares a TIN with the member's PCP or is the PCP's covering network physician

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- Any services from network OB-GYN (specialists, nurse practitioners, nurse midwives and physician assistants)
- Routine refractive eye exam from network providers, including network optometrists
- Mental health/substance use disorder services with network behavioral health clinicians
- Services rendered in any emergency room
- Services rendered in network urgent care centers, network convenience care clinics or network virtual visits (e.g., telehealth)
- Services from network pathologists, radiologists or anesthesiologists
- Virtual health services from network health care professional for primary or urgent care needs
- Physician services for emergency/unscheduled admissions or emergency ambulance services
- Any services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons or network team surgeons
- Outpatient network labs, network X-rays or network diagnostic services (Note: Services billed by network specialists require referral)
- Network rehabilitative services (e.g., physical, occupational, speech, aural and cognitive therapies), with exception of manipulative therapies
- Treatment and vision therapy (e.g., physician services) (Note: Services billed by network specialists require referral)
- Any other network services as required by state mandates
- Any prior authorizations that have already been submitted and approved
- Services provided by Indian Health Service

Referral guidelines

Each referral may include up to 6 visits. Unused visits expire 6 months from the referral start date.

After the 6 visits are used or expire, the PCP may submit another referral to the network specialist for up to 6 visits.

For members with certain chronic conditions, we accept referrals for up to 99 visits in a 6-month referral period.

Chronic conditions eligible for standing referrals of up to 99 visits:

- Allergy rhinitis
- AIDS/HIV
- Amyotrophic lateral sclerosis
- Anemia
- Cancer
- Cystic fibrosis
- Epileptic seizure
- Fracture care (we don't require that you specify the fracture care procedure in the referral)
- Glaucoma
- Myasthenia gravis
- Multiple sclerosis
- Parkinson's disease
- Renal failure (acute)
- Seizure
- Thrombotic microangiopathy

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Chapter 8: Optum pharmacy

Formulary – requesting exceptions

Physicians may, without penalty, request coverage for prescription drugs that fall outside established coverage guidelines, Formulary guidelines or standard treatment protocols. These requests may be made on behalf of individual members. Requests are made through the portal at **UHCprovider.com**. The request will be reviewed by a clinical pharmacist, who may approve or deny the request and if necessary, consult with a medical director. Additional information may be required from you to fully evaluate the request.

Formulary – prior authorizations

Some drugs in the Formulary require prior authorization. Prescriptions presented to a pharmacy that require prior authorization will reject. More information about these requirements can be found and completed through CoverMyMeds or SureScripts. Visit **UHCprovider.com** for information on how to submit these online. Once filled out and submitted to the review team, the request will be evaluated within 24 hours and a decision made within turnaround-times based on the member's benefit. You will be notified, by fax, of an approval. If the prior authorization is denied, you will be copied on the denial letter sent to the member.

Current prior authorization forms for individual drugs are available at:

UHCprovider.com

Phone – **1-800-228-3643**

Fax – 1-866-539-1092

Specialty pharmacy network

Optum Specialty Pharmacy is the resource for RMHP members to receive specialty drugs. A complete listing of specialty drugs is available at **UHCprovider.com**.

Specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling. Most benefit plans administered by RMHP provide a different level of coverage or tier for specialty drugs.

Some specialty drugs may be available at retail and specialty pharmacies. Other specialty medications, called limited distribution, are only available at certain specialty pharmacies. As our exclusive specialty pharmacy, if Optum Specialty Pharmacy is able to distribute most of these medications, members are required to use Optum Specialty Pharmacy if they can supply the drug. If Optum Specialty Pharmacy cannot distribute a limited distribution drug, please refer to the specialty drug list, which contains additional information regarding the specialty pharmacy you should use.

Mail order prescriptions

RMHP contracts with Optum Mail Order for mail order pharmacy services. Members generally pay lower copay for a 90-day supply from a mail order pharmacy. Mail order prescriptions should always be written for up to a 90-day supply of medication.

Medication therapy management

UnitedHealthcare offers medication therapy management (MTM) services to all of our interested members. There is no charge for this service.

MTM services combine a thorough review of the member's medication history by a UnitedHealthcare

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employed or contracted clinical pharmacist with a written summary of findings and suggestions for alternative therapy.

Each member requesting MTM will be carefully evaluated with regard to:

- Appropriateness of drug therapy regimen given the disease(s) present
- Duplicative or unnecessary therapy
- Under- or over-utilization
- Drug interactions
- Alternative medications that could result in lower costs
- Issues that may be affecting compliance
- Principles of sound, evidence-based medicine will be applied to each review

Medicare Part D members

An important aspect of Medicare Part D is the mandatory requirement for provision of formal MTM services by Part D plans in an effort to ensure patients with high drug costs are receiving absolutely optimal medication therapy, both from a clinical and economic standpoint.

Eligible Medicare Part D members will be enrolled in a structured MTM program performed primarily by a small number of contracted clinical pharmacists. If medication issues are identified, the MTM pharmacist will contact the provider(s) and the member with a letter and may follow up by telephone. The MTM pharmacist is available to answer any medication-related questions and to assist members and physicians in improving medication compliance. The recommendations of these MTM pharmacists are not intended to supersede or interfere with a physician's care of their patient.

RMHP Part D members will be automatically enrolled in the program if they meet the following criteria:

- Members must qualify each calendar year
- Part D drug costs likely to exceed the dollar threshold set by CMS each year
- Multiple chronic diseases within a specified time frame from the defined list used by RMHP (such as asthma, COPD, CAD, CHF, diabetes, hypertension). The number of unique diseases to qualify is set each year.
- **Multiple Part D-covered drugs**
  The number of Part D drugs to qualify is set each year. Members may opt out of the MTM Program at any time by notifying RMHP.

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Chapter 9: Provider rights and responsibilities

Accommodations for people with disabilities

Members enrolled in federally funded programs that have communication disabilities have a right to interpreter services to render effective communication in connection with the provision of covered services. As a RMHP participating physician or provider, it is your responsibility to provide interpretive services for RMHP members enrolled in federally funded programs, at no cost to the member.

If your office is unable to accommodate the requests, please coordinate with RMHP for the provision of interpretive services by calling or directing the member to call RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP.

RMHP recommends you have a policy and/or procedure that documents how you ensure effective communication with members of limited English proficiency or members with a sensory impairment.

RMHP also urges you to ensure your office and/or facilities are able to accommodate people with disabilities and/or special health care needs.

Accommodations for non-English-speaking members

Members enrolled in federally funded programs who are non-English-speaking have a right to interpreter services to render effective communication in connection with the provision of covered services. As an RMHP participating physician or provider, it is your responsibility to provide interpretive services for RMHP members enrolled in federally funded programs, at no cost to the member.

If your office is unable to accommodate requests, RMHP provides access to a language line for providers seeing RMHP members. Translators representing multiple languages are available and can be arranged by calling RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP.

Advance directives policy

Policy on advance directives in compliance with the Patient Self-Determination Act of 1990

For the purposes of this policy, an advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to a member's wishes about medical treatment should they become incapacitated.

RMHP provides written information, at the time of enrollment, to each adult who enrolls with RMHP, describing:

- A person's right under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to have advance directives
- RMHP's written policy with respect to the person's right to make health care and advance directive decisions and the way such rights may be carried out

RMHP's policy regarding advance directives requires that:

- RMHP ensures compliance with state laws regarding advance directives
- Documentation is maintained in the member's medical record about the existence of advanced directives
- Provision of health or medical care is not conditioned on whether or not the member has signed an advanced directive or otherwise judge a member based on whether or not the member has signed an advance directive

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- Staff to be trained concerning its policies on advance directives
- Community education be provided regarding advance directives

Practitioner requirements related to advance directives

If a member gives a practitioner an advanced directive, it must be included in the member's medical record. Practitioners may not condition the provision of health or medical care or otherwise judge a member based on whether or not the member has signed an advance directive. Staff must also be trained concerning the practitioner's policies on advance directives.

Certain practitioners that provide care to Medicare or RMHP PRIME members–including hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for RMHP purposes, providers of personal care services), hospices and religious nonmedical health care institutions–have an additional responsibility to document in a prominent part of the medical record whether or not a member has an advance directive. Under 42 CFR 489.102, these practitioners also are required to maintain written policies about advance directives and to provide written in formation (at the times specified in 42 CFR 489.102(b)) to members about:

- Their rights under the state law to create an advance directive
- The policy of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience

Practitioner responsibility related to objections to an advance directive on the basis of conscience

If a practitioner is unable to implement a patient's advance directives, please notify the member as well as your provider relations representative by phone or in writing describing your objection and indicating you are unable to implement an advance directive on the basis of conscience.

If you are the member's PCP, RMHP will request the member in question be assigned to a new PCP. The member's former and new PCP will be notified of the change. The member (or the member's representative) will be counseled regarding the change and the details related to the PCP's objections. We also encourage the PCP to discuss any and all advance directive issues with the member if they have not already done so.

If you are a specialist, RMHP will notify the member's PCP and request the PCP refer the member to a different specialist. In addition, it is appropriate the specialist and the PCP discuss advance directives issues together.

If at any time the PCP, specialist, or member requests additional information regarding RMHP's role in this process, the requesting party will be provided the details and counseled to discuss the issue with other parties involved.

Verifying eligibility, benefits and your network participation status

Check the member's eligibility and benefits prior to providing care. Doing this:

- Helps ensure you submit the claim to the correct payer
- Allows you to collect copayments where applicable
- Determines if a referral, prior authorization or notification is required
- Reduces denials for non-coverage

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information.

There are 4 easy ways to verify eligibility and benefits as shown in the Online/interoperability resources and how to contact us section in Chapter 1: Introduction.

Eligibility grace period for Individual Exchange Plan members and D-SNP

When individuals enroll in a health benefit plan on the exchange, Connect for Health Colorado, they are required to provide a 3-month grace period before terminating coverage. A 6-month grace period is required for D-SNP. The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least 1 full month's premium within the benefit year.

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Additionally, for individuals who do not receive federal subsidy assistance, plans are required to provide a grace period consistent with state law (typically 30 or 31 calendar days) before terminating coverage.

You can verify if the member is within the grace period when you verify eligibility.

Refer to the Chapter 4: Individual Exchange Plans for more information.

Understanding your network participation status

Your network status is not returned on 270/271 transactions. Know your status prior to submitting 270 transactions. As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status for the medical or pharmacy benefit plan (and tier status for commercial tiered benefit plans) while checking eligibility and benefits in the UnitedHealthcare Provider Portal or by calling us at **1-888-478-4760** (individual and family plans). If you are not participating in the member's benefit plan or are outside the network service area for the benefit plan, the member may have higher costs or no coverage.

Commercial only

For more information about tiered benefit plans, visit **UHCprovider.com/plans** > Select your state > Commercial > UnitedHealthcare Tiered Benefit Plans.

Benefits questions

Address all benefits questions to RMHP Member Services by calling:

Members

- Individual and Family Plans at **1-888-809-6539**
- RMHP PRIME and RAE at **1-800-421-6204**
- Medicare at **1-800-982-5195**
- CHP+ at **1-877-668-5947**
- D-SNP at **1-800-701-9054**

Providers

- Individual and Family Plans at **1-888-478-4760**
- RMHP PRIME and RAE at **1-800-421-6204**
- Medicare at **1-877-842-3210**
- CHP+ at **1-877-668-5947**
- D-SNP at **1-800-701-9054**

Please DO NOT quote our benefits to members or attempt to interpret them. The information on all RMHP plan benefits in this manual is in summary form only. Complete details are available in the appropriate Member EOC and through Member Services.

CLIA regulations

Providers with laboratory testing facilities must hold a valid CLIA certification or Waiver of a CLIA Certificate of Registration in 1992, phased in through 1994, and amended in 1993, 1995 and 2003. Labs will not be eligible for reimbursement from RMHP without a valid certification for the type of testing performed. See **Lab Charges – Billing Guidelines** for additional information.

Closing a practice to new members

Providers who choose to close their practice to new members must do so for all RMHP members. Providers may not close their practice to specific lines of business or products.

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance. Changes to panel status apply to all patients for all lines of business (LOB) and products for which a health care provider is participating. If you feel that exceptional circumstances exist, you may request to have a different panel status for an LOB or product. Include the exception in the written request. Approval is at our discretion. We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators. Access My Practice Profile in the UnitedHealthcare Provider Portal at **UHCprovider.com/mpp** to update your information.

RMHP member dismissal process

At RMHP, we want to ensure you have all of the information you need to help you best serve our members – your patients. We understand that it may, at times, be necessary for a provider to dismiss an RMHP

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member from your care who is enrolled in a RMHP product.

In this instance, you must do the following:

- Contact RMHP at RMHPCareManagementreferrals@uhc.com to arrange for a care coordinator to work with the member to understand the impact of their behavior on their ability to remain with your practice
  - RMHP/Community Care Teams can use motivational interviewing and other skills so that the relationship with your practice can be preserved. During this time, the member should be given a verbal warning.
- If the issue is not resolved with at least 45 days of active intervention by a care coordinator, send a written letter to the member to advise them of the dismissal from your practice
- The dismissal must be done in writing, through delivery that confirms receipt to the patient, such as certified mail or hand-delivery. The dismissal letter should/must include:
  - That you agree to provide 60 days of emergency coverage while the patient obtains a new provider
  - That the patient can contact RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-800-980-5195** for Medicare or **1-800-701-9054** for D-SNP, for assistance in finding a new provider
- Notification that patient records will be sent to the new provider upon receipt of written authorization from the patient

Send a copy of the letter to RMHP Care Management Team by secure email or mail, if needed:

Rocky Mountain Health Plans
Attn: Care Management Team
P.O. Box 10600
Grand Junction, CO 81501-5600

The RMHP Care Management team will use this information to help find an alternative provider for the member's care.

Circumstances that may result in member dismissal

A PCP may dismiss a member for any of the following reasons:

- A documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet other member responsibilities
- The member fails repeatedly to follow the recommended treatment plan or medical instructions
- The provider cannot provide the level of care necessary to meet the member's needs
- The provider moves out of the service area
- The member and/or member's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff and/or other patients

If the member's behavior or misconduct poses an imminent threat to the PCP, to other staff/providers or to other members, the PCP may request an expedited dismissal after it has provided the member exhibiting the behavior or misconduct an oral warning.

A member cannot be dismissed due to:

- A member's disability or illness, or costs that the disability or illness might involve (e.g. providing an interpreter for a member who is d/Deaf or deaf-blind)
- The member's gender, race, religion, disability, color, national origin, age, sex, gender identity or sexual orientation
- The member's diminished mental capacity
- Any behavior of the member resulting from the member's special needs, unless those behaviors seriously impair the PCMP's ability to furnish services to that member or other members.

If you have any questions, we're here to help. Please contact RMHP Provider Services at **1-888-478-4760** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE, **1-877-668-5947** for CHP+, **1-877-842-3210** for Medicare or **1-800-701-9054** for D-SNP.

Credentialing, re-credentialing, and delegated credentialing

For credentialing, re-credentialing and delegated credentialing information, please go to UHCprovider.com > Our Network > Join our network.

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To change an existing TIN or to add a physician or health care provider

To submit the change, complete and email the Provider Demographic Change Form to the appropriate email address listed on the form. The Provider Demographic Change Form is available on UHCprovider.com/findprovider. You can also submit detailed information about the change and the effective date of the change on your office letterhead. Send it to us using the email address on the bottom of the demographic change request form.

To update your practice or facility information

You can make demographic updates every 90 days to your practice information by:

1. Using Provider Directory Snapshot within CAQH ProView.
2. Accessing the UnitedHealthcare Provider Portal and using My Practice Profile for health care providers; UnitedHealthcare Facility/Practice Profile for facilities.
3. Emailing the completed Provider Demographic Change Form to the appropriate email address listed on the bottom of the form.
4. Calling our Enterprise Voice Portal at **1-877-842-3210.**

We monitor sanction activity from state licensing boards, CMS, Office of Inspector General (OIG) and other regulatory bodies. If we find a health care provider has a sanction that results in loss of license or governmental authorization, we terminate them from our network.

Health care provider office site quality review

We have office site standards that you must follow, including:

- Physical accessibility, such as handicapped accessible
- Physical appearance and cleanliness of the site
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of treatment record keeping (e.g., secure/confidential filing system)

Emergency care and on-call physician

Any physician may provide necessary emergency medical attention for an illness or injury to any RMHP member. The PCP should, however, be notified as soon as reasonably possible. In most instances, there is a copayment for emergency room visits. Follow-up visits must take place in the physician's office rather than in the emergency room.

Urgent and emergent, life- and limb-threatening care is available, without prior authorization, for all members 24 hours a day, 7 days a week. Additionally, members may receive emergency services and urgently needed services while temporarily outside the service area. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services.

When possible, members should contact their PCP, who can provide guidance for the urgent care needs. Urgent care centers are available for members within certain communities.

Members may obtain emergency care by dialing 911 or going to the nearest hospital emergency room. Treatment of life- and limb-threatening emergencies is covered whether received from a participating or nonparticipating facility.

Office emergency services

The office emergency services code 99058 should be used only in situations in which a patient presents to the physician's office with an emergent problem that might typically be seen in an ER which disrupts other scheduled office services in addition to the basic service, such as lacerations, fractures, chest pain or acute shortness of breath. This code will be used in addition to an office visit or a procedure code and may require submission of office notes.

On-call physician

When a PCP is off-duty, they must provide 24-hour coverage through a colleague with comparable

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qualifications who is also a participating physician (or who has a covering physician agreement) with RMHP. The on-call (covering) physician is authorized and responsible for providing care to RMHP members to the same extent as the PCP. When covering for another provider, the on-call (covering) physician agrees to accept as full payment for services rendered to the member, the amounts which RME pays to the provider being covered for (based upon the fee schedule in effect at the time the services are rendered). They may refer and order labs, X -rays and other diagnostic tests. The on-call physician may bill RMHP directly, indicating the on-call situation and the name of the physician for whom he/she was taking calls. A nonparticipating physician may provide coverage only if it is an emergency, unless an RMHP CM nurse has authorized the visit.

Compliance

UnitedHealthcare, a subsidiary of UnitedHealth Group (the "Company"), is dedicated to the highest standards of integrity. As one of the country's leading health and well-being companies, the Company's reputation ranks high among its most important assets. Customers, employees, regulators, health care professionals, investors and others expect honesty and integrity in their dealings with the Company. These qualities are embedded in the Company's core values.

Because the Company is committed to the highest standards of integrity, it has implemented the UnitedHealth Group Compliance and Ethics Program. The program promotes compliance with applicable legal requirements, fosters ethical conduct within the Company, and provides guidance to its employees, contractors, and suppliers (i.e. vendors). Additionally, the program focuses on increasing the likelihood of preventing, detecting and correcting violations of law or Company policy. The implementation of such a program, however, cannot guarantee the total elimination of improper employee, contractor or supplier conduct. If misconduct occurs, the Company will investigate the matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations. Preventing, detecting and correcting misconduct safeguards the Company's reputation, assets, and the reputation of its employees.

Any individual who has knowledge of facts, and who has concerns about known or suspected violations of laws or regulations, or concerns about questionable conduct, should report the violation.

To report a known or suspected violation or concern to UnitedHealthcare, call the Compliance & Ethics Help Center – available 24 hours a day, 7 days a week at **1-800-455-4521**.

Noncovered services

If you provide services to a RMHP member that are determined "not a benefit of the member's plan," you may collect directly from the member. If you are uncertain about a member's benefits, call RMHP Member Services for verification. With respect to RMHP PRIME and CHP+ members, RMHP recommends that you obtain a statement signed by the member (or responsible party) acknowledging that the specific service not a covered benefit and agreeing to pay.

Out-of-network/out-of-plan services

For members of RMHP PRIME, Medicare, CHP+ and RMHP Individual and Family Plans, except for medical emergencies and urgent care services, prior authorization is required for any services from a nonparticipating provider prior to rendering services. Only the member's PCP, covering physician or PCP staff may submit a request for approval to obtain services from out-of-network providers.

Please use the prior authorization form to submit your request. The following information is required to process the request:

- The complete name, address and tax ID of the specialist, lab or ancillary provider who will bill RMHP for services
- The patient's diagnosis
- The name of the specialist recommending the out-of-network service, if applicable
- The effective date, place of service, and type of services requested
- Procedure codes

To expedite the review process, please include medical records to justify the reason for requesting approval to obtain services from a nonparticipating provider. The out-of-network prior authorization is valid only for the services specified by the CM nurse(s) on the prior authorization form.

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Primary Care Provider

Depending on a member's plan, the member may be required to select a participating physician as their PCP upon enrollment. The PCP is responsible for the patient's total care and coordinates all medical care provided to the member. The PCP agrees to provide primary, preventive, acute, chronic and comprehensive health care management for the member. The PCP should explain the member's right to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment. This right includes the preparation of advance directives, or written instructions expressing the member's wishes about their medical treatment should they become unable to make those decisions on their own. (Please see the Advance Directives Policy.)

Additional PCP responsibilities

- Maintain a complete and accurate record of the member's health and health care
- Refer the member to specialty physicians and other health care providers when appropriate
- Arrange for copies of laboratory results and other health records to accompany the patients referred to specialty physicians and other service providers as appropriate to enhance continuity of care and to reduce the need for duplication of diagnostic procedures
- Evaluate and incorporate into the member's health record information received from specialty physicians and other providers
- Arrange for elective admission for inpatient hospital care when appropriate, including completion of the steps required to demonstrate the necessity for such admission
- Take responsibility for case management (solely or jointly with the specialist) as soon as possible after receiving information that a member of their primary care practice has been hospitalized on an emergency basis, whether in or out of the service area
- Maintain and operate their practice in a manner that protects the health and safety of RMHP members and provides reasonable access for acute and scheduled appointments

Provide official notice

Notify us, at the address in your Agreement, within 10 calendar days if any of these situations occur:

- Material changes to, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice (for physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility)
- Relocation or closure of your practice, and, if applicable, transfer of member records to another physician/facility
- External sanctions or corrective actions levied against you by a government entity

Provide timely notice of demographic changes- primary care physicians

As a PCP, you are responsible for monitoring your office capacity based on member assignments and for notifying us if you have reached your maximum capacity. A self-reporting tool is available for you to generate a PCP panel roster report using UHCprovider.com/reports.

We have developed specific definitions for open, closed or existing-only practices to promote consistency throughout the participating health care provider network related to acceptance of new or transferring members. For purposes of this section, a new member may be a member who has switched health plans and/or coverage plans, such as a member who switches from a Fee-For-Service (FFS) plan to a Commercial HMO/MCO plan. Follow these definitions:

- Open status – the PCP's practice is open to additional new members and transferring members
- Closed status – the PCP's practice is closed to all new members and transferring members
- Existing-only status – the PCP's practice is only open to new or transferring members who have an established chart with the health care provider's office

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Notification of changes must be proactive

Every quarter, you, or an entity delegated to handle credentialing activities on behalf of us (a "delegate"), are expected to review, update and attest to the health care provider information available to our members. If you, or the delegate, cannot attest to the information, you must correct it online or through the Provider Service Center. You, or the delegate, must tell us of changes to the information at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph. You and the delegates are required to update all health care provider information, such as the following:

- Patient acceptance status
- Address(es) of practice location(s)
- Office phone number(s)
- Email address(es)
- Health care provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number
- NPI(s)
- Languages spoken/written by staff
- Ages/genders served
- Office hours

Delegates are responsible for notifying us of these changes for all of the participating health care providers credentialed by the delegate. If you or a delegate fails to (1) update records, or (2) give 30 days prior notice of changes, or (3) attest to the information, you, or the participating health care providers credentialed by the delegate, may be subject to penalties. Penalties may include a delay of processing claims or the denial of claims payment, until the records are reviewed and attested to or updated.

If a health care provider leaves your practice, notify us immediately. This allows us to timely notify impacted members. When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

PCP changes - member requested

RMHP strongly supports a member's relationship with their PCP; however with most plans, we no longer require member's to notify us when they change their PCP.

- Colorado Doctors Plan (CDP) members are required to have a PCP listed with RMHP
  - CDP members may request a change in PCP assignment by calling RMHP Member Services or use the online through myuhc.com. Members must be registered to use the member portal.
- RAE-only members must notify Health First Colorado by calling **1-888-367-6557** or by visiting the Health First Colorado website

PCP-consultant relationship

The PCP must make copies of pertinent tests, reports or medical records available to any provider used as a consultant. Documentation of information provided and the date it was sent should be included in the member's medical record.

The consulting physician is responsible for reporting findings and recommendations in writing to the PCP before performing any elective procedure. If the consult is done on an emergency basis, the consulting physician must try to contact the PCP by telephone. The consulting physician must submit a written report as documentation in the patient's medical record.

Confidentiality - member

Members of RMHP have certain rights of privacy as it relates to their health information. It is important for you to understand how we protect the health information of our members.

- Employees of Rocky Mountain Health Management Corporation agree at the time of hiring and on an annual basis to maintain the confidentiality of protected health information
- Most RMHP members are asked to read and sign the Application for Enrollment form when they enroll.

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The application includes information authorizing any physician, health care provider, hospital, other medical facility, insurance company or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage to give RMHP such information and to supplement such information as RMHP requests. This is referred to as the member's routine consent.

- Members have the right to approve the release of information through special consents. RMHP may request a unique medical records release form when necessary to receive information from entities as previously mentioned.
- RMHP is a "covered entity" under HIPAA and is subject to the HIPAA Privacy Rule found at 45 CFR, parts 160 and 164
- RMHP does not generally keep completed medical records regarding our members. A member may access their medical records through the PCP, or other providers. RMHP provides access to its members to the records that RMHP does keep consistent with HIPAA.
- RMHP has a policy regarding the use of member data for measurement purposes. Except when agreements to protect confidentiality are in place, information requested is given in de-identified or aggregate form and is only provided upon request. All requests from external entities to use de-identified or aggregate member data are reviewed by RMHP personnel.

RMHP complies with all applicable HIPAA regulations, including the privacy, security, and transactions and code set regulations. RMHP Notice of Privacy Practices, which further explains our members' privacy rights, is distributed to all subscribers and is made available to all individuals at **UHCprovider.com** or by calling Member Services. Similarly, providers who are "covered entities" under HIPAA must comply with all applicable regulations.

Cultural competence

Cultural competence is defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations."

Culture shapes how people experience their world. Decisions on quality of work and family life and how to relate to others are determined in part by culture. Culture is the shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people. It is a vital factor in both how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by race and ethnicity but also by factors such as geography, age, religion, gender, sexual orientation and socioeconomic status.

In a society as culturally diverse as the United States, medical providers and others in health care delivery need the ability to communicate with diverse communities and the knowledge to understand culturally influenced health behaviors.

Providing patients with quality health care and helping people to change risky behavior patterns and understand the benefits of healthy living are all hallmarks of the kind of good practices health care professionals in the United States strive to achieve. Unfortunately, practitioners in this country also face many unique obstacles to the level of care they would like to deliver. Some of these obstacles involve cultural misunderstandings and miscommunications with patient populations whose languages, experiences and backgrounds differ from those of their providers.

Public health studies consistently show improved health outcomes as providers bridge cultural gaps between themselves and their patients.

- Communication and understanding lead to improved diagnoses and treatment plans. The improved patient satisfaction leads to greater compliance with those plans and fewer delays in seeking care.
- Cultural competence allows the provider to obtain more specific and complete information to make an appropriate diagnosis
- Cultural competence facilitates the development of treatment plans that are followed by the patient and supported by the family
- Cultural competence enhances the compatibility between Western and traditional cultural health practices

Cultural competence and building healthy communities through community development programs go hand-in-hand.

RMHP values diversity and encourages all participating providers to be aware and sensitive to the cultural differences that exist in our diverse communities.

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In support of this philosophy, RMHP advocates for continued education and diversity training. For more information on how you may obtain subject matter pertaining to cultural competency programs, please contact the U.S. Department of Health & Human Services, Office of Minority Health:

- Phone – 1-844-899-8057
- Website –thinkculturalhealth.hhs.gov

Cultural competency training and information

For cultural competence training and information, please consult UHCprovider.com > Resources > Resource Library > Patient Health and Safety > Cultural Competency.

Equal opportunity policy statement

It is the policy of RMHP to provide equal opportunity and to prevent discrimination based on race, color, sex, national origin, age or disability in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law.

All federally funded benefits and services are provided in accordance with Title VI of the Civil Rights Act, as amended, Section 504 of the Rehabilitation Act, as amended, the Age Discrimination Act of 1975, as amended, the Americans with Disabilities Act of 1990, as amended, as well as other related laws. All subcontractors are notified of their responsibility to comply with these laws.

The EEO Officer is responsible for compliance with sate and federal equal opportunity laws. This EEO Officer is also responsible for implementing the Equal Opportunity Plan. If you would like more information regarding these provisions, or if you believe you have not been treated in accordance with this policy, please contact the member concerns coordinator at 1-800-346-4643 or 1-970-243-7050, TTY for the hearing impaired: 711.

Provider tools and resources

Online resources

There are a number of ways clinicians, practice managers, administrative staff, facilities and hospital can stay up to date on items of interest from UnitedHealthcare.

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, quality programs and more.

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Chapter 10: Fraud, waste and abuse

Fraud, waste and abuse in health care

The purpose of our fraud, waste and abuse (FWA) program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. Our program has 2 main functions:

- UnitedHealthcare payment integrity, Optum entities and others perform our payment integrity functions to help:
  - Ensure reimbursement accuracy
  - Keep up to date on new and emerging FWA schemes
  - Discover methodologies and technologies to combat FWA
- Special Investigations Units (SIUs) perform prospective and retrospective investigations of suspected FWA committed against our benefit plans and programs

This program is part of our compliance program led by our chief compliance officer. Our compliance department works closely with internal business partners in developing, implementing and maintaining the program.

If you identify compliance issues and/or potential FWA, report it to us immediately so we can investigate and respond appropriately. Refer to the Online/interoperability resources and Contact Us section in [Chapter 1: Introduction](#) for contact information. UnitedHealthcare prohibits any form of retaliation against you if you make a report in good faith.

Report suspected fraud or abuse

When you report a situation you believe is fraud, waste or abuse, you are doing your part to protect patients, save money for the health care system and prevent personal loss for others. Taking action and making a report is an important first step. After your report is made, UnitedHealthcare works to detect, correct and prevent FWA in the health care system.

You can report to UnitedHealthcare online on [uhc.com/fraud](#) or by calling **1-844-359-7736**.

False Claims Act

RMHP complies with requirements of the Deficit Reduction Act of 2005 by giving you information about our fraud and abuse policies in this manual and by providing information about the False Claims Act. The False Claims Act is a federal law that provides the government a tool to prevent and detect FWA. The False Claims Act prohibits any person from knowingly submitting a false or fraudulent claim for payment from government funds, including the Medicare and RMHP PRIME programs.

Anyone that knowingly submits a false claim for payment by the US Government is liable for fines of up to 3 times the amount paid for the false claim, administrative penalties (up to $11,000 per false claim) and legal fees. The individual may also be subject to criminal prosecution. The CMS and the Colorado Department of HCPF (Medicaid) can report suspected false claims to the U.S. Department of Justice.

The federal False Claims Act also contains a provision allowing for individuals to bring legal suit on behalf of the government if the individual has evidence of false claims. This is called a qui tam suit or “whistleblower” suit. When a qui tam suit is initiated by an individual, the purpose is to recover amounts for the government paid for false health care claims. If the suit is ultimately successful, the whistleblower may be awarded a percentage of any funds that are recovered. The federal False Claims Act contains “whistleblower” protection for employees. Protection is extended to any employee that is discharged, demoted, suspended, threatened, harassed or discriminated against as a result of the employee relaying information regarding false claims.

The state of Colorado has specific laws regarding false claims. Under the Colorado False Medicaid Claims statute (25.5-4-306), the state may bring a civil action against any person who has intentionally or with reckless disregard submitted a false Medicaid claim.

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An individual may be ordered to pay to the state full restitution in addition to a civil penalty of up to $50,000 or 2 times the amount of medical assistance paid.

Fraud – audit of Medicare claims

CMS requires RMHP to audit claims and identify providers who are billing both RMHP and Medicare, and who receive duplicate payment.

Please be aware RMHP is an authorized CMS contractor for processing Part B claims for its members.

Providers should NOT bill both Medicare and RMHP and accept primary payment from both payers. If this happens, providers must refund RMHP's payment.

If our audit reveals a pattern (more than 1 or 2) of duplicate payments have been made to the same provider, RMHP will pursue a more thorough audit of that provider's billing records.

Where a pattern of duplicate billings and payments is detected, RMHP is required to notify and work with the Office of the Inspector General for HHS in Denver on case development and possible criminal prosecution. You will be notified in writing of the violation and notification.

Crossover billings to RMHP for secondary consideration with a copy of your CMS 1500 or UB-94 and a copy of the Explanation of Medicare Benefits are not considered duplicate payments. Please direct any questions to your provider relations representative.

Hold harmless policy

The following clause is included in all provider contracts and survives the termination of any agreement.

"No Recourse Against Covered Persons or Colorado. In no event, including, but not limited to, nonpayment by Rocky Mountain Entities (RME), RME's insolvency, or breach of this Agreement, shall Contractor o r a Group Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person, the state of Colorado, any Federal Health Care Program or State Health Care Program or persons (other than the RME) acting on the covered person's behalf, for services provided pursuant to this Agreement. This provision does not prohibit the contractor or a group physician from collecting copayments, coinsurance and deductibles as specifically provided in the covered person's health care plan or fees or supplemental charges for uncovered services delivered on a fee-for-service basis to covered persons. This provision shall survive the termination of this Agreement, regardless of the reason for termination, including insolvency of RME, and shall be construed to be for the benefit of covered persons, the state of Colorado and any federal health care program or state health care program. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the contractor or a group physician and a covered person or persons acting on a covered person's behalf insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to this Agreement. No changes, modifications, additions or deletions shall be made to the provisions of this paragraph without the prior written consent of the Secretary of the United States Department of Health and Human Services and such changes, modifications, additions or deletions shall become effective on a date no earlier than 30 days after the Colorado Commissioner of Insurance has received written notice of such proposed changes, modifications, additions, or deletions with regard to health care plans which are not self-insured health care plans. This paragraph shall not apply in the event of the insolvency of a self-insured employer who offers a self-insured health care plan administered by RME."

Locum tenens

RMHP follows Medicare guidelines and will recognize the use of a locum tenens for 60 consecutive days. Please bill services for the locum tenens under the name and provider number of the participating physician. Use modifier Q6 to indicate that services were provided by locum tenens. No credentialing is required for this short-term or intermittent coverage.

If the services of a locum tenens are required for a period longer than 60 consecutive days, please notify your provider relations representative, who will work with you to credential the physician.

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Mid-levels

RMHP requires the mid-levels be assigned a unique provider number and services be billed under the name and provider number assigned to the extender to ensure correct reimbursements per contract and accurate collection of utilization data.

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Chapter 11: Medical records

Release of information and transfer of records

Each provider will make health service records for RMHP members in their care available during reasonable hours to other participating providers and to authorized individuals employed by RMHP in accordance with HIPAA and the terms of the RMHP provider agreement.

Consistent with HIPAA, each member's health service record will be held in strictest confidence, with the understanding that HIPAA allows the RMHP representative and/or certain government agencies and regulators who monitor RMHP access to the medical record.

In the event the provider should retire, die or terminate their contract or otherwise cease to care for RMHP members, the complete health service record on file for that member (from the date they first became a member and/or provider's patient while a member) or a copy of that health service record will be transferred to the provider who assumes responsibility for the RMHP member's health care.

Should any RMHP member leave a provider's care by transferring to another provider:

- If required by HIPAA, the member will provide a signed request for transfer of their complete medical records to the participating provider of their choice. Upon receipt of such a request, the first provider will transfer a copy of the medical record to the designated provider.
- Should any member leave a provider's care because of disenrollment or become inactive for any other reasons, the former member may provide a signed written request for transfer of their complete medical records to a provider of their choice.

In the event the former member does not elect to have their health medical records transferred, their provider will maintain said record for a period of at least 7 years, unless a longer time frame for retention of records is required by legal requirements applicable to RMHP. Generally, longer time frames apply for medical records of RMHP PRIME recipients, Medicare beneficiaries, and RAE and CHP+ members. In the event of a state or federal government audit, the records must be maintained through resolution of the audit findings. The record is to be kept in safe storage in a manner ensured to preserve its confidentiality.

RMHP members are to be treated with respect and their right to confidentiality protected. Patient medical records, including those stored electronically, shall be maintained in an adequately secure environment.

RMHP complies with all applicable HIPAA regulations, including the privacy, security and transactions and code set regulations, by the compliance dates for those regulations. Similarly, providers who are "covered entities" under HIPAA must comply with all applicable regulations.

Office records – primary care

The medical record is an important source of patient information vital to the provision of quality medical care. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized and maintained in a format that facilitates retrieval of information and assures confidentiality.

All records should include:

- General information
- A basic information sheet containing name, age (date of birth) and sex as well as parental and custodial information should be included for children
- A medical history, a family history, and a personal history
- Allergies or drug reactions
- Immunization status assessed and tracked
- An up-to-date list of the patient's medical problems
- An up-to-date list of the patient's current medications
- Each page in the record contains the patient's name or ID number

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- All entries are dated and contain the author's identification
- Provider signature

Office visit information

- The primary problem for which the physician was consulted
- Any pertinent history or physical examination data
- A diagnosis, impression, or assessment and subsequent data
- A plan, including any medications or tests ordered
- EKGs mounted, labeled and interpreted
- Interpretation of office X-rays
- Any procedure or study for which there is a separate charge made – such as pulmonary function studies, audiograms, A and B scans, allergy testing, and EMGs – should have a report in the chart. The report should be recorded in a fashion that a physician trained to do so would be able to retrieve and interpret the data
- Office surgical procedures, including anesthetic used, if any, and specimens submitted for pathologic examination
- Documentation of patient instructions regarding the diagnosis and its management
- Telephone conversations with the patient involving medical advice or a change in therapy
- Periodic health screening examinations
- Health history changes or new complaints, if any, since the last examination
- A physical examination describing all systems examined
- The PCP should make copies of pertinent test, reports and medical records and make them available to a consulting provider and document this in the medical record
- Advance directives, if executed, are documented

Reports and summaries

- Dated laboratory and radiology reports
- Consultation reports
- Hospital discharge summaries

Official records – specialist

In addition to the general record maintenance points, communication with the referring physician is important. RMHP expects to find evidence of such communication in the charts, either in the form of a letter to the referring physician or a copy of office notes. This communication should occur after the initial evaluation and periodically thereafter whenever recommendations or therapy are changed and, at minimum, yearly for a stable patient.

All records should include:

- General information
- A basic information sheet containing name, date of birth and sex
- A medical history, a family history, personal history and current medications list
- Allergies or drug reactions
- An up-to-date list of the patient's medical problems
- An up-to-date list of the patient's current medications
- Each page in the record contains the patient's name or ID number
- All entries are dated and contain the author's identification
- Consultation reports and any material provided by the referring or PCP
- Dated laboratory and radiology reports
- Hospital discharge summaries, history, physical examination and operative notes where applicable
- Provider signature

Office visit information

- The primary problem for which the specialist was consulted
- Pertinent history (subjective data)
- Pertinent objective data to include any laboratory, X-ray or other test
- Any impression or assessment
- Recommendations or a plan of therapy with a written copy forwarded to the referring physician
- Documentation of patient instructions regarding the diagnosis and its management
- Recommendation to return to the referencing physician, if applicable
- Telephone conversations with the inpatient involving medical advice or a change in therapy

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Reports and summaries

- Office diagnostic test, EKGs and other office tests (such as radiology, pulmonary function tests, allergy tests, EEGs, ultrasound) are to be documented and interpreted in the chart and maintained and mounted in such a way as to make them easy to retrieve and review
- There must be an entry in the patient's record for office surgical procedures, including the indications, anesthetic used (if any) and the specimen(s) submitted for pathologic examination (if any)

Consent to disclose substance use disorder information

On Jan. 1, 2020, the federal government has set forth a new regulation on requirements to disclose substance use disorder (SUD) information (Regulation 42 C.F.R).

If you are a provider who provides SUD services to RMHP members, you must obtain a written consent from the member, to authorize the disclosure of information related to the treatment of SUD to RMHP. The appropriate form can be found at **UHCprovider.com** or you may contact your provider relations representative for a copy of the form.

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Chapter 12: Member rights and responsibilities

The following text is reproduced from the Member Handbook.

Individual and Family Plan members

It is your right to:

- Select a PCP or you may be required to select a PCP based on your plan. Your PCP or doctor will provide or arrange for all your health care needs.
- Receive information about RMHP's services, practitioners, providers and member rights and responsibilities
- Receive information about changes to your health plan
- Be treated with respect and with recognition of your dignity and right to privacy
- Accept or refuse treatment to the extent provided by Colorado state law
- Take part in making decisions about your health care
- Have talks with providers about proper or medically needed treatment choices for your conditions regardless of cost or benefit coverage
- Bring complaints or appeals to both RMHP and the insurance commissioner of the state of Colorado
- Expect all aspects of your care to be kept private as required by law
- Make recommendations regarding RMHP's rights and responsibilities policy

It is your responsibility to:

- Tell your doctor about any advance directives about your health care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Follow the plans and instructions for care that you and your health care provider have agreed on
- Assume responsibility for your own health and well-being
- Learn about your health care benefits, procedures, and limitations
- Be helpful and considerate with health care providers and staff
- Tell Member Services of any changes to your membership
- Let us know if you move. RMHP will change your address in our records if it receives notice from the U.S. Postal Service of a different address for you.
- Assume responsibility for copays and costs for certain health care services, including copays for both your health plan and any services that are not covered
- Give RMHP and your provider all necessary information to offer you correct health care

RMHP PRIME, RAE and CHP+ members

It is your right:

- To get information about RMHP and its services, doctors, and health care providers and to get information about your rights and responsibilities
- To be treated with respect and with recognition of your dignity and right to privacy
- To accept or refuse medical treatment to the extent provided by Colorado state law and to participate in making decisions about your health care
- To have open discussions with health care providers about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage, and presented in a manner appropriate to your condition and ability to understand
- To make appeals, and to bring complaints to RMHP, the insurance commissioner of the state of Colorado, or the Department of HCPF
- To be furnished health care services in accordance with federal health care regulations for access and availability, care coordination and quality
- To expect all communications regarding your care to be kept confidential as required by law
- To freely exercise your rights without being treated differently

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- To be free from the use of physical restraint or being isolated. These methods may not be used to make you cooperate, to punish you, for the ease of the caregiver, or as a way of getting back at you
- To get family planning services from an Health First Colorado provider, in or out of RMHP network with no referral
- To request and receive your medical records and to have them changed according to federal law
- To get a second opinion with no referral and at no cost to the member
- To be free from discrimination based on race, color, national origin, age, disability, sex, sexual orientation or gender identity
- To make recommendations regarding RMHP rights and responsibilities policy
- To use any hospital or other setting for emergency care

It is your responsibility:

- To choose a PCP for each member of your family and to let that PCP know of any advance directives regarding your medical care
- To let your PCP direct your health care with specialists and other health care providers, except in cases of medical emergencies, urgent care when outside the service area, obstetrical or gynecological care, and eye care
- To learn about your RMHP health care benefits, procedures and limitations and to be cooperative and considerate with health care providers and staff
- To notify RMHP Member Services of membership or address changes, marriage, birth of a child or adoption of a child
- To take responsibility for copayments and costs for certain health care services and any services that are not covered by Health First Colorado
- To understand your health problems and participate in making treatment goals
- To provide the health care provider with all information needed for you to receive appropriate care and to follow the care and instructions agreed upon with your provider
- To tell your providers about any advance directives about your health care
- To follow any protocols of a responsible third party payer (such as other insurance) prior to receiving any nonemergency services
- To provide RMHP with written notice after filing a claim or action against a third party responsible for your illness or injury.
- To tell RMHP about any other insurance you may have, including Medicare
- To file a complaint or grievance, please follow the rules as described in the Appeal and Grievance section of this manual

Medicare members

Member rights:

- We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- We must treat you with fairness and respect at all times
- We must ensure that you get timely access to your covered services and drugs
- We must protect the privacy of your personal health information
- We must give you information about the plan, its network of providers and your covered services
- We must support your right to make decisions about your care
- You have the right to get help if you believe you are being treated unfairly or your rights are not being respected
- You have the right to make recommendations regarding the RMHP member rights and responsibilities policy

Member responsibilities

- Get familiar with your covered benefits and rules you must follow to obtain these covered benefits
- Let us know if you have any other health insurance coverage or prescription drug coverage in addition to our plan
- Tell your doctor and other health care providers that you are enrolled in our plan
- Help your doctors and other providers help you by giving them information, asking questions and following through on your care
- Be considerate and respectful of other patients
- Pay what you owe
- Tell us if you move

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Chapter 13: Definitions

Abuse
Actions that may, directly or indirectly, result in unnecessary costs to the health insurance plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or medically unnecessary services. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Active course of treatment
An ongoing course of treatment for a life-threatening condition

1. An ongoing course of treatment for a serious acute condition, chronic condition, or life -limiting illness
2. The second or third trimester of pregnancy through the postpartum period
3. An ongoing course of treatment for a health condition, whether physical health, mental health, behavioral health, or substance abuse disorder, for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes

Ancillary Product Providers
Companies who provide the following types of products including related technical services: durable medical equipment (Including braces and orthotics), oxygen suppliers, medical supplies and miscellaneous ancillary products

Ancillary Service Providers
Providers who offer or perform the following types of services including any related technical services: podiatry, physical therapy (including manipulative therapy, sports medicine) occupational therapy, dentists and oral surgeons, clinical radiology, clinical pathology, speech therapy, audiology, dietitians, certified nurse midwives and other miscellaneous ancillary providers

Case management
A collaborative process that assesses, coordinates, monitors and evaluates options and services to meet an individual's health needs. This is accomplished through communication among providers, hospital/facility staff, and the patient/family to promote quality, cost-effective, efficient outcomes.

Counties with Extreme Access Considerations (CEAC)
As defined by the U.S. Centers for Medicare & Medicaid Services (CMS), with a population density of Less than 10 people per square mile, based on U.S. Census Bureau population and density estimates

Department
References to the "department" means Health First Colorado

Emergency medical condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services
A medical or mental health screening examination that is within the capability of the emergency department of a hospital or freestanding emergency room, including ancillary services routinely available to the emergency department to evaluate the emergency medical or mental health condition; and also defined as within the capabilities of the staff and facilities available at the hospital, further medical or mental health examination and treatment as required to stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition

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Emergent care
With respect to an individual member, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition

Essential Community Provider (ECP)
A provider that serves predominantly low-income, medically underserved individuals, such as health care providers defined in the federal law and under part 4 of article 4 of title 25.5, C.R.S.4

Fraud
Health care fraud is a crime that involves misrepresenting information, concealing information or deceiving a person or entity to receive benefits, or to make a financial profit (18 U.S.C.§1347).

Frontier County
A county with a population density less than or equal to 6 persons per square mile

High-Impact Specialist
A type of specialist who treats specific conditions that have serious consequences (high-morbidity/mortality rates) for the member and require significant resources (determined annually by reviewing the National Centers for Health Statistics Data Briefs for the previous year)

High-Volume Specialist
A type of specialist who treats a significant portion of an organization's membership (determined annually)

High-Volume Behavioral Health Care Providers
A type of behavioral health, mental health and substance abuse disorder specialist who treats a significant portion of an organization's membership (determined annually)

Institutional Providers
Participating facilities limited to hospitals, hospice organizations, dialysis, mental health facilities and skilled nursing facilities

Mental Health, Behavioral Health, and Substance Use Disorder Providers
To include psychiatrists, psychologists and peers, licensed clinical social workers, psychiatric nurses, licensed addiction counselors and licensed professional counselors

Network
A group of participating providers providing services under a managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan

Pharmacy
Facility that is registered with the State Board of Pharmacy and has obtained all other required state and or federal licenses or registrations. Includes retail, long-term healthcare, home infusion, specialty and mail-order pharmacies

Primary Care Physicians (PCP)
A participating health care profession designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. (For the purpose of network adequacy measurements, PCPs for adults and children includes these provider types: pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrician*/gynecologist*, physician assistants and nurse practitioners supervised by, or collaborating with, a PCP)

*Not considered a PCP with Colorado Doctors Plan on the Front Range

Rural County
A county with a total population of less than 100,000 people

Specialist
A physician or nonphysician health care professional who:

- Focuses on a specific area of physician, mental or behavioral health or a group of patients
- Has successfully completed required training and is recognized by the state in which they practice to provide specialty care

Urban County
A county with a total population equal to or greater than 100,000 people

Urgent care
Medical care needed to treat an injury or illness of a less serious nature than those requiring emergency care but required to prevent serious deterioration of the person's health.

Urgent Care Center
A medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of nonlife- and limb threatening illnesses and injuries. Urgent care centers are enhanced by on-site radiology and laboratory services and operate in a location distinct from a freestanding or hospital-based emergency department. Care is rendered under the medical

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direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-ins patients seeking medical attention during all posted hours of operation

Waste

The over-utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

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