Table of Contents

About RMHP and the RAE .......................................................................................................................... 3
   Introduction ............................................................................................................................................... 4
   Commitment to High-Quality Health Care .............................................................................................. 4
   About the RAE ......................................................................................................................................... 4
   Transition from the BHOs to the RAES ................................................................................................. 5
   Resources for Providers ......................................................................................................................... 5

About the Services ....................................................................................................................................... 6
   Services Provided by Regional Organizations ....................................................................................... 7
   Covered Services ..................................................................................................................................... 7
   Services Requiring Prior Authorization ............................................................................................... 10
   Short-term Behavioral Health Services in the Primary Care Setting .................................................... 11
   Capitated Behavioral Health Benefit Covered Services and Diagnoses ................................................. 12
   Continuum of Services .......................................................................................................................... 16
   Substance Use Disorders Services ......................................................................................................... 18
   EPSDT Program Information .................................................................................................................. 19
   Care Coordination ................................................................................................................................ 22

About Policies & Procedures ...................................................................................................................... 23
   Verification of Eligibility & Enrollment ................................................................................................. 24
   Provider Availability for Member Access to Care .................................................................................. 25
   Members Access to Behavioral Health Care ......................................................................................... 27
   Expectations of Providers for Emergency Access ................................................................................ 27
   Coordination of Care Requirements ...................................................................................................... 28
   The following parties must maintain communication from the date of admission through the date of discharge: 28
   Coordination of Behavioral Health and Primary Care ........................................................................ 29
   Facilitating Improved Integration of Services and Coordination of Care ............................................. 29
   Mental Health Inpatient Care Requirements ......................................................................................... 29
   Utilization Management Procedures ...................................................................................................... 31
   Higher Level of Care: Inpatient, Partial Hospital, Residential, Day Treatment, and Intensive Community-Based Services Prior Authorization ................................................................. 33
   Claims .................................................................................................................................................... 36
   Claims Billing Information ..................................................................................................................... 37
   General Medical Record Requirements ............................................................................................... 44
   Quality Assurance and Compliance ...................................................................................................... 45
   Behavioral Health Quality Program ...................................................................................................... 46
   Compliance .............................................................................................................................................. 50
   Reporting Fraud Waste and Abuse ......................................................................................................... 50
   Get Help from RMHP............................................................................................................................. 50
ABOUT RMHP AND THE RAE
Introduction

Rocky Mountain Health Plans (RMHP) is committed to ensuring providers have the tools and resources necessary to best serve Members of Health First Colorado (Colorado’s Medicaid Program).

We created this guide to help RMHP Behavioral Health providers understand Health First Colorado’s Regional Accountable Entity (RAE), our role as the RAE for Western Colorado and Larimer County, and ensure successful delivery of health care services to RMHP Members.

Commitment to High-Quality Health Care

RMHP prioritizes the administration and management of high-quality health care and the development of care coordination processes in primary care, behavioral health, and community-based settings among multiple providers and at different levels of care through defined, inter-organizational workflows. We facilitate the exchange of Member-centered data among providers and community service organizations in an inclusive network of care.

Our key differentiators include:

- Strong local relationships and established, inter-organizational business processes;
- An interdisciplinary model for care coordination, which is staffed by physical and behavioral health clinicians, as well as social workers and peers - all of whom are well versed in connecting Members to community resources;
- Superior technology, data sharing, and data management resources; and
- A transparent and participatory program governance model directly connected to our communities.

RMHP seeks to address the following key objectives as the regional organization under the RAE:

**Whole-Person and Member-Centric Foundation:** Organize the entire RAE model around the goals and needs of our Members, as those persons who have aspirations and impactful contributions to offer the community.

**Expansive, Inclusive Network:** Establish, incentivize, and maintain a broad and comprehensive network that is informed by Member choice and includes single-provider practices, large group clinics, specialty providers and facilities, and Community Mental Health Centers.

**Diverse, Knowledgeable, and Local Leadership:** Establish the focus of leadership and decision making firmly within a local, multi-disciplinary, multi-sector community governance model.

**Integrated Care:** Achieve the deepest possible degree of coordination and collaboration among Physical health, behavioral, and human service organizations — and ensure that resources and talent at every level are put to the most productive use.

**Expertise and Resource Commitment:** Deliver significant expertise, technology, research and development, and capital investment within a national enterprise available to local leaders, with the autonomy to close gaps, learn, and innovate rapidly.

**Transparency and Accountability:** Establish clear, straight lines of accountability to the Colorado Department of Health Care Policy and Financing (the Department) that allow for the efficient fulfillment of all deliverables and public reporting duties, with an appropriate separation of controls, checks, and balances in a framework that ensures competence and continuity without sacrificing access or transparency.

About the RAE

In October 2017, the Department awarded RMHP the contract as the RAE for Region 1 of the Health First Colorado Accountable Care Collaborative (ACC). This contract is effective July 1, 2018. Under the RAE contract, RMHP serves as the regional organization and is responsible for connecting Health First Colorado Members with both primary care and behavioral health services for Region 1, which includes Western Colorado and Larimer County.
This builds upon our foundation of our previous services as a Regional Care Collaborative Organization (RCCO), growing our community-oriented approach for Health First Colorado Members.

The RAE for Region 1 includes:

- The services previously performed by RMHP as the RCCO, including the primary care medical provider network and care coordination services;
- The services previously performed by the regional Behavioral Health Organization (BHO), including managing covered services under the Medicaid Capitated Behavioral Health Benefit;
- The Western Colorado payment reform initiative known as RMHP Prime; and
- Additional services to support whole person care, including activities to address social determinants of health.

With the transition to the RAE, the terms RCCO and BHO will no longer be used.

Transition from the BHOs to the RAEs

RMHP is responsible for coordinating behavioral health for Health First Colorado Members and administering the State of Colorado’s Capitated Behavioral Health Benefit. These duties were previously contracted by regional BHOs and now will be performed by the RAEs (or regional organizations).

Effective July 1, 2018, all behavioral health providers wishing to receive reimbursement for providing services covered by the Capitated Behavioral Health Benefit must contract directly with the RAE. Importantly, behavioral health providers must be enrolled as a Health First Colorado provider before they can be credentialed and contracted with the RAE.

Resources for Providers

RMHP’s Provider Relations team is available to answer questions about credentialing and contracting at 888-286-3113 or RAEnet@rmhp.org.

Providers can also visit rmhp.org and select I am a Provider to find more information about the RAE, as well as common forms and resources for providers, in the Provider Resources section.

RMHP offers providers a secure provider portal called accessRMHP. This portal provides information about Member eligibility, benefits, and copays; claim status; prior authorizations; code lookup; and much more.

Please note, RMHP RAE Member information is not available in accessRMHP; however, RMHP Prime Member information can be viewed.

For assistance with registering for accessRMHP, please contact your RMHP Provider Relations Representative.
ABOUT THE SERVICES
Services Provided by Regional Organizations

Enrollment with a regional organization is determined by Health First Colorado based on the region of the Member’s attributed primary care medical provider. As some Members access care from a primary care medical provider (PCMP) in a county other than their current county of residence, it is very important for providers to verify Health First Colorado eligibility AND the Member’s regional organization. Claims and prior authorizations for behavioral health services must be submitted to the Member’s regional organization. A Member’s regional organization also may change if the Member’s primary care medical provider (PCMP) changes. For this reason, it is important to verify the applicable regional organization at each date of service. The participating Regional Organizations include:

Rocky Mountain Health Plans
Phone: 888-282-8801
Email: customer_service@rmhp.org
Hours: Monday – Friday, 8 a.m. – 5 p.m.
Web / Live Chat: rmhp.org

Colorado Access
Phone: 303-368-0037 or 855-267-2095 (toll free)
Hours: Monday – Friday, 8 a.m. – 5 p.m.
Web: coaccess.com

Colorado Community Health Alliance
Phone: 303-256-1717 or 855-627-4685 (toll free)
Hours: Monday – Friday, 8 a.m. – 5 p.m.
Web: cchacares.com

Health Colorado, Inc.
Phone: 888-502-4185; Care Coordination: 888-502-4186
Hours: Monday – Friday, 8 a.m. – 5 p.m.
Web: healthcoloradorae.com

Northeast Health Partners
Phone: 888-502-4189
Hours: Monday – Friday, 8 a.m. – 5 p.m.
Web: northeasthealthpartners.org

Covered Services

Effective July 1, 2018, RMHP is responsible for covering and administering behavioral health services for RMHP Members of Health First Colorado throughout Western Colorado and Larimer County.

Behavioral Health

The following mental health and substance use disorders (SUD) services are covered by the RAE:

• Alcohol/drug screen counseling
• Behavioral health assessment
• Emergency and post-stabilization care services
• Inpatient psychiatric hospital services
• Medication assisted treatment
• Medication management
• Outpatient day treatment
• Outpatient hospital services
• Psychotherapy: family, individual, individual brief, and group
• Rehabilitative services
• School-based services (for children with Individual Education Programs –IEPs)
• Social ambulatory detoxification
• Substance use disorder assessment
• Targeted case management
• Additional benefits known as 1915(b)(3) services, which can be accessed at Community Mental Health Centers and other participating community providers
• Vocational services
• Intensive case management
• Prevention/early intervention activities
• Clubhouse and drop-in centers
• Residential
• Assertive community treatment (ACT)
• Recovery services
• Respite services

**Alcohol/drug Screen Counseling:** Substance use disorder counseling services are provided along with screening to discuss results with a Member.

**Assessment - Behavioral Health Assessment:** Face-to-face clinical assessment of a Member by a behavioral health professional that determines the nature of the Member's problem(s); factors contributing to the problem(s); a Member’s strengths, abilities and resources to help solve the problem(s); and any existing diagnoses.

**Assessment - Substance Use Disorder Assessment:** An evaluation designed to determine the most appropriate level of care, based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug/alcohol use, abuse or dependence and related problems, and the comprehensive treatment needs of a Member with a drug or alcohol diagnosis.

**Emergency and Post-Stabilization Care Services**

**Inpatient Psychiatric Hospital Services**

- **For Members under 21 years old.** A program of care for Members age 20 and under in which the Member remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the state. Members who are inpatient on their 21st birthday are entitled to receive inpatient benefits until discharged from the facility or until their 22nd birthday, whichever is earlier, as outlined in 42 C.F.R. § 441.151.

- **For adults ages 21 to 64 years.** A program of psychiatric care in which the Member remains twenty-four (24) hours a day in a facility licensed as a hospital by the state, excluding state institutes for mental disease (IMDs).

- **For Members age 65 years and over.** A program of care for Members age 65 and over in which the Member remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the state.

- The Contractor’s responsibility for all inpatient hospital services is based on the primary diagnosis that requires inpatient level of care and is being managed within the treatment plan of the Member.
• The Contractor shall be financially responsible for the hospital stay when the Member’s primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures (including labs and ancillary services). [See Capitated Behavioral Health Benefit Covered Services & Diagnoses on page 10 for covered diagnoses]

• The Contractor shall not be financially responsible for inpatient hospital services when the Member’s primary diagnosis is physical in nature, even when the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis. [Note – if Member is RMHP Prime, RMHP is responsible for this benefit as a physical health benefit.]

• The Contractor shall not be financially responsible for inpatient hospital services when the Member’s primary diagnosis is a substance use disorder that is evident at the time of admission.

• The Contractor shall be financially responsible for a Member’s admission to any free standing inpatient psychiatric facility, when the Member is presenting with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment to determine whether or not the primary diagnosis occasioning the Member’s admission to the hospital is a mental health disorder or substance use disorder.

• The Contractor shall be financially responsible until a substance use disorder diagnosis is determined to be the primary diagnosis, at which point the Contractor shall no longer be responsible for continued acute stabilization, safety, and assessment services associated with that admission.

• If a mental health disorder is determined to be the primary diagnosis, the Contractor shall be financially responsible for the remainder of the inpatient hospital services, as Medically Necessary in accordance with 10 CCR 2505-10 § 8.076.1.8. The assessment period shall generally not exceed 72 hours.

• The Contractor may cover, but may not require the Member to use, Institutions for Mental Disease (IMDs) in lieu of short-term inpatient psychiatric hospital care when determined medically appropriate and cost-effective, in compliance with 42 CFR 438.3(e)(2). Short term stays in an IMD must be for lengths of stay of no more than 15 days during the period of the monthly capitation payment.
Services Requiring Prior Authorization

Prior authorization is required for inpatient hospitalizations, partial hospitalizations, acute treatment units, short and long-term residential, day treatment, intensive outpatient programs, testing, and electroconvulsive therapy. For Notifications by the Admitting Facility, call RMHP at 888-282-8801. The table below identifies the behavioral health services requiring prior authorization by RMHP for RAE Members.

Behavioral Health Services Requiring Prior Authorization by RMHP for RAE Members

<table>
<thead>
<tr>
<th>Service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Treatment Unit (ATU)</td>
<td>H0017</td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>Professional 90870</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>All admissions to inpatient psychiatric facilities, and when primary diagnosis is a covered psychiatric/mental health diagnosis.</td>
</tr>
<tr>
<td>Outpatient:</td>
<td></td>
</tr>
<tr>
<td>• Behavioral Health Day Treatment</td>
<td>H2012</td>
</tr>
<tr>
<td>• Intensive Outpatient Programming for SUD</td>
<td>H0015</td>
</tr>
<tr>
<td>• Intensive Outpatient Programming</td>
<td>S9340</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>H0035 Rev code 0900</td>
</tr>
<tr>
<td>Residential Treatment:</td>
<td></td>
</tr>
<tr>
<td>• Short-Term</td>
<td>H0018</td>
</tr>
<tr>
<td>• Long-Term</td>
<td>H0019</td>
</tr>
<tr>
<td>• Psychiatric</td>
<td>H0017</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139</td>
</tr>
</tbody>
</table>

The list of covered services requiring prior authorization by RMHP may change from time to time. The most up-to-date prior authorization policies, procedures, and list of services subject to authorization and covered by RMHP under the RAE contract can be found at [rmhp.org](http://rmhp.org) under I am a Provider / Provider Resources / Prior Authorization.

Submitting Prior Authorizations

For RMHP RAE Members, prior authorizations and behavioral health prior authorization requests are submitted to RMHP by calling RMHP at 888-282-8801.
Short-term Behavioral Health Services in the Primary Care Setting

The Department allows and encourages the provision of up to six sessions of short-term behavioral health services at their Primary Care Medical Provider (PCMP) clinic. The rendering provider on the claim must be a Health First Colorado-enrolled, licensed behavioral health clinician. The PCMP may be reimbursed fee-for-service (FFS) for up to six (6) visits per state fiscal year (defined as July 1-June 30). A visit is defined as a single date of service. These visits will not require a diagnosis covered by the capitated behavioral health benefit. That said, PCMPs must use the most appropriate diagnosis that supports medical necessity.

The following procedure codes are included as Short-Term Behavioral Health Services:

- Diagnostic evaluation without medical services (90791)
- Psychotherapy – 30 minutes (90832)
- Psychotherapy – 45 minutes (90834)
- Psychotherapy – 60 minutes (90837)
- Family psychotherapy without patient (90846)
- Family psychotherapy with patient (90847)

While the intent of the policy is to increase access to behavioral health services that can address a low-acuity condition within six (6) visits, we understand that there may be times when a member requires additional services. In these instances, there are two options for accessing additional services.

1. A PCMP that has a licensed behavioral health clinician who is contracted as part of the RMHP (RAE) behavioral health network may submit claims to RMHP for reimbursement of additional visits beyond six (6) during a state fiscal year. All additional visits must be provided in accordance with RMHP utilization management policies and procedures.

2. A PCMP with a licensed behavioral health clinician that is not contracted as part of the RMHP (RAE) behavioral health network can work with RMHP to transition a member’s care to another behavioral health provider. Any additional visits beyond six (6) during a state fiscal year will be denied FFS reimbursement.

*This excludes any primary care provider that is on the same site as a Medicaid enrolled community mental health center CMHC.*
### Capitated Behavioral Health Benefit Covered Services and Diagnoses

**Specialty Behavioral Health Codes**

Reimbursed under the behavioral health capitation, when the service is for a covered behavioral health diagnosis and is billed by a Behavioral Health Specialty Provider, non-physician practitioner group, or an FQHC or RHC using revenue code 0900.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00104</td>
<td>Anesthesia for ECT</td>
</tr>
<tr>
<td>90785</td>
<td>Interactive Complexity*</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy - 30 mins.</td>
</tr>
<tr>
<td>90833</td>
<td>Psytx pt &amp;/or Family w/ E&amp;M 30 mins.</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy - 45 mins.</td>
</tr>
<tr>
<td>90836</td>
<td>Psytx pt &amp;/or Family w/ E&amp;M 45 mins.</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy - 60 mins.</td>
</tr>
<tr>
<td>90838</td>
<td>Psytx pt &amp;/or Family w/ E&amp;M 60 mins.</td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy (w/o Patient)</td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy (w/ Patient)</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple Family Group Psytx</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
</tr>
<tr>
<td>90870</td>
<td>ECT</td>
</tr>
<tr>
<td>90875</td>
<td>Indv. Psychotherapy Biofeedback 30 min.</td>
</tr>
<tr>
<td>90876</td>
<td>Indv. Psychotherapy Biofeedback 45 min.</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral Status Exam</td>
</tr>
<tr>
<td>96121</td>
<td>Neurobehavioral Status Exam; add’l. hrs**</td>
</tr>
<tr>
<td>96130</td>
<td>Psych Testing Eval Services; first hr</td>
</tr>
<tr>
<td>96131</td>
<td>Psych Testing Eval Services; add’l. hrs**</td>
</tr>
<tr>
<td>96132</td>
<td>Neuropsych Testing Eval Services; first hr</td>
</tr>
<tr>
<td>96133</td>
<td>Neuropsych Testing Eval Services; add’l hrs**</td>
</tr>
<tr>
<td>96136</td>
<td>Psych or Neuropsych Test Admin &amp; Scoring; 30 min</td>
</tr>
<tr>
<td>96137</td>
<td>Psych or Neuropsych Test Admin; add’l. 30 min**</td>
</tr>
<tr>
<td>96138</td>
<td>Psych or Neuropsych Test Admin, by Tech; first 30 min</td>
</tr>
<tr>
<td>96139</td>
<td>Psych or Neuropsych Test Admin, by Tech; add’l. 30 min**</td>
</tr>
<tr>
<td>96372</td>
<td>Ther/proph/diag inj, sc/im</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care management training</td>
</tr>
<tr>
<td>97537</td>
<td>Community/work reintegration</td>
</tr>
<tr>
<td>G0176</td>
<td>Activity Therapy 45 min. or More</td>
</tr>
<tr>
<td>G0177</td>
<td>Training Re: Care of MH Problem</td>
</tr>
<tr>
<td>H0006</td>
<td>Alcohol/Drug Case Management</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol/Drug Intensive Outpatient</td>
</tr>
<tr>
<td>H0017</td>
<td>BH Residential w/o Room/Board</td>
</tr>
<tr>
<td>H0018</td>
<td>BH Short-Term Res. w/o Room/Board</td>
</tr>
<tr>
<td>H0019</td>
<td>BH Long-term Red w/o Room/Board</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone Admin/Service</td>
</tr>
<tr>
<td>H0033</td>
<td>Oral Med Admin Observation</td>
</tr>
<tr>
<td>H0034</td>
<td>Med Training/Support per 15 min.</td>
</tr>
<tr>
<td>H0035</td>
<td>MH Partial Hospitalization less 24 hr.</td>
</tr>
<tr>
<td>H0036</td>
<td>Comm Psych Treatment per 15 min.</td>
</tr>
<tr>
<td>H0037</td>
<td>Comm Psych Treatment, per diem</td>
</tr>
<tr>
<td>H0038</td>
<td>Self-Help/Peer Services per 15 min.</td>
</tr>
<tr>
<td>H0039</td>
<td>Assertive Comm Treatment per 15 min.</td>
</tr>
<tr>
<td>H0040</td>
<td>Assertive Comm 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 Not-in-Home per diem</td>
</tr>
<tr>
<td>H2001</td>
<td>Rehab Program 1/2 day</td>
</tr>
<tr>
<td>H2012</td>
<td>BH Day Treatment, per hour</td>
</tr>
<tr>
<td>H2014</td>
<td>Skills Train and Dev. 15 min.</td>
</tr>
<tr>
<td>H2015</td>
<td>Comprehen Comm Support per 15 min.</td>
</tr>
<tr>
<td>H2016</td>
<td>Comprehen Comm Support per diem</td>
</tr>
<tr>
<td>H2017</td>
<td>Psysoc Rehab SVC, per15 min.</td>
</tr>
<tr>
<td>H2018</td>
<td>Psysoc Rehab SVC, per diem</td>
</tr>
<tr>
<td>H2021</td>
<td>Com Wrap-Around SV, 15 min.</td>
</tr>
<tr>
<td>H2022</td>
<td>Com Wrap-Around SV, per diem</td>
</tr>
<tr>
<td>H2023</td>
<td>Supported Employ, per diem</td>
</tr>
<tr>
<td>H2024</td>
<td>Supported Employ, per diem</td>
</tr>
<tr>
<td>H2025</td>
<td>Supp Maint Employ, 15 min.</td>
</tr>
<tr>
<td>H2027</td>
<td>Psych ED Service, per 15 min.</td>
</tr>
<tr>
<td>H2030</td>
<td>MH Clubhouse per 15 min.</td>
</tr>
<tr>
<td>H2031</td>
<td>MH Clubhouse per diem</td>
</tr>
<tr>
<td>H2032</td>
<td>Activity Therapy per 15 min.</td>
</tr>
<tr>
<td>H2033</td>
<td>Multisys Ther/ Juvenile 15 min.</td>
</tr>
<tr>
<td>S3005</td>
<td>Performance Measurement, Depression</td>
</tr>
<tr>
<td>S5150</td>
<td>Unskilled Respite Care, per 15 min.</td>
</tr>
<tr>
<td>S5151</td>
<td>Unskilled Respite Care, per diem</td>
</tr>
<tr>
<td>S9445</td>
<td>Patient ED Non-Phys, Indv.</td>
</tr>
<tr>
<td>S9480</td>
<td>Intens Outpatient Psych per diem</td>
</tr>
<tr>
<td>S9485</td>
<td>Crisis Interv MH per diem</td>
</tr>
<tr>
<td>T1005</td>
<td>Respite Care Service 15 min.</td>
</tr>
<tr>
<td>T1017</td>
<td>Targeted Case Management *must be billed with psychotherapy code</td>
</tr>
</tbody>
</table>

*Must be billed with psychotherapy code

** Listed separately in addition to primary procedure code
Behavioral Health Codes

Reimbursed under the behavioral health capitation, when the service is for an appropriate diagnosis that supports medical necessity and is billed by a Behavioral Health Specialty Provider, non-physician practitioner group or an FQHC or RHC using revenue code 0900.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Diagnostic Eval w/o Medical Services</td>
</tr>
<tr>
<td>90792</td>
<td>Diagnostic Eval w/ Medical Service</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for Crisis 60 mins.</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for Crisis - add’l. 30 mins.</td>
</tr>
<tr>
<td>98966</td>
<td>HC Pro Phone Call 5–10 min.</td>
</tr>
<tr>
<td>98967</td>
<td>HC Pro Phone Call 11–20 min.</td>
</tr>
<tr>
<td>98968</td>
<td>HC Pro Phone Call 21–30 min.</td>
</tr>
<tr>
<td>H0001</td>
<td>Alcohol and/or Drug Assessment</td>
</tr>
<tr>
<td>H0002</td>
<td>Alcohol and/or Drug Screening</td>
</tr>
<tr>
<td>H0004</td>
<td>Alcohol and/or Drug Services</td>
</tr>
<tr>
<td>H0005</td>
<td>Alcohol and/or Drug Services</td>
</tr>
<tr>
<td>H0023</td>
<td>BH Outreach / Drop-in</td>
</tr>
<tr>
<td>H0025</td>
<td>BH Prevention Education</td>
</tr>
<tr>
<td>H0031</td>
<td>MH Assessment by Non-Phys</td>
</tr>
<tr>
<td>H0032</td>
<td>MH Service Plan Devel by Non-Phys</td>
</tr>
<tr>
<td>H2000</td>
<td>Comprehensive Multi-Discipline Edu</td>
</tr>
<tr>
<td>H2011</td>
<td>Crisis Intervention per 15 min.</td>
</tr>
<tr>
<td>S9453</td>
<td>Smoking Cess Class, Non-Phys, per ses.</td>
</tr>
<tr>
<td>S9454</td>
<td>Stress Manage, Non-Phys, per ses.</td>
</tr>
<tr>
<td>T1007</td>
<td>Alcohol / Sud Plan Dev / Mod Inc Vitals</td>
</tr>
<tr>
<td>T1019</td>
<td>Personal Care Services per 15 min.</td>
</tr>
<tr>
<td>T1023</td>
<td>Program / Project Screen of Indv. per enc.</td>
</tr>
</tbody>
</table>

Evaluation & Management Consultation Codes

Reimbursed under the behavioral health capitation, when the service is provided for a covered behavioral health diagnosis, regardless of the billing provider.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Outpatient Consultation 15 min.</td>
</tr>
<tr>
<td>99242</td>
<td>Outpatient Consultation 30 min.</td>
</tr>
<tr>
<td>99243</td>
<td>Outpatient Consultation 40 min.</td>
</tr>
<tr>
<td>99244</td>
<td>Outpatient Consultation 60 min.</td>
</tr>
<tr>
<td>99245</td>
<td>Outpatient Consultation 80 min.</td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient Consultation</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient Consultation</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient Consultation</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient Consultation</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient Consultation</td>
</tr>
</tbody>
</table>
### Evaluation & Management Emergency Department Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Requires problem-focused history, problem-focused examination, straightforward medical decision making</td>
</tr>
<tr>
<td>99282</td>
<td>Requires expanded problem-focused history, expanded problem-focused examination, low-complexity medical decision making</td>
</tr>
<tr>
<td>99283</td>
<td>Requires expanded problem-focused history, expanded problem-focused examination, moderate-complexity medical decision making</td>
</tr>
<tr>
<td>99284</td>
<td>Requires detailed history, detailed examination, moderate-complexity medical decision making</td>
</tr>
<tr>
<td>99285</td>
<td>Requires comprehensive history, comprehensive examination, high-complexity medical decision making</td>
</tr>
</tbody>
</table>

### Evaluation & Management Codes

Reimbursed through the behavioral health capitation for a covered behavioral health diagnosis when the service is billed by a Behavioral Health Specialty Provider.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or OP - New, 10 min.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or OP - New, 20 min.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or OP - New, 30 min.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or OP - New, 45 min.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or OP - New, 60 min.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or OP - Other</td>
</tr>
<tr>
<td>99212</td>
<td>Office or OP - Est. 10 min.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or OP - Est. 15 min.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or OP - Est. 25 min.</td>
</tr>
<tr>
<td>99215</td>
<td>Office or OP - Est. 40 min.</td>
</tr>
<tr>
<td>99217</td>
<td>Observ. Care Discharge Day Mgmt.</td>
</tr>
<tr>
<td>99218</td>
<td>Initial Observ. Care, 30 min.</td>
</tr>
<tr>
<td>99219</td>
<td>Initial Observ. Care, 50 min.</td>
</tr>
<tr>
<td>99220</td>
<td>Initial Observ. Care, 70 min.</td>
</tr>
<tr>
<td>99221</td>
<td>Initial Hospital Care</td>
</tr>
<tr>
<td>99222</td>
<td>Initial Hospital Care</td>
</tr>
<tr>
<td>99223</td>
<td>Initial Hospital Care</td>
</tr>
<tr>
<td>99224</td>
<td>Subsequent Hospital Care - 15 min.</td>
</tr>
<tr>
<td>99225</td>
<td>Subsequent Hospital Care - 25 min.</td>
</tr>
<tr>
<td>99226</td>
<td>Subsequent Hospital Care - 35 min.</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent Hospital Care</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent Hospital Care</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent Hospital Care</td>
</tr>
<tr>
<td>99234</td>
<td>Same Day Admit / DC, 40 min.</td>
</tr>
<tr>
<td>99235</td>
<td>Same Day Admit / DC, 50 min.</td>
</tr>
<tr>
<td>99236</td>
<td>Same Day Admit / DC, 55 min.</td>
</tr>
<tr>
<td>99238</td>
<td>Hospital Discharge Day</td>
</tr>
<tr>
<td>99239</td>
<td>Hospital Discharge - Manage</td>
</tr>
<tr>
<td>99304</td>
<td>Initial Nursing Facility, 25 min.</td>
</tr>
<tr>
<td>99305</td>
<td>Initial Nursing Facility, 35 min.</td>
</tr>
<tr>
<td>99306</td>
<td>Initial Nursing Facility, 45 min.</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent Nursing Facility, 10 min.</td>
</tr>
<tr>
<td>99308</td>
<td>Subsequent Nursing Facility, 15 min.</td>
</tr>
<tr>
<td>99309</td>
<td>Subsequent Nursing Facility, 25 min.</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent Nursing Facility, 35 min.</td>
</tr>
<tr>
<td>99315</td>
<td>Nursing Facility Discharge, 30 min.</td>
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<tr>
<td>99316</td>
<td>Nursing Facility Discharge, 30+ min.</td>
</tr>
<tr>
<td>99318</td>
<td>Annual Nursing Facility Assmt.</td>
</tr>
<tr>
<td>99324</td>
<td>Dom, Res, Custodial - New, 20 min.</td>
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<tr>
<td>99325</td>
<td>Dom, Res, Custodial - New, 30 min.</td>
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<tr>
<td>99326</td>
<td>Dom, Res, Custodial - New, 45 min.</td>
</tr>
<tr>
<td>99327</td>
<td>Dom, Res, Custodial - New, 60 min.</td>
</tr>
<tr>
<td>99328</td>
<td>Dom, Res, Custodial - New, 75 min.</td>
</tr>
<tr>
<td>99334</td>
<td>Dom, Res, Custodial - Est., 15 min.</td>
</tr>
<tr>
<td>99336</td>
<td>Dom, Res, Custodial - Est., 40 min.</td>
</tr>
<tr>
<td>99337</td>
<td>Dom, Res, Custodial - Est., 60 min.</td>
</tr>
<tr>
<td>99341</td>
<td>Home Care - New, 20 min.</td>
</tr>
<tr>
<td>99342</td>
<td>Home Care - New, 30 min.</td>
</tr>
<tr>
<td>99343</td>
<td>Home Care - New, 45 min.</td>
</tr>
<tr>
<td>99344</td>
<td>Home Care - New, 60 min.</td>
</tr>
<tr>
<td>99345</td>
<td>Home Care - New, 75 min.</td>
</tr>
<tr>
<td>99347</td>
<td>Home Care - Est., 15 min.</td>
</tr>
<tr>
<td>99348</td>
<td>Home Care - Est., 25 min.</td>
</tr>
<tr>
<td>99349</td>
<td>Home Care - Est., 40 min.</td>
</tr>
<tr>
<td>99350</td>
<td>Home Care - Est., 60 min.</td>
</tr>
<tr>
<td>99366</td>
<td>Team Conf. w/ Patient by HC pro</td>
</tr>
<tr>
<td>99367</td>
<td>Team Conf. w/o Patient by Physician</td>
</tr>
<tr>
<td>99368</td>
<td>Team Conf. w/ Patient by HC Pro</td>
</tr>
<tr>
<td>99441</td>
<td>Telephone by Phys. 5–10 min.</td>
</tr>
<tr>
<td>99442</td>
<td>Telephone by Phys. 11–20 min.</td>
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<tr>
<td>99443</td>
<td>Telephone by Phys. 21–30 min.</td>
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## BH Specialty Provider Types

<table>
<thead>
<tr>
<th>PROVIDER TYPE (PT)</th>
<th>SPECIALTY TYPE</th>
<th>PROVIDER TYPE DESCRIPTION</th>
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<tbody>
<tr>
<td>35</td>
<td>360</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>37</td>
<td>520</td>
<td>Licensed Psychologist</td>
</tr>
<tr>
<td>38</td>
<td>521</td>
<td>Licensed Behavioral Health Clinician</td>
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<tr>
<td>63</td>
<td>399</td>
<td>Substance Use Disorder Individual*</td>
</tr>
<tr>
<td>64</td>
<td>477</td>
<td>Substance Use Disorder Clinics</td>
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</tbody>
</table>

*This provider type is no longer available for new enrollments*

## ICD-10-CM Code Ranges

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<td>F51.03</td>
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<td>F51.9</td>
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<td>F63.9</td>
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<td>F99</td>
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<td>R45.1</td>
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</tr>
<tr>
<td>R45.5</td>
<td>R45.82</td>
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</table>
Evaluation & Management Add-On Codes
Reimbursed under the behavioral health capitation when billed with an Evaluation & Management code covered under the behavioral health capitation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 min. with PT and/or Family mbr when Performed with an E&amp;M</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 min. with PT and/or Family mbr when Performed with an E&amp;M</td>
</tr>
<tr>
<td>90838</td>
<td>60 min. with PT and/or Family mbr when Performed with an E&amp;M</td>
</tr>
</tbody>
</table>

The Following Revenue Codes (In Addition to Those Represented in Appendix Q) May be Covered Under the Capitated Behavioral Health Benefit

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0906</td>
<td>Behavioral Health Treatments/Services (Also See 091X - An Extension of 090X) Intensive Outpatient Services - Chemical Dependency BH/Intens OP/Chem Dep**</td>
</tr>
<tr>
<td>0907</td>
<td>Behavioral Health Treatments/Services (Also See 091X - An Extension of 090X) Community Behavioral Health Program (Day Treatment) BH/Community</td>
</tr>
<tr>
<td>0912</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Partial Hospitalization - Less Intensive BH/ Partial Hosp</td>
</tr>
<tr>
<td>0913</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Partial Hospitalization - Intensive BH/Partial Intens</td>
</tr>
<tr>
<td>0916</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Family Therapy BH/Family RX</td>
</tr>
<tr>
<td>0917</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Bio Feedback BH/Biofeed</td>
</tr>
<tr>
<td>0918</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Testing BH/Testing</td>
</tr>
<tr>
<td>0919</td>
<td>Behavioral Health Treatments/Services - Extension of 090X Other Behavioral Health Treatments/Services BH/Other</td>
</tr>
<tr>
<td>0960</td>
<td>Professional Fees (Also See 097X and 098X) General Classification Pro Fee</td>
</tr>
<tr>
<td>0961</td>
<td>Professional Fees (Also See 097X and 098X) Psychiatric Pro Fee/Psych</td>
</tr>
<tr>
<td>1000</td>
<td>Behavioral Health Accommodations General Classification</td>
</tr>
<tr>
<td>1001</td>
<td>Behavioral Health Accommodations Residential - Psychiatric</td>
</tr>
<tr>
<td>1003</td>
<td>Behavioral Health Accommodations Supervised Living*</td>
</tr>
<tr>
<td>1005</td>
<td>Behavioral Health Accommodations Group Home***</td>
</tr>
</tbody>
</table>

* For mental health diagnoses only  
** For Substance Use Disorder (SUD) diagnoses only  
*** For members under the age of 21

For any additional clarification on all coding please refer to the Uniform Service Coding Standards Manual located on the HCPF website: [colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20July%2028%202018.pdf](colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20July%2028%202018.pdf)

Continuum of Services

The RMHP Provider Network is designed to include a wide array of services that support therapeutic interventions at the level of intensity indicated by the strengths and needs of each unique person served. Many of these services are offered through our Community Mental Health Center (CMHC) providers. However, routine outpatient assessment, psychotherapy, psychological testing, and medication management services are also offered by our network of independent outpatient providers. Hospitalization and residential levels of care are offered by contracted network facilities and some CMHCs. The care delivery system has been developed to ensure that, from the moment they access services, Health First Colorado Members are directed to the most appropriate level and type of behavioral health care, in geographically convenient locations. RMHP providers, facilities and other treatment programs are screened against credentialing standards, qualifications in specialty areas, and managed care experience. Authorizations for payment of services are determined through the application of medical necessity criteria and use of clinical judgment.
Clinical Services Descriptions

**Alternative Treatment Unit (ATU):** A 24-hour psychiatric treatment program that provides supervision and treatment in a structured environment, which may or may not be medically staffed 24 hours a day. ATU services are designed for Members without acute medical conditions who require short-term care. Medical consultation must be available.

**Crisis Outpatient Services:** Crisis outpatient services are provided in response to a crisis that results in acute destabilization of functioning and are focused on rapid restoration of functioning in the community. These services are provided in an outpatient office, home environment or other community setting. They are time-limited services and may include a wide variety of intensive individual, couples, family treatment and case management services.

**Crisis Stabilization/Observation:** Crisis Stabilization Unit (CSU) services are available in many areas. These programs are designed to provide evaluation and stabilization for Members in crisis and in need of intensive observation. Treatment interventions are focused on mobilizing support and resources so that the Member can be managed in a less restrictive setting. CSU services vary by provider and location, with a common goal of helping Members in crisis receive services at the least restrictive level. CSUs are staffed by behavioral health professionals, who provide continuing assessment of treatment needs and will facilitate transition of care to higher levels of care such as inpatient treatment, if needed. CSU staff will also help Members transition to lower levels of care during aftercare planning, which may include outpatient therapy and medication management, as examples.

**Day Treatment for Children and Adolescents:** Day Treatment programs are designed for treatment of serious covered disorders that cause significant impairment in usual life/school activities. Day Treatment is a time-limited treatment program that offers academic services together with therapeutically intense, multimodal, and structured clinical services.

**Emergency Services:** Services used during a behavioral health emergency, which are unscheduled and immediate, and needed to evaluate or stabilize an emergency condition.

**Evaluation/Assessment Services:** Diagnostic assessment of the Member who presents for treatment to determine the Member’s needs and strengths and to recommend the appropriate level of care and focus of treatment.

**Family Preservation Services:** Time-limited, in-home treatment to maintain the child in the home or to facilitate reunification of the child with the family.

**Home Based Services:** Services, which can vary in intensity and duration, provided in the home to assess and stabilize a Member’s symptoms, and to maintain and/or improve a Member’s level of functioning.

**Inpatient Hospitalization:** Treatment of a mental health condition requiring 24-hour supervision, observation and intervention, in a structured therapeutic medical environment with 24-hour nursing care. This is the most restrictive level of care and generally applies to those Members who are experiencing mental health symptoms resulting in behaviors that cause significant danger to themselves or others, or cause the Member to be significantly disabled and unable to meet their basic needs.

**Intensive Case Management:** Services typically provided by Community Behavioral Health Center staff for coordination of services, support, advocacy and to assist Members with the recovery process.

**Medication Management and Medication Assisted Therapy:** Interventions by a psychiatrist or other professional with prescription authority that include: evaluation, administration and monitoring of medications prescribed for the treatment of a covered behavioral health disorder. Members may also spend time with a nurse or physician’s assistant, who reviews symptoms and side effects, instructs the Member in symptom management, administer injections, monitors oral medication, and/or performs other adjunctive services on behalf of the psychiatrist, e.g. for methadone and/or suboxone.

**Mobile Assessment:** An assessment of a Member’s treatment needs by a clinician who travels to the Member’s location in the community, including an emergency room.

**Outpatient Hospital Based Laboratory Services:** Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the Member’s behavioral health treatment or condition. Please note all laboratories must be CLIA certified.
Outpatient Treatment: Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the Member’s behavioral health treatment or condition. Please note all laboratories must be CLIA certified.

Partial Hospitalization Program: A structured, intensive, time-limited program designed to provide diagnosis and treatment for Members who require more structure than is provided by outpatient therapy in order to continue to reside in the community.

Post-stabilization Services: Services that are provided in relationship to an emergency medical condition and are provided after a Member is stabilized in order to maintain the stabilized condition.

Psychological Testing: Administration of standardized tests and assessment techniques by a licensed psychologist for the purpose of diagnosis or treatment of a covered mental health diagnosis. Psychological testing supplements standard clinical assessment and evaluation.

Psychosocial Rehabilitation: A comprehensive array of services that supports the recovery of a person with a serious mental illness. Services focus on individualized assessment through application of an approved model, goal setting by the Member, and direct skills training.

Residential Treatment: Twenty-four-hour services, in approved programs, that provide extensive structure and individualized treatment for covered mental health diagnoses and significant associated deficits in functioning that results in the inability to live in the community.

Respite: Respite care provides a planned break for families or Members in dealing with long-term or severe mental illness. Respite care can be provided in a variety of settings either in the home or away from the home.

School-Based Intensive Outpatient Services: Services that are designed for children at risk of school failure or are candidates for expulsion due to symptoms or behavior that results from a behavioral health diagnosis. They are typically identified by school personnel. Services include family, group, and individual psychotherapy, play therapy, parent support, classroom behavior consultation, mentoring, psychiatric and nursing services coordinated with school nurse. Services are school-based and integrated with the student's academic day.

Vocational Services: Services for any Member interested in pursuing educational or work opportunities. Services may include assessment, prevocational training, job training, supported employment, social skills training, coaching, and referral to related agencies. Help all providers connect Members to adjunctive services including physical health, specialty services, and community care. For assistance, call RMHP at 888-282-8801.

**Substance Use Disorders Services**

RMHP outpatient treatment for Members with substance use disorders includes a more comprehensive array of services available to assist Members in their recovery. The list below includes services for treating a Member with a covered substance use disorder. If there are additional outpatient services a Member needs, please contact RMHP to request authorization at 888-282-8801.

Substance use disorders services are available through the RAE based on covered diagnoses and medical necessity for the particular service. If a requested service does not meet medical necessity criteria, or is not a covered diagnosis for the RAE, then Health First Colorado cannot fund the treatment. In this event, it may be helpful for providers to be aware of other funding sources such as the regional Managed Service Organizations in Region 1: Signal Behavioral Health Network and West Slope Casa.

These funding sources may be available for some Members when treatment is not approved through Health First Colorado funding. Self-pay may be another option for Members in these circumstances.

Providers are encouraged to submit their requests for authorization for review for services they feel are medically necessary so RMHP can review the request and make a determination regarding medical necessity.

Providers should become familiar with the RAE diagnoses, medical necessity criteria, and billing and coding standards.
Services are provided by Community Mental Health Centers and facilities licensed by the Office of Behavioral Health that are a part of our independent network of outpatient providers. Providers who are not part of the RMHP’s network for Health First Colorado Members should contact the Provider Relations Department of RMHP for any inquiries regarding joining the network. Provider Relations can be reached at 888-282-8801. Current providers in the RMHP network, should also contact Provider Relations to discuss approval for program additions such as substance use disorder treatment procedures to current contracts.

**Evaluation/Assessment Services:** Diagnostic assessment of the Member who presents for treatment to determine the Member’s needs and strengths and to recommend the appropriate level of care and focus of treatment.

**Outpatient Treatment:** Least restrictive level of care in which the Member participates in face-to-face assessment, counseling and routine case management services delivered in a behavioral health provider’s office or other community setting. Individual and group therapy may be provided based on the assessment and needs of the Member. Family therapy and medication management services are also available when medically necessary.

**Patient education related to alcohol and/or drug screening results:** Verbal discussion with the Member providing the results of positive screens focused on patterns of use, relapse prevention and progress towards recovery goals of the Member.

**Peer services:** Services provided to Members by others with lived experience with substance use recovery and/or mental health treatment. Peers are trained to help Members identify strengths, develop and work towards personal recovery goals and maintain hope during the recovery process. Skills for relapse prevention are also a focus of these services.

**Medication-Assisted Treatment:** Includes use of medications along with behavioral interventions such as group and individual therapy to assist Members in an integrated treatment approach addressing medical and psychosocial needs of Members as they recover.

**Social Detoxification Services:** Services provided by non-medical facilities to oversee and assist Members who experience withdrawal from alcohol and/or drugs. A safe environment is provided and staff Members help keep Members comfortable as they are in the process of detoxification.

*The benefit for substance use disorders does not include any inpatient or residential treatment at this time.*

**EPSDT Program Information**

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program**

EPSDT is a special health care program for children and youth. It aims to ensure they receive preventive, dental, behavioral health, developmental and specialty services. With EPSDT, any medically necessary health care service is covered. A service may be covered even if it is not a Health First Colorado benefit; no arbitrary limitations on services are allowed. Any person enrolled in the Health First Colorado program can get EPSDT services if they are 20 years old or younger; this age group is automatically enrolled. All Health First Colorado providers can offer EPSDT services.

Regarding copays:

- Children 18 years old and younger are eligible for EPSDT, with no co-pay, for any covered service.
- Adults 19 and 20 years old are eligible for EPSDT, but may have a small co-pay for some services.
- Children in Department of Social and Human Services custody are eligible for ESPDT services with no co-pay, if they are 18 or younger. They may have some co-pays if they are 19 or 20 years old.
**EPSDT Assessment**

EPSDT Assessment is conducted by PCMP or Pediatricians to screen for mental health care and other health care issues. EPSDT stands for:

- **Early**: Find and assess problems early
- **Periodic**: Check children’s health at several ages
- **Screening**: Check physical, mental, developmental, dental, hearing, vision and other health areas
- **Diagnostic**: Do follow-up tests when a health risk or problem is found
- **Treatment**: Correct, reduce or control health problems

Under EPSDT, children and youth can get all medically necessary care, such as:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations
- Immunizations (shots) and vaccines
- Lab tests, including lead poisoning testing
- Health and preventive education
- Vision services
- Dental services
- Hearing services

**Well-Child Check-Ups**

Well-child check-ups are regularly scheduled medical examinations that make sure a child or adolescent is healthy and meeting the expected developmental milestones. The provider can identify physical and behavioral health risks early and correct, reduce or control health problems.

They also can ensure that a child gets necessary immunizations and screenings at the right ages. Well-child check-ups are more comprehensive than sports physicals. A child should get well-child check-ups at the following ages:

- 2 – 4 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once per year from ages 3 – 20
Medical Necessity For EPSDT

The term “medical necessity” means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or costlier treatment options, and
2. Meets at least one of the following criteria: a. The service will prevent, or is reasonably expected to prevent or diagnose, the onset of an illness, condition, primary disability, or secondary disability.
3. The service will, or is reasonably expected to cure, correct, reduce, or ameliorate the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.
4. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury, or disability.
5. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.
6. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

Treatment

Medically necessary health care services must be made available for the treatment of all physical and mental illnesses or conditions discovered by any screening or diagnostic procedure. Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a state’s Medicaid plan. To learn more about Colorado’s EPSDT benefit, please call the Department of Healthcare Policy and Financing (HCPF) at 303-866-6167, visit their EPSDT website colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt, or call the RMHP Office of Member and Family Affairs.

The State of Colorado also may provide the following through Healthy Communities and other programs:

- Educate all eligible Members about the EPSDT Program.
- Describe the available benefits in greater detail.
- Help find a primary care physician or other medical providers as needed.
- Arrange for an appointment, if the Member needs help.
- Communicate options for transportation assistance, if necessary.
- Follow-up on screening appointments.
- Follow-up includes assistance to reschedule the missed appointment.

EPSDT Care Providers

EPSDT exams are performed by or under the supervision of a certified Medicaid physician, dentist or other provider who is qualified to provide medical services and is appropriately revalidated and/or enrolled for these services with HCPF. Behavioral health providers are required to:

- Assess new Members to determine that EPSDT screenings have been occurring.
- Refer Members to their PCMP, if screenings are not being conducted.
- Provide behavioral health assessment/treatment upon referral from a PCP who desires
- Additional behavioral health services, in which medical necessity has been determined.
- Communicate with the PCMP regarding any pertinent findings/actions.
- Document all actions in the Member’s clinical record.
Because assessing physical health is an important component of providing comprehensive behavioral health care, we require all behavioral health providers to ensure that their Health First Colorado clients who are under age 21 have had an EPSDT well-child exam, according to the well child check-up schedule listed above. You must contact the Member’s PCMP or talk with the child’s parent or guardian to determine if this has happened. If the child or youth does not have a PCMP or has not been screened according to the recommended schedule, you should contact the Family Health Coordinators in your community to facilitate the screening process. A list of Family Health Coordinators can be found at colorado.gov/pacific/hcpf/family-health-coordinator-list.

If additional assistance is needed, or if you have questions about EPSDT resources, you can call RMHP at 888-282-8801.

Care Coordination

Care Coordination services for RAE Members are provided through RMHP with support from participating PCMP providers and integrated community care teams (where available). Care Coordination services focus on the whole person and assess and address areas of need related to physical health, behavioral health, and social determinants of health. RMHP also serves as a bridge and connector of our Members to needed services and care. Care Coordinators are here to help all providers connect Members to adjunctive services including physical health, specialty services, and community care. For assistance, call RMHP at 888-282-8801.
ABOUT POLICIES & PROCEDURES
Join the RMHP RAE Network

Credentialing and Contracting

Under RAE, RMHP’s responsibility to behavioral health providers includes:

• Developing and maintaining a credentialed and contracted statewide network of behavioral health providers (both individual providers and facilities) to provide covered behavioral health services;

• Providing utilization management of covered behavioral health services;

• Reimbursing behavioral health providers for services covered under the Capitated Behavioral Health Benefit; and

• Providing training and support to behavioral health providers.

Steps to Participate

Step 1: Enroll/revalidate as a Health First Colorado provider

Providers that have not yet enrolled and revalidated with Health First Colorado through the Colorado interChange must complete this process to contract with RMHP’s RAE behavioral health network. Information about this requirement can be found on the Department’s website.

Step 2: RMHP Credentialing

Behavioral health providers that wish to participate with RMHP must complete RMHP’s standard credentialing process and agree to accept RMHP’s RAE fee schedule agreement to be a participating RMHP RAE provider.

Current RMHP credentialed behavioral health providers are not required to complete additional credentialing by RMHP; however, they must agree to accept RMHP’s RAE fee schedule agreement to be a participating RMHP RAE provider.

RMHP’s credentialing forms are available at rmhp.org by visiting the I am a Provider section and selecting Join the Network.

Letters of Agreement

RMHP may enter into letters of agreement with some behavioral health providers to encourage and foster continuity of care for Members. These letters of agreement are also known as Single Case Agreements.

RMHP anticipates these letters of agreement are applicable primarily for behavioral health providers outside Region 1 who are providing necessary services to an RMHP RAE Member, and due to its scope of practice will likely not serve RMHP Members often.

These letters of agreement also may be used at initial RAE implementation if a Region 1 provider is an existing Health First Colorado provider and the provider’s RMHP credentialing application has not yet been completed in the RMHP process.

Verification of Eligibility & Enrollment

Providers are responsible for confirming Health First Colorado eligibility and RAE enrollment eligibility of Members before providing services. Determination of eligibility and enrollment with RMHP as the regional organization is based on the State of Colorado’s eligibility standards developed and applied by the Department.
**Electronic Eligibility Verification**

Eligibility and enrollment must be verified by using the Colorado interChange. The interChange is updated in “real time” and serves as the most accurate method for determining eligibility.

Documentation relating to Health First Colorado eligibility verification, including regional organization and RMHP Prime enrollment should be retained by the RMHP network provider, as these documents will be required to support a provider appeal if a claim is denied due to patient eligibility and enrollment status. If the Department retroactively adjusts eligibility, claims payment may be retracted if you are unable to demonstrate eligibility was verified at the time of service. Visit the [Department’s web portal](#). A user name and password is required.

**ID Cards**

RMHP does not distribute ID cards to RAE Members. The State does also not distribute ID cards to Health First Colorado Members. Eligibility verification through Colorado interChange does not require a Member’s ID number and can be verified by using identifiers such as date of birth and name. RMHP will continue to distribute an RMHP Member ID card to RMHP Prime Members.

**Member Choice of Providers**

Members and families can choose any RMHP Provider who is licensed, credentialed and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A Member may request that a provider be considered to join the relevant RAE. In cases of a Member already in treatment with a provider at the time the Member obtains RMHP eligibility, for the purpose of continuity of care, the Member’s provider may request a Single Case Agreement and treatment may be continued. In cases involving special needs, RMHP may offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria. Under certain circumstances Members may request an out-of-network provider. These circumstances may include:

1. The service or type of provider the Member needs is not available in our network.
2. The network provider refuses to provide the treatment requested by the Member on moral or religious grounds.
3. The Member’s primary provider determines that going to a network provider would pose a risk to the Member.
4. The Member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship.

**Provider Availability for Member Access to Care**

Federal regulations prohibit discrimination against Health First Colorado beneficiaries. Any practice which selectively excludes Members from available treatment services and/or appointments may be in violation of those regulations. A statement by your scheduler or voicemail that you are “not currently accepting RMHP Medicaid clients” constitutes discrimination.

All RMHP providers must have appointments available for Health First Colorado Members as specified below, according to State/Federal regulation and the provider contract:

1. **Routine Access:** A routine appointment must be available within 7 business days of a Member’s request. Under the RMHP Medicaid provider contract, providers are required to offer a routine appointment within seven business days. If a provider offers a Member a routine appointment within seven business days and the Member declines and chooses an appointment outside of seven business days, the access requirement is met. Members must be offered the same hours of availability as all other insurance Members.
2. **Routine Outpatient Appointment Following an Inpatient or Residential Discharge**: A routine appointment must be available within seven business days after discharge from an inpatient psychiatric hospitalization or residential facility.

3. **Urgent Access**: Urgent care (appointments) shall be available within 24 hours from the initial identification of need. 
   **Urgent Definition**: A request from a Member or designated Member representative for situations or circumstances for which there is the potential for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR potential for serious impairment to bodily functions without treatment, OR potential for serious dysfunction of any bodily organ or part without treatment. The appointment should be scheduled within 24 hours of the initial request.

4. **Emergency Access**: Emergency services shall be available by phone, including by TTY accessibility, within 15 minutes of the initial contact, in person within one hour of contact in urban and suburban areas, in person within two hours of contact in rural and frontier areas.
   **Emergency Definition**: Conditions, situations or circumstances for which there is the risk for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR for serious impairment to bodily functions without treatment, OR for serious dysfunction of any bodily organ or part without treatment.

5. **Inpatient and Residential Treatment post-discharge follow-up appointments**: Outpatient follow-up appointments are required within seven business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post discharge follow-up are required, documented in the discharge care plan, within seven business days after discharge from a residential treatment facility.

6. **Hours of Operation**: Providers who serve Health First Colorado Members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Providers are encouraged to offer flexible appointment times or after regular business hours’ appointments to Members whenever possible.

7. **Extended Hours of Operation**: Extended hours of operation and covered service coverage must be provided at least two days per week at clinic treatment sites which should include a combination of additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours.

8. **Waiting Room Time for Scheduled Member Appointments**: A Health First Colorado Member who arrives on time for their scheduled appointment shall wait no longer than 15 minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the Member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by having the wait time policy reviewed with the Member at the initiation of treatment. Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent / emergency requests.

9. **Evening and/or Weekend Support Services**: Members and families should have access to clinical staff over evenings and weekends, not just an answering service or referral service staff.

10. **Ongoing mental health and substance use disorders services**: Services shall be scheduled and continually provided for within two weeks from an initial assessment or intake appointment. Ongoing services include, but are not limited to:
    - Assignment to a therapist and individual / group therapy

11. **Routine outpatient appointments**: Following intake/initial assessment, routine outpatient appointments shall occur at least three times within 45 days.
Members Access to Behavioral Health Care

A Member can access behavioral health care in four ways:

1. A Member, family member, provider, or advocate for the Member can call RMHP toll-free, seven days a week for emergency or non-emergency situations, clinical assessment, and referral to the most appropriate provider.

2. The Member can call or walk into any one of the Colorado Community Mental Health Centers (CMHC) or contact a network provider office and receive a face-to-face clinical evaluation and request services.

3. The Member can be referred by their primary care physician, social services caseworker, court system or other community agency through the access points described above.

4. The Member can go to or be brought to any emergency room. A face-to-face evaluation may be arranged with an area crisis evaluator. The crisis evaluator participates in disposition recommendations.

Expectations of Providers for Emergency Access

In order to comply with emergency access standards under the provider’s contract, our expectations for independent providers are:

- If an independent provider is contacted by a Member in crisis, the provider will conduct an assessment to determine whether the Member’s situation can be handled outside of the emergency room. This assessment should follow the standards as indicated in item 4, Emergency Access, above.

- If the Member goes directly to the ER, or if the provider determines the Member in crisis is best assessed in the ER, the provider will be available to the CMHC emergency services team to provide background information, diagnosis and other pertinent details on the Member in crisis. This will assist the CMHC emergency services clinician in conducting the Member’s evaluation, and may result in the most appropriate disposition for the Member.

- Providers are required to give contact information to Members on their voicemail to include one of the following: the provider’s pager, the provider’s cell phone number, or how to reach a covering clinician with whom the provider contracts to provide coverage when the treating provider is not reachable.

- Quarterly test calls are performed at random by the RMHP Quality Improvement staff to monitor provider compliance with these standards. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider’s nonresponse to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services.

Outpatient providers are expected to offer 24-hour personal emergency access to their Members or have formal arrangements for emergency coverage by another practitioner. An answering service/machine which refers all callers to an emergency room, community mental health center, crisis or other agency is not acceptable unless the provider has established a formal contract for emergency coverage with the agency. In all cases, providers must obtain prior authorization for inpatient care by calling RMHP 24 hours a day, seven days a week, at 888-282-8801.
Coordination of Care Requirements

The following parties must maintain communication from the date of admission through the date of discharge:

- The Outpatient Behavioral Health Provider
- The RMHP Care Advocate from Utilization Management
- The RAE (or proxy) Transition of Care planner
- A Member of the clinical team familiar with the care of the Member

Coordination of care discussions include aftercare planning and should occur at least 48 hours prior to discharge. If the hospital plans to recommend a step down to any level of care other than outpatient, it must involve a referral to the RMHP Care Advocate managing the inpatient admission and discussion with the outpatient BH Provider and Transition of Care planner. The referral must occur prior to discharge to ensure that a decision can be made prior to the Member discharge from inpatient care. Referrals for Partial Hospitalization, Intensive Outpatient, Acute Treatment Unit or other services should be made to RMHP at least two days prior to discharge to ensure a timely decision can be reached. Additional Requirements include:

- Frequent coordination of care and unrestricted communication with the outpatient BH Provider and Transition of Care planner, including:
  - Contact by a practitioner involved with the Member’s care (i.e. an active representative of the treatment team such as the Member’s assigned social worker, therapist or prescriber)
- Communication with the outpatient BH Provider within 24 hours of admission
  - Exchange of pertinent history
  - Establishing connection
  - Discharge planning
  - Updates by the attending physician or other treatment staff on progress, medications, family sessions/needs, aftercare referrals
- Examples of coordination of care:
  - Progress updates with a focus toward discharge readiness
  - Medication feedback or discussion of previous medications
  - Development of Transition Plan to outpatient receiving team, especially for any patient on a mental health certification with or without Court Ordered Medications
  - Barriers to discharge (resource needs, family, placement)
  - Aftercare referrals to services other than Outpatient need to be given to the RMHP Utilization Management Care Advocate staff and discussed with the Discharge Planner
  - Contact at least 24 hours prior to discharge to ensure aftercare plans are in place
  - The hospital must be responsive to the RAE and/or outpatient BH Provider and return calls within 24 hours
  - Face to face meetings with the Member when requested by the outpatient BH Provider and/or Discharge Planner, to be facilitated by the hospital staff in a timely manner
  - Calls/emails from the outpatient BH provider and/or Discharge Planner returned within 24 hours or by the next business day
Coordination of Behavioral Health and Primary Care

All Members should have a Primary Care Medical Provider (PCMP). RMHP can assist Members in finding a PCMP. Coordination with the PCMP is necessary to promote integrated care, particularly related to medication management. Coordination with primary care is the responsibility of the Primary Behavioral Health Provider.

Facilities/Programs

Facilities/programs receive referrals and authorizations from RMHP. Prior authorization is always required. RMHP Care Advocates are available at: 888-282-8801, 24 hours a day, seven days a week for prior authorization.

Emergency Departments

After initial emergency department triage, authorization for further inpatient evaluation and/or treatment must be obtained from a RMHP. At most hospitals, an independent assessment by a Community Mental Health Center (CMHC) crisis evaluator or another outpatient BH Provider is required to assist in diversion, crisis stabilization, and referral to follow-up.

Eligibility Verification

Providers should confirm eligibility of RAE Members before providing services. Determination of eligibility and enrollment in the Accountable Care Collaborative program is based on the State of Colorado eligibility standards developed and applied by the Department of Health Care Policy and Financing. Health First Colorado eligibility should be verified by using the system available through the State of Colorado, the Colorado interChange.

The Department's interChange is updated in “real time” and serves as the most accurate method for determining eligibility. Documentation relating to eligibility verification for Members enrolled in the Medicaid Accountable Care Collaborative, including RAE Members and RAE Members also enrolled in RMHP Prime should be retained by the RMHP network provider, as these documents will be required support a provider appeal if a claim is denied due to patient eligibility and enrollment status. If the Department retroactively adjusts eligibility, claims payment may be retracted if you are unable to demonstrate eligibility was verified at the time of service.

The Department's web portal is: https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider. A user name and password is required.

Collection of Co-Payments / Deductibles

Members covered through Health First Colorado are not subject to co-pays or deductibles. Collection of fees directly from an RMHP Health First Colorado Member may result in termination as a participating provider. This includes charges for non-covered services, including missed appointments.

Facilitating Improved Integration of Services and Coordination of Care

An integrated and well-coordinated system of care is necessary to ensure positive treatment Outcome for Health First Colorado Members. RMHP requires coordination of services for all of our Members and offers care coordination to all Members. RMHP requires that the primary outpatient provider engages in coordination of care with other treating providers. Member consent is required for coordination of care with other providers. Member consent is not required for coordination of care with RMHP when the Member is being treated for a covered mental health diagnosis; however, the Member’s consent is required when the treatment is for a covered substance use disorder.

Mental Health Inpatient Care Requirements

These Mental Health Inpatient Care Requirements are for coordinating with our partner CMHC’S or other outpatient BH Provider for the clinical care provided by facilities to Members. These requirements are not intended to cover the UM process between facilities and RMHP’s Care Managers.
Inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. 24-hour skilled psychiatric nursing care, daily psychiatric/medical evaluation and management and a structured treatment milieu are required. These services must be documented daily and appropriately in the treatment records and are subject to audit. Inpatient treatment settings must provide all of these services at the appropriate intensity, frequency, and with a focus on initiating and sustaining active treatment from admission through discharge, with timely assessment and adjustment of medications, ensuring treatment participation, and collaborative and prompt communication with the associated CMHCs.

**Clinical Requirements: Assessment**

- An initial visit with a psychiatrist, or other psychiatric practitioner with prescriptive authority (e.g., Physician Assistant, Nurse Practitioner, Resident Physician) and psychiatrist consultation, for evaluation and treatment planning within 24 hours of admission.
- A comprehensive bio-psychosocial history including, at a minimum:
  - History of presenting illness
  - Psychiatric history, substance use history
  - Medical history
  - Family history
  - Social history
  - Current medications
  - Allergies
- Comprehensive review of systems
- Full mental status examination
- Initial psychiatric assessment/formulation including current Diagnostic and Statistical Manual-based diagnoses
- Risk assessment
- Individualized overall assessment / formulation of key issues and recommended interventions
- Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate

**Clinical Requirements: Subsequent Treatment**

A documented daily visit with an attending, licensed, prescribing psychiatric provider, to include:

- Collection and review of interim history
- Evaluation and documentation of the Member’s current mental status
- Assessment of the Member’s progress in relation to their presenting problems
- Justification of continued need for inpatient care
- Update of the treatment plan, including medication strategy
- Progress note documentation as required in this handbook
- Other daily interventions
- Individual psychotherapeutic intervention focused on presenting problems (may be part of the prescriber visit)
- Group/milieu activity
- Safety planning as indicated
- Discharge planning and coordination with CMHC or community provider receiving post discharge care of client (evidenced from first days of admission)
Clinical Requirements: Discharge

- Documentation of the discharge plan including follow-up appointments per handbook guidelines, discharge medications, and emergency contacts delivered to the patient in writing with a face-to-face review.
- Provision of a 30-day prescription for discharge medications with confirmation that the Member has the resources to obtain medications or documentation that a new prescription is not required.
- Any prescribed medications requiring pre-authorization in order to be filled must have the pre-authorization obtained by the hospital staff prior to the Member being discharged.
- Transfer of certification to outpatient level of care with or without court ordered medications requires advance notification and discussion with receiving CMHC.
- The liaison can coordinate direct communication with the CMHC treatment team, and a treatment plan that bridges a certified patient from inpatient to outpatient receiving team must be developed before discharge.
- The prescriber’s dictated discharge summary must be faxed to the outpatient provider within 72 hours of discharge.

Utilization Management Procedures

All authorization decisions are based on the determination of medical necessity for the requested service, and on the Level of Care Guidelines. Services may be authorized only for covered services and covered diagnoses per our contract with the Department of Healthcare Policy and Financing (the Department). Providers are expected to cooperate fully with RMHP Care Advocates and medical staff to provide accurate and timely clinical information to assist with this process. This may include submission of verbal reports or written documentation (including treatment plans). All documentation needs to be submitted in English, even if records in the client’s chart are kept in another language. Participation in telephonic or face-to-face staffing’s may be required for complex cases. Clinical and Medical staff will make every effort to make decisions in a manner that allows providers to focus on the care of Members and will not ask for more information than is necessary to make an appropriate decision regarding medical necessity of the service in question.

Medical necessity means a Medical Assistance program, 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.
- 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 or primarily 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 experimental or investigational; and
- Is not more costly than other equally effective treatment options.

Clinical Criteria utilized for decision making include the definition of medically necessary services. Guidelines, comprised of admission criteria, exclusion criteria, continued stay criteria and discharge criteria for the specific level of care requested. Utilization management (UM) is the responsibility of the RMHP Clinical Departments. Care Advocates perform clinical reviews for all levels of care that require prior authorization via telephonic discussions and review of written clinical records. The frequency of review varies with the intensity of the level of care being provided and the clinical needs of the Member. Member consent is not required for provider participation in UM activities except for those UM activities related to substance use disorders services, when it is specifically required by law (42 CFR, part 2).
RMHP Care Advocates are responsible for the following functions:

- To conduct reviews with treatment providers to verify medical necessity based on the Department’s treatment criteria at point of access, for continuing care, and aftercare.
- To ensure that the evaluation of the Member includes pertinent psychosocial, medical and psychiatric/behavioral health information to support the diagnosis and impairments determined by the provider.
- To ensure that service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the provider, are coordinated with other service delivery persons or agencies, and are consistent with the Department’s clinical criteria.
- To be a catalyst to encourage good coordination of care, prompting providers to involve all appropriate treatment team Members in the delivery of integrated care designed to assist the Member in overall health. To this end, to listen for needs that may be unrelated to the behavioral health authorization decision, but may be having a significant impact by creating barriers to discharge or contributing to re-admissions (e.g., physical health needs, housing, transportation, other waiver services.)
- To ensure that level-of-care and treatment decisions are based on medical appropriateness and necessity, as described in the clinical criteria and guidelines, and are designed to achieve desired Member outcomes within an optimal time frame.
- To ensure that discharge planning begins at admission, that the planning involves the Member, significant others and other representatives who will ensure implementation of the discharge plan, that clear and specific criteria for discharging Members from treatment are established at the outset of treatment, that the plan is realistic and attainable, and that it is both understood by and agreed to by the Member and family/significant others as appropriate.
- To provide consultation to treatment team Members when needs of Members are complex.

Provider Responsibilities in Utilization Management

RMHP contracted providers are required to:

- Complete a comprehensive assessment of the Member at the start of treatment that clearly provides rationale for the diagnosis and the mix of services provided to the Member.
- Provide accurate clinical information that is consistent with the Member’s written documentation in the chart, to support authorization requests.
- Keep track of authorizations and their use of authorized services to allow them to make timely requests for re-authorizations.
- Begin discharge planning at the time of admission, for all levels of care.
- Submit complete and accurate discharge and aftercare plans to RMHP and all related aftercare providers within 72 hours of discharge. Member care and quality treatment are significantly impacted following inpatient treatment without this data.
- For inpatient and residential levels of care, to complete a discharge plan for each Member within 48 hours of admission and have this plan signed by the Member and guardian/family member, as appropriate. This plan needs to be in the Member’s chart.
- For any plan not completed within 48 hours, the chart needs to contain documentation of the clinical reason why this was not possible.
- Provide services in the least restrictive environment possible for the Member.
- Follow all documentation requirements, including updated and accurate written treatment plans that guide their services to RMHP Members.
- Provide clinical information verbally, when requested, to assist with an authorization decision.
• Provide a copy of the Member’s written treatment plan or treatment notes, when requested.
• Respond in a timely manner when clinical or medical staff reach out to them to confirm information (clarify their authorization request, confirm Member’s start or end date of treatment, or other treatment details.)
• Request initial authorizations for outpatient services (that require prior authorization) no more than 30 calendar days after the initial assessment for outpatient services, and prior to admission to inpatient, or higher level of care services.
• Request concurrent authorizations on the last covered day for higher level of care services, or no later than 30 calendar days after the date of service for outpatient services.
• Request authorization only for services they feel meet medical necessity guidelines.
• Follow the Uniform Service Coding Standards Manual guidelines in providing care at the approved place of service, by the appropriately qualified staff person. You may be able to find the latest version on the Colorado Official State website [https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20July%202028%202018.pdf](https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20July%202028%202018.pdf)

**Outpatient Care**

• A treatment plan is required for all outpatient services, and must include time limited and measurable objectives. It must be formulated with Member or guardian input, and signed by the Member and/or guardian. Providers are not routinely required to submit a treatment plan to receive initial authorizations, but should be prepared to submit the plan upon request, if needed.
• Network providers do not need prior authorization of evaluation or most outpatient services. However, there are a few that do require prior authorization (reference Services Requiring Prior Authorization)
• Family therapy is conducted for the treatment of the identified Member’s covered diagnosis only and billed under this individual’s RMHP coverage.
• Separate billing for other family Members who participate in the family therapy sessions is not allowed.
• For contracted providers, medication management does not require authorization.

**Higher Level of Care: Inpatient, Partial Hospital, Residential, Day Treatment, and Intensive Community-Based Services Prior Authorization**

Prior authorization is required for all inpatient, partial hospital, residential, intensive outpatient services and day treatment services. Inpatient services are not a covered service when the primary diagnosis is a Substance Use Disorder.

RMHP may require an independent assessment by a Community Mental Health Center (CMHC) Crisis Evaluator. In most cases, the Care Advocate will consult with the local CMHC for availability of diversion services prior to authorizing higher levels of care.

For inpatient care, providers must direct Members to a RMHP contracted facility to ensure eligibility for hospitalization benefits. If a contracted facility is not available, RMHP will work with a willing non-contracted facility to insure timely admission of a Member in need of inpatient care. Providers are to collaborate with RMHP Utilization Management and the CMHC evaluators or other outpatient BH Provider to assist Members in receiving treatment at a lower level of care if needed, to meet the requirement that RMHP Members receive treatment at the least restrictive level of care.

Collaboration includes the provision of verbal or written treatment information to another provider, if indicated.
Inpatient care may require coordination of care with the CMHC for RMHP admissions, to obtain the best treatment benefit for each Member and arrange appropriate aftercare services. Care should be coordinated by a social worker or Member of the treatment team with firsthand knowledge of the Member’s symptoms and care. This should begin on the day of admission and occur routinely and regularly throughout the hospitalization. Inpatient care providers must follow the Inpatient Treatment Guidelines at the end of this handbook.

**Higher Level of Care Continued Authorization Inpatient, Partial Hospitalization, Residential, Day Treatment and Intensive Outpatient Services**

- Pre-authorization of continuing higher levels of care requires a telephonic or written review between the provider and the RMHP Utilization Management Care Advocate. Providers should follow the instructions of the Care Advocate regarding the clinical information needed. Most authorizations will be completed via telephonic review, but occasionally, written documentation is needed to determine medical necessity.
- RMHP requires active collaboration with the RAE or proxy discharge planner. Providers not participating in care coordination for discharge planning and care coordination may receive an administrative denial of services.
- To evaluate the higher level of care request, the Care Advocate will require detailed information concerning the Member’s need for continuing care (i.e., measurable treatment goals, and discharge plans, current condition, and any additional services). It is the responsibility of the hospital’s designated case manager (social worker or UR representative) to call the Engagement Center for all scheduled reviews and continued authorization prior to expiration of the current authorization. Late requests may not be retroactively authorized and may be administratively denied.

**Hospital Professional Charges**

Some facility contracts are all-inclusive. Some contracts may exclude telephonic reviews. Professional charges may be included in contract rates. It is the responsibility of the facility to negotiate reimbursement with the professional staff, and to be familiar with the requirements of their contract in regard to UM procedures.

**Emergency Services**

1. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:
   - A. Placing the patient’s health in serious jeopardy
   - B. Serious impairment to bodily functions or
   - C. Serious dysfunction of any bodily organ or part.
2. Emergency services do not require prior authorization.
3. Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the Member has received care.

**Authorization When Level of Care Changes**

1. Authorization of care does not extend from one level of care to another. RMHP must be notified immediately when a Member is discharged from any level of care and a RMHP must receive the discharge and aftercare plan in writing.
2. Authorization for treatment at a new level will be based on the current clinical presentation, treatment plan and continuity-of-care concerns.
3. A new authorization will be required with any change in the level of care.
4. Any unused portions of prior-to-admission outpatient authorizations are null and void once an inpatient / partial hospital / alternative level of care case is opened.
Electroconvulsive Therapy (ECT)
All inpatient and outpatient ECT requires pre-authorization. ECT requests must be reviewed by the RMHP Medical Director.

Psychological Testing (All Testing Requires Pre-Authorization)
The use of psychological testing can be very beneficial when it provides information relevant to the treatment of a psychiatric condition in a timely manner. Rather than being considered a routine procedure in an individual’s treatment, testing should be requested only when other interventions have not been successful in providing sufficient information with which to develop an appropriate treatment plan.

When psychological testing is necessary, it should be requested in order to address specific questions which may be useful in diagnostic clarification and subsequent treatment planning. Specific testing procedures selected by the psychologist should demonstrate a focused approach toward addressing the referral questions. “Standard psychological test batteries” are discouraged. Educational testing (e.g., learning disabilities assessments), vocational testing, and testing conducted in order to rule out medical conditions (e.g., many neuropsychological assessments) are excluded benefits and will not be authorized.

Guidelines
- One unit of testing equals one hour for psychological testing
- Testing is only authorized for face-to-face administration of testing procedures by a psychologist or psychometrician working under the supervision of a psychologist (i.e., chart reviews and testing feedback sessions are not to be authorized as a psychological testing procedure).
- The use of self-administered objective inventories is encouraged prior to requesting more extensive testing. One hour can be authorized by RMHP for such screenings. The following is a list of the most frequently requested inventories:
  - MMPI-2: Minnesota Multiphasic Personality Inventory-2 (Adult)
  - MMPI-A: Minnesota Multiphasic Personality Inventory-Adolescent
  - MCMI-II: Millon Clinical Multiaxial Inventory-II (Adult)
  - MAPI: Millon Adolescent Personality Inventory
  - MACI: Millon Adolescent Clinical Inventory
  - PIC: Personality Inventory for Children
- When such inventories do not provide sufficient information, additional testing may be warranted. Authorization for personality assessments varies depending upon the nature of the questions being asked and the specific tests being proposed to address those questions. The following tests are the most often utilized for personality assessment and the standard authorization allowed for each procedure is:
  - Rorschach Projective Technique, 1.5 hours
  - Apperception Technique (TAT, CAT, or Roberts), 1.0 hours
  - Projective Drawings (DAP or H-T-P or Kinetic Family Drawing), 0.5 hours
  - Beck Depression Inventory, 0.5 hours
  - Reynolds Depression Scales (Child, Adolescent, or Adult), 0.5 hours
- Completion or Incomplete Sentences Procedures, 0.5 hours
- Bender Visual-Motor Gestalt Test, 0.5 hours
- The use of intellectual assessments can be authorized only if they are being used to clarify a psychiatric diagnosis or to determine whether treatment might need to be modified because of a Member’s intellectual disability. Appropriate uses would be for assessment of psychosis, neuropsychological screening, and, in some instances, the assessment of attention deficit disorders. The most often requested procedures for intellectual assessments are the Wechsler Scales:
- WPPSI-R (preschool), 1.5 hours
- WISC-IV (children & adolescents), 1.5 hours
- WAIS-IV (adults), 1.5 hours

Attention Deficit Disorder Assessments
- There is wide variation between practitioners in conducting these assessments. Focused evaluations can generally accomplish this assessment in one to three hours. Full, comprehensive, neuropsychological evaluations, which are often requested (sometimes from six to 12 hours), are not medically necessary to identify and diagnose Attention Deficit Disorder (ADD) or Attention Deficit / Hyperactivity Disorder (ADHD).
- The following are the most commonly used procedures for ADD/ADHD assessments.
  - Rating scales (Parent’s, Teacher’s, Connors scales, etc.) 0.5 hours
  - CBCL (Child Behavior Checklist) 0.5 hours
  - Gordon Diagnostic System 1.0 hours
  - TOVA (Test of Variables of Attention) 1.0 hours
  - WISC-IV (Wechsler Intelligence Scale for Children – IV) 1.5 hours

Neuropsychological Assessments
- Neuropsychological assessments will be authorized for individuals receiving mental health services only when treatment planning considerations warrant such an evaluation. Generally, neuropsychological evaluations can be completed within six hours.

Claims
Effective July 1, 2018, RMHP is responsible for covering and administering behavioral health services, including mental health services and substance use disorders treatment, for RMHP Members of Health First Colorado throughout Western Colorado and Larimer County. Regional BHOs covered these services previously. For RMHP RAE Members also enrolled with RMHP Prime, RMHP continues responsibility for covering medical and pharmacy claims for these Members. Below is where RMHP Members’ claims should be sent.

For RMHP RAE Members:
- Behavioral health claims are submitted to RMHP.
- Physical health claims are submitted to DXC, the fiscal agent for the Department

For RMHP Prime Members:
- Behavioral health claims are submitted to RMHP
- Physical health claims are submitted to RMHP
Submission of Claims to RMHP

Providers are responsible for submitting claims to RMHP for payment. For services covered by RMHP, including behavioral health services for RMHP RAE Members and medical services for RMHP Prime Members, providers familiar with the RMHP claims submission process should continue to submit claims following standard RMHP policies and procedures.

Electronic Delivery

RMHP encourages providers to submit claims electronically. RMHP accepts submissions from most major clearinghouses. A complete list of contracted clearinghouses can be found at rmhp.org. For providers that wish to send 837I and/or 837P transactions, RMHP has more information and the commonly used forms on rmhp.org under I am a Provider in the Provider Resources section.

Paper Delivery

You may also submit claims directly to RMHP at the below address. If claims are submitted on paper they must be submitted on a CMS 1500 or UB-04/CMS 1450. These forms can also be found on the commonly used forms on rmhp.org under I am a Provider in the Provider Resources section. If your claims are prepared by a computerized billing service, be sure your office staff is familiar with and understands RMHP’s claim submission requirements.

Via mail

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

Filing Limits

The following claim submission deadlines apply:

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

Submission of Claims to DXC

Physical health claims for RMHP RAE Members will be processed by DXC, the fiscal agent for the Department, following Health First Colorado rules.

Claims Billing Information

Incomplete Claims Are Not Clean Claims

In accordance with Senate Bill 10-16-106.3, RMHP will notify the provider within 30 calendar days if the resolution of a claim requires additional information. As indicated in this section the provider will be given a full explanation of what additional information is needed. Claims with invalid or incomplete information will be denied with an Explanation of Benefit advising the provider of the incorrect or invalid information. Effective will be rejecting “Not Clean Claims” via 277CA for electronic claims or a letter for paper claims instead of processing and denying with the notices provided via EOBs. Claims that are not clean will not be uploaded in to the RMHP system.

The provider is required to submit a “corrected” claim to RMHP providing the updated information for payment consideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher may not be considered for payment.
If RMHP is unable to locate a Member’s Health First Colorado ID provided on the claim form, the claim will be denied with an Explanation of Payment indicating the Member is “unknown.” If possible, RMHP will indicate the Member’s name in the patient account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim submitted for consideration. Please be sure to send all requested information within the account-specific timely filing guidelines.

Paper Claims Submission Address:
Rock Mountain Health Plans
ATTN: Claims
P. O. Box 10600
Grand Junction, CO 81502-5600

Required Claim Elements
Claims for covered services rendered to Members should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by RMHP included. The following lists capture the RMHP required claim fields to make a clean claim for the UB04 and CMS-1500.

Tips for Completing the UB04 (CMS-1450) Claim Form
• All data elements noted as required must be provided, but they must also be current and match what the Member has on file. If the Member’s ID on the claim is illegible, or does not match what the client has provided to us, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the Member’s ID card, and validate that it is current at the time of each visit.
• There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.
• Claims that are not submitted on a CMS 1500 2012-02 or a UB04 often will not contain the information we need to consider the claim clean and will cause the claim to take a longer processing time. Claims submitted on old claim forms may be returned or denied.
• Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to the RMHP companion guide to be considered clean. In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the participating provider will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status. Guidance on completion of UB-04 and CMS-1500 forms, or their electronic equivalents, is available on the ‘Provider’ section of the website and within this handbook.
• For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the provider does not follow the guidelines, claims will still be processed; however manual intervention will be required which may delay claims processing. Tips for completing paper claims:
  ◦ Use machine print
  ◦ Use original red claim forms
  ◦ Use black ink
  ◦ Print claim data within the defined boxes on the claim form
  ◦ Use all capital letters
  ◦ Use a laser printer for best results
Claims Processing

RMHP will process complete and accurate claims submitted by providers for covered services rendered to Members in accordance with normal claims processing policies and procedures, the payment terms included in the provider agreement, and applicable state and/or federal laws, rules and/or regulations, with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider for covered services or in a request for submission of treatment records.

Provider agrees that no payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for covered services provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care will be at the contracted reimbursement rate in effect on the date of admission.

Payment for services rendered to Members is impacted by the terms in the provider agreement, the Member’s eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any preauthorization/certification/notification requirements, Member expenses, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Note: Regardless of any provision to the contrary, providers acknowledge and agree that the payment rates in the provider agreement extend and apply to covered services rendered to Members of benefit plans administered in whole or in part by RMHP.

Coordination of Benefits

Some Members may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers. Providers should obtain information from Members as to whether the Member has health benefits coverage from more than one source, and if so, provide this information to RMHP. By Federal mandate, providers must exhaust all other insurance coverage and payment prior to billing Health First Colorado for covered services. To the extent not otherwise required by applicable laws or regulations, providers agree that in no event will payment from primary and secondary payers for covered services rendered to Members exceed the rate specified in the provider agreement.

Authorization, certification or notification requirements under the Member’s benefit plan still apply in coordination of benefits situations.

NOTE: Some benefit plans require that the Member update at designated time periods (e.g., annually) other health benefit coverage information. Claims may be denied in the event the Member fails to provide the required other coverage updates.

Overpayment Recovery

Providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. RMHP will notify providers and providers of overpayments identified by RMHP, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
• Claims allowed/paid greater than billed
• Inpatient claim charges equal to the allowed amounts
• Duplicate payments
• Payments made for individuals whose benefit coverage is or was terminated
• Payments made for services in excess of applicable benefit limitations
• Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits
• Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

Subject to the terms of the provider agreement and applicable state and/or federal laws and/or regulations, RMHP will pursue recovery of overpayments through:

• Adjustment of the claim or claims in question creating a negative balance reflected on the PSV (claims remittance)
• Written notice of the overpayment and request for repayment of the claims identified as Overpaid

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter, RMHP will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. RMHP may use automated processes for claims adjustments in the overpayment recovery process.

In those instances, in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than ninety (90) calendar days, RMHP reserves the right to issue a demand for re-payment.

Should a provider fail to respond and/or provide amounts demanded within the thirty (30) calendar days of the date of the demand letter, RMHP will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections. If the provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider may submit a request for additional review from RMHP in writing such that the written request for review is received by RMHP on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; provider’s name, identification number and contact information, Member name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

If you choose to remit a check to cover an overpayment, please mail it to the address below:

   Rocky Mountain Health Plans
   ATTN: Finance Department
   P.O. Box 10600
   Grand Junction, CO 81502-5600

Requests For Review

Providers may request review of a RMHP claims determination. All requests for review must be submitted in writing or made telephonically to the address and/or telephone number on the Member’s identification card within sixty (60) calendar days or the time period specified in the provider agreement (if any) from the date of RMHP’s original claim determination. Requests for review received beyond the above noted time period will not be reviewed and are considered ‘expired.’
Claims Disputes

Providers must exhaust all administrative processes concerning unresolved claims disputes pursuant to the terms of the provider agreement, and more specifically any dispute resolution provisions, prior to pursuing any legal or equitable action.

Claims Appeal Process

If you feel RMHP has made an incorrect payment or processing decision on a claim, you may file a claim appeal by writing a letter to RMHP and provide the reason you believe the claim should be reprocessed.

In the letter be sure to include the Member’s name and ID number, date(s) of service, service, and provider's name. Your letter and supporting documentation should be sent to the following address:

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

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included. Adjustments and Reversal Requests may be requested by calling Customer Service.

Resubmissions

Incomplete Claims

1. Claims may be “zero-paid” by RMHP in the case of incorrect or incomplete required data elements.
2. RMHP will notify the provider via the Provider Summary Voucher, of those data elements requiring completion or correction.

Resubmissions

1. Claims that are “zero paid” due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days from the date on the Provider Summary Voucher.
2. Providers may resubmit corrected claims by mail or EMC
3. Corrected claims should have a clear indication on the claim that the claim is a “Corrected Claim”

Claims Billing Audits

RMHP reviews and monitors claims and billing practices of providers in response to referrals. Referrals may be received from a variety of sources, including, without limitation:

- Members
- External referrals from state, federal and other regulatory agencies
- Internal staff
- Data analysis
- Whistleblowers
- Others who express a concern about potential fraud, waste, or abuse
RMHP also conducts random audits. RMHP conducts the majority of its audits by reviewing records providers either fax or mail to RMHP, but in some instances on-site audits are performed as well. Record review audits, or discovery audits, entail requesting an initial sample of records from the provider to compare against claims submission records. Following the review of the initial sample, RMHP may request additional records and pursue a full/comprehensive audit.

Records reviewed may include, but are not limited to:

Unless otherwise required by a specific client or a government agency, RMHP utilizes the Office of Inspector General's (OIG) Random Sample Determination Tool (RAT-STATS) to select a random and statistically valid sample of eligible records.

- Financial
- Administrative
- Current and past staff rosters
- Treatment records
  - For the purposes of RMHP’s audits, the ‘treatment record’ includes, but is not limited to:
    - Progress notes
    - Medication prescriptions and monitoring
    - Documentation of counseling sessions
    - The modalities and frequency of treatment furnished
  - Results of clinical tests. It may also include summaries of the:
    - Diagnosis
    - Functional status
    - Treatment plan
    - Symptoms
    - Prognosis, and
    - Progress to date.

Providers must supply copies of requested documents to RMHP within the required time. The required time will vary based on the number of records requested but will not be less than ten (10) business days when providers are asked to either fax or mail records to RMHP.

For the purpose of on-site audits, providers must make records available to RMHP staff during the audit. Providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. RMHP will not accept additional or missing documentation and/or records once this form is signed, including for the purposes of a request for appeal.

RMHP will not reimburse providers for copying fees related to providing documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state or federal law, rule or regulation.

In the course of an audit, documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered.
Providers’ strict adherence to these guidelines is required. A Member’s treatment record must include the following core elements:

- Member name
- Date of service
- Rendering provider signature and/or rendering provider name and credentials
- Diagnosis code
- Start and stop times (e.g., 9:00 to 9:50),
- Time-based CPT codes
- and service code to substantiate the billed services

Documentation must also meet the requirements outlined in this handbook. RMHP coordinates claims billing audits with appropriate RMHP clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for refund. Following completion of review of the documents and records received, RMHP will provide a written report of the findings to the provider. In some instances, such report of the findings may include a request for additional records.

- **Education / Training** – RMHP may require the provider to develop an educational/training program addressing the deficiencies identified. RMHP may provide tools to assist the provider in correcting such deficiencies.
- **Corrective Action Plan** – RMHP may require the provider to submit a corrective action plan identifying steps the provider will take to correct all identified deficiencies. Corrective action plans should include, at a minimum, confirmation of the provider’s understanding of the audit findings and agreement to correct the identified deficiencies within a specific timeframe.
- **Repayment of Claims** – The audit report will specify any overpayments to be refunded. The overpayment amount will be based on the actual deficiency determined in the audit process, or the value of the claims identified as billed without accurate or supportive documentation. RMHP does not use extrapolation to determine recovery amounts. The provider will be responsible for paying the actual amount owed, based on RMHP’s findings within ten (10) business days, unless the provider has an approved installment payment plan.
- **Monitoring** – RMHP may require monitoring of claims submissions and treatment records in 90-day increments until compliance is demonstrated. The participating provider’s monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.
- **National Credentialing Committee (NCC) Reporting / Contract Termination** – RMHP’s NCC may decide that the results of an audit warrant the provider’s involuntary disenrollment before the provider has satisfied any required corrective action plans or recoupments. If a provider reported to the NCC is not immediately disenrolled and is permitted to remain active by accepting a corrective action and/or recoupment plan, but later fails to follow through, the provider may be re-addressed by the NCC and involuntarily disenrolled for breach of contract.

**Audit Appeals**

If the provider disagrees with an audit report’s findings, the provider may request an appeal of the audit report of findings. All appeals must be submitted in writing and received by RMHP on or before the due date identified in the report of findings letter. Appeals must include:

- a copy of the audit report of findings letter
- the provider’s name and identification number
- contact information
- identification of the claims at issue, including the name or names of the Members, dates of service
- an explanation of the reason/basis for the dispute
RMHP will not accept additional or missing documentation and/or records associated with billing errors once the signed form certifying the original documentation was submitted prior to the audit.

The provider’s appeal will be presented to the RMHP National Compliance Program Integrity Subcommittee within forty-five (45) days of receiving the provider’s request for appeal. The subcommittee is comprised of RMHP employees who have not been involved in reaching the prior findings. The subcommittee will review the provider’s appeal documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The RMHP staff member/auditor who completed the provider’s audit will present his/her audit findings to the subcommittee but will not vote on the appeal itself. The subcommittee will uphold, overturn, uphold in-part, or pend the appeal for more information. Once a vote is taken, it will be documented and communicated to the provider within ten (10) business days of the subcommittee’s meeting. If additional time is needed to complete the appeal, RMHP will submit a letter of extension to the provider requesting any additional information required of the provider and estimating a time of completion. If repayments or a corrective action plan (CAP) are required, the provider must submit the required repayments or CAP within ten business days of receiving the subcommittee’s findings letter, unless an installment payment plan is approved. RMHP will take appropriate legal and administrative action in the event a provider fails to supply requested documentation and Member records or fails to cooperate with an RMHP investigation or corrective action plan. RMHP may also seek termination of the provider agreement and/or actions to recover amounts previously paid on claims involved in the investigation or requests for records. RMHP will report any suspicion or knowledge of fraud, waste or abuse to the appropriate authorities or regulatory agency as required or when appropriate.

**General Medical Record Requirements**

The State is in the process of developing and implementing a new treatment data collection system, the Data Integration Initiative (DII). RMHP will alert providers when the new system is live and will advise on the use of the system. Additionally, RMHP has medical record requirements for Members receiving services at any level of intensity:

I. **Coordination of Care:** All providers must coordinate care with any client’s PCMP and with other treatment providers, to include Member’s outpatient therapist or prescriber. If a Member does not have a PCMP, providers are to assist the Member in locating one. Assistance is also available at the RMHP and may be obtained by calling 888-282-8801.

   • **Missed Appointments:** Providers are expected to contact Members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider’s assessment of risk potential related to the missed appointment. Actions are to be documented in the Member’s medical record.

II. **Discharge Plan:** Within 48 hours of admission to inpatient or residential care, the Member’s chart must include a written discharge plan, signed by the Member and parent/guardian/family member as appropriate. If the plan is not completed within 48 hours, the chart must contain the clinical rationale for why it was not completed, and it should be completed as soon as clinically appropriate.

III. **Medical Record and Treatment Plan:**

   A. All documentation must be contained in the Member’s medical record. Additionally, all Member medical records must contain a comprehensive biopsychosocial assessment, measurable treatment goals, signed progress notes, and a discharge plan. The treatment plan should indicate involvement of a Member’s family / significant others when clinically indicated. If not clinically indicated, this should be noted as a part of the plan. Medical and psychological treatment documentation and progress notes must be current, dated and signed, and treatment plans must be updated regularly.
B. The provider initiating treatment must formulate an initial treatment plan with input from the Member. The treatment plan should describe the specific target problems or symptoms, and identify strengths and supportive resources, as well as the diagnosis, planned interventions at the level of care proposed and clear, time limited and measurable criteria for discharging the Member from treatment that are agreed upon by Member and provider. Discharge criteria may be modified as a Member’s circumstances change; modifications will be documented in the Member’s treatment plan. The treatment plan must be signed by the Member or the Member’s guardian. If the Member refuses to sign, this too should be documented in the record.

C. Progress notes must reflect that treatment provided to the Member at each session is tied to the goals of the treatment plan.

D. We require thorough documentation of regular communication with other providers, including physical health providers, and an integrated treatment plan.

E. Medical records are subject to quality of care and financial audits. Client consent is not necessary.

VI. Advanced Directives

It is the policy of RMHP to inform Members of their right to make medical decisions in compliance with the Patient Self-Determination Act (s. 4206 s. 4751; Pub L No. 101-508) and the Colorado Medical Treatment Decision Act (CRS 15.18.103.) and to assist them in exercising this right. Notification is made through a description of The Acts in the Member Handbook.

A. If a Member requests additional information on The Acts from the provider, the Member can be referred to the RAE Office of Member and Family Affairs, the Member Handbook, or the RAE website.

B. For help writing an Advanced Directive, refer the Member to her/his PCMP or to the Colorado Bar Association. In Colorado, Advanced Directives, as defined in the Patient Self-Determination Act, apply to medical/surgical procedures, not psychiatric conditions.

C. Providers are encouraged to assist Members to develop crisis plans that define the Member’s wishes in time of psychiatric crisis.

D. Providers are required to ask Members if they have an Advanced Directive and are encouraged to ask if they would like a copy placed in their mental health record. Providers must document in a prominent part of the individual’s current medical record whether or not the individual has executed an advanced directive. If the Member is incapacitated at the time of admission, the provider shall ask the family or significant other if the Member has an Advanced Directive and shall give the family information about advanced directives. At such time as the Member is able to understand the question, the provider must again ask if the Member has an Advanced Directive and, if so, document that in the medical record.

E. A provider may not condition a Member’s care or treatment on whether or not he/she has executed an Advanced Directive.

Providers must inform Members how to report a grievance to the appropriate state agency, if an Advanced Directive is not followed.

Quality Assurance and Compliance

To assure quality of care, timely access to services, and appropriate management of utilization, RMHP will maintain quality assurance and oversight of the behavioral health network. This quality oversight includes, but is not limited to:

- Corrective Action Plans
- Documentation and Chart Audits
- Colorado Client Assessment Report (CCAR) submissions
Community Mental Health Centers and other large group providers who submit CCAR files directly to the Office of Behavioral Health (OBH) will continue to do so.

For small practices not currently submitting CCAR files to OBH, OBH has recommended that RAEs begin submitting behavioral health data for smaller in network providers once the new Data Integration Initiative (DII) is deployed.

This guidance from OBH allows the RAE to be aligned with our contractual obligation if all community mental health center records are submitted. OBH will require a plan to onboard smaller providers once the DII is live so OBH may receive complete data submission. At the implementation of the DII, RAEs will then contractually be responsible for appropriate behavioral health care treatment data submissions to OBH for the entire behavioral health network.

- Site Reviews
- Network Monitoring of Service Billing and Utilization

**Behavioral Health Quality Program**

The objective of RMHP is to assess and improve the quality and effectiveness of care delivered to Colorado Health First Colorado Members. The program is designed to quantify provider performance so data can be used to recognize quality care, identify provider and facility best practices, improve provider network services, and identify areas for continuing education. Measures of performance and outcome as well as practitioner practice patterns are reviewed. Other areas reviewed may include treatment record documentation, compliments, grievances/Member satisfaction, and quality of care and utilization patterns. Providers will receive formal, written feedback on their performance.

**Quality Of Care**

RMHP has a joint Quality of Care Committee that oversees the investigation and resolution of all quality of care issues. Please contact RMHP to report any quality of care issues identified in the provision of services to Members by emailing our Quality of Care Team at QualityofCareConcern@rmhp.org or calling RMHP at 888-282-8801. Potential quality of care indicators monitored by RMHP include the following types of quality of care issues:

- Provider inappropriate and/or unprofessional behavior
- Clinical practice-related issues
- Access to care-related issues
- Attitude and service-related issues

Providers are required to respond to Quality of Care inquiries, assist with investigations, provide corrective action plans when requested, and report on progress toward addressing concerns through corrective actions as requested.

**Treatment Record Audits**

RMHP may request treatment records for documentation reviews, quality of care reviews, state Health First Colorado audits or reviews verifying that services billed are documented in Member’s treatment record and include all required elements. As a RMHP provider, you are expected to comply with all requests for Member treatment records as specified in your contract.
Confidentiality

To support quality management responsibilities for oversight of Member care, RMHP has in place strict confidentiality policies and procedures regarding the protection and disclosure of Member information. These policies and procedures ensure that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA, 42 CFR Part 2) and accreditation requirements. RMHP ensures that all such information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. In addition, RMHP maintains information systems to collect, maintain, and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as well as a plan for secure storage, maintenance, tracking, and destruction of Member-identifiable clinical information. RMHP staff engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information. Reference to individual providers or Members is redacted to safeguard the Member’s identity. Confidential information may include but is not limited to:

- Protected Health Information (PHI)
- Certification of behavioral health treatment
- Claims processing information
- Utilization review
- Peer review
- Response to congressional inquiries (made at the request of the Member)
- Appeals
- Quality assurance

Consents to Disclose Substance Use Disorder Information

For each Member receiving substance use services, the providers shall obtain a release of information, compliant with 42 C.F.R. § 2.31, authorizing the provider to disclose information related to the Member and their of Substance Use Services to RMHP for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such information by the RMHP to the Department of Health Care Policy and Financing (the “Department”), as required by and for the purposes set forth in the RMHP’ contracts with the Department.

Providers shall retain and maintain each such consent for a period of at least six years from the last effective date of such consent. If a Member refuses to sign such a consent, providers shall document their efforts to obtain such a consent and shall notify RMHP prior to billing for the provision of substance use services for such Members.

Providers and delegated entities are expected to safeguard the confidentiality of treatment record information related to both active and past clients. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.

Medical Record Documentation Standard

RMHP has specific documentation standards that must be adhered to by all providers. These standards incorporate all federal and state Health First Colorado documentation requirements as well as good professional practice. They are intended to insure the highest quality of care, reduce medical errors, and achieve full compliance with federal, state, and RMHP audit requirements. All providers must maintain a comprehensive medical record for each Member served. At a minimum, the medical record substantiates the diagnosis, the medical necessity of care, the quality of care, the progress of care, and the claims submitted for reimbursement. While network Community Mental Health Centers follow the applicable Division of Behavioral Health regulations regarding medical records (2 CCR 502-2 and 2 CCR 502-1), all RMHP providers must meet the following minimum standards for their own medical records.
General Requirements

- Each record includes the Member’s identification including but not limited to:
  - Age
  - Date of birth
  - Gender
  - Address
  - Employer or school
  - Home and work telephone numbers
  - Emergency contacts
  - Marital/legal status and
  - Financial information

- Each record includes appropriate consent forms and guardianship information.

- Each record contains a statement as to whether or not a Member over age 18 has an Advanced Directive (AD) and contains a statement that you provided AD information if requested.

- Each record contains a statement as to whether or not a Member under age 21 has had a well-child exam (Early Periodic Screening Diagnosis and Treatment requirement) in the last year and results of the exam if related to the mental health condition, or a referral to a Primary Care Physician if no recent exam has occurred.

- Each record contains a copy of Health First Colorado client rights and responsibilities signed by the Member.

- Each record contains a copy of the Member’s signed acknowledgement that s/he received your Notice of Privacy Practices.

- Each record contains a copy of your professional disclosure form signed by the client.

- Each record contains a copy of any release of information (to PCP or other parties as indicated) signed by the Member, or a statement that Member refused to sign. Releases must meet all HIPAA and 42 CRF Part 2 requirements.

- Each record contains an assessment of transportation needs and documentation that the provider helped to arrange transportation when necessary. Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions, current medications, allergies, retardation or organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, cultural and social conditions affecting the Member and family; past or present history of abuse; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances).
  - For children and adolescents, the assessment includes a developmental history (e.g., physical, psychological, social, intellectual and academic).
  - For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues.
Each record includes a mental status examination documenting the Member’s presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others.

- Each record includes a clinical formulation describing the reasoning and justification for the diagnosis, and a current Diagnostic and Statistical Manual (DSM) diagnosis based on psychiatric, psychological, substance use or medical condition. The formulation includes sufficient description of the criteria per the current DSM to support the diagnosis. Any subsequent changes in diagnosis must be similarly documented and explained.
- The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record.

Service/Treatment Plan:

Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider’s intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution.

- The treatment/service plan is consistent with the Member’s diagnosis and needs as identified in the assessment.
- There is documented evidence in a progress note that the Member (and parent/guardian, if applicable) participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates.
- The treatment/service plan must include specific criteria for discharging the Member from treatment that are agreed upon by the Member and provider. Discharge criteria may be modified as a Member’s circumstances change; modifications will be documented in the Member’s treatment plan.
- The treatment plan addresses coordination of care with other relevant providers.
- The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the Member’s condition or service needs occurs. The plan is revised as necessary. For Members involuntarily receiving services pursuant to Section 27-65-101 et seq., CRS, the plan must be reviewed monthly. The treatment plan for substance use diagnoses is completed every 45 days in accordance with OBH standards. The Member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.

Progress Notes:

- Each record includes a progress note for each encounter which describes the goal/objective being addressed during the session, the Member’s efforts in achieving treatment/service plan goals/objectives, and the treatment interventions used by the provider to assist the Member.
- Each progress note includes information relevant to the claim for payment, including date, start time, duration or end time, CPT code, place of service, diagnosis being treated, persons present, and provider signature with credentials and date signed.
- Case management notes reflect the name and agency of person contacted, start time and duration, and the content of each contact.
- Progress notes document an ongoing assessment of Member safety (e.g., dangerous to self or others) and substance use/abuse issues, if applicable, and how these have been addressed.
- For Members who become homicidal, suicidal or unable to conduct activities of daily living, the record documents prompt referral to the appropriate level of care.
- Each record documents attempts at outreach for persons who unexpectedly miss scheduled appointments.
Miscellaneous:

- As applicable, each record includes results of laboratory tests, psychological testing, and consultation reports.
- As applicable, each record indicates what medications have been prescribed, the dosages of each, the dates of initial prescription or refills, prescriber information, and informed consent for medication.
- Each record documents preventive and recovery-focused services as appropriate, such as relapse prevention, wellness programs, lifestyle changes, and referrals to community resources.
- Each record documents continuity and coordination of care between the Care Coordinator (Primary Clinician), consultants, ancillary providers and health care institution/providers, and other community services agencies.
- Each record documents the date(s) of follow-up appointments or, as appropriate, discharge plans and summary.
- All entries are dated.
- All entries include the legible identity of the rendering provider’s name, professional degree, and identification number, if applicable.
- All entries are legible to someone other than the writer, and written/typed in black or blue ink.

Compliance

RMHP maintains a Compliance Plan to provide guidance and assist the organization in carrying out our daily activities within appropriate legal standards. These obligations apply to our relationships within the RMHP community – Members, providers, contractors, regulators, consultants, and employees. Our Compliance Plan is a critical component of our overall compliance program. This plan is available at rmhp.org.

Reporting Fraud Waste and Abuse

Providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, use of CPT codes not documented in the treatment record, etc.). Reports and questions may be made in writing to RMHP at the address below or by calling the RMHP Customer Service at 888-282-8801.

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

Get Help from RMHP

RMHP is here to help. Our local Customer Service team can provide you with answers you need, when you need them. Thank you for being a valued partner of RMHP.

Call 888-282-8801

Email customer_service@rmhp.org

Visit rmhp.org