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NOTE: This Provider Manual is not a complete resource for all up-to-date policies and procedures. Please contact RMHP for timely updates and questions.

Updates reflected as of December, 2021.
This Provider Manual is a resource of information designed to assist provider offices in successfully delivering health care services to patients covered by RMHP. This Provider Manual includes:

- Information about our products
- Credentialing 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 & Responsibilities
- An array of web-based tool

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, alerts on the portal located on our website, or in the Rocky Mountain Health| Provider Edition newsletter, which is distributed by mail.

This manual is not a contract. It is an extension of the participating provider’s service 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.

* Rocky Mountain Health Maintenance Organization (RMHMO), doing business as Rocky Mountain Health Plans (RMHP), is a wholly-owned subsidiary of United HealthCare Services, Inc. (UHS), which is a wholly-owned subsidiary of UnitedHealth Group Incorporated (UHG). RMHMO has contracted with UHS to provide personnel services and manage its business affairs.
WELCOME TO ROCKY MOUNTAIN HEALTH PLANS

Rocky Mountain Health Plans (RMHP)* is Colorado-based and Colorado-focused. We were founded in Grand Junction more than 40 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 two organizations share a commitment to helping Members live their healthy best. This relationship gives RMHP Members access to national resources, such as a national provider network for Commercial 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 more than 327,000 Members, including individuals, families, employer groups, Medicare and Health First Colorado 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 commercial health care plans to private and public employer groups and to individuals and families throughout Colorado. RMHP also contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage Plans and with the Colorado Department of Health Care Policy and Financing (HCPF) to administer RAE and RMHP Prime health care benefits to six 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.

Looking for more information? We take pride in our service, and we’re committed to helping our Members and our providers get the answers you need, when you need it.

Visit rmhp.org  Log in to access|RMHP  Call 800-346-4643 (TTY:711)
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, and 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

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.

Non-Discrimination 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 non-publicly-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).
Contact Information

RMHP Main Numbers

Grand Junction Main Telephone ................................................................. 970-243-7050 or 800-346-4643
Grand Junction Main Fax Number ............................................................. 970-244-7880

RMHP Customer Service

Telephone ........................................................................................................ 970-248-5036 or 800-854-4558
Deaf or Hard of Hearing ................................................................................ TTY: 711

Contact Customer Service for:

- General claims questions
- Prior authorization status
- Eligibility, benefit, and copay questions
- Provider participation status inquires
- Remittance questions
- Coordination of benefits inquiries

Departments

Behavioral Health

RMHP MHSA ............................................................................................. 855-886-2832
Facility Admissions Prior Authorizations .................................................. 855-886-2832

Care Management

Case Management Referrals ....................................................................... 970-248-8718 or 800-793-1339
Disease Management Referrals .................................................................... 888-847-6466

Credentialing

For questions about credentialing, contact your Provider Relations Representative....970-244-7798 or 888-286-3113

Pharmacy Services

General Pharmacy Questions (Prior Authorizations) .................................. 970-248-5031 or 800-641-8921

Provider Relations

Contact your Provider Relations Representative........................................... 970-244-7798 or 888-286-3113

Contact your Provider Relations Representative for:

- Credentialing
- Timely filing requirements
- Contract issues including questions on allowable amounts
- Office education
- Updating demographic information
2022 Holiday Schedule

RMHP offices will be closed on the following holidays:

December 31, 2021* .......................................................... New Year’s Day 2022
January 17 ........................................................................ Martin Luther King, Jr. Day
May 30 ............................................................................... Memorial Day
July 4 .............................................................................. Independence Day
September 5 ..................................................................... Labor Day
November 24 and November 25 ........................................ Thanksgiving Break
December 26 ...................................................................... Christmas

* Due to New Year’s Day 2022 falling on a Saturday, the holiday will be observed on the day before, putting into the 2021 holiday schedule.

Hours of Operation

RMHP hours of operation for provider phone calls are Monday through Friday from 8 a.m. to 5 p.m.

Behavioral Health hours of operation for phone calls are 24/7.

Customer Service phone hours of operation for Members per line of business are listed below:

**Commercial Members** ................................................................................................................. 970-243-7050
Monday through Friday from 8 a.m. to 5 p.m.

**RMHP Prime, RAE, and CHP+ Members** .............................................................................. 888-282-8801
Monday through Friday from 8 a.m. to 5 p.m.

**Medicare Members** ...................................................................................................................... 970-244-7912
April 1 – September 30, Monday through Friday from 8 a.m. to 8 p.m.
October 1 – March 31, seven days a week from 8 a.m. to 8 p.m.
Assistance for Providers and Sources of Information

Customer Service Representatives

RMHP Customer Service 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.

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 intend 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.

- Filing claims with RMHP
- Contracts
- Prior authorization process
- Electronic claims submission
- Website tools

If you need training assistance or would like to schedule a virtual or onsite office site visit, please call your Provider Relations Representative to make arrangements.

RMHP Website Resources

Our website, rmhp.org, includes useful tools and resources to help you serve your RMHP patients better. Available on our website are commonly used forms, clinical guidelines, decision support tools, patient education and self-management tools for chronic conditions, newsletters, a directory of acronyms, glossary of terms, links to useful sites, and more.
access|RMHP, is your secure Provider Portal, available at rmhp.org to all participating RMHP providers, and facilities. There are numerous day-to-day tools available as well as helpful links to the RMHP Formularies, Code Lookup (to search for ICD-10, CPT, and HCPCS codes), and the Provider Directory.

access|RMHP, your secure Provider Portal, gives you access to important information to help you serve our Members. You must register to access the site the first time.

This special providers-only site gives you access to:

- Validate eligibility
- Review benefits
- Check claims
- Verify remittances
- Submit prior authorizations

access|RMHP Registration

Before your provider office can register with access|RMHP, RMHP must set up security requirements and register a Main Office Contact account to ensure we are protecting all secure information. The Main Office Contact account is designated for the person responsible for supervision of office personnel, management of the business office, and/or oversight of all administrative, security, and payer related functions within the facility or practice. The Main Office Contact account will create the provider office’s account access for access|RMHP. The Main Office Contact can then designate additional staff to be Main Office Contacts if needed.

Please Note: Only one person (Main Office Contact) per office needs to complete these registration steps. If you are unsure if your office already has a Main Office Contact account please email rmhmo.pr@rmhp.org to verify before completing the registration process.

Follow these steps to set up the Main Office Contact account and get started with access|RMHP.

1. Complete the Main Office Contact Registration form available at rmhp.org.

2. RMHP will initiate the portal registration and security process (Note: This process may take 3-5 business days (excluding US Federal holidays).

3. RMHP will send you a registration email to set up your One Healthcare ID and password for your access|RMHP Main Office Contact account. (Note: If you already have an active One Healthcare ID and password you will still need to complete these registration steps.)

4. Login to access|RMHP with your new One Healthcare ID credentials to set up your office staff registration.

Service Maps

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.

Below are our service areas by line of business so you better understand who we serve and in what parts of our beautiful state.
Definitions

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, Dieticians, Certified Nurse Midwives, and Other Miscellaneous Ancillary Providers

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 ten (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 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

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
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, 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 health care, 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, PCP’s for adults and children includes there provider types: Pediatrics, General Practice, Family Medicine, Internal Medicine, Geriatrics, Obstetrician* / Gynecologist*, Physician Assistants and Nurse Practitioners supervised by, or collaborating with, a primary care physician)

* 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 non-physician health care professional who:
Focuses on a specific area of physician, mental or behavioral health or a group of patients; and
Has successfully completed required training and is recognized by the state in which He / She practices to provide specialty care
Urban County:
A county with a total population equal to or greater than 100,000 people

Urgent Care Center:
An urgent care center is a medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of non-life 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 direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-ins patients seeking medical attention during all posted hours of operation

Access to Care

Network of Acute Care Hospitals, Primary Care Physicians and Specialists

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

In establishing and maintaining our network of providers, 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, primary care physicians, specialists and sub-specialists who meet RMHP’s credentialing and quality standards within the service area.

For those plans with a pharmacy benefit, RMHP offers a network of participating pharmacies throughout its service area. Our policy is to offer contracts to any willing pharmacy provider who meets our licensure and credentialing standards, which is willing to provide services to Members at reasonable rates for the services provided, and are willing to negotiate in good faith. RMHP 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 does not use quality measures, Member experience measures, or cost-related measures to select practitioners or facilities. In establishing and maintaining our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. Set forth below 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 the DOI and/or HCPF. 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 on the availability of providers is performed using geo analysis data to measure provider availability. 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 in the event inadequacies are identified.

RMHP provides Members with information on how to access the care they need. Directions on how to obtain primary care, specialty care, after-hours and emergency care, 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 strives to maintain an appropriate number of providers to ensure accessibility and range of services. When feasible, contracts are negotiated with ancillary providers that have multiple statewide locations to ensure coverage to all service areas.

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

- In response to a specific need identified by RMHP’s Quality Improvement Committee;
- In response to requests from Members;
- Due to 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 to ensure accessibility and range of services.

**Service Coverage**

RMHP highly encourages all providers to have the following service coverage standards in order to meet the need of our Members:

- Minimum hours of Provider operation to include service coverage from 8:00 am – 5:00 pm Mountain Time, Monday through Friday
- Providers shall provide for extended hours, outside the hours from 8:00 am – 5:00 pm, on evenings and weekends and alternatives for emergency room visits for after-hours urgent care
- Providers shall ensure that 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**

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**Commercial Network Availability Standards**

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### Geographic Access Standards

#### Commercial Network Geographic Standards

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**Prime Network Geographic and Time Standards**

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**Behavioral Health Network**

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<tr>
<td>Pediatric Primary Care</td>
<td></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Gynecology, OB / GYN</td>
<td>30</td>
<td>30</td>
<td>45</td>
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<td></td>
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<td></td>
<td>60</td>
</tr>
<tr>
<td>Behavioral Health Network</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hospitals (acute care)</td>
<td>20</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Psychiatrists and other psychiatric prescribers - Adult</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Psychiatrists and other psychiatric prescribers - Pediatric</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Mental Health Provider - Adult</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Mental Health Provider - Pediatric</td>
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<td>30</td>
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</tr>
<tr>
<td>Substance Use Disorder Provider - Adult</td>
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<td>60</td>
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<tr>
<td>Substance Use Disorder Provider - Pediatric</td>
<td>30</td>
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</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Urban County</th>
<th>Rural County</th>
<th>Frontier County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Max Time</td>
<td>Max Distance</td>
<td>Max Time</td>
</tr>
<tr>
<td></td>
<td>(minutes)</td>
<td>(miles)</td>
<td>(minutes)</td>
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<tr>
<td></td>
<td>Max Distance</td>
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<td></td>
<td>Max Distance</td>
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<td></td>
<td>(miles)</td>
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<td>(miles)</td>
</tr>
<tr>
<td>Pediatric Primary Care</td>
<td>30</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Pediatric Specialty Care including PT / OT / ST</td>
<td>30</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Gynecology, OB / GYN</td>
<td>30</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Hospitals (acute care)</td>
<td>20</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Behavioral Health Network</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hospitals (acute care)</td>
<td>20</td>
<td>20</td>
<td>30</td>
</tr>
</tbody>
</table>
## Appointment Availability

RMHP annually monitors to ensure Primary Care, Specialty and Behavioral Health Care practitioners meet the needs of our Member’s based on internal / external Appointment Availability standards set forth by the Colorado Division of Insurance, National Committee for Quality Assurance, as well as Governmental Programs.

In order to do so, RMHP enlists the assistance from our Member’s in the form of survey’s which are distributed throughout all lines of business and plans. Each survey contains questions pertaining to timeframes 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 Availability Standards

#### Commercial Network Appointment Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard</th>
<th>Time Frame Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>24 hours a day / 7 days a week</td>
<td>Met 100% of the time</td>
</tr>
<tr>
<td>Urgent Care Medical, Behavioral and Substance Use</td>
<td>Within 24 hours</td>
<td>Met 100% of the time</td>
</tr>
<tr>
<td>Primary Care Routine and non-urgent symptoms</td>
<td>Within 7 calendar days</td>
<td>Met ≤ 90% of the time</td>
</tr>
<tr>
<td>Behavioral Health, Mental Health and Substance Use</td>
<td>Within 7 calendar days</td>
<td>Met ≤ 90% of the time</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 7 calendar days</td>
<td>Met ≤ 90% of the time</td>
</tr>
<tr>
<td>Primary Care Access to after-hours care</td>
<td>Office number answered 24 hours a day 7 days a week by answering service or instructions on how to reach a physician</td>
<td>Met ≤ 90% of the time</td>
</tr>
<tr>
<td>Preventive visit / well visits</td>
<td>Within 30 calendar days</td>
<td>Met ≤ 90% of the time</td>
</tr>
<tr>
<td>Specialty Care Non-urgent</td>
<td>Within 60 calendar days</td>
<td>Met ≤ 90% of the time</td>
</tr>
</tbody>
</table>

#### Prime Network Appointment Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours after initial identification of need</td>
</tr>
<tr>
<td>Outpatient Follow-up Appointments</td>
<td>Within 7 days after discharge from hospitalization</td>
</tr>
<tr>
<td>Non-urgent, Symptomatic Care Visit</td>
<td>Within 7 days after the request</td>
</tr>
<tr>
<td>Well Care Visit</td>
<td>Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the Department’s accepted Bright Futures schedule</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

| Behavioral Health |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------|
| By Phone          | Within 15 minutes after the initial contact, including TTY accessibility |
| In Person         | Urban: Within 1 hour of contact, Rural and Frontier: Within 2 hours after contact |

<table>
<thead>
<tr>
<th>Emergency Behavioral Health Care</th>
<th>Within 15 minutes after the initial contact, including TTY accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Within 1 hour of contact, Rural and Frontier: Within 2 hours after contact</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-urgent, Symptomatic Behavioral Health Services</th>
<th>Within 7 days after Member’s request</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Provider shall not consider administrative intake appointments or group intake processes as a treatment.</td>
<td></td>
</tr>
</tbody>
</table>

* Provider shall not place Members on waiting lists for initial routine service requests.

### RAE Network Appointment Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours after initial identification of need</td>
</tr>
<tr>
<td>Outpatient Follow-up Appointments</td>
<td>Within 7 days after discharge from hospitalization</td>
</tr>
<tr>
<td>Non-urgent, Symptomatic Care Visit</td>
<td>Within 7 days after the request</td>
</tr>
<tr>
<td>Well Care Visit</td>
<td>Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the Department’s accepted Early Periodic Screening, Diagnostic and Treatment (EPSDT) schedules</td>
</tr>
</tbody>
</table>

### Behavioral Health

<table>
<thead>
<tr>
<th>Emergency Behavioral Health Care</th>
<th>By Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Within 1 hour of contact, Rural and Frontier: Within 2 hours after contact</td>
</tr>
</tbody>
</table>

**Non-urgent, Symptomatic Behavioral Health Services**

* 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 Appointment Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgently Needed Services</td>
<td>Within 24 hours of notification of the Member’s need for those services to the Member’s PCP</td>
</tr>
<tr>
<td>Outpatient Follow-up Appointments</td>
<td>Within 7 days after discharge from hospitalization</td>
</tr>
<tr>
<td>Non-emergent, Non-urgent Medical</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Non-urgent, Symptomatic Care</td>
<td>Within 7 calendar days of the Member’s request for services</td>
</tr>
</tbody>
</table>

* 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.
Non-symptomatic 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

<table>
<thead>
<tr>
<th>Service</th>
<th>By Phone</th>
<th>In Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Behavioral Health Care</td>
<td>Within 15 minutes after the initial contact, including TTY accessibility</td>
<td>Within 1 hour of contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural and Frontier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 2 hours after contact</td>
</tr>
<tr>
<td>Non-urgent, Symptomatic Behavioral Health Services</td>
<td>Within 7 days after Member’s request</td>
<td></td>
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<td></td>
<td>* Provider shall not place Members on waiting lists for initial routine service requests</td>
<td></td>
</tr>
</tbody>
</table>

Products & 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 Group and 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, he or she is 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.
PPO Group Plans

PPO Members have the option of receiving care from participating or nonparticipating providers. In most cases, Members pay a higher deductible, copayment, and coinsurance, and have a higher out-of-pocket maximum, when receiving care from nonparticipating providers.

RMHP offers access to a national network of physicians, hospitals, and other health care professionals. Members can get care from a national network provider outside of Colorado, and the services will be covered as an in-network benefit. Members can access the national network when traveling, temporarily residing outside Colorado, or when choosing to seek care outside of Colorado.

Types of Products and Programs

Commercial Products

RMHP markets a variety of benefit plans with varying levels of coverage and flexibility. Plans are marketed throughout Colorado and include many HMO and PPO plan selections, including High Deductible Health Plans used with Health Savings Accounts. RMHP health plans may be fully insured or have shared funding with an employer. 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

Plan Features

No Referrals

No referrals from PCPs to participating specialists are required for any RMHP health plan. In most cases, Members pay a lower copayment for services obtained from a PCP type than for services obtained from a specialist.

PCP Selection

Colorado Doctors Plan on the Front Range require a PCP. For all other plans, Members are encouraged to select a PCP. Claims are not denied if a Member sees a participating provider who is not his or her PCP.

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 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 rmhp.org, or a provider may call Customer Service at any time to check which services are on the list.

Covered Services

Covered services, limited services, and non-covered services (exclusions) may be identified by calling RMHP Customer Service or logging into accessRMHP.
Employer Group Plans

- RMHP offers HMO and PPO plans to commercial employer groups.
- Statewide HMO Small Group Plans – Rocky Mountain Summit

Regional HMO Small Groups Plans

Rocky Mountain Range – offered in these Western Colorado counties: Archuleta, Delta, Dolores, Grand, Gunnison, Hinsdale, Jackson, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Rio Blanco, Routt, San Juan, and San Miguel counties. Denver and Colorado Springs physicians are also part of the network.

- Rocky Mountain Canyon – offered in Archuleta, Dolores, La Plata, Montezuma, and San Juan counties
- Monument ONE – offered in Mesa County

Regional PPO Employer Group Plans

Monument Health – offered in Mesa County

Individual Plans

- Monument Health HMO – offered in Mesa and Delta counties
- Monument ONE – offered in Mesa County
- Rocky Mountain Valley – offered in Archuleta, Dolores, Eagle (Basalt), Garfield, Gunnison, Hinsdale, La Plata, Montezuma, Montrose, Ouray, Pitkin, San Juan and San Miguel counties

Member Eligibility

Providers must verify eligibility with each patient encounter. If a Member requests services at your office but does not have his or her card, you should check the person’s eligibility by checking accessRMHP, the Provider Portal. See the RMHP Website Resources section or call your Provider Relations Representative for details. Or call RMHP Customer Service 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 “PPO” if the plan is a PPO plan
- The plan description will always contain “HMO” if the plan is a commercial HMO 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
RMHP sends a new ID card if there is a change to the Member’s name, Member ID number, or medical or pharmacy plan.

RMHP Membership ID Card Examples
Medicare 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 Members must use participating providers except for urgent / emergent care or when out-of-network services have been approved by the plan in advance.

Medicare Counties

- Delta
- Mesa
- La Plata
- Montezuma

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 clients living in the following counties under its RMHP Prime plan:

- Garfield
- Montrose
- Gunnison
- Pitkin
- Mesa
- Rio Blanco

RMHP Prime Member Eligibility

All RMHP Prime Members receive a RMHP 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 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 Customer Service to verify eligibility before billing.

**Child Health Plan Plus**

CHP+ is public low-cost health insurance for certain pregnant women 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 women and children are enrolled by applying at a local county office or application assistance site, or online at [Colorado.gov/PEAK](http://Colorado.gov/PEAK).

**CHP+ Counties**

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

**Colorado’s Accountable Care Collaborative (ACC) Program**

The goal of this program is to improve health outcomes of Members of Health First Colorado through a coordinated, client- / family-centered system that proactively addresses Members’ health needs. RMHP serves Members in Western Colorado and Larimer County.

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 services rendered. You can access eligibility on the Department website to confirm Member eligibility. Additionally, Members receive a letter from the Department confirming their participation in the program.

ACC Member 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 Customer Service and Care Coordination for this Member population.

**ACC / RAE Counties**

- Archuleta
- Eagle
- Gunnison
- La Plata
- Moffat
- Delta
- Garfield
- Hinsdale
- Larimer
- Montezuma
- Dolores
- Grand
- Jackson
- Mesa
- Montrose
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 copy or out-of-network liability for services that did not obtain a pre-authorization or for non-covered 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 a Copay Summary.

Payment for services may be collected from or billed to a CHP+ Member only if the specific service rendered is non-covered 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 service 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 women do not have a co-pay.

The standard CHP+ copayments range from $0 to $20 per visit. CHP+ Program copayments are based on family size and income. Copayment amounts are listed on the Member’s RMHP Member ID card. 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 will pay 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 Health First Colorado. The Member should never pay more than their minimal Prime copay, if any. Please see the RMHP Prime section for additional information on RMHP Prime, including a Copay Summary.

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 a PPO 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.

**Supplemental Networks**

**Chiropractic Coverage**

*Landmark Healthcare*

RMHP offers coverage for chiropractic services as an optional supplement to its group commercial health plans. Members enrolled on the chiropractic supplement are required to use providers who participate with Landmark Healthcare to obtain covered services.

Most Employer Group and Individual Members have chiropractic services built into their plans. Claims are submitted to American Specialty Health Network (ASH). (MT edit)

*Medicare: American Specialty Health Network (ASH) provides a discount network for our Medicare Membership for Chiropractic Care, Massage Therapy, Fitness Centers, Dietician and Acupuncture Services.*

ASH also provides Medicare-covered chiropractic services to RMHP Medicare Members.

*Individual RMHP Medicare Members: Claims are submitted to RMHP. For services to be covered by RMHP, Members must receive services from an ASH provider.*

*Certain Employer Group Members: Claims are submitted to ASH. Medicare-covered chiropractic services and some additional benefits are covered when provided by an ASH provider.*

**Behavioral and / or Mental Health**

Full Continuum of SUD Benefits offered in 2021

- Effective January 1, 2021, the Department of Health Care Policy and Financing (HCPF) will be ensuring 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 will be 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 determine 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, Prime, CHP+ on page 58.

Special Connections (a program for pregnant women on Colorado Medicaid who have alcohol and / or drug use problems) will become part of the capitated behavioral health benefit managed by RMHP. The Office of Behavioral Health will continue to certify those programs.

Benefit Exclusions

- Contact Customer Service for a complete list of exclusions per Member’s Evidence of Coverage.

Guidelines

- The diagnosis must be coded according to DMS 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

Codes

The following tables were copied from the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services, issued by the Department of Health Care Policy and Financing.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and / or other drug treatment program, per diem</td>
</tr>
</tbody>
</table>

### SUD Residential Treatment – Clinically Managed Low-Intensity Residential Services: ASAM level 3.1

<table>
<thead>
<tr>
<th>CPT/HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and / or other drug treatment program, per diem</td>
</tr>
</tbody>
</table>

**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, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing

**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) utilized 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.

**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:

**Example Activities**

This per diem could include services such as:

1. Substance use disorder assessment
2. Individual and family therapy
3. Group therapy
4. Alcohol / drug screening counseling
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.

5. Service planning
6. Discharge planning

<table>
<thead>
<tr>
<th>Applicable Population(s)</th>
<th>Unit</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Child (0 – 11)</td>
<td>☒ Adult (21 – 64)</td>
<td>☐ Encounter ☐ 15 Minutes Minimum: N/A</td>
</tr>
<tr>
<td>☒ Adol (12 – 17)</td>
<td>☒ Geriatric (65+)</td>
<td>☒ Day ☐ 1 Hour Maximum: 24 Hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Program Service Category (ies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of Service (POS)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ RSATF (55)</td>
<td></td>
</tr>
</tbody>
</table>

### SUD Residential Treatment – Clinically Managed Population – Specific High-Intensity Residential Services: ASAM level 3.3

<table>
<thead>
<tr>
<th>CPT / HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and / or other drug treatment program, per diem</td>
</tr>
</tbody>
</table>

**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 he or she is 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, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing

**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. Participation 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) utilized 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 documentation for each service.

**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: U
- Special Connections services use an additional modifier:
  - Third position: HD

**Example Activities**

This per diem could include services such as:

1. Substance use disorder assessment
2. Individual and family therapy
3. Group therapy
4. Alcohol / drug screening counseling
5. Service planning
6. Discharge planning
Room and board is billed separately to the Office of Behavioral Health or their designee.

<table>
<thead>
<tr>
<th>Applicable Population(s)</th>
<th>Unit</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Child (0 – 11)</td>
<td>☒ Adult (21 – 64)</td>
<td>☒ Encounter ☒ 15 Minutes Minimum: N/A</td>
</tr>
<tr>
<td>☒ Adol (12 – 17)</td>
<td>☒ Geriatric (65+)</td>
<td>☒ Day ☒ 1 Hour Maximum: 24 Hours</td>
</tr>
<tr>
<td>☒ Young Adult (18 – 20)</td>
<td>☒ Adult (21 – 64)</td>
<td>☒ Encounter ☒ 15 Minutes Minimum: N/A</td>
</tr>
</tbody>
</table>

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.

Place of Service

☒ RSATF (55)

SUD Residential Treatment – Clinically Managed High-Intensity Residential Services: ASAM level 3.5

<table>
<thead>
<tr>
<th>CPT / HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and / or other drug treatment program, per diem</td>
</tr>
</tbody>
</table>

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 client’s needs.

Technical Documentation Requirements

See Appendix B, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing

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. Participation 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) utilized 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 documentation for each service.

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. Substance use disorder 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

Applicable Population(s)

| ☒ Child (0 – 11) | ☒ Adult (21 – 64) |
| ☒ Adol (12 – 17) | ☒ Geriatric (65+) |
| ☒ Young Adult (18 – 20) | ☒ Adult (21 – 64) |

<table>
<thead>
<tr>
<th>Unit</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Encounter ☒ 15 Minutes Minimum: N/A</td>
<td>☒ Day ☒ 1 hour Maximum: 24 Hours</td>
</tr>
</tbody>
</table>
Facility Type

<table>
<thead>
<tr>
<th>Program Service Category (ies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ HF (SUD) (First position)</td>
</tr>
<tr>
<td>☒ U5 (Second position)</td>
</tr>
<tr>
<td>For Special Connections ONLY:</td>
</tr>
<tr>
<td>☒ HD (Third position)</td>
</tr>
</tbody>
</table>

Place of Service (POS)

| ☒ RSATF (55) |

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### SUD Residential Treatment - Medically Monitored Intensive Inpatient Services: ASAM level 3.7

<table>
<thead>
<tr>
<th>CPT / HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036</td>
<td>Alcohol and/or other drug treatment program, per diem.</td>
</tr>
</tbody>
</table>

**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, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing

- **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. Participation 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) utilized and the individual’s response to the intervention(s)

**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 3.7 services are as follows:

- First position: HF
- Second position: U7
- Special Connections services use an additional modifier:
  - Third position: HD

Room and board is billed separately to the Office of Behavioral Health or their designee.

This per diem could include services such as:

1. Substance use disorder assessment
2. Individual and family therapy
3. Group therapy
4. Alcohol / drug screening counseling
5. Occupational therapy
6. Recreational therapy
7. Vocational rehabilitation
8. Service planning
9. Discharge planning
10. Medical or nursing services

**Applicable Population(s)**

| ☒ Child (0 – 11) | ☒ Adult (21 – 64) |
| ☒ Adol (12 – 17) | ☒ Geriatric (65+) |

**Example Activities**

- Encounter: 15 Minutes
- Day: 1 Hour

**Minimum: N/A**

**Maximum: 24 Hours**
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) or as a hospital (general or specialty). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

**Place of Service (POS)**
- 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)

<table>
<thead>
<tr>
<th>CPT / HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0010</td>
<td>Alcohol and / or drug services, acute detoxification (residential addiction program inpatient)</td>
</tr>
</tbody>
</table>

**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, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy & Financing

**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. Participation 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) utilized 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.

**Example Activities**

This per diem could include services such as:

1. Substance use disorder 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 Populations**

<table>
<thead>
<tr>
<th>Unit</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter</td>
<td>15 Minutes</td>
</tr>
<tr>
<td>Day</td>
<td>1 Hour</td>
</tr>
</tbody>
</table>

Minimum: N/A
Maximum: 24 Hours

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### 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.
Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

### Place of Service (POS)

- ☒ CMHC (53)
- ☒ Outp Hospital (22)
- ☒ Independent Clinic (49)

### SUD Residential Treatment – Medically Monitored Inpatient Withdrawal Management: ASAM level 3.7WM

<table>
<thead>
<tr>
<th>CPT / HCPCS Procedure Code</th>
<th>Procedure Code Description</th>
<th>Minimum Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0011</td>
<td>Alcohol and / or drug services; acute detoxification (residential addiction program inpatient)</td>
<td>See Appendix B, p. 15 of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD) Services from the Department of Health Care Policy &amp; Financing</td>
</tr>
</tbody>
</table>

#### 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.

#### Minimum Documentation Requirements

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.

### 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.

### Example Activities

This per diem could include services such as:

1. Substance use disorder 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 Populating (s)

| ☒ Child (0 – 11) | ☒ Adult (21 – 64) | ☒ Adol (12 – 17) | ☒ Geriatric (65+) |

| ☒ Young Adult (18 – 20) |

| ☐ Encounter | ☐ 15 Minutes | ☐ Day | ☐ 1 Hour | ☐ 15 Minutes | ☐ Day | ☐ 1 Hour |

**Minimum: N/A**

**Maximum: 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 3.7WM 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.

- ☒ HF (SUD) (First position)
Physical, Occupational, and Speech Therapy

Colorado Physical Therapy Network (CPTN)

RMHP contracts PT / OT / ST providers on the Front Range through Colorado Physical Therapy Network (CPTN). Front Range providers interested in participating with the RMHP PT / OT / ST provider panel must contract directly through CPTN.

CPTN may be contacted at coloradophysicaltherapynetwork.com/ or 303-757-7004.

All other providers interested in participating with RMHP may submit requests directly to RMHP. Requests will be reviewed on a case by case basis depending on the needs of our networks.

Medicare Exception: Part B providers for physical therapy, occupational therapy and speech therapy should bill Medicare first for RMHP Medicare Members.

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, beginning with the date of the first treatment. For children ages 0-3, the benefit is unlimited through the Early Prevention Program.

Home Health Services

Commercial / 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 his/her place of residence. Custodial (non-skilled 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 Directory of Participating Physicians and Contracting Providers, available online at rmhp.org 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.

**Medicare**

RMHP does not approve or deny Home Health services for Medicare Members. Home Health services for Medicare Members must be provided by a Medicare certified Home Health Agency, and claims are submitted to Original Medicare first.

**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.

- Skilled home health services are intermittent services from nurse / pulmonary therapist / PT / OT / ST / HHA / MSW / dietician – 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; and
- The Member is expected to make significant improvement in 60 days; and
- When there is a physician order for the service; and
- When the services are reasonable and necessary; and
- 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

**Claims**

**Forms and Filing Requirements**

**Claim Forms**

Providers are responsible for submitting claims to RMHP for payment. Please call Provider Relations if you have questions or need assistance with billing. RMHP encourages providers to submit claims electronically. RMHP contracts with multiple clearinghouses that will transmit your claims electronically. In addition, you may submit directly to RMHP. For more information and a list of contracted clearinghouses, please refer to our website at rmhp.org.

If claims are submitted on paper they must be submitted on a CMS 1500 or UB-04/CMS 1450. These forms can be found on our website at rmhp.org. If your claims are prepared by a computerized billing service, be sure the staff is familiar with and understands RMHP claim submission requirements.

Mail claims to:

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

**Claim Filing Requirements**

**How to File a Claim with Rocky Mountain Health Plans**

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.

**Essential Fields**

Clean claims, as defined in Section 10-16-106.5(2), Colorado Revised Statutes, shall be submitted on the appropriate uniform claim form (the American Dental Association Dental Claim Form, the CMS 1500, or the CMS 1450/UB-04) and include all the essential fields as described below.

*The following fields of the American Dental Association Dental Claim Form (2000 version) must be completed before a claim can be considered a “clean claim”:*
Field 15 .................................................................................................................. subscriber identification number
Field 20 .................................................................................................................. patient name
Field 21 .................................................................................................................. patient birth date
Field 22 .................................................................................................................. patient gender
Fields 24–33 .......................................................................................................... services provided
Field 36 .................................................................................................................. information release
Field 37 .................................................................................................................. assignment of benefits (required if payment is to be made to provider)
Field 38 .................................................................................................................. place of treatment
Field 45 .................................................................................................................. cause of illness / injury
Field 48 .................................................................................................................. name and address of billing dentist / entity
Field 49 .................................................................................................................. National Provider Identifier
Field 50 .................................................................................................................. dentist license number
Field 51 .................................................................................................................. dentist / entity identification number
Field 52 .................................................................................................................. dentist / entity phone number
Field 53 .................................................................................................................. treating dentist signature

The following fields of the CMS 1500 Claim Form must be completed before a claim can be considered a “clean claim”:
Field 1A .................................................................................................................. insured identification number
Field 2 ..................................................................................................................... patient name
Field 3 ..................................................................................................................... patient birth date and sex
Field 5 ..................................................................................................................... patient’s address
Field 6 ..................................................................................................................... patient’s relationship to insured
Field 9A .................................................................................................................. other insurance (only if 11D is answered “yes”)
Field 10A–C ............................................................................................................ relation of condition to employment, auto accident or other accident
Field 12 .................................................................................................................. information release (“signature on file” is acceptable)
Field 13 .................................................................................................................. assignment of benefits (signature on file” is acceptable)
Field 14 .................................................................................................................. date of onset of illness or condition
Field 17 .................................................................................................................. name of referring physician (if applicable)
Field 21A–L ............................................................................................................ diagnosis code(s)
Field 24 .................................................................................................................. A, B, D, E, F, G (C, H Medicaid only) details about services provided
Field 24 .................................................................................................................. I, J: Non-NPI provider information
Field 25 .................................................................................................................. federal tax ID number
Field 26 .................................................................................................................. Patient’s account number
Field 28 .................................................................................................................. total charge
Field 31 .................................................................................................................. signature of provider including degrees or credentials (provider name sufficient)
Field 32 ........................................................................... address of facility where services were rendered
Field 32A ........................................................................... National Provider Identifier (NPI)
Field 32B ........................................................................... Non-NPI (QUAL ID), as applicable
Field 33 ........................................................................... provider’s billing information and phone number
Field 33A ........................................................................... National Provider Identifier
Field 33B ........................................................................... Non-NPI (QUAL ID), as applicable

The following fields of the CMS 1450 (UB-40) Claim Form must be completed before a claim can be considered a "clean claim":
Field 1 ........................................................................... servicing provider’s name, address, telephone number
Field 3 ........................................................................... patient’s control or medical record number
Field 4 ........................................................................... type of bill code
Field 5 ........................................................................... provider’s federal tax ID number
Field 6 ........................................................................... statement covers period from / through
Field 8 ........................................................................... patient name
Field 9 ........................................................................... patient address
Field 10 ........................................................................... patient date of birth
Field 11 ........................................................................... patient sex
Field 12 ........................................................................... date of admission
Field 13 ........................................................................... hour of admission
Field 14 ........................................................................... type of admission / visit
Field 15 ........................................................................... admission source code
Field 16 ........................................................................... discharge hour (for maternity only)
Field 17 ........................................................................... patient discharge status
Field 31–36 ........................................................................ occurrence information (accidents only)
Field 42 ........................................................................... revenue code
Field 44 ........................................................................... HCPCS / Rates HIPPS Rate Codes
Field 45 ........................................................................... service / creation date (for out-patient services only)
Field 46 ........................................................................... service units
Field 47 ........................................................................... total charges
Field 50 ........................................................................... payer(s) information
Field 53 ........................................................................... assignment of benefits
Field 56 ........................................................................... National Provider ID
Field 58 ........................................................................... insured name
Field 59 ........................................................................... relationship of patient to insured
Field 60 ........................................................................... insured’s unique ID number
Field 67 ..............................................................principal diagnosis code (indicate 'yes', 'no', or 'exempt' for Present on Admission)
Field 69 ..............................................................admission diagnosis code (inpatient only)
Field 74 ..............................................................principal procedure code and date (if applicable)
Field 76 ..............................................................attending physician name and ID (NPI or QUAL ID)

Please be aware even when you submit a completed claim form, RMHP may request additional information consistent with Colorado Division of Insurance Regulation 4-2-24.

Claims Edit Portal

Professional Claim Entry Guide

The Claims Edit Portal is a web-based, easy-to-use, application intended for users to submit hypothetical claims through the claims editing system and view the results of clinical editing of that claim. Users can immediately view the results for each submitted claim through the Portal interface. The Portal also provides the ability for users to look up previously submitted claims and view the clinical editing results. Claims results are displayed with line-by-line edits, edit rationale, and detailed sourcing.

Claim lookup results will only provide information on the coding edits that occurred on a given claim; it will not provide final disposition of the adjudication of the claim. Claims submitted through the Portal are 'hypothetical claims' and do not guarantee payment or denial of similarly-billed claims.

- **Gender** – Required field
  - User must select the gender of the patient.
  - The acceptable values in the drop down list for the gender field are Male and Female.

- **Date of Birth**
  - User must enter the patient's date of birth in this field.
  - The date format for this field is MM/DD/YYYY. The user can also click on the calendar icon to the right of the field to select the date of birth.

- **Claim Type**
  - Select the appropriate claim type

- **Procedures, Modifiers, and Diagnoses**
  - Separate additional procedures, modifiers, and diagnoses with a coma
  - No space is required

- **Code Type**
  - The Claims Edit System defaults to ICD-10 with a capability to choose ICD-9

- **Specialty** – Required field
  - Use the attached link to search for the correct specialty type

- **Amount**
  - The Claim Edit System will not calculate the allowed amount

- **Add Lines**
  - Additional lines are added by selecting the Add Lines button
All lines do not have to be populated prior to submitting the claim for analysis.

- Submit
  - After the Submit button is selected, the claim analysis results and the disclosures will be displayed.
- To begin a new claim, select the New Claim button.
- Use the back arrow in the browser to return to Professional Claim Entry page to correct any errors.
- If you need to delete a row you will need to begin with a new claim.
- Export to PDF
  - Opens and saves the results in a printer friendly format.
  - The PDF will include all information available from the Claim Analysis Results screen, including the full disclosure text.

If you have additional questions related to the use of the Claims Edit Portal please contact your Provider Relations Representative.

Electronic Submission

RMHP prefers to receive claims electronically. RMHP accepts electronic claims via a direct submission or through a clearinghouse. For a list of clearinghouses contracted to submit claims to [http://bit.ly/1iJQ6wO](http://bit.ly/1iJQ6wO). If your clearinghouse is not listed, please contact it to see if it is able to forward the claims to one of the clearinghouses listed so it can be then forwarded to RMHP.

All electronic submitters must complete a transaction form and be set up prior to sending claims.


The ANSI X12N implementation guides have been established as the standard of compliance for transactions and are available electronically.

RMHP provides companion documents that go with the standard implementation guides. Throughout these companion documents (which are subject to change), specific segment and data element requirements are outlined in order for RMHP to process data. They are only a supplement to the ANSI X12N implementation guides and do not contradict any requirements.


Direct Submitters

We offer our web server for submission of files. The transmission reports are also posted to the web for downloading and there are no "per claim" charges if you transmit to us directly. If you are using a clearinghouse and are interested in submitting to us directly or would like to be able to access your accept/reject reports off of the web, please contact our EDI department at:

Help Line: 970-244-7893 or 800-311-5269.

Email: edicoordinator@rmhp.org

Direct submitters must test with RMHP prior to submitting electronic claims.

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, 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 two separate claims: The mother’s claim(s), and the baby’s claim(s). Please bill the mother and baby on the same claim for PRIME only.

We will adjudicate both claims under the mother’s Member number. If the mother 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 allows 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 [www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/IVDRegulatoryAssistance/ucm124269.htm](http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/IVDRegulatoryAssistance/ucm124269.htm)

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 non-covered services or specialty services such as personal convenience items. Payment for services may be collected from or billed to a Medicaid (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 RMHP Customer Service immediately. It is the policy of RMHP to retract credited amounts from the Provider Remittance.

Provider Remittance

Electronic Funds Transfer Registration

Providers may register for Electronic Funds Transfer on RMHP’s Provider Portal by following the steps below.

EFT Registration procedure:

• Go to the main login page on access|RMHP. Select Claims & Payment and then Provider Net and follow the directions on the ProviderNet website.
  o The registration process for EFT is through ProviderNet | Change Healthcare
• If a provider / practice is signed up for EFTs from other carriers they may recognize the Change Healthcare site

• One of the steps in the registration process is to sign and return a form and voided check to Change Healthcare
  
  o If the provider / practice is on file for EFTs through Change Healthcare this step does not need to be completed

• To register, providers will need a recent HMO and HCO check number and a sample claim
  
  o Providers will need to register for both RMHP HMO and HCO remittance advice

• One a provider / practice is receiving an EFT, they will no longer receive a paper voucher from RMHP
  
  o PDF’s will be available to print from Change Healthcare

• The current turn-around time to complete a registration for EFT is 10 – 20 days

835 Electronic Voucher Information

835 Electronic Voucher information is now available. Contact your Provider Relations Representative for additional information.

Explanation of Payment Guide

Ambulatory and facility providers receive remittance data in the same format. Many providers will receive two remittances each week, one for RMHP and the other for RMHCO lines of business. The following is an explanation of the information presented on the Provider Remittance.

The remittance will display any retraction or outstanding balance information on the first page. If your office does not have an outstanding balance owed to RMHP, this information will not be included.

• Account Balance Owed to RMHP / RMHCO – This box contains detailed information regarding claims that are being retracted

• Patient Name – Member’s name

• Account # - The office’s account number submitted on the original claim
  
  o If your office does not submit an account number, this column will be blank

• DOS – Date of Service submitted on the original claim

• Original Amount Retracted – This is the amount that was paid on the original processing of the claim

• Beginning Balance Forward – The amount that is outstanding on the date of this remittance.
  
  o If monies have been retracted from a previous remittance or have been refunded by the office, those amounts would have been subtracted from the original amount, resulting in this beginning balance.

• Credit Activity on this Remittance – This is any credit activity being applied to the outstanding balance from this week’s remittance

• Ending Balance Amount After This Activity – Any money still outstanding after credit activity has been applied. If this amount is over 30 days old, please issue a refund for this amount to clear your outstanding account balance

• Age of Balance – This indicates the age of your outstanding balance

• Message – This message indicates any action you need to take regarding your outstanding balance.
- RMHP attempts to retract any outstanding balances from future claim payment, although this is not always possible. If the account ages over 30 days, RMHP will ask for a refund
- Claim Payment Detail – The area above the claims detail contains important messages from RMHP.
  - It will indicate any closures of the business due to holidays as well as other information
- Payee ID – The provider number designated for payment
- Patient Name – The Member’s name
- Acct # – Your office's account number
- Patient ID – The Member’s RMHP ID number
- Plan – Supplies a short description about the Member's plan type
- From / To – Date(s) of service submitted
- Proc / Rev Code – Procedure or rev codes submitted
- Charge – The amount your office charged for services provided
- Disallow – Any amounts charged for services not covered by RMHP. These amounts are not billable to the Member.
- Allowed Amount – The allowed amount per contract for the CPT or Health Care Procedure Coding System (HCPCS) code if you are an ambulatory provider. If you are a facility provider, the allowed amount will be "rolled up" into one line item to allow for your discounted rate, case rate, or per diem calculation
- PT RESP – Includes any applicable copays, coinsurance, and deductibles. Please note, if RMHP collects the copay, that amount will not be included in this column
- COB Adj – The amount paid by the primary insurance carrier
- Risk W / H – The amount withheld to contingency reserve if you are subject to a contractual withhold. This amount should never be billed to the Member
- Int Amt / Prmpt Pay Disc – Interest paid is listed in the top field. A prompt pay discount amount, if your contract allows, is listed in the lower field
- Net Paid – The full payment for the service
- Provider Name – The provider of service

**Please Note:** Individuals who are dually eligible for both Medicare and RMHP Prime coverage with RMHP will report two 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. In some instances, there may be enrollees with dual coverage under RMHP Prime and a commercial health plan. Those claims will also be coordinated and be reported as two 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, itemizations, etc. 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 rmhp.org.

- Please send only the documentation specifically requested. If you need clarification, please call Customer Service at 800-854-4558 or 970-248-5036. 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 one date of service.

**Clinical Editing Criteria**

RMHP has incorporated the use of a software program designed to review claims for coding appropriateness.

This program checks to see whether the information submitted on the claim is accurate and makes clinical sense. It also checks whether the billing is within the global fee maximums, appropriate care guidelines, and standard medical billing protocols.

It is an automated claims processing tool that helps ensure payment consistency based on national standards. It applies standardized criteria to all providers.

Claim payments made to you by RMHP may be subject to a contingency reserve (withhold), depending on your contractual agreement. Contact the Provider Relations department for specific information regarding our clinical editing criteria or contingency withhold.

**Surgery Guidelines**

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

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

Multiple procedures will be reimbursed at 100 percent of the allowable for the procedure deemed primary and 50 percent 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 non-physician surgical assistants will be reimbursed at a percentage of the allowable of the primary surgeon as indicated in your contract.

Non-physician surgical assistants will be reimbursed at 12 percent of the surgeon’s allowable.

Non-physician 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 ONE surgical assistant will be reimbursed per surgical session.

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

RMHP will not reimburse non-physician surgical assistants for RMHP Prime Members with the exception of nurse mid-wives who assist with a C-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 1st. Do not include June and July dates of service on one 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.

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.

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.

Correction Process

If you think a claim needs to be reprocessed, please call RMHP Customer Service before you re-bill. A RMHP Customer Service Representative may be able to help you request reprocessing without sending a new claim. If the correction requires a corrected claim form, you will be given directions on how to file. If you prefer to send your correction request in writing, please follow the instructions on the Claims Action Request Form located at rmhp.org. We highly encourage the use of this form to ensure timely processing of your request.

Refunding Rocky Mountain Health Plans

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 Customer Service 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 examples below 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 Customer Service 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 Claim Action Request Form located at rmhp.org.

**Provider Dispute Resolution**

If you have a claim that has processed correctly per available criteria and want to dispute the claim, you need to file a Provider Dispute Resolution Form. The Provider Dispute Resolution Form can be found on rmhp.org.

Mail the Provider Dispute Resolution Form with supporting documentation to:

Rocky Mountain Health Plans
Attn: Dispute Resolution Coordinator
P.O. Box 10600
Grand Junction, CO 81502-5600

These types of claims are most commonly classified as an appeal:

<table>
<thead>
<tr>
<th>Denial Reasons</th>
<th>Submit Claim Action Request form with this information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied due to clinical edits</td>
<td>You wish to provide pertinent chart notes</td>
</tr>
<tr>
<td>Denied as not medically necessary</td>
<td>You have billed primary insurance and now have EOB</td>
</tr>
<tr>
<td>Denied for lack of admission notification</td>
<td>You have corrected the claim to match</td>
</tr>
<tr>
<td>Denied for lack of prior authorization or census</td>
<td></td>
</tr>
<tr>
<td>Denied as out of timely filing</td>
<td></td>
</tr>
<tr>
<td>Denied as units exceed a Care Management authorization</td>
<td></td>
</tr>
<tr>
<td>Denied as units were reduced by a Care Management authorization</td>
<td></td>
</tr>
</tbody>
</table>

RMHP’s goal is to make a decision regarding a provider appeal within 30 days from the date the appeal is received. If the appeal decision results in the claim being reprocessed, RMHP’s goal is to complete the process within 30 days from the date of the decision. If RMHP stands on the denial, you will be notified of the decision in writing and provided an explanation of the steps to continue the appeal process.

On occasion it is necessary for a provider office or facility to correct a claim already submitted. If you are still within your timely filing period, it is preferred that you submit a new claim with just the new charge(s). If you are out of your timely filing period a new claim should be resubmitted directly to the Research Team with the correction and clearly
marked “Corrected Claim.” Please submit the corrected claim with the Claim Action Request Form, located at rmhp.org.

If your system is unable to reprint the complete claim, you may submit just the line item(s) you would like to correct. Mark your submission as a “Corrected Claim” and submit to the RMHP Research Team with the Claim Action Request form.

Your corrected claim will appear on the appropriate Provider Remittance with either additional monies paid or the retracted amount noted.

Please call your Provider Relations Representative if you have questions.

Claims Involving Other Insurance

Coordination of Benefits (COB)

Sometimes an RMHP Member may have other insurance coverage. Regarding COB, examples include a group policy through his/her 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 one 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:

- One 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 one year from the date of the EOMB.

Third Party Liability

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.

**Injuries Involving a Third Party**

In order to expedite claims for Members who sustain injuries due to another party’s negligence or on someone else’s property, the following information is required on the claim:

- Where the accident occurred
- What injuries resulted and how they were incurred
- The responsible party’s name and address
- Examples include dog bites and falls in public place

For faster TPL For faster TPL turnaround time, you can use one of the following three methods. Copy the Injury Information Form and have Members fill it out at the time of their visits. A copy of this form is located on the website rmhp.org.

Mail the completed Injury Information Form to us:

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

Fax the completed Injury Information Form to: 970-244-7858 Attention TPL Team

Email injury information directly to the TPL team: TPL@rmhp.org

**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 his/her 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 rmhp.org.

**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 Customer Service. 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).
Appeals – Commercial

Member

Member appeals are initiated by the Member, or provider on behalf of a Member, regarding an initial denial.
Appeals for Commercial Members must be made in writing within 180 days of the notice of the denial.

How to Appeal a Utilization Management (UM) Denial

When an initial denial is based on an RMHP Utilization Management decision (as discussed elsewhere in this manual), the Member is notified of the denial and the appeal process.

Reconsideration

Providers may request, orally or in writing, a peer-to-peer communication with a Medical Director who made an initial denial to discuss RMHP’s decision. Such peer-to-peer conversation must be requested within seven days of the date of RMHP’s initial denial. The peer-to-peer conversation must be initiated by a provider, and not by a Member. Having the peer-to-peer conversation is not a prerequisite to a Member appeal. After a request for a peer-to-peer conversation, RMHP will have the conversation, and will then make a reconsideration decision within five days of the request for the peer-to-peer conversation. To request a peer-to-peer conversation please call Customer Service at 970-243-7050 or 800-346-4643.

Standard Appeal

The right to appeal decisions of RMHP’s Utilization Management Program is available to all plan physicians on behalf of Members and to Members directly, as outlined in the RMHP Evidence of Coverage (EOC) and the provider’s contract. The standard appeal will be considered and a response made within the regulated timeframes from the date the request for review was received.

Expedited Appeal

When an initial determination to deny authorization of a health care service is made (1) prior to a service being rendered, (2) after a Member has received emergency services but before the Member has been discharged from a facility or, (3) at least 24 hours before a previously authorized course of treatment expires, and the attending physician believes the determination warrants immediate appeal, the attending physician may appeal to the RMHP Chief Medical Officer / Associate Medical Director. A written decision regarding the expedited appeal shall be made by our RMHP Chief Medical Officer / Associate Medical Director within 72 hours after the review has commenced.

Further information with respect to Medicare and RMHP Prime Member appeals can be found in the Medicare and RMHP Prime sections of this Manual.

Division of Insurance

Written inquiries from the Division of Insurance will be answered with a complete written response by the appropriate RMHP employee within 20 calendar days from the date of the inquiry, unless another time period is specified by statute, regulation or by the Division in writing.

Appeal and Grievance Processes – 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 may complain about anything the Member is unhappy about or has a problem with. A Designated Client Representative (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 877-HELP-123 (877-435-7123), TTY users call 711. The Member can email them at help123@maximus.com.

In addition to filing an appeal or grievance with RMHP, the Member may file for a State Fair Hearing with the State of Colorado. The State Fair Hearing process is described in Section C below.

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:

- 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 below
- 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 two 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 Customer Service.

Within two working days of the day RMHP receives the Member Appeal, RMHP will notify the Member in writing acknowledging RMHP received the Member's appeal. In that letter RMHP will tell the Member how they may get a copy of RMHP’s file about their appeal. RMHP will also give the Member a chance to give RMHP any more information about the appeal. If the Member would like to meet a person face-to-face at RMHP to listen to additional information about the appeal, arrangements can be made. Or the Member may send more information to RMHP.

The Appeals and Grievance Coordinator will get all the facts about the case. Within 10 working days after RMHP hears from the Member, RMHP will send the company's decision in writing. After this review, RMHP may decide to change its action.
**Expedited (fast) Review**

Expedited or Fast 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 appeal review within 72 hours of the request. Because of this short timeframe, 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**

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 before RMHP makes a decision. A State Fair Hearing 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 below 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 of DCR must tell RMHP they want to keep receiving services within 10 days after receiving the notice of the appeal resolution
  
  - Providers may not ask to have benefits continue while the appeal is being reviewed
- An RMHP provider must have ordered the services
- 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 Customer Service.

**Section B. File a Grievance**

The Member may have a problem or be unhappy with RMHP 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.

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 Customer Service
- 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 two 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 two 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:

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

The Member may also call 303-866-4623 or send an e-mail message 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

A State Fair Hearing 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 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 Customer Service 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  
Main Phone: 303-866-2000  
Phone: 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
• To choose someone to represent them at the State Fair Hearing
• To present information or evidence to the administrative judge during the hearing
• To 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 Customer Service at 970-243-7050 or 800-346-4643.

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 his or her representative and file an appeal on his or her 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, or 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, he or she must produce other appropriate legal papers supporting his or her 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 one 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 in order to continue representation. However, the photocopied form is only good for one year after the date of the enrollee’s signature.

Any appeal received with a photocopied representative from more than one 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 two 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 two calendar days before discharge. Please note a new OMB-approved Form must be used. The most current forms are available at [http://go.cms.gov/1fH3gu5](http://go.cms.gov/1fH3gu5) at the link for Hospital Discharge Appeal Notices.
Notice of Medicare Non-Coverage (NOMNC)

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 two calendar days in advance of the services ending. The facility is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) on behalf of RMHP to all Medicare Members no later than two (2) days before their covered services end. All Members must receive a NOMNC, even if they agree services should end.

RMHP providers must use the Office of Management and Budget (OMB)-approved standardized notice which can be found by visiting CMS.gov.

Select Medicare


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 Customer Service department at 970-248-5036.
Provider Appeal

Definition

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
- Coordination of Benefits / Third Part 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. The Provider Dispute Resolution Form should be used when requesting a provider appeal. The form is available on the RMHP website at rmhp.org.

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 is 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 timeframe, 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

Commercial, Medicare, and CHP+ Members

Appeals must be received within 180 days from the date of the original remittance advice, or such other timeframe 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.

Overriding Timely Filing

Waiver of the timely filing requirement is only permitted when RMHP has received supporting documentation indicating the Member or provider originally submitted the claim within the applicable timely filing period.

If the claim was originally filed through Electronic Data Interchange (EDI) a copy of RMHP electronic accept / reject report must be provided. Clearinghouse transmittal reports do not qualify as proof of timely filing.

If the provider originally received incorrect insurance information the provider has 30 calendar days from the date the provider is advised of the correct insurance information to file the claim with the correct carrier. If the provider has not obtained correct insurance information within 12 months from the date of service, the claim will remain denied.

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. This is included in the Provider Manual for your information.

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 Original 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; and
- 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 time frames discussed below 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 three calendar days that the Appeal will be decided within the time frame for a standard Appeal (30 calendar days).

To request an Appeal: the Member, any physician, or the Member’s appointed representative may call, write, fax, or visit RMHP.

Rocky Mountain Health Plans
Attn: Member Appeals Department
P.O. Box 10600
Grand Junction, CO 81502-5600
Phone: 970-248-5036 or 800-854-4558
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.

Advanced Beneficiary Notice of Non-Coverage (ABN) vs. Organization Determination

Per the May 5, 2014, CMS memo titled “Improper Use of Advance Notices of Non-coverage”, the ABN is intended for use only for Beneficiaries covered under Original 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 non-coverable 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 his or her appeal rights. For more information on the organization determination process, go to http://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
  - www.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
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. See Preferred Option 1.

Option 1 Preferred: Use DSI’s web-based portal for real-time, point of service claim adjudication (described above). Enroll online at enroll.edispense.com. This adjudication system is provided at no cost to the provider.

Option 2 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 Customer Service for a list of pharmacies that administer vaccines.

Option 3 Non-preferred: 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 RMHP (on the website or by calling RMHP Customer Service). 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 the RMHP Pharmacy department at 970-248-5031 or 800-641-8921.

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. Below is a chart that illustrates allowed and disallowed marketing activities.

<table>
<thead>
<tr>
<th>Allowed</th>
<th>Disallowed</th>
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<tbody>
<tr>
<td>General Activities</td>
<td></td>
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<tr>
<td>Engage in discussions with Medicare beneficiaries when patients seek information or advice regarding Medicare options</td>
<td>Distribute contracted plan materials / applications within an exam room setting</td>
</tr>
<tr>
<td>Provide the names and / or contact information of contracted plans</td>
<td>Offer sales / appointment forms for any contracted plan</td>
</tr>
<tr>
<td>Provide information and assistance in applying for low-income subsidy (LIS)</td>
<td>Accept enrollment applications for any contracted plan</td>
</tr>
<tr>
<td>Make available and / or distribute contracted plan marketing materials including provider affiliation (see below) materials for contracted plans as long as provider offers the option of making available and / or distributing marketing materials available for all contracted plans.</td>
<td>Make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests</td>
</tr>
<tr>
<td>If provider agrees to make available and / or distribute plan marketing materials for some of its contracted plans it must accept future requests from other contracted plans</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Consequence</td>
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<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide objective information on plan sponsor’s specific plan formularies, based on a particular patient’s medications and health care needs</td>
<td>Mail marketing materials on behalf of contracted plans</td>
</tr>
<tr>
<td>Provide objective information regarding contracted plans, including information such as covered benefits, cost sharing, and utilization management tools</td>
<td>Offer anything of value to induce a contracted plan enrollee to select them as their provider</td>
</tr>
<tr>
<td>Make available and / or distribute PDP enrollment applications for all plans with which you participate</td>
<td>Offer inducements to persuade beneficiaries to enroll in a particular plan or organization</td>
</tr>
<tr>
<td>Refer patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, county offices of Health and Human Services, local Social Security Office, CMS’ website at <a href="http://www.medicare.gov/">www.medicare.gov/</a></td>
<td>Accept compensation directly or indirectly from the plan for beneficiary enrollment activities</td>
</tr>
<tr>
<td>Print out and share information with patients from CMS’ website, or 800-MEDICARE</td>
<td>Make available and / or distribute MA, MA-PD or Cost enrollment applications for plans with which you participate</td>
</tr>
<tr>
<td><strong>Affiliation Announcements</strong></td>
<td></td>
</tr>
<tr>
<td>May announce <strong>new affiliations</strong> and <strong>repeat affiliation</strong> announcements for contracted plans through general advertising (e.g. radio, television)</td>
<td>Cannot distribute affiliation communication materials that describe plans in any way (e.g. benefits, formularies) without obtaining prior approval from plans sponsors / CMS</td>
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<tr>
<td><strong>New Affiliation Announcement:</strong></td>
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<tr>
<td>Occurs when you have entered into a new contractual relationship with a health plan</td>
<td>Cannot announce new affiliation of a new contracted plan via direct mail, email or phone, listing the newly contracted plan, more than one time</td>
</tr>
<tr>
<td>Providers may make new affiliation announcements within the first 30 days of the new contract agreement</td>
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<tr>
<td>An announcement to patients through direct mail, email or phone of a new affiliation which names only one plan sponsor may occur <strong>only once</strong></td>
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<tr>
<td><strong>Repeat Affiliation Announcement:</strong></td>
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<tr>
<td>Additional direct mail and / or email communications to patients regarding affiliations must include all plans with which the provider contracts</td>
<td>Cannot distribute materials describing contracted plans (other than CMS developed documents such as Medicare &amp; You) without contracted plan / CMS review approval</td>
</tr>
<tr>
<td><strong>Note:</strong> Any affiliation communication materials that describe plans in any way (e.g. benefits, formularies) must be submitted to contracted plan for submission to CMS for review and approval. Materials that indicate the provider has an affiliation with certain contracted plans and only list plan names and / or contact information do not require CMS approval.</td>
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<tr>
<td><strong>Comparative / Descriptive Materials About Contracted Plans</strong></td>
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<tr>
<td>Comparative and descriptive material about contracted plans written by CMS or previously approved by CMS, for example, Medicare &amp; You and CMS Medicare Prescription Drug Finder information may be distributed without contracted plan / CMS approval</td>
<td>Cannot distribute documents that compare or describe contracted health plans (beyond just the name / contact information) that have not been reviewed by contracted plan and CMS</td>
</tr>
<tr>
<td><strong>Distribute printed information comparing the benefits of different contracted plans (all or a subset) in a service are when the comparison is done by an objective third party (e.g. SHIPs, State agency or independent research organizations that could conduct studies).</strong></td>
<td>Cannot distribute documents that rank order or highlight specific plans – other than information created by CMS or an objective third party.</td>
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<td>Distribute comparative / descriptive materials on contracted plans if these materials are submitted to contracted plan in advance for review and submission to CMS. Distribute documents that only list the names / contact information of contracted plans without prior plan or CMS approval.</td>
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<tr>
<td><strong>Provider Website</strong></td>
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<tr>
<td>Provide links to contracted plan enrollment applications and / or provide downloadable enrollment applications. Must provide the links / downloadable formats to enrollment applications for all contracted plans May also include a link to the CMS Online Enrollment Center</td>
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<td><strong>Benefits Questions</strong></td>
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<tr>
<td>Address all benefits questions to RMHP Customer Service by calling 970-248-5036 or 800-854-4558. 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 Customer Service. <strong>Representatives Filing Appeals for Enrollees</strong></td>
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RMHP Prime, RAE and CHP+

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

A “Medically Necessary” health care good or service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. Medical necessity means that a good or service:

- Is provided in accordance with generally accepted professional standards for health care in the United States
- Is clinically appropriate in terms of type, frequency, extent, site and duration;
- Is not primarily for the economic benefit of the provider of primary for the convenience of the client, caretaker, or provider;
- Is delivered in the most appropriate setting(s) required by the client’s condition;
- Is not experimented or investigational; and
- Is not more costly than other equally effective treatment options.

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.
Female Members 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.

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.

**RMHP Prime**

All Prime Members receive an initial screening for special health care needs following enrollment.

Female Members 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 nonparticipating 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 Periodic Screening Diagnosis and Treatment (EPSDT)**

RMHP works closely with the State of Colorado to ensure all RMHP Prime and RAE enrolled children and youth receive the appropriate screening, diagnosis, treatment, and immunizations needed to develop into healthy, active adults. One program geared toward that objective is the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. This is a benefit program designed to enhance primary care, with emphasis on prevention, diagnosis, and timely treatment. The program includes periodic screenings, which are often called “well-child exams” by providers and their staff. 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. EPSDT coverage ends with the Member’s 21st birthday (coverage is through age 20). EPSDT visits must occur within two weeks of the date the visit is requested by the Member.

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
- As defined in the periodicity schedule
- 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”
• Select “Billing Manuals”
• Once in “Billing Manuals” select CMS 1500 and scroll down to EPSDT
• Click on the hyper link 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 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services that are not covered by RMHP, but are covered by Health First Colorado (wrap-around services, see table pages 73 – 74) to RMHP’s Care Management Department.

Vaccines for Children (VFC) Program

RMHP does not reimburse for Prime Member vaccines as they are available through the Vaccines for Children 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 Customer Service at 970-248-5036 or 800-854-4558.

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.

In order to receive sterilization services, the following criteria must be met:

• The client must be at least 21 years of age;
• The client may not be currently institutionalized for the care and treatment of mental illness;
• He or she 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 (1) in the case of premature delivery, must state the expected date of delivery; or (2) in the case of abdominal surgery, must describe the emergency.

A copy of this form is available at our website, rmhp.org, as well as www.colorado.gov/pacific/hcpf/provider-forms and at http://1.usa.gov/ic52Z5.

RMHP Prime Copay

In most cases, RMHP Prime Members will pay copayments directly to the provider at the time of service. Certain Members are considered to be copay exempt (see below). As a provider, you can choose to waive copayments, but you cannot deny care if a Member is unable to pay. The most common copayments are in the following chart.

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

- Children 18 and under
- Pregnant women
- 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

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit</td>
<td>No copay (PCP); $2 (Specialist, FQHC, Rural Health Clinics)</td>
</tr>
<tr>
<td>Hospital</td>
<td>$10 per day inpatient; $4 outpatient services</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>No copayment if determined an emergency; $6 per visit if not an emergency</td>
</tr>
<tr>
<td>Lab Work</td>
<td>$1 per date of service</td>
</tr>
<tr>
<td>X-rays</td>
<td>$1 per date of service</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$1 per date of service</td>
</tr>
<tr>
<td>Second Opinions *</td>
<td>No copay</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>No copayment</td>
</tr>
<tr>
<td>Prescriptions – Generic Drugs</td>
<td>$1 generic, including injectables (31-day supply)</td>
</tr>
<tr>
<td></td>
<td>$1 for up to a 31-day supply from a retail pharmacy</td>
</tr>
<tr>
<td></td>
<td>$2 for a 90-day supply from a mail-order pharmacy</td>
</tr>
<tr>
<td>Prescriptions – Brand Name Drugs</td>
<td>$3 for up to a 31-day supply from a retail pharmacy</td>
</tr>
<tr>
<td></td>
<td>$6 for a 90-day supply from a mail order pharmacy</td>
</tr>
</tbody>
</table>
* 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 Customer Service 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.

Wrap-Around Services

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

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
- Private duty nursing
- Extraordinary home health
- Skilled nursing facility services
- Orthodontia assessment and coverage for some children
- Limited Case Management Services
- Hearing aids and batteries, auditory training, audiological assessment and hearing evaluation
- Dental services for children and adults
- 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 non-medical transportation
- Personal care benefit for children
- Inpatient substance abuse rehabilitation treatment for individuals aged 20 and under

More information about these wrap-around services can be found in the 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:

<table>
<thead>
<tr>
<th>SERVICE / PROCEDURE</th>
<th>RMHP BENEFIT</th>
<th>Health First Colorado WRAP-AROUND BENEFIT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Services – Children Hearing Aids</td>
<td>See Comments</td>
<td>Yes See Comments</td>
<td>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</td>
</tr>
<tr>
<td>Service Type</td>
<td>Children</td>
<td>Adults</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Auditory Training</td>
<td>No</td>
<td>Yes</td>
<td>Services also include Cochlear implants, batteries and supplies for children, and for adults under limited circumstances.</td>
</tr>
<tr>
<td>Audiological Assessment and Evaluation</td>
<td></td>
<td></td>
<td>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 one year of age or earlier.</td>
</tr>
<tr>
<td>Dental Services – Children</td>
<td>No</td>
<td>Yes</td>
<td>Dental care including exams, cleanings, x-rays and some restorative services covered as a wrap-around benefit. Limited to $1000 each benefit year.</td>
</tr>
<tr>
<td>Dental Services – Adults</td>
<td>No</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>Extra-Ordinary Home Health Services – Expanded EPSDT</td>
<td>No</td>
<td>Yes</td>
<td>Included: case management (for Model 200 children), home modification, electronic monitoring, personal care, and non-medical transportation.</td>
</tr>
<tr>
<td>HCBS Services</td>
<td>No</td>
<td>Yes</td>
<td>RMHP does not cover private-duty nursing, but State Medicaid may cover it.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.</td>
</tr>
<tr>
<td>Hospice</td>
<td>No</td>
<td>Yes</td>
<td>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 &amp; RMHP Case Manager.</td>
</tr>
<tr>
<td>Intestinal Transplants</td>
<td>Immuno- suppressive meds only</td>
<td>Yes</td>
<td>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 &amp; RMHP Case Manager.</td>
</tr>
<tr>
<td>Private Duty Nursing (PDN)</td>
<td>No</td>
<td>Yes</td>
<td>Nursing services only.</td>
</tr>
<tr>
<td>Skilled Nursing Facility – skilled nursing and rehabilitation services</td>
<td>Not a covered benefit</td>
<td>31 plus days</td>
<td>Skilled Nursing Facility charges (skilled nursing and rehabilitation services) beginning on day 31 of client meets level of care certification.</td>
</tr>
</tbody>
</table>

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.
RMHP Timely Filing Limit

Based on RMHP’s Prime contract with the Department, the following claim submission deadlines now apply:

- Standard RMHP Prime claims
  o 120 days from the date of service
- Medicare Crossover claims
  o 120 days from the Medicare processing date
- Third-party primary payment
  o 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 health care needs following enrollment when they are able to be reached through a Welcome call.

Female Members 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. 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 Continuity of Care 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 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 four 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>RMHP Copay Level L</th>
<th>RMHP Copay Level M</th>
<th>RMHP Copay Level H</th>
<th>RMHP Copay Level HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Individual/Family)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-Pocket Limit (Individual/Family)</td>
<td>None</td>
<td>5% of annual family income adjusted for family size</td>
<td>5% of annual family income adjusted for family size</td>
<td>5% of annual family income adjusted for family size</td>
</tr>
<tr>
<td>Routine Medical Office Visits</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Hospital/Other Facility Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient</td>
<td>$0</td>
<td>$2</td>
<td>$20</td>
<td>$50</td>
</tr>
<tr>
<td>- Physician</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>- Outpatient/Ambulatory</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$3</td>
<td>$3</td>
<td>$30</td>
<td>$50</td>
</tr>
<tr>
<td>Laboratory and X-ray</td>
<td>$0</td>
<td>$0</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Mental Disorders/Mental Illness Care</td>
<td>$0</td>
<td>$2/office visit</td>
<td>$5/office visit</td>
<td>$10/office visit</td>
</tr>
<tr>
<td>- $2/admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $20/admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment Services</td>
<td>$0</td>
<td>$2</td>
<td>$5</td>
<td>$10</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$0</td>
<td>$1/generic or brand name</td>
<td>$3/generic $10/brand name</td>
<td>$5/generic $15/brand name</td>
</tr>
</tbody>
</table>

**RAE Behavioral Health Telemedicine**

In alignment with the Colorado Department of Health Care Policy and Financing, 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 below) not previously allowed to be delivered via 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, timeframes 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 via telemedicine must continue to employ accountability measures to safeguard that Members are benefiting from programming. These measures include 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 (www.hhs.gov/hippa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telemedicine/index.html).

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 via 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 back-up 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 via a telemedicine modality (including, but not limited to: rules and regulations from Health Care Policy and Financing, Office of Behavioral Health, Colorado Division of Insurance, CDC, SAMSHA, and Centers for Medicare and Medicaid Services).

3. Billing and Coding Guidance:
   a. Providers are required to abide by all Medicaid billing and coding policy as outlines in the state Uniform Service Coding Standards Manual (USCSM) and requires all services billed in accordance with the USCSM, including services delivered via telemedicine.
   b. In addition, the following claim guidance must be followed to receive a reimbursement and to allow identification of services as provided via telemedicine during the COVID-19 State of Emergency:
      i. CMS 1500 Professional Claims:
         1. Place of Service code 02 must be indicated on all CMS 1500 professional claims for telemedicine
         2. All codes outlined in the USCSM are allowed with the exception of those codes listed below in the Telemedicine Services Exception Code table
      ii. UB-04 Institutional Claims:
         1. The GT modifier must be appended to the UB-04 institutional claim form with the service’s procedure code
   c. 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.

4. Medical Record Standards and Documentation:
   a. Providers must obtain and document the Member’s consent to receive services through telemedicine prior to rendering services
   b. 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90870</td>
<td>Electroconvulsive Therapy</td>
</tr>
<tr>
<td>99217</td>
<td>Observation care discharge day management</td>
</tr>
<tr>
<td>99218</td>
<td>Initial observation care, per day, for the evaluation &amp; management of a patient</td>
</tr>
<tr>
<td>99219</td>
<td>Initial observation care, per day, for the evaluation &amp; management of a patient</td>
</tr>
<tr>
<td>99220</td>
<td>Initial observation care, per day, for the evaluation &amp; management of a patient</td>
</tr>
<tr>
<td>99221</td>
<td>Initial Hospital Care (30 min.)</td>
</tr>
<tr>
<td>99222</td>
<td>Initial Hospital Care (50 min.)</td>
</tr>
<tr>
<td>99223</td>
<td>Initial Hospital Care (70 min.)</td>
</tr>
<tr>
<td>99224</td>
<td>Subsequent Observation Care (15 min.)</td>
</tr>
<tr>
<td>99225</td>
<td>Subsequent Observation Care (25 min.)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>99226</td>
<td>Subsequent Observation Care (35 min.)</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent Hospital Care (35 min.)</td>
</tr>
<tr>
<td>99234</td>
<td>Observation or Inpatient Hospital Care, Low Complexity (40 min.)</td>
</tr>
<tr>
<td>99235</td>
<td>Observation or Inpatient Hospital Care, Mod Complexity (50 min.)</td>
</tr>
<tr>
<td>99236</td>
<td>Observation or Inpatient Hospital Care, High Complexity (55 min.)</td>
</tr>
<tr>
<td>99238</td>
<td>Hospital Discharge Day Management: 30m or Less</td>
</tr>
<tr>
<td>99239</td>
<td>Hospital Discharge Day Management: more than 30m</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for new or established patient (30 min.)</td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient consultation for new or established patient (20 min.)</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient consultation for new or established patient (40 min.)</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient consultation for new or established patient (55 min.)</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient consultation for new or established patient (80 min.)</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient consultation for new or established patient (110 min.)</td>
</tr>
<tr>
<td>99281</td>
<td>Emergency Department Visit, Focused</td>
</tr>
<tr>
<td>99282</td>
<td>Emergency Department Visit, Expanded, Low Complexity</td>
</tr>
<tr>
<td>99283</td>
<td>Emergency Department Visit, Expanded, Mod Complexity</td>
</tr>
<tr>
<td>99284</td>
<td>Emergency Department Visit, Detailed</td>
</tr>
<tr>
<td>99285</td>
<td>Emergency Department Visit, Comprehensive</td>
</tr>
<tr>
<td>G0176</td>
<td>Activity Therapy, Such As Music, Dance, Art Or Play Therapies 45 min or more</td>
</tr>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems</td>
</tr>
<tr>
<td>H0017</td>
<td>BH residential without room/board</td>
</tr>
<tr>
<td>H0018</td>
<td>BH short term res without room/board</td>
</tr>
<tr>
<td>H0019</td>
<td>BH long term res without room/board</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone admin/service</td>
</tr>
<tr>
<td>H0033</td>
<td>Oral med admin direct observation</td>
</tr>
<tr>
<td>H0035</td>
<td>MH Partial Hospitalization less than 24 hr.</td>
</tr>
<tr>
<td>H0036</td>
<td>Community psychiatric supportive treatment, face to face, per 15 min</td>
</tr>
<tr>
<td>H0037</td>
<td>Community psychiatric treatment, per diem</td>
</tr>
<tr>
<td>H0043</td>
<td>Supported housing, per diem</td>
</tr>
<tr>
<td>H0044</td>
<td>Supported housing, per month</td>
</tr>
<tr>
<td>H0045</td>
<td>Respite care services, not in the home, per diem</td>
</tr>
<tr>
<td>H2001</td>
<td>Rehab program 1/2 day</td>
</tr>
<tr>
<td>H2030</td>
<td>Mental Health clubhouse per 15 min</td>
</tr>
<tr>
<td>H2031</td>
<td>Mental Health clubhouse per diem</td>
</tr>
<tr>
<td>H2032</td>
<td>Activity therapy per 15 min</td>
</tr>
<tr>
<td>S3005</td>
<td>Performance measurement, depression</td>
</tr>
<tr>
<td>S5150</td>
<td>Unskilled respite care, not hospice; per 15m</td>
</tr>
<tr>
<td>S5151</td>
<td>Unskilled respite care, not hospice; per diem</td>
</tr>
<tr>
<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
</tr>
</tbody>
</table>
Utilization and Care Management

About Utilization and Care Management — Philosophy and Purpose

The RMHP Utilization and Care Management Programs are essential for medical management of all lines of business including commercial, CHP+, RAE and RAE 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 contracting providers and facilities or choose to seek services with non-contracted 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 Utilization and Care Management towards the efficiency and appropriateness of care within the delivery system. Program objectives for the following year are identified and implemented.

Staff Availability

Rocky Mountain Health Plans (RMHP) staff is available during normal business hours Monday through Friday, 8 a.m. to 5 p.m. for calls, faxes and secure e-mails including Utilization and Care Management issues. Behavioral Health Utilization and Care Management staff are available after hours 24/7, please call 888-282-8801. You may also make arrangements in advance to speak to Care Management staff after normal business hours by calling your Provider Relations Representative at 970-244-7798.

RMHP UM and CM staff have password protected, confidential voice mail in order to receive inbound calls after normal business hours. Calls will be returned as soon as possible but no later than one business day.

Additionally, you can refer a patient to Case Management by completing the RMHP online Provider Referral form on our website at rmhp.org.

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 Utilization and Care Management services. All minutes, records, reports, worksheets, studies, or other materials collected as part of the Utilization and / or Care Management 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.
Individual practitioner data may be utilized at the time of re-credentialing.

RMHP complies with all applicable HIPAA regulations including the privacy, security, and transactions and code set regulations. The RMHP Notice of Privacy Practices, which further explains our Members’ privacy rights, was distributed to all subscribers and providers on or before April 14, 2003. Similarly, providers who are “covered entities” under HIPAA must comply with all applicable regulations.

Goals and Objectives

- The Utilization and Care Management Program goals and objectives are as follows:
- To support and augment the Rocky Mountain Health Management Corporation’s, (Rocky Mountain Health Plans) 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-/under-utilization 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 seven years, unless a longer timeframe for retention of records is required by legal requirements applicable to RMHP. Generally, longer timeframes apply for medical records of RMHP Prime Recipients, Medicare Beneficiaries, RAE and CHP+ Members.

Organizational Structure

Responsibility and Accountability

RMHP Board of Directors (BOD) delegates decision-making authority for the UM and CM Programs to the RMHP Chief Medical Officer (CMO). The CMO, Associate Medical Directors, Medical Advisory Council (MAC), and the Directors of UM and CM are responsible for administering the Programs. The Pharmacy Account Manager is responsible for administering the PM Program and related pharmacy benefits.

The following individual and organizations play key roles in RMHP’s UM, CM and PM Programs:

RMHP’s Board of Directors

- Delegates responsibility for oversight of the clinical quality improvement, medical management, pharmacy programs, and peer review, credentialing and re-credentialing processes to the CMO.

Quality Improvement Committee

- Provide oversight and coordination of all aspects of the RMHP corporate quality improvement program and the organization-wide efforts designed to improve the value of health care delivered to RMHP Members.
- The QIC reports to the CMO and the COO, who are accountable to the Senior Leadership group and the RMHP BOD.

Medical Advisory Council (MAC)

- The MAC is composed of the CMO, Associate Medical Directors, Pharmacy Account Manager, and key management staff representing Utilization Management, Care Management, Quality Improvement, Pharmacy, and Provider Network Management
- Review and approve policies and all activities that govern RMHP Utilization Management, Care Management, Pharmacy, and Clinical Quality Improvement operations.

CMO

- Health care provider qualifications, peer review, credentialing and licensure
- Is responsible to the RMHP BOD for overall development, implementation, execution, and annual evaluation of the CM Program.
- Provides medical direction and support to the UM and CM Staff
- Provides overall direction of Utilization and Care Management activities, including oversight of Clinical Pharmacy activities
- Appoint and designate Associate Medical Directors

Associate Medical Directors (Medical Doctors Licensed in the State of Colorado)

- Health care provider qualifications, peer review, credentialing and licensure
- Provide medical direction and support to the UM and CM staff
• Make denial decisions or modifications in requests for medical services from practitioners based upon medical necessity and utilizing evidence-based criteria

• Review and decide UM cases, including all Medically Necessary Denials

Pharmacy Account Manager

• A licensed Clinical Pharmacist who oversees Pharmacy Operations and creation of all policies related to the provision of the Pharmacy benefit and pharmaceutical management procedures, including formulary development and implementation, pharmaceutical utilization management, and the promotion of clinically appropriate use of pharmaceuticals by prescribers via drug formulary development, prior authorization, step therapy, and quantity limit criteria.

Utilization and Care Management Staff

• The UM and CM Departments consists of an interdisciplinary team including nurses, Behavioral Health Practitioners, Clinical Managers, Directors of UM and CM, CMO, and Associate Medical Directors.

• The RMHP Utilization and Care Management Programs can be defined in terms of several integrated processes:
  o Prospective, concurrent, and retrospective care management
  o Discharge planning
  o Case management
  o Quality improvement
  o Claims review

The Utilization and Care Management Programs are a diverse and integrated set of Programs representing the full continuum of care and utilizing active participation from contracting physicians. All processes are performed to evaluate the clinical necessity, appropriateness, efficacy of health services and procedures, and level of care. Intensity of services is evaluated with information regarding the severity of the Member’s illness.

Delegated Activities

In circumstances where it is appropriate to delegate utilization management responsibilities, Rocky Mountain Health Plans remains accountable for the requirements of the utilization management process.

In the event utilization management activities are delegated, a written description outlining responsibilities of Rocky Mountain Health Plans and the delegated agency, including delegated utilization management activities, frequency of reporting, performance evaluations, and appropriate action plans, are addressed in the contract of any entity to which utilization management 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 consultation and involvement, contract alterations, or revocation of delegation. Any compensation which may be paid for utilization management services do not provide incentives for the entity to deny, limit, or discontinue medically necessary services to the Member.

An evaluation of the delegated utilization management activities is performed prior to delegation and the signing of the contract and then at least annually by reviewing and approving the delegated agency’s Utilization Management Program. Reports with specific utilization management data will be analyzed at least semi-annually. All other necessary data for tracking purposes will be extracted from the Rocky Mountain Health Plans database as needed. By executing an agreement, the delegated entity agrees to abide by Rocky Mountain Health Plans’ policies and procedures regarding delegated utilization management and the philosophies as outlined in the Rocky Mountain Health Plans Utilization Management Program Description.
Collaboration with Quality Improvement

Rocky Mountain Health Plans recognizes and embraces the need for a collaborative and contractual relationship with our providers in administering our quality improvement and utilization review programs. These programs directly benefit our Members by establishing and meeting their health care needs in the most efficient delivery possible, and by helping to save cost by using best practices to manage our Members individual care. Our collaborative approach allows our providers to share utilization data and performance metrics, which in turn allows Rocky to conduct a myriad of compliance, health initiatives, and ongoing monitoring processes, targeted at maximizing cost effective and efficient health delivery to all of our Members.

RMHP has a Quality Improvement (QI) infrastructure necessary to improve the quality and safety of clinical care and services it provides to its Members. One of the functions of the CM processes is to provide early identification of QI issues with timely reporting of those issues to the QI Department for review.

During any of the UM and CM processes (prospective, concurrent, retrospective, Case Management, Disease Management, etc.), quality issues may be identified by UM nurses, CM nurses, Behavioral Health Practitioners and Medical Directors. Issues such as Adverse Events and Sentinel Events are reported to the QI Department and regulatory agencies as required. Quality of care issues identified by a Member, Physician, or Provider are referred to the QI Department.

The QI Program Description describes how issues referred to the QI Department are handled and responded to. All Member records requested and referred to QI are kept strictly confidential through the entire case referral and review process.

As a part of the evaluation of the UM Program, trends of over- or under-utilized are referred to the CMO and the MAC as appropriate.

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 970-263-5552 or 855-830-1565.

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 Case Management 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. Continuity of Care is described as follows:

- Continuity and coordination of medical care is evaluated based upon whether a Member is undergoing an Active Course of Treatment

Active Course of Treatment is defined as:

1. An ongoing course of treatment for a life-threatening condition;
2. An ongoing course of treatment for a serious acute condition, chronic condition, or life-limiting illness;
3. The second or third trimester of pregnancy through the postpartum period; or
4. 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.

A Member must have been undergoing treatment, or have been seen at least once in the last twelve (12) months, by the provider being removed or leaving the network for that Member to be considered in an Active Course of Treatment.

**Definition of 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. An emergency medical condition is defined as 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

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 woman or her 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 description above. 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.
**Definition of Urgent Care**

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

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.

Rocky Mountain 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.

**Case Management** is 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. The Case Management Program is more completely detailed in the Case Management Program Description and the CM 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.

**Utilization Management** provides a framework for managing and monitoring the utilization of resources to maximize the effectiveness of care provided to our Members. The Utilization Management Program includes: prospective review, concurrent and retrospective review, case management, quality improvement and disease state management referral, and monitoring of physician under- / over-utilization. The program consists of the above 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 Utilization Management 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. Rocky Mountain’s UM and CM staff are composed of Registered Nurses and Behavioral Health Practitioners supported by the Chief Medical Officer and Associate Medical Directors to perform comprehensive Utilization Review of primary, ancillary, specialty, in-patient, and outpatient care. All Rocky Mountain Medical Directors and the Chief Medical Officer 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 its decisions on utilization of the most current edition of MCG (formerly Milliman Care Guidelines®), approved RMHP guidelines and 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 Original Medicare by way of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) that are prepared by the Center for Medicare and Medicaid Services (CMS), fiscal intermediary, or Durable Medical Equipment Medicare Administrative Contractor (DME MAC) may be used. If no nationally established criteria are available, RMHP develops internal Clinical Practice Guidelines or policy through the New Technology Assessment and Guideline Physician Advisory Committee (NTAG).

Clinical practice guidelines align with the Dual Special Needs Plan and the Medicare Advantage Plan. Provider / Practice performance for adherence to clinical practice guidelines 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 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, availability of behavioral health services, and availability of 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 from a Utilization Management nurse or practitioner by emailing **CMresearch@rmhp.org**, by calling 970-248-8718 or 800-793-1339, or by sending a written request to:

Rocky Mountain Health Plans  
Attn: Care Management
Utilization Management

The Utilization Management (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 Chief Medical Officer perform the Utilization Management functions. The Chief Medical Officer 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, he/she consults 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 timeframes 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, Director of Utilization Management, 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 primary care physician, 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 primary care physician and/or other treating clinicians (peer-to-peer) and the RMHP Medical Director(s).

Medical necessity evaluation is determined by examining contributing history with sufficient clinical information 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 timeframes 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 urgent 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 Utilization Management Program applies to all RMHP Members (all individuals in all age groups, in all lines of business).

Unfair Discrimination

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

Affirmative Statement

When RMHP and the Utilization Management 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.

Case Management

RMHP offers a comprehensive Care Management 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, Rocky Mountain Health Plans offers registered nurses, certified case managers and care coordinators to work one-on-one 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

Rocky Mountain Health Plans offers formal Case Management 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
- **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

Rocky Mountain Health Plans allows continuation of treatment for Members undergoing an Active Course of Treatment.
“Active Course of Treatment” is defined as:

1. An ongoing course of treatment for a life-threatening condition;
2. An ongoing course of treatment for a serious acute condition, chronic condition, or life-limiting illness;
3. The second or third trimester of pregnancy through the postpartum period; or
4. 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.

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) ninety (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; or (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 fifteen (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 fifteen (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; and (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.

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 970-248-8718 or 800-793-1339. You may also call Customer Service at 970-248-5036 or 800-854-4558 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) programs for its Members to promote self-management skills, provide disease specific education, and encourage communication between Member and Provider. RMHP currently offers Diabetes and COPD Disease Management programs targeting all RMHP Members who meet the clinical criteria for the programs.
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 Clinical Practice Guidelines 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 disease management 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 in 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 clinical 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 Provider**

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 9-1-1 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).

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 Utilization Management. 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 Primary Care Physician or a participating physician and RMHP authorization are required for out-of-network services that are a benefit of the Member’s Evidence of Coverage and are medically necessary for RMHP Prime, CHP+, Medicare, and RMHP Commercial HMO Plans. Out-of-network providers are physicians, facilities, ancillary providers, and mental health providers who do not contract with RMHP to provide services to Members.

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

Prior Authorization Policies and Procedures

DME / Surgery Approval Process

The physician’s staff may request prior authorization on-line by answering a few questions regarding your patient’s condition and obtain an immediate response regarding approval or denial.

• Submit requests on-line at access|RMHP Provider Portal
  o 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 access|RMHP Provider Portal.

Effective April 4, 2016, all providers are required to request all prior authorizations via 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.

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

Approximately 60 percent 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 access|RMHP 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 Customer Service at 800-854-4558 or 970-248-5036. 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 County and within Colorado, must be made through eviCore online at www.evicore.com or by telephone at 800-792-8750.
- Genetic testing must be submitted through eviCore online at www.evicore.com or by telephone 800-792-8750. For additional information, access the RMHP Lab Quick Reference Guide, located at rmhp.org.

To submit a behavioral health service prior authorization request for RMHP Commercial, Medicare, and CHP+ Members:

- Access the secure RMHP Provider Portal, access|RMHP, 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 rmhp.org.
- Contact RMHP at 855-886-2832 for hospital notification

Guidelines and Responsibilities of Provider

Providers must follow the prior authorization guidelines. All out-of-plan services that are non-emergent 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 Customer Service). 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 Evidence of Coverage (EOC).

Helpful Hints for the Prior Authorization Process – Office Staff

Please use the on-line at access|RMHP Provider Portal. 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 above. You can contact the Customer Service 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 MD or non-MD 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.

- 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.

- **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).

**Please Note:** When adequate information is submitted, notification of prior authorization determination will be done in the following timeframes:

**STANDARD PRE-SERVICE REVIEW TIMEFRAMES:**

- Commercial Members: 5 calendar days
- RMHP Prime & CHP+ Members: 10 calendar days
- Medicare Members: 14 calendar days

**EXPEDITED REVIEW TIMEFRAMES:**

- Commercial 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 facsimile 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.
Durable Medical Equipment (DME) and Supplies

A written order for 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 durable medical equipment and supplies that require authorization can be requested through your Provider Relations Representative or visit the RMHP website at rmhp.org.

Please contact the Provider Relations Representative for your area if you have questions.

Pharmacy

Pharmacy Department

The RMHP pharmacy account team is responsible for establishing and maintaining the RMHP pharmacy network and drug formulary with the goal of providing a drug benefit for Members that allows for therapeutically sound, cost-effective drug therapy that ensures delivery of high-quality pharmacy services.

RMHP's pharmacy account team are heavily involved in researching the primary literature to assess the most current evidence available for both new and existing drug therapies. The RMHP pharmacy account team will provide drug information and results of our research to any interested provider upon request.

RMHP Pharmacy Help Desk is available Monday through Friday, 8:00 a.m. – 5:00 p.m., to assist pharmacy providers in processing drug claims and prior authorization requests.

   Phone: 970-248-5031 or 800-641-8921
   Fax: 970-248-5034

Formulary – Copay Tiers

RMHP has a tiered formulary pharmacy benefit for most commercial 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 Dual Special Needs population Members. Both formularies include comprehensive, pharmaco-economically, and clinically sound coverage of Part D drugs.

Commercial Formularies are named Good Health, Advantage Four-Tier and Essential Plus Five-Tier. Self-administrable injectables are a prescription drug benefit. Since these injectables are considered a prescription drug benefit, they will not be covered if billed via a physician’s office. Non-self-administered injectables billed via a physician’s office will be subject to the medical benefit cost sharing.
The RMHP Pharmacy and Therapeutics Committee 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 rmhp.org, or by calling 800-843-0719, ext. 5186. Please check the RMHP website listed above 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 800-843-0719, ext. 5182.

**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 via the portal at uhcpvider.com. Exception requests for Members on the Good Health formulary must be submitted to RMHP via the fax number on the form. The request will be reviewed by a Clinical Pharmacist, who may approve or deny the request after appropriate consultation 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. We encourage pharmacies to call the RMHP Pharmacy Help Desk, rather than the prescriber, when they receive these prescriptions. The RMHP Pharmacy Help Desk will fax you the appropriate PA form. Once filled out and submitted to the review team, the request will be evaluated within 24 hours and a decision made within turn-around-times based on the Members benefit. You will be notified, via 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 rmhp.org.

- **Specialty Pharmacy Network**
  - Telephone: 800-228-3643
  - Fax: 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 rmhp.org.

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 that you should use.
Mail Order Prescriptions
RMHP contracts with OptumRx 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 a 90-day supply of medication.

Medication Therapy Management
UnitedHealthcare (UHC) 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 an UHC 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 via 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 his or her 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 timeframe from the defined list used by Rocky Mountain Health Plans (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 Rocky Mountain Health Plans.

Any provider who would like to request management medication review may do so for Members who are not covered by Part D by calling 877-288-5773 or 970-255-5677 or by emailing RxMedReview@rmhp.org. Providers may also call RMHP Customer Service at 970-248-5036 or 800-854-4558.
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 in order 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 Customer Service at 970-243-7050 or 800-346-4643.

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 in order 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 Customer Service at 970-243-7050 or 800-346-4643.

Advance Directives Policy


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; and
- 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
- 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 non-medical 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 information (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 Primary Care Physician (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 he/she has 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.

Benefits Questions

Address all benefits questions to RMHP Customer Service by calling:

- Members: 970-243-7050 or 800-346-4643
- Providers: 970-248-5036 or 800-854-4558

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 Customer Service.

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 on page 44 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.

RMHP Member Dismissal Process

At Rocky Mountain Health Plans (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 Member from your care who is enrolled in a RMHP Product.

In this instance, you must do the following:

- Contact RMHP at 970-248-8718 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 her / him of the dismissal from your practice.
- The dismissal must be done in writing, via 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 at 800-346-4643 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 by mail, fax or secure email to your Provider Relations Representative:

Rocky Mountain Health Plans
Attn: Provider Relations Representative Name
P.O. Box 10600
Grand Junction, CO 81501-5600
Fax: 970-244-7957

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 primary care provider 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 deafblind).
- 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 at 800-346-4643.

**Covering Physicians**

There are two instances in which RMHP requires a formal agreement with a nonparticipating physician who is covering for a participating physician:

- When a new physician joins a practice and the physicians participate with RMHP
  - The covering physician will be a PCP, he / she may not be designated as a Member’s PCP until / she is participating (fully credentialed and with the proper agreement in place).
- When a physician who does not wish to participate with RMHP covers for a participating physician
  - A Covering Physician Agreement is required to accommodate payment to the nonparticipating physician should he / she see a RMHP Member while covering

**Credentialing and Re-credentialing**

Credentialing is the process used to ensure a quality practitioner panel. RMHP is able to select the best trained, most qualified practitioners to provide care to our Members as a result of this process.

RMHP currently performs the following types of credentialing:

- Initial Credentialing
- Re-credentialing
- Mid-cycle Credentialing
- Delegated Credentialing

Applicants have the right to receive the status of their credentialing application, upon verbal or written request. Information that may be shared with the applicant include date application received, missing application items, verifications received / pending, and expected date of Medical Director or Credentialing Committee review.

Applicants have the right to review their credentialing file only upon written request approved by the Medical Director. Review of such files will be conducted in the presence of Credentialing staff, Medical Director, or designee. Nothing may be removed from the file. Only public documents or information supplied by the practitioner or addressed to the practitioner may be viewed or copied from the file. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.
Applicants have the right to correct erroneous information submitted to RMHP by a third party. In the event information obtained during the credentialing process varies substantially from the information provided by the applicant, RMHP staff will notify the applicant in writing and provide an opportunity for the applicant to submit additional information or explanation or correct erroneous information submitted by another source. Upon receipt, RMHP staff will provide confirmation to the applicant verbally or in writing. If the applicant does not respond in writing to the request within thirty (30) business days, the credentialing application will be ceased.

**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, he/she must provide 24-hour coverage by a colleague with comparable 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). He/she 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**

RMHP is committed to complying with the laws and regulations, following appropriate business practices, and taking appropriate corrective action with regard to all illegal or wrongful activities discovered.

RMHP’s values reflect our concern for our communities and our commitment to legal and appropriate business practices. These values serve as the foundation for our business decisions and relationships, and the guiding tenets for RMHP’s Compliance Plan / Code of Conduct. RMHP will take prompt steps to correct any violation of the Compliance Plan / Code of Conduct.
RMHP maintains the Compliance Plan / Code of Conduct to provide guidance and assist us in carrying out our daily activities within appropriate legal standards. These obligations apply to our relationships within the RMHP community — providers, Members, contractors, regulators, consultants, and employees. Our Compliance Plan / Code of Conduct is a critical component of our overall compliance program.

The Compliance Plan / Code of Conduct is designed to alert individuals to the types of conduct that could create exposure. Being aware of these areas should enable individuals to identify potential problems. RMHP depends upon each individual at all times to rely upon his or her good judgment and do the right thing. This includes:

- Upholding all applicable laws and regulations
- Refraining from engaging in activity which may jeopardize the organization
- RMHP has implemented programs to further such awareness and to monitor and promote compliance with all applicable laws and regulations
- Reporting Compliance Issues and Potential Violations of Law and Conduct

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 RMHP:

Call the RMHP Compliance / Fraud Hotline at 970-248-5101 or 888-237-1179. This RMHP corporate hotline has been established for circumstances where confidentiality and anonymity are desired or required. RMHP will maintain the confidentiality of the individual reporting the issue to the fullest extent allowed by law and the nature of the investigation. Although you are encouraged to identify yourself, the call can be an anonymous report. You may leave an anonymous message on the hotline or leave your name and telephone number so that the Director of Legal and Regulatory Affairs or the Compliance Officer can return your call.

Alternatively, you may send a written report to:

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

Email to: medicarecompliance@rmhp.org

**Fraud and Abuse in Health Care**

RMHP considers fraud to be the intentional misrepresentation of a fact the organization relies upon and which causes a loss of property. A typical loss of property in health care is services or money. RMHP interprets abuse to be any activity that unjustly robs the health care system but which does not constitute fraud. The main difference is the intent to unjustly collect dollars from the health care system. There is no intent, or intent cannot be proven, in a case of abuse.

The difference between fraud and abuse includes:

- Fraud is a criminal act; abuse is not
- If fraud occurs, a crime has been committed and criminal prosecutions may take place
- If abuse occurs, the insurer may seek to recover monies that have been paid
  - In most cases a crime has not been committed
- The major difference is the intent of the person
Waste is the careless, negligent, or frivolous misuse of human or financial resources or provision of medically unnecessary or inappropriate provider services, that materially affects cost to RMHP.

Health care fraud and abuse is expensive and growing more costly each year for the health care industry. According to the Federal Bureau of Investigation (FBI), health care fraud costs the country an estimated $80 billion a year. As a result, health care fraud is a major concern of the federal government and is one of the top priorities for the FBI. Preventing and detecting fraud, waste and abuse are also important to RMHP.

The majority of Individuals working and interacting in the health care system are honest. RMHP is committed to preventing, detecting, investigating, and prosecuting all forms of health care and insurance fraud, waste and abuse. Fraud may be committed when an employee, agent, Member, provider, supplier, or any other individual knowingly and with intent deceives, misleads, makes false representations, or conceals information or any material fact on an application for evidence of coverage, renewal documents, rating of insurance policies, or claims submission / processing or breaches security of the company’s data processing systems.

The RMHP Internal Audit (IA) Department not only includes fraud detection steps in its audit programs, but also investigates assertions of fraud, waste, and abuse. The IA Manager is responsible for implementing a comprehensive plan to detect, correct, and prevent fraud, waste and abuse. The RMHP Fraud and Abuse Deterrence Committee is a standing committee of six (6) persons which includes others as needed. Committee members discuss each case presented, determine the best course of action to take based on findings, and agree on a plan of action.

If legal action or prosecution is warranted in cases of fraud or abuse, retained attorneys are available to provide advice on strategy and making recommendations to the IA Manager and the Fraud and Abuse Deterrence Committee. Attorneys are also available for consultation on making any reports to law enforcement, if necessary, on pursuing any recourse in the courts, as well as on advice for making any required notifications to appropriate agencies.

If you become aware of or suspect someone of fraud, waste, or abuse please contact the RMHP IA Manager.

    Rocky Mountain Health Plans
    Attn: Internal Audit Manager
    PO Box 10600
    Grand Junction, CO 81502-5600

You may also:

    Call the RMHP Compliance / Fraud Hotline (You can remain anonymous via this method) at 970-248-5101 or 888-237-1179.

    Email to: medicarecompliance@rmhp.org

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 fraud, waste and abuse. 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 three 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 Centers for Medicare and Medicaid (CMS) and the Colorado Department of Health Care Policy and Financing (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. An individual may be ordered to pay to the State full restitution in addition to a civil penalty of up to $50,000 or two 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 one or two) 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 or 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 Contractor or a Group Physician from collecting Co-Payments, 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 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 thirty (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.

**Mid-Lessons**

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. See Credentialing on page 98 for more information.

**Non-covered 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 Customer Service 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 Commercial 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 in order 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.
Primary Care Physician (PCP)

Depending on a Member’s plan, the Member may be required to select a participating physician as his/her 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 his/her 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 his/her medical treatment should he/she become unable to make those decisions on his/her 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 in order 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 his or her primary care practice has been hospitalized on an emergency basis, whether in or out of the service area
- Maintain and operate his/her practice in a manner that protects the health and safety of RMHP Members and provides reasonable access for acute and scheduled appointments

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 Customer Service or use the online through MyRMHP (Member must be registered to use the Member portal.)
- RAE only Members must notify Health First Colorado by calling 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. 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 mentioned above.

- RMHP is a “covered entity” under HIPAA and is subject to the HIPAA Privacy Rule found at 45 C.F.R., parts 160 and 164.

- RMHP does not generally keep completed medical records regarding our Members. A Member may access his/her medical records through the primary care physician, 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 rmhp.org or by calling customer service. Similarly, providers who are “covered entities” under HIPAA must comply with all applicable regulations.

Medical Records | Release of Information and Transfer of Records

Each provider will make health service records for RMHP Members in his/her 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 his/her contract or otherwise cease to care for RMHP Members, the complete health service record on file for that Member (from the date he/she 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 his/her complete medical records to the participating provider of his/her 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 his / her complete medical records to a provider of his / her choice.

In the event the former Member does not elect to have his/her health medical records transferred, his/her provider will maintain said record for a period of at least seven years, unless a longer timeframe for retention of records is required by legal requirements applicable to RMHP. Generally, longer timeframes apply for medical records of RMHP Prime Recipients, Medicare Beneficiaries, 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
• 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 primary care physician 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 above, 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 primary care physician.
- 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

Reports and Summaries

- Office diagnostic test, EKGs, and other office tests (such as radiology, pulmonary function tests, allergy tests, EEGs, ultrasound, etc.) 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 January 1, 2020 the Federal Government has set forth a new regulation on requirements to disclose Substance Use Disorder Information (Regulation 42 C.F.R).

If you are a provider who provides Substance Use Disorder (SUD) services to Rocky Mountain Health Plan Members, you (provider) must obtain a written consent from the Member, to authorize the disclosure of information related to the treatment of SUD to the Health Plan (Rocky Mountain Health Plans). The appropriate form can be found at rmhp.org or you may call or contact your Provider Relations Representative for a copy of the form.

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 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. 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:

U.S. Department of Health & Human Services
Office of Minority Health
Phone: 844-899-8057
Website: www.thinkculturalhealth.hhs.gov/index.asp

Cultural Competency Training

RMHP encourages providers to complete A Family Physician's Practical Guide to Culturally Competent Care, a free web-based training program for physicians and medical staff. Upon successful completion of all modules, physicians can earn up to 9 CME hours of category one credit and 2 ERS points from COPIC, 10.8 CEU Credits for nurses, or 3 contact hours (0.3 CEUs) for pharmacists.

The three module themes include:

• Culturally Competent Care
• Language Access
• Organizational Support

Once training is started, the program bookmarks where you left off and will start at that point the next time the program is accessed. Register at http://1.usa.gov/NwkL4x and begin the training today.

Benefits of the program include providing better care for a culturally diverse population, experiencing better clinical outcomes, avoid miscommunications due to cultural differences, and more.

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 State 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:

Member Concerns Coordinator
Phone: 800-346-4643 or 970-243-7050
TTY for the hearing impaired: 711

**Member Rights and Responsibilities**

The following text is reproduced from the *Member Handbook*. This information has been included in the Provider Manual for your information.

**Commercial 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 frank 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 Customer Service 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 Rocky Mountain Health Plans 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 refuses 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 Rocky Mountain Health Plans, the Insurance Commissioner of the State of Colorado, or the Department of Health Care Policy and Financing

• 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

• 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 Rocky Mountain Health Plans 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 make recommendations regarding Rocky Mountain Health Plans Rights and Responsibilities policy

It is your responsibility:

• To choose a Primary Care Physician (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 Rocky Mountain Health Plans health care benefits, procedures, and limitations and to be cooperative and considerate with health care providers and staff

• To notify Rocky Mountain Health Plans Customer Service 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 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 understand your health problems and participate in making treatment goals
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 Rocky Mountain Health Plans 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

Provider Tools

Provider Edition Newsletter

Good Health - Provider Edition is the quarterly publication of the Provider Relations department at RMHP. Each edition provides information that will update your Provider Manual. We suggest you retain the newsletter as a reference tool. It is also available on the RMHP website, rmhp.org.

Forms

The most up-to-date forms can be found by visiting rmhp.org or by calling 970-244-7798.