



ROCKY MOUNTAIN

HEALTH PLANS®

Good health. That's the plan.

GOOD HEALTH

PROVIDER EDITION

FALL 2007

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Did you know that being a Provider for Rocky Mountain Health Plans has additional benefits?

A few highlighted in this edition are:

- Free educational lecture series to assist you and your offices on understanding Advanced Directives along with how to assist and educate your patients. (See page 5)
- RMHP commitment to our communities with highlights of our continued coverage of CHP+. (See page 7)
- A local health plan presence that is involved in our state. Check out RMHP's CEO John Hopkins in the September edition of *Managed Healthcare Executives*, for an article on the changes in health care. www.managedhealthcareexecutive.com.
- Customer Service you can count on: The *Health Matters 2007 Quality Report*, produced by the Colorado Business Group on Health, has been released. Colorado Business Group on Health is a non-profit business coalition whose goals are to provide information on health care quality to consumers and to report Member satisfaction survey information. In the 2007 *Health Matters Quality Report*, Rocky Mountain Health Plans scored **significantly higher than other health plans** for helpful customer service, trouble-free access to specialty care, and timely handling of medical claims.



Please route this important information to:

- Physicians
- Office Manager
- Billing Office
- Receptionist
- Other

RMHP QI Study Results

The 2006 Rocky Mountain Health Plans clinical study results for breast cancer screening, cervical cancer screening, childhood immunizations, and adolescent immunizations are summarized below.

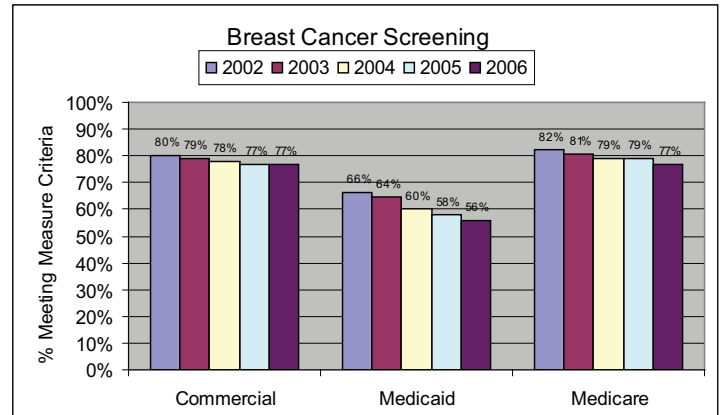
(Data Source: Retrospective claims and medical chart abstraction data).

Breast Cancer Screening

Study Population Definition: The HEDIS sample of female RMHP Members age *42 to 69 who were continuously enrolled through the measurement year (January 01 through December 31, 2006) and the year prior to the measurement year, allowing for no more than one gap in enrollment of up to 45 days during each year. Study includes Members having at least one mammogram in either the measurement year or the previous year.



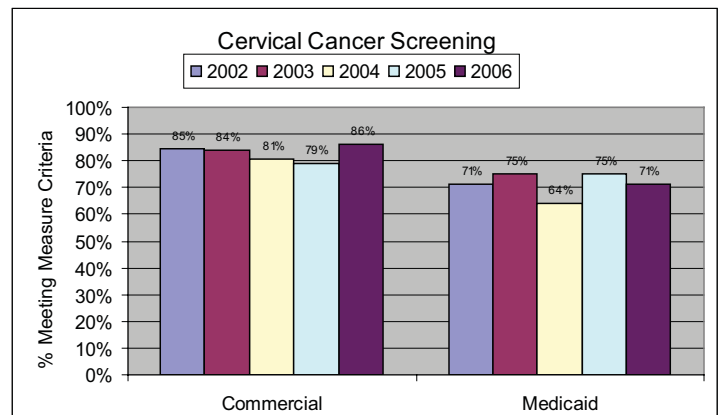
*Statistical variance noted to this year results related to age changes from prior collection years.



Cervical Cancer Screening

Study Population Definition: The HEDIS sample of female RMHP Members age *24 to 64 who were continuously enrolled through the measurement year (January 01 through December 31, 2006) and the two years prior to the measurement year, allowing for no more than one gap in enrollment of up to 45 days during each year. Study includes Members having one or more Pap tests in either the measurement year or the two years previous to the measurement year.

*Statistical variance noted to this year results related to age changes from prior collection years.

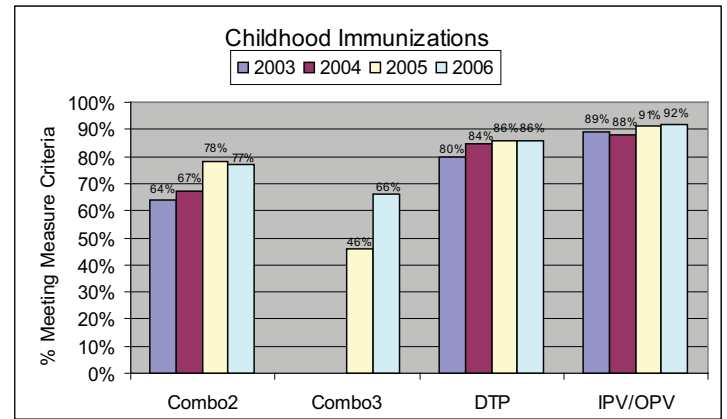


Childhood Immunizations

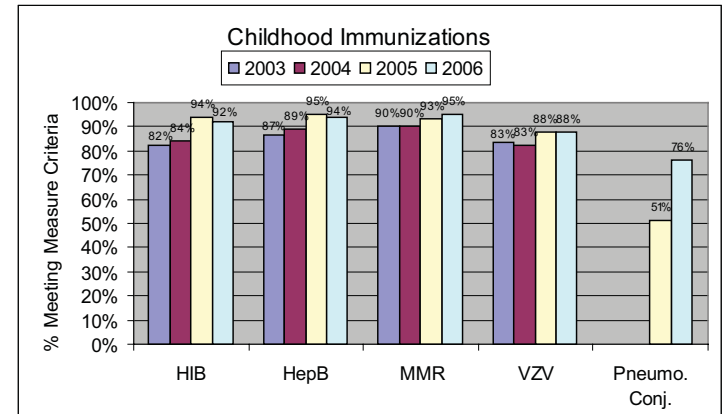
Study Population Definition: The HEDIS sample of RMHP Members who turned two years old during the measurement year (January 01 through December 31, 2006) who were continuously enrolled from 12 months immediately preceding their second birthday, and who have had no more than one gap in enrollment of up to 45 days during the 12 months immediately preceding their second birthday. Note: Combo 1 was retired last year.

Combo 2 = 4 DPT/DTaP
3 IPV
1 MMR
3 Hib
3 Hep B
1 VZV

Combo 3 = 4 DPT/DTaP
3 IPV
1 MMR
3 Hib
3 Hep B
1 VZV
4 PCV



* % reflects combined rates of Medicaid and Commercial population



* % reflects combined rates of Medicaid and Commercial population

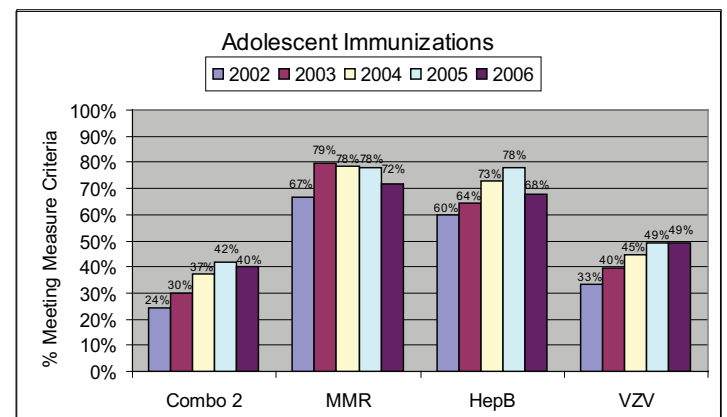
Adolescent Immunizations

Study Population Definition: The HEDIS sample of RMHP Members who turned 13 years old during the measurement year (January 01 through December 31, 2006) who were continuously enrolled during the 12 months prior to the thirteenth birthday, and who have had no more than one gap in enrollment of up to 45 days during the 12 months immediately preceding their thirteenth birthday. Note: Combo 1 was retired this year.

Combo 2 = 1 or 2 MMR
3 Hep B
1 VZV

The information used to calculate HEDIS (Health Plan Employer Data and Information Set) rates is obtained from Member data collected from claims and through medical record reviews in physician offices. Thank you for making medical records available for this important effort. We appreciate your cooperation during our data collection process.

If you would like more information, please contact Jackie Hudson, RN, Quality Improvement Program Manager at 970-248-5190 or jackie.hudson@rmhp.org.



* % reflects combined rates of Medicaid and Commercial population

Timely Filing Appeals Information

Per regulation 4-2-23 of the Colorado Division of Insurance, appeals for claims denied for failure to meet timely filing requirements must be submitted to RMHP in writing. Please use the standardized Colorado Medical Society Provider Dispute Resolution Form when submitting a request for a provider appeal (form available on-line at www.rmhp.org , Provider, Commonly Used Forms).

Claims that are submitted after the timely filing deadline as defined in the provider's contract are denied by RMHP as out of timely filing. If a claim was denied for timely filing, the contracted provider may not bill the Member for the service. The provider can appeal the decision by submitting a written request (Provider Dispute Resolution request) including supporting documentation to prove that the claim was filed within a timely manner.

An appeal must be requested within 12 months from the date of the original Remittance Advice. If the claim is related to a coordination of benefits (COB) with a federally funded health benefit plan, including Medicare and Medicaid, the provider has 36 months from the date of service to request a review.

Acceptable documentation to override timely filing

- The provider must make the determination that the claim is not on file with RMHP within the provider's contracted timely filing requirement. The claim(s) must then be submitted within 30 days of the date the determination was made, or within the contracted timely filing requirement whichever is greater, for waiver of timely filing to be considered. Claims status is available through Access RMHP or by calling RMHP customer service.
- If the provider originally received incorrect insurance information and the date of service (DOS) is beyond the contracted timely filing period, the provider has 30 calendar days from the date the provider is advised of the correct insurance information to file the claim. If a provider has not obtained correct insurance information within 12 months from the date of service the claim will remain denied.
- If the claim was filed through Electronic Data Interchange (EDI) a copy of RMHP's electronic claims transmittal report must be provided with the request. If the claim was rejected the provider must correct and resubmit the claim within the contracted timely filing or 30 days, whichever is greater. If the problem cannot be corrected, paper submission of the claim is recommended to ensure timely filing. Acknowledgement reports from the provider's clearinghouse are not an acceptable proof of timely filing; the report has to clearly indicate it is an Acceptance/Rejection Report.
- If the Member is a Medicaid member and the provider was unable to determine that the patient had Medicaid coverage until the timely filing period expired the provider may file a Late Bill Override Date (LBOD) with the provider appeal. Please note: the provider has 60 days from the date the claim processed to request an appeal for a Medicaid member.

Coding Tips

Procedure G8300 is billed for original Medicare Members only. Please do not use this code when billing Rocky Mountain Health Plans Medicare Members.

Billing For Flu Shots

For those of you that bill for flu shot clinics, roster billings will not be accepted at RMHP. Please submit a completed CMS 1500 form for each flu shot recipient. Code the 90471 for the administration fee, plus an additional line item for the 90658 - flu vaccine.

Advanced Directives

Did you know that fewer than 25 percent of Americans have documented their choices for medical care at the end of life? Having those choices documented ahead of time, when you are still able to make those decisions for yourself, can save your family members and close friends the stress and anguish of having to make those decisions for you.

The Rocky Mountain Health Plans Foundation is sponsoring a Five Wishes Advance Directives Program statewide to teach people about their options for dealing with important end-of-life issues. Our program has been very well received throughout Colorado, and we would like to extend our offer to you and your employees. Our free lecture series is an hour program hosted for groups of 15 or more and includes:

- Advance care planning
- Planning and communicating advance care wishes
- Conveying wishes to doctors and family members
- Living Will
- Medical Durable Power of Attorney
- End-of-life legal issues and medical ethics

Drs. Bruce Richards and Jim Karel provide valuable information regarding Advance Directives – the Durable Medical Power of Attorney and the Living Will. Your employees will use this worksheet to complete their five wishes, a legal document that will ensure family members and health care providers are aware of what they want regarding end-of-life care.

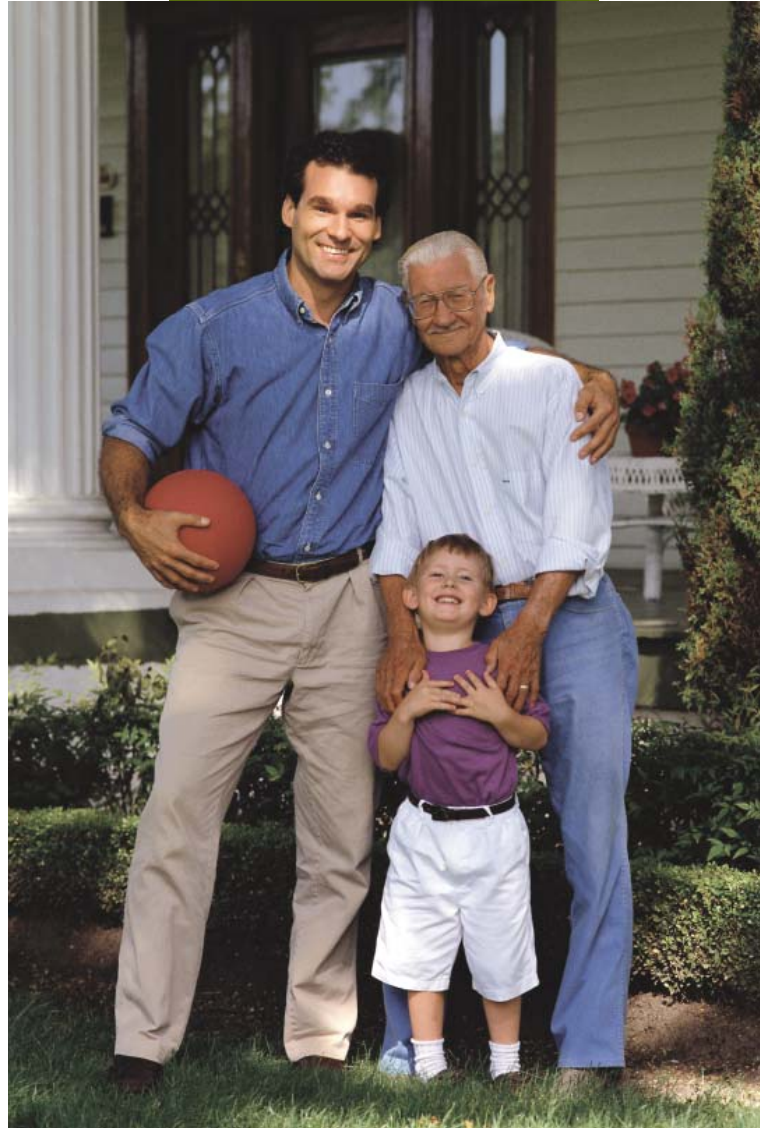
Bruce Richards, MD, is founder of the Advance Medical Directives Program and former president of the Colorado OB/GYN Society and the International Society for the Advancement of Humanistic Studies in Medicine. Previously he served on the boards of directors of the COPIC Foundation and the Grand River Hospital District.

Jim Karel, MD, is the former president of the Denver Medical Society, the Colorado Society of Internal Medicine, and the internal medical section of St. Luke's Hospital in Denver. After retiring from internal medicine, Jim sought pastoral training and now serves as a chaplain at the Hospice of St. John in Lakewood, Colorado. He is a member of the Denver Community Bioethics Committee, the Metro Denver End-of-Life

Coalition, and the Ethics Committee of National Jewish Hospital and Research Center.

To schedule this very important program at your worksite please contact Dr. Bruce Richards at: brucerichards@aol.com (preferred contact method) or 970-285-6102.

Good advanced planning for health care decisions is, in reality, a continuing conversation – about values, priorities, the meaning of one's life, and quality of life.



RMHP Now Offers Medigap Plans A, C, F & G

RMHP is committed to our Medicare members and is excited to announce additional options for those Medicare members wanting options outside of our traditional HMO plans. In order to serve those Medicare beneficiaries that have traditionally preferred Medicare Supplement policies, RMHP is introducing Medigap Supplement Insurance plans to beneficiaries in Colorado effective September 2007.

- RMHP's Medigap plans are traditional Medicare Supplemental policies, meaning that Members may access any Medicare Provider. Your RMHP provider contract is not applicable to these policies
- Medicare Providers submit claims directly to Medicare, then the claim will crossover to RMHP. Supplemental benefits will be paid without requiring the provider to bill RMHP on a secondary basis.
- **IMPORTANT NOTE:** The billing process will **not** change for our Medicare Cost Plan Member services, please continue to bill RMHP directly for Part B services for those members.

How can I distinguish a Medicare HMO Member from a Medigap Member? What does the Medigap Member card look like?

The Member card is clearly identifiable by the RMHP Medigap logo. The Group ID is also listed as "Medigap."



Can I see a Member's eligibility for Medigap using the Provider Portal?

Yes, you are able to clearly view the Member's status as an RMHP Medigap enrollee in the Provider Portal. You will be able to see the following information:

Carrier: Rocky Mountain Health Plans
Product: Medigap
Group: Medigap Individual Group
Benefit Plan: Medigap Plan F – Initial Premium (or other Plan A, C, F or G)
Start Date: As Appropriate

Do I need to get prior-authorization for any services provided to Medigap Members?

No, prior-authorization is not required for any services provided to Medigap Members. Since all claims are filed to Medicare first, Medicare determines if a service is covered or not.

How does my office bill for services?

You bill Medicare first (through the Medicare Carrier, Intermediary or DMERC (Durable Medical Equipment Regional Carrier) for all Medicare covered services, both Part A and Part B. Medicare pays their portion to you. The claim will then automatically "cross over" to RMHP from Medicare. RMHP will pay our portion to you. Rarely should you have to bill RMHP for any services.

What will happen if I mistakenly send RMHP a claim for a Medigap Member as I do for HMO Members?

If you submit a claim for a Medigap Member to RMHP directly, as you do for Medicare HMO Members, the Medigap claim will be denied with the advice to bill Medicare.

Can I bill RMHP Medigap Members for leftover balances not paid by RMHP?

You may bill the Member for any Medicare-covered services not paid by the RMHP Medigap plan up to the Medicare allowed amounts. You may also bill the Member for any services not covered by Medicare just as you do now with Original Medicare Members.

Who do I call if I have questions about a claim that has been sent to RMHP after Medicare has paid (or denied) their portion?

Once the claim is received by RMHP, an RMHP Customer Service Representatives will be able to check claim status as we do now for claims that are submitted to RMHP after Medicare has paid their portion.

Does a provider need to contract with RMHP (or amend their current agreement) to see Medigap members?

No, the provider does not need to do anything contractually to see Medigap Members. There is no network for the Medigap product.

Balance Billing For RMHP Members Who Have A Capped Benefit For Preventive Care

The Professional Relations Department at RMHP receives numerous inquiries about how an office is to bill for a claim that is processed under a member's capped benefit. Certain RMHP Plans carry a benefit limitation cap for an annual exam, mammogram and PSA.

Please note that when these capped benefit amounts apply, the member's allowable will display on the Remittance Advice, rather than the provider's allowable per contract. You will need to manually calculate and apply the adjustment that is required in order to bill for the correct balance the member may owe the office. For instance:

- RMHP member has an annual exam 99385 and the claim processes with an allowable of \$100.00 – the member benefit.
- Provider billed \$200.00
- Provider's contracted allowable for the code is \$179.00

The office may balance bill the member the difference between the contract allowable and the \$100.00 benefit amount; that is, \$79.00. Billing would adjust the \$21.00 as usual to a contract adjustment.

When this calculation applies, it will be indicated by an adjustment code of ZZ9, "Annual Physical Benefit Maxed".

A Tradition of Service

Child Health Plan Plus (CHP+) is the State's low-cost program for children who do not qualify for Medicaid and are not covered by other insurance. RMHP serves those Members residing in Delta, Mesa and Montrose counties. RMHP has served as a carrier for many years and is pleased to continue into the 2007-2008 contract year. When you think about what makes Rocky Mountain Health Plans different, our service to 39,500 Members of government programs including Medicare, Medicaid and CHP+ is right there at the top!

- No benefits or eligibility changes will occur for the period July 1, 2007 to June 30, 2008.
- On January 1, 2008, cervical cancer immunization and services for children under the age of 3 who have developmental delays will be added as benefits.
- On March 1, 2008, eligibility will be expanded from coverage of children whose parents earn up to 200% of the Federal Poverty Level (FPL), to cover children of parents who earn up to 205% of the FPL.





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Access RMHP Provider Quick Reference

Log In

- After RMHP has confirmed your registration, go to www.healthtrioconnect.com
- Enter your **User ID** and **Password** and click **Sign In**.
- If you've been inactive in Access RMHP for 20 minutes, you will be automatically logged out and you'll need to log back in.



Check Eligibility

- Use the Eligibility Search on the Home Page or click **Eligibility** under Office Management – it's the same search.
- Check eligibility each time you see a patient.
- Enter the **Patient's Name** or **Member ID** or the subscriber's **Social Security Number**. You can add search criteria: As of Date, Birth Date, Gender, or Age.
- Click **Search**.
- If you're having trouble searching by Member ID, search by Name.

Eligibility Search

Conduct Eligibility Search

Patient: Last Name Member ID Social Security Number

Search Filters

As of: Birth Date:

Gender: Age:

Check Benefits

- From Eligibility Search Results, click the patient's **Name**.
- The most requested benefit information is displayed. If you have questions about other benefits, call RMHP Customer Service.

Eligibility Detail as of 27 Jun 2006									
Patient Information									
Name	Abby Powell			Birth Date					15 Dec 1966
Sex	Female			PCP					Darren Peters
Member ID	123456789 00			Phone					(970) 555-1212
Address	1000 Marrow St Grand Junction, CO 81425								
Benefit Information									
Benefit Description	Copy	Coinsurance	Deductible Individual	Deductible Family	Benefit Limit	Dollar Limit	Out of Pocket Max Individual	Out of Pocket Max Family	
Office Visit - PCP	\$25	0%	None	None	None	None	None	None	
Office Visit - Specialist	\$50	0%	None	None	None	None	None	None	
Preventive Care Office Visit	\$25	0%	None	None	1 visit/year	None	None	None	
Well Child Care	\$25	0%	None	None	None	None	None	None	

Questions? Call your PR Representative.



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Check Claims

- In Office Management, click **Claims** link.
- Enter **Claim Number** or search by **Patient** or **Provider**.
- You can also modify the **Date of Service Start** and **End** dates.
- Click **Search**.
- Searching by a specific claim number will override the Date of Service Start and End date fields.

Claim Status Search	
Claim Number	<input type="text"/>
Date of Service Start	4/17/2006 <input type="text"/>
Date of Service End	7/17/2006 <input type="text"/>
Patient	<input type="radio"/> Last Name <input checked="" type="radio"/> Member ID <input type="radio"/> Patient Account Number <input type="text"/> (Patient List) <input type="button" value="v"/>
Provider	<input checked="" type="radio"/> Last Name <input type="radio"/> Tax Id <input type="text"/>
<input type="button" value="Search"/> <input type="button" value="Clear"/>	

Check Remittance Advices

- In Office Management, click **Claims** link.
- Click the **Remittance Advice** tab.
- Search by **Provider**, **Patient**, **Check Number**, **Claim Number**, or **Date**.
- You can use multiple search criteria to narrow your search.
- Click **Search**.

Remittance Advice	
By Provider	
<input type="radio"/> Last Name <input checked="" type="radio"/> Provider TIN	<input type="text"/>
By Patient	
<input checked="" type="radio"/> Last Name <input type="radio"/> Member ID	<input type="text"/>
By Remittance Advice	
<input checked="" type="radio"/> Check Number <input type="radio"/> Claim Number	<input type="text"/>
By Date	
<input checked="" type="radio"/> Check Date <input type="radio"/> Date of Service	<input type="text"/>
<input type="button" value="Search"/> <input type="button" value="Clear"/>	

Check Authorizations

- In Office Management, click the **Referrals/Auths** link.
- Search by **Patient**, **Requesting Provider**, **Servicing Provider**, **Authorization Number**, **Authorization Type**, **Start/End Date** or **Status**.
- Click **Search**.
- The Request Number is the Authorization Number.
- The authorization must fall within the date range. If you're having trouble finding an authorization, change the dates to include the date of the authorization.

Status			
Search by Any Combination			
Patient	(None) <input type="button" value="v"/>	or	<input type="radio"/> Last Name <input checked="" type="radio"/> Member ID <input type="radio"/> Member SSN <input type="text"/>
Requesting Provider	No Referred By List	or	<input checked="" type="radio"/> Last Name <input type="radio"/> Provider UPIN <input type="text"/>
Servicing Provider	No Referred to List	or	<input checked="" type="radio"/> Last Name <input type="radio"/> Provider UPIN <input type="text"/> Specialty Type <input type="button" value="v"/>
Request Number	<input type="text"/>	Requested Service	<input checked="" type="checkbox"/> Specialist <input checked="" type="checkbox"/> Outpatient <input checked="" type="checkbox"/> Admission <input checked="" type="checkbox"/> Transportation <input checked="" type="checkbox"/> Home Care
Start Date	6/17/2006 <input type="text"/>	End Date	7/17/2006 <input type="text"/>
Service Request Status	<input checked="" type="checkbox"/> Pending <input checked="" type="checkbox"/> Approved <input checked="" type="checkbox"/> Denied		
Sort	Select Sort <input type="button" value="v"/>	<input checked="" type="checkbox"/> Ascending	
<input type="button" value="Search"/> <input type="button" value="Clear"/>			

Questions? Call your PR Representative.

Save Over \$3 per Claim!

You may be signed up for Access RMHP for providers, but do you know how much money you save by using it?

A recent study published by Milliman, a health care technology consulting firm, calculated the estimated cost savings of using electronic transactions as opposed to manual transactions to be up to \$3.73 per claim. Even if you do not submit electronic claims, your office can still save over \$5,000/yr by using electronic verification of benefits and claim status!

You know the facts about electronic claims submissions. The table below shows the savings that your practice could experience in about a year's time:



	Manual Cost	Electronic Cost	Savings Per Transaction	Transactions Per Year	Estimated Annual Savings
Claims Submission	\$6.63	\$2.90	\$3.73	6,200	\$23,126
Eligibility Verification	\$3.70	\$0.74	\$2.96	1,250	\$3,700
Claim Status	\$3.70	\$0.37	\$3.33	620	\$2,064.6
Total					\$28,890.60

WOW — in over a year's time your practice could experience over \$28,000 in savings just by using electronic transactions!

In addition to the financial savings of electronic claim submission, electronic eligibility verification allows offices to easily validate every patient's insurance eligibility on every visit, reducing the collection and billing costs of patients without coverage – reducing bad debt. Looking up claims status will keep claims from denying out of timely filing since it allows a quick check to assure a claim is in process at the carrier.

Access RMHP for Providers can save medical practices money and time by processing administrative tasks electronically. If you aren't registered, please do so TODAY at www.rmhp.org. If you are registered, be sure to utilize the benefits and SAVE MONEY FOR YOUR PRACTICE!

Important Notice Regarding Tamper Proof Prescription Pad Legislation

Rocky Mountain Health Plans wishes to clarify two important points in regards to section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Act of 2007. This legislation requires prescribers to use tamper-resistant prescription pads for any new prescription given to a Medicaid recipient on or after October 1, 2007.

1. Due to the short timeline with which this legislation was passed down, The Colorado Department of Health Care Policy and Financing (HCPF Department) will NOT be enforcing the 'Tamper Proof Prescription' legislation at this time. Please reference this excerpt from the enclosed Colorado HCPF bulletin:

"...The Department will not audit pharmacies for accepting any non-tamper resistant prescriptions from prescribers during phase one. In the event CMS audits pharmacies for compliance with this law, the Department will not take back any payments for claims on non-complaint prescription pads during this phase..."

2. According to CMS guidance Rocky Mountain Health Plan's Medicaid patients are excluded from this rule. The Federal Legislation has created exceptions to the 'Tamper Proof Prescription' legislation which includes Medicaid patients managed by an HMO. Please refer to the following excerpt from the enclosed Colorado HCPF bulletin:

"...Prescriptions paid for by a managed care entity, drugs provided in nursing facilities and intermediate care facilities for the developmentally disabled, and other specified institutional and clinical settings are exempt from the tamper-resistant prescription pad requirements..."

Please refer to the bulletin issued by The Colorado Health Care Policy & Financing Department which addresses this legislation in its entirety. This bulletin can be found online at the following address: <http://www.chcpf.state.co.us/HCPF/Pharmacy/phmindex.asp>

If you have any questions or concerns, please feel free to contact RMHP's Pharmacy Help Desk at 1-800-641-8921 or Kim Benson at the Colorado HCPF Department.

CORNER

CODERS

Clean Claim Tips

To ensure timely processing of your claim please note the following clean claim requirements. If the required filing information is not submitted it may delay the processing of your claim.

- In field 31 please list the servicing provider's name. Submitting the claim with "SIGNATURE ON FILE" **DOES NOT** meet clean claim requirements.
- If the claim is submitted with the provider's NPI number in field 24 (column J) it must match the servicing provider's name in field 31.

If the Member has other insurance coverage please fill out Field 9 with the following information to ensure timely processing of your claim.

- Other insured's name
- Other insured's policy or group number
- Other insured's date of birth
- Employer's name or school name
- Insurance plan name or program name

PROVIDER RMHP WEBSITE TIPS

We'd like to point out some of the forms that you will find on www.RMHP.org. Within the For Providers section, select Commonly Used Forms. You'll find the following forms, among others:

- Provider Information Update/Change Form
- Claim Action Request
- Provider Dispute Resolution
- Injury Information
- CMS 1500 Claim Form
- UB-04 Claim Form
- UM Preauthorization Request Form
- DME Authorization Form
- Pregnancy Notification/Procedure Form
- And Others

Reminder: Member Confidentiality

RMHP provides a website (*Access RMHP* for Members) for Members where they can view their claims information. Providers should be aware that RMHP restricts parental access to details regarding certain sensitive data about minor children such as treatment for sexually transmitted diseases, HIV, and drug and alcohol abuse. Similar restrictions are in place for the Member Explanation of Benefits. Providers may get requests from Members for information about these specially protected services. Please be aware of any possible confidential restrictions in place for services provided to minor children.

- Front Range and Eastern Plains Professional Relations: 303-689-7372 or 719-253-3901
- Western Slope and San Luis Valley Professional Relations: 970-244-7798 or 888-286-3113

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