



2026 Care Provider Manual

Physician, Care Provider, Facility and Ancillary
Colorado Rocky Mountain Health Plans

Welcome

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

Click to access different care provider manuals:

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

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



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

Using this care provider manual

This care provider manual contains information designed to assist care provider offices in successfully delivering health care services to patients covered by Rocky Mountain Health Plans. This care provider manual includes:

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

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

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

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

If there is a conflict between language in your Agreement and this care provider manual, defer to language in the care provider manual. All applicable federal and state statutes and regulations or state contracts supersede language in your Agreement and care provider manual.

UnitedHealthcare reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

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Chapter 1: Introduction

Rocky Mountain Health Plans is Colorado-based and Colorado-focused. We were founded in Grand Junction more than 50 years ago to provide Coloradans access to high-quality health care. We continue this commitment and combine the personalized attention, quality care and comprehensive coverage that our members deserve and have come to expect from their local health insurance carrier.

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

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

About our plans

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

Through contracts with participating providers, RMHP offers Individual and Family Plan health care plans to individuals and families throughout Colorado. RMHP also manages plans in partnership with the Colorado Department of Health Care Policy and Financing (HCPF) to administer RMHP PRIME health care benefits to members in western Colorado counties. In addition, RMHP serves as the Regional Accountable Entity (RAE) for Health First Colorado's Accountable Care Collaborative (ACC) in Region 1. RMHP also serves as the administrator on behalf of Northeast Health Partners (NHP) for RAE Region 2. RMHP administers the CHP+ program in multiple Western Slope counties.

Our mission

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

- Supplemental coverage options
- Online tools and services to help make health care choices easier
- Coordination of care for patients levels of risk
- A commitment to helping your patients navigate health care coverage decisions

Philosophy of care

RMHP believes in developing long-term partnerships with our members and providers:

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

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

Nondiscrimination in providing services

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

Objections to providing services based on moral or religious grounds

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

Medically necessary defined

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

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

The fact that a provider may prescribe, order, recommend or approve care, treatment, services or supplies does not itself make such care, treatment, services or supplies medically necessary.

The fact that a participating physician or other health care professional may prescribe, order, recommend or approve a service or supply does not make such service or supply medically necessary.

If standards regarding whether health care services are medically necessary are subject to dispute, such standards shall be as determined solely by the medical director.

Affirmative statement

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

Contact us

Topic	Contact	Information
RMHP Member Services	- Individual and Family Plans (IFP) 1-888-809-6539 - RMHP PRIME and RAE 1-800-421-6204 - CHP+ 1-877-668-5947	Individual and Family, RMHP PRIME and RAE, and CHP+ available Monday–Friday, 8 a.m.–5 p.m. Call for information about: - General claims - Prior authorization status - Eligibility, benefit and copay - Care provider participation status - Remittance - Coordination of benefits
Behavioral health	1-855-886-2832	Available 24 hours a day, 7 days a week.
Care management	- Case management referrals, option 6 1-970-248-8718 or 1-800-793-1339 - Disease management referrals 1-888-847-6466, option 6	Available 24 hours a day, 7 days a week.
Credentialing	1-970-244-7798, option 4, then select the plan from the automated system	For questions about credentialing, contact provider relations.
Pharmacy (Optum Rx®)	- CHP 1-877-305-8952 - IFP 1-844-569-4143 - RMHP Prime 1-877-305-8952	Optum Rx® oversees and manages our network pharmacies.
Medical drug coverage	1-888-397-8129	Specialty guidance program (SGP) manages physical and behavior medical drug reviews and cancer guidance program (CGP) manage cancer and cancer related medical drug reviews. SGP is available Monday–Friday, 6 a.m.–6 p.m. MT and CGP is available Monday–Friday, 8 a.m.–5 p.m.
Provider Services	- IFP 1-888-478-4760 - RMHP PRIME and RAE 1-800-421-6204 - CHP+ 1-877-668-5947	Available Monday–Friday, 8 a.m.–5 p.m. CT. Chat support available 7 a.m.–7 p.m. CT at UHCprovider.com/chat.

2026 holiday calendar

RMHP offices will be closed on the following holidays:

- January 1 – New Year’s Day
- January 19 – Martin Luther King, Jr. Day
- May 25 – Memorial Day
- July 4 – Independence Day
- September 7 – Labor Day
- November 26 and 27 – Thanksgiving Break
- December 25 – Christmas

Assistance for care providers and sources of information

• Member Service representatives

RMHP Member Services representatives are highly knowledgeable about our operations and trained to provide assistance with claims status, payment explanations, eligibility, benefit and copay information, care provider status, check amounts, remittance inquiries, and primary care provider (PCP) information.

• Provider relations representatives

Provider relations representatives are responsible for educating care providers about RMHP’s philosophy, functions and requirements. Education comes in many forms, including virtual or onsite orientations, workshops, management seminars, office presentations and through information found in this care provider manual, which is updated periodically throughout the year.

• Join our network

For instructions on joining the UnitedHealthcare provider network, go to UHCprovider.com/join. There you will find guidance on our credentialing process, how to sign up for online tools and other helpful information.

• Changes in physician status

Contact a provider relations representative immediately with the following information if there has been a change in the status of your practice.

- Your address or telephone number have changed
- You have added an additional practice location or phone number
- Your federal tax identification number has changed
- You are planning to leave your practice. RMHP requires a minimum of a 60-day advance notification of your intent to terminate your contract. This allows RMHP to notify members of your change in status.

- You have changes in your physician group
- You plan to close your practice to “new patients”, as that term is defined in Colorado law, C.R.S. 25-37-101

• Orientation in your office

An RMHP provider relations representative is available to assist you and your staff with RMHP procedures. If you need training assistance or would like to schedule a virtual or onsite office site visit, please call your provider relations representative.

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

• UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24 hours, 7 days a week within the **UnitedHealthcare Provider Portal**.

You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling. See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

Available benefit plan information varies for each of our **UnitedHealthcare Provider Portal** tools. Here are the most frequently used tools:

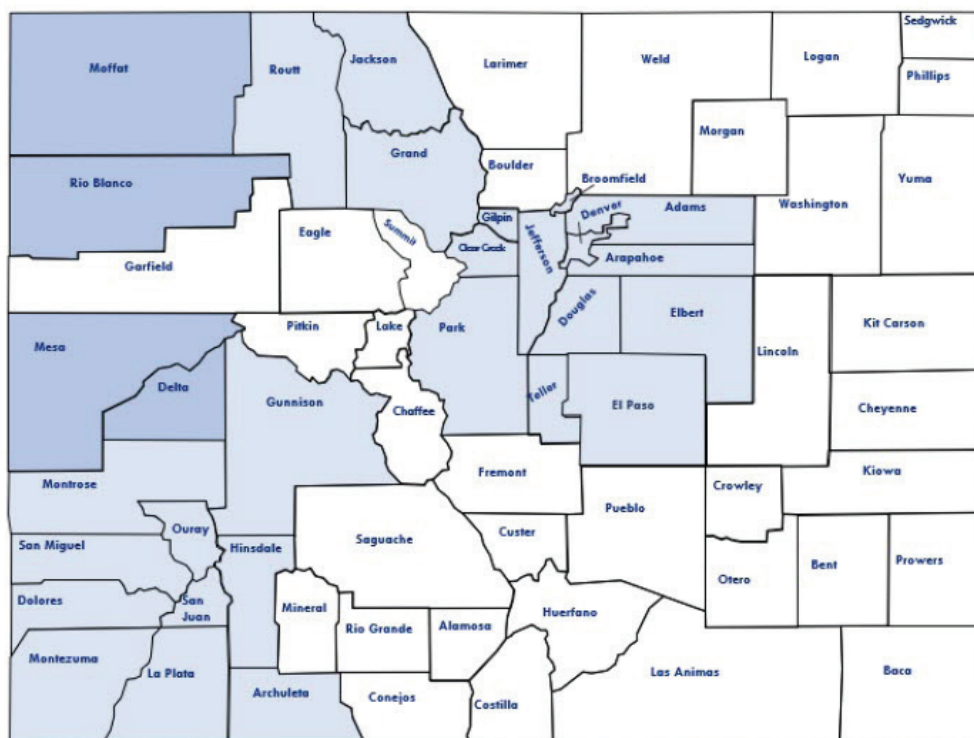
- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
- **Prior authorization and notification** – Submit notification and prior authorization requests. For more information, go to UHCprovider.com/priorauth.
- **Submit notification and prior authorization requests for IFP behavioral health** – Go to UHCprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-prior-auth.html

- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable drugs by selecting the prior authorization drop-down in the **UnitedHealthcare Provider Portal** landing page. You will be directed to prior authorization and notification capability to complete your requests.
- **My Practice Profile** – View and update your health care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mypracticeprofile.
- **Document Library** – Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to UHCprovider.com/documentlibrary.
- **Paperless delivery options** – Eliminate paper mail correspondence. In Document Library, you can set up daily or weekly email notifications to alert you when we add new letters to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of correspondence. This tool is available to One Healthcare ID primary access administrators only.
- **Chat support now available** – Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**. Available Monday–Friday, 7 a.m.–7 p.m. CT, chat support can help with claims, prior authorizations, credentialing and member benefits.

Service map

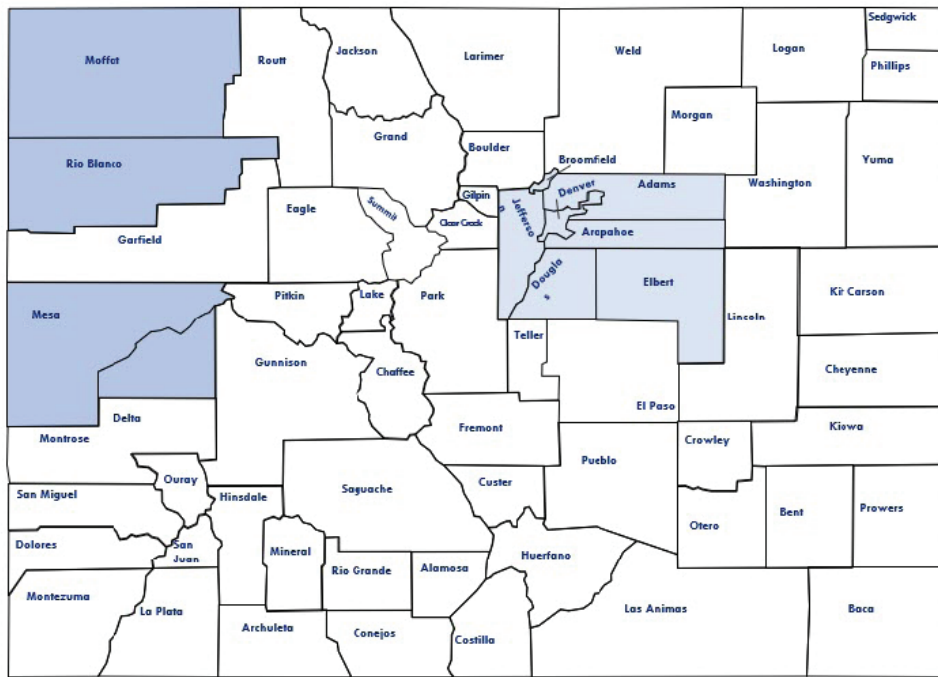
RMHP has covered Colorado for more than 45 years. We know what makes our state unique, including what our members need to remain healthy, happy and secure. We've helped Coloradans find plans that fit their Colorado lifestyle, and we've worked with amazing care providers to help our members get the care they deserve. Following are our service areas by line of business so you better understand who we serve and in what parts of our beautiful state.

Monument Health HMO Network



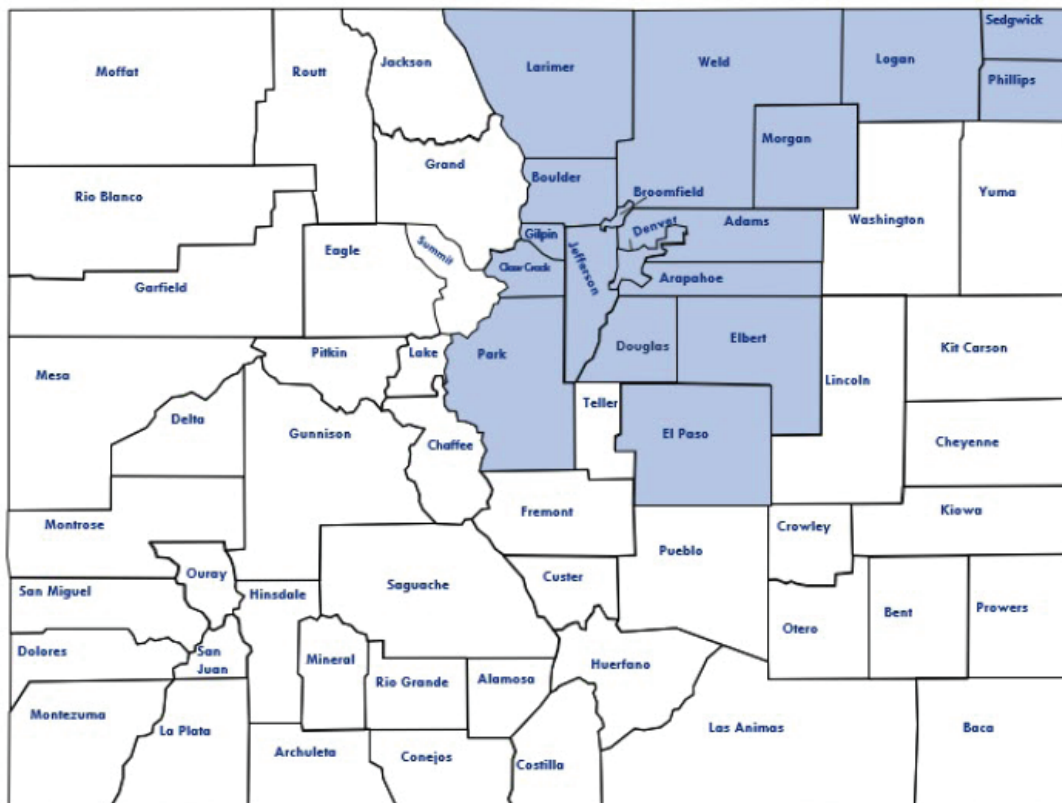
- Available to residents for enrollment
- Access to the RMHP provider network
Enrollment is not available, however, participating physicians and facilities in these counties are in-network

Monument Health ONE Network Access



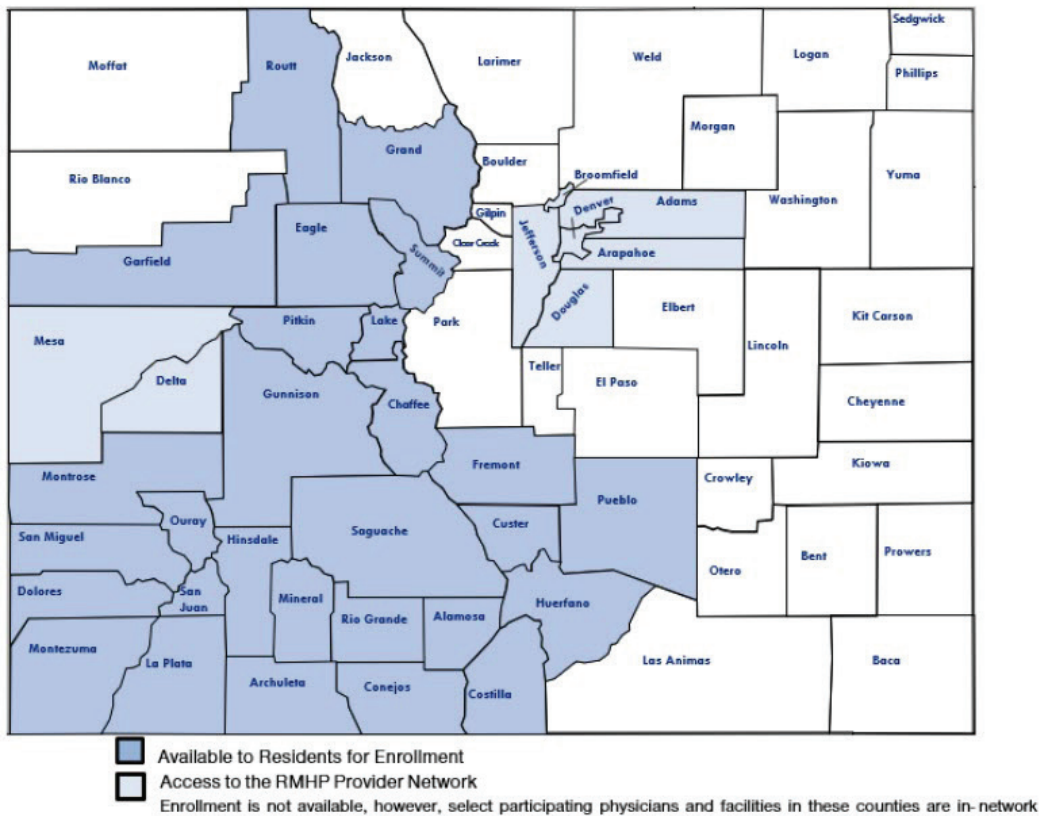
- Available to residents for enrollment
- Access to the RMHP provider network
- Enrollment is not available, however, select provider access includes University Hospital, Children's Hospital, and SCL Health providers and facilities

Colorado Doctors Plan



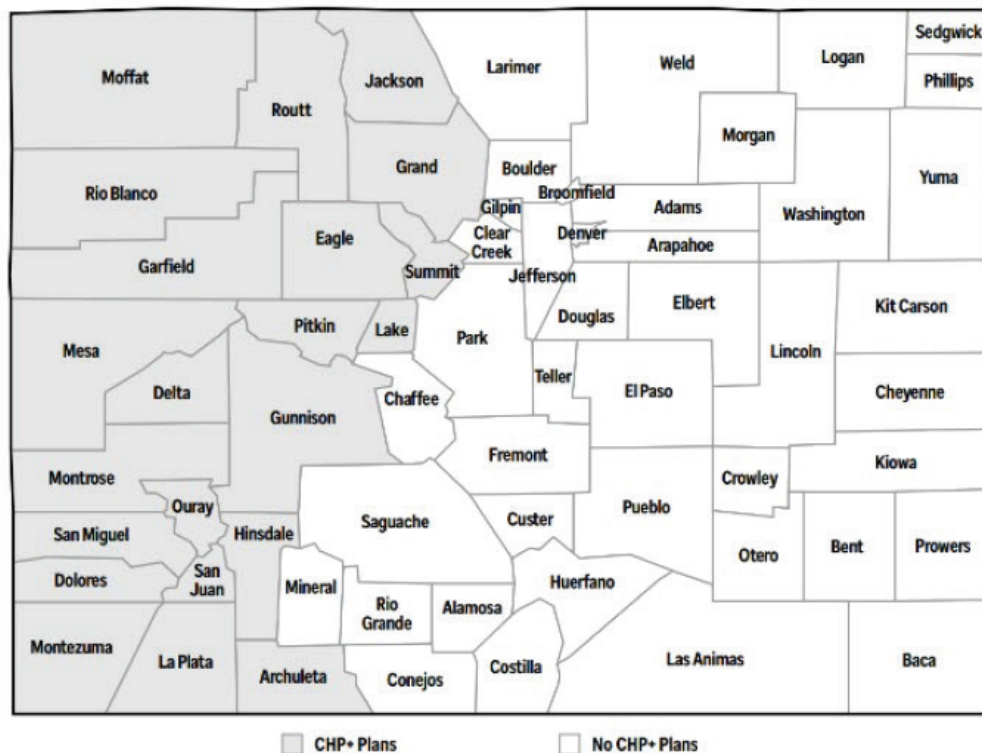
- Available to residents for enrollment

Rocky Mountain Valley HMO Network Access



Service area map

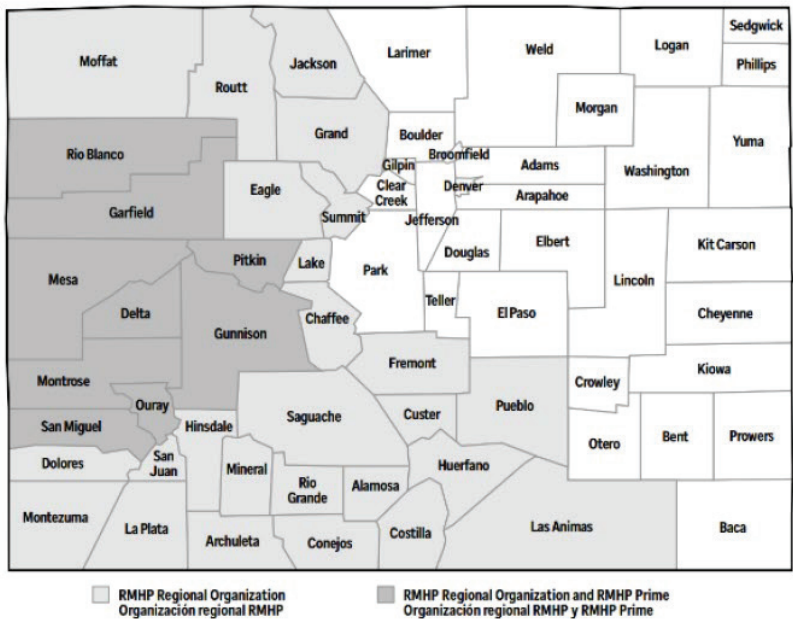
RMHP services CHP+ Members in the 22 counties identified below.



RMHP regional organization access map

This map shows the RMHP regional organization access area. Health First Colorado Members in these areas belong to the RMHP regional organization. Some Members in select counties may also be enrolled in our health plan called RMHP Prime.

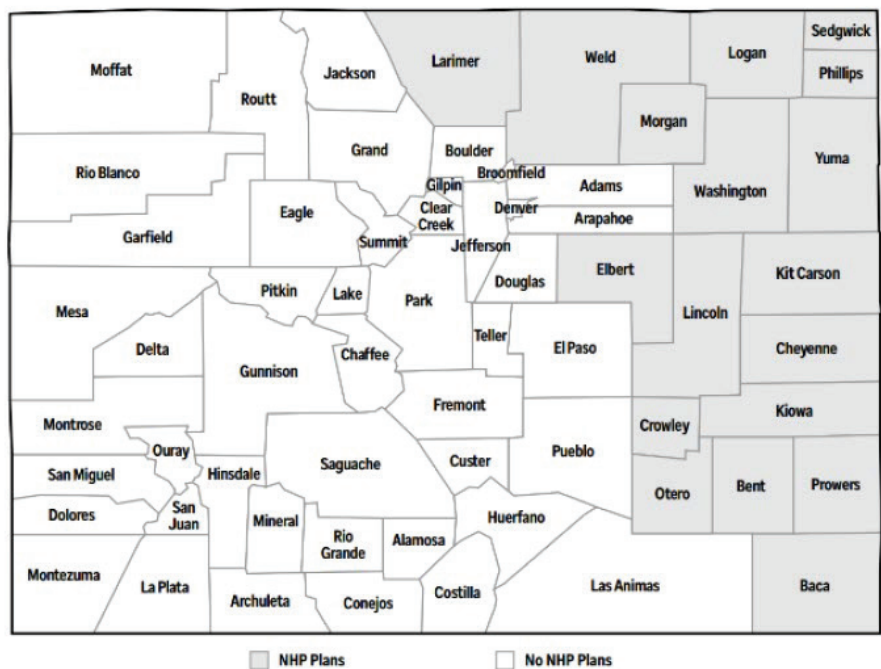
We work with providers across the state. You do not have to be in one of these counties to see a provider. You can see any provider that is listed in this directory.



NHP regional organization access map

This map shows the NHP regional organization access area. Health First Colorado Members in these areas belong to the NHP regional organization.

We work with providers across the state. You do not have to be in one of these counties to see a provider. You can see any provider that is listed in this directory.



Northeast Health Partners

This provider manual is part of your Medicaid provider contract. Please note that your Regional Accountable Entity (RAE) behavioral health contract with Rocky Mountain Health Plans applies to both RAE Region 1 and Region 2. RAE Region 2, managed by Northeast Health Partners (NHP), has contracted with Rocky Mountain Health Plans (RMHP) to enhance behavioral health and substance use disorder (SUD) administrative services beginning July 1, 2025.

Key services RMHP will provide include:

- Behavioral health and SUD care provider contracting
- Behavioral health and SUD care provider credentialing
- Call center support
- Behavioral health & SUD care provider relations
- Prior authorizations
- Claims processing
- Utilization management

NHP will continue to manage care coordination and primary care contracting.

Regions 1 and 2 share many similarities, primarily rural and frontier communities. Both regions require innovative approaches and a strong focus on elevating provider and member voices to meet unique community needs. NHP and RMHP will strive to address these challenges, and each will bring their valuable expertise to their shared mission in Regions 1 and 2.



Access to care

Network of acute care hospitals, primary care providers and specialists

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

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

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

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

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

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

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

Process for monitoring and assuring network sufficiency

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

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

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

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

County designations

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

Service coverage

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

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

Individual and Family Plan networks				
Classification	County			
Large Metro	Denver			
Metro	Adams Arapahoe Boulder	Broomfield Douglas El Paso	Jefferson Larimer Weld	
Micro	Eagle Garfield	La Plata Mesa	Pueblo Summit	
Rural	Archuleta Alamosa Chaffee Clear Creek Delta Elbert	Fremont Gilpin Lake Logan Montezuma	Montrose Morgan Otero Pitkin Rio Grande	Teller
CEAC	Baca Bent Cheyenne Conejos Costilla Crowley Custer	Dolores Grand Gunnison Hinsdale Huerfano Jackson Kiowa Kit Carson	Las Animas Lincoln Mineral Moffat Ouray Park Phillips Prowers	Rio Blanco Routt Saguache San Juan San Miguel Sedgwick Washington Yuma

PRIME, RAE 1, RAE 2 and CHP+					
Classification	County	Network			
		Prime	RAE 1	RAE 2	CHP+
Large Metro Metro	Denver		X	X	
	Adams		X	X	
	Arapahoe		X	X	
	Boulder		X	X	
	Broomfield		X	X	
	Douglas		X	X	
	El Paso		X	X	
	Jefferson		X	X	
	Larimer		X	X	
Micro	Weld		X	X	
	Eagle		X	X	X
	Garfield	X	X	X	X
	La Plata		X	X	X
	Mesa	X	X	X	X
	Pueblo		X	X	
Rural	Summit		X	X	X
	Alamosa		X	X	
	Archuleta		X	X	X
	Chaffee		X	X	
	Clear Creek		X	X	
	Delta	X	X	X	X
	Elbert		X	X	
	Fremont		X	X	

PRIME, RAE 1, RAE 2 and CHP+					
Classification	County	Network			
		Prime	RAE 1	RAE 2	CHP+
Rural continued	Gilpin		X	X	
	Lake		X	X	X
	Logan		X	X	
	Montezuma		X	X	X
	Montrose	X	X	X	X
	Morgan	X	X	X	
	Otero		X	X	
	Pitkin		X	X	X
	Rio Grande		X	X	
	Routt		X	X	X
	Teller		X	X	
CEAC	Baca		X	X	
	Bent		X	X	
	Cheyenne		X	X	
	Conejos		X	X	
	Costilla		X	X	
	Crowley		X	X	
	Custer		X	X	
	Dolores		X	X	X
	Grand		X	X	X
	Gunnison	X	X	X	X
	Hinsdale		X	X	X
	Huerfano		X	X	

PRIME, RAE 1, RAE 2 and CHP+					
Classification	County	Network			
		Prime	RAE 1	RAE 2	CHP+
CEAC continued	Jackson		X	X	X
	Kiowa		X	X	
	Kit Carson		X	X	
	Las Animas		X	X	
	Lincoln		X	X	
	Mineral		X	X	
	Moffat		X	X	X
	Ouray	X	X	X	X
	Park		X	X	
	Phillips		X	X	
	Prowers		X	X	
	Rio Blanco	X	X	X	
	Saguache		X	X	
	San Juan		X	X	X
	San Miguel	X	X	X	
	Sedgwick		X	X	
	Washington		X	X	
	Yuma		X	X	

Availability standards

Individual and Family Plan networks			
Care provider/facility type	Large Metro	Metro	Micro
Primary care	1:1,000	1:1,000	1:1,000
Pediatrics	1:1,000	1:1,000	1:1,000
OB/GYN	1:1,000	1:1,000	1:1,000
Mental health, behavioral health and substance use disorder care providers	1:1,000	1:1,000	1:1,000

PRIME, RAE 1, RAE 2 and CHP+ networks				
Care provider/facility type	Prime	RAE 1	RAE 2	CHP+
Adult primary care	1:1,200	1:1,200	1:1,200	1:1,800
Mid-level adult primary care	1:1,200	1:1,200	1:1,200	1:1,200
Pediatric primary care	1:1,200	1:1,200	1:1,200	1:1,800
Specialists	1:1,800	N/A	N/A	1:1,800
Adult mental health	1:1,200	1:1,200	1:1,200	N/A
Pediatric mental health	1:1,200	1:1,200	1:1,200	1:1,800
Substance use disorder	1:1,200	1:1,200	1:1,200	1:1,800

Geographic access standards

Individual and Family Plan networks					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum distance (miles)				
Primary care	5	10	20	30	60

Individual and Family Plan networks					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum distance (miles)				
Gynecology, OB/GYN	15	30	60	75	110
Pediatrics - routine/primary care	5	10	20	30	60
Allergy and immunology	15	30	60	75	110
Cardiothoracic surgery	15	40	120	120	140
Cardiovascular disease	10	20	35	60	85
Chiropractic	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/ Otolaryngology	15	30	60	75	110
Gastro-enterology	10	30	45	60	100
General surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious diseases	15	40	75	90	130
Licensed clinical social worker	5	10	20	30	60
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological surgery	15	40	75	90	130

PRIME network geographic and time standards

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Adult primary care	20	10	30	15	40	20	60	30	90	60
Pediatric primary care	20	10	30	15	40	20	60	30	90	60
Gynecology OB/GYN	20	10	30	15	40	20	60	30	90	60
Specialist (adult)	30	15	45	30	80	60	90	75	120	110
Specialist (pediatric)	30	15	45	30	80	60	90	75	120	110
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100
Pharmacy	10	5	15	10	30	20	40	30	70	60
Behavioral health network										
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100
Psychiatrists and other psychiatric prescribers - adult	20	10	45	30	60	45	75	60	110	100
Psychiatrists and other psychiatric prescribers - pediatric	20	10	45	30	60	45	75	60	110	100
Mental health care provider - adult	20	10	30	15	40	20	60	30	90	60
Mental health care provider - pediatric	20	10	30	15	40	20	60	30	90	60

Chapter 1: Introduction

PRIME network geographic and time standards

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Substance use disorder provider - adult	20	10	30	15	40	20	60	30	90	60
Substance use disorder provider - pediatric	20	10	30	15	40	20	60	30	90	60

CHP+ network geographic and time standards - goal ≥ 90%

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Pediatric primary care	20	10	30	15	40	20	60	30	90	60
Pediatric specialty care, including PT, OT, ST	30	15	45	30	80	60	90	75	120	110
Gynecology OB/GYN	20	10	45	30	80	60	90	75	120	110
Pharmacy	10	5	15	10	30	20	40	30	70	60
Hospital (acute care)	20	10	45	30	80	60	75	60	110	100

Chapter 1: Introduction

Behavioral health network										
Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100
Psychiatrists and other psychiatric prescribers - pediatric	20	10	45	30	60	45	75	60	110	100
Mental health care provider - pediatric	20	10	30	15	40	20	60	30	90	60
Substance use disorder care provider - pediatric	20	10	30	15	40	20	60	30	90	60
RAE Region 1 and RAE Region 2 network geographic and time standards										
Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Adult primary care	20	10	30	15	40	20	60	30	90	60
Pediatric primary care	20	10	30	15	40	20	60	30	90	60
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100

Behavioral health network										
Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)	Max time (minutes)	Max distance (miles)
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100
Psychiatrists and other psychiatric prescribers - adult	20	10	45	30	60	45	75	60	110	100
Psychiatrists and other psychiatric prescribers - pediatric	20	10	45	30	60	45	75	60	110	100
Mental health care provider - adult	20	10	30	15	40	20	60	30	90	60
Mental health care provider - pediatric	20	10	30	15	40	20	60	30	90	60
Substance use disorder care provider - adult	20	10	30	15	40	20	60	30	90	60
Substance use disorder care provider - pediatric	20	10	30	15	40	20	60	30	90	60

Individual and Family Plan networks					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum distance (miles)				
Oncology - medical, surgery	10	30	45	60	100
Oncology - radiation, oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine pediatric vision services	15	30	60	75	110
Orthopedic surgery	10	20	35	60	85
Psychiatry, rehabilitative medicine	15	30	60	75	110
Plastic surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	5	10	20	30	60
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular surgery	15	40	75	90	130
Other medical provider	15	40	75	90	130
Dentist	15	30	60	75	110
Pharmacy	5	10	20	30	60

Individual and Family Plan networks					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum distance (miles)				
Acute inpatient hospital	10	30	60	60	100
Cardiac surgery program	15	40	120	120	140
Cardiac catheterization services	15	40	120	120	140
Critical care services	10	30	120	120	140
Outpatient dialysis	10	30	50	50	90
Surgical services (outpatient or ASC)	10	30	60	60	100
Skilled nursing facilities	10	30	60	60	85
Diagnostic radiology	10	30	60	60	100
Mammography	10	30	60	60	100

Individual and Family Plan networks					
Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum distance (miles)				
Physical therapy	10	30	60	60	100
Occupational therapy	10	30	60	60	100
Speech therapy	10	30	60	60	100
Inpatient psychiatric facilities	15	45	75	75	140
Orthotics and prosthetics	15	30	120	120	140
Outpatient infusion/chemotherapy	10	30	60	60	100
Other facilities	15	40	120	120	140

Appointment availability

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

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

Appointment standards

Individual and Family Plan network

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

PRIME Network

Service type	Standard
Urgent care	Within 24 hours after initial identification of need.
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization.
Nonurgent, symptomatic care visit	Within 7 days after the request.

PRIME Network		
Service type	Standard	
Well care visit	Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the department’s accepted EPSDT schedules.	
Behavioral health		
Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility.	
	Urban and suburban, in person: within 1 hour of contact.	Rural and frontier, in person: within 2 hours after contact.
Nonurgent, symptomatic behavioral health services	Within 7 days after member’s request. * Care provider shall not consider administrative intake appointments or group intake processes as a treatment.	
Medication-assisted treatment evaluation	Within 72 hours after the request.	

*Care provider shall not place members on waiting lists for initial routine service requests.

RAE Region 1 and RAE Region 2 networks		
Service type	Standard	
Urgent care	Within 24 hours after initial identification of need.	
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization.	
Nonurgent, symptomatic care visit	Within 7 days after the request.	
Well care visit	Within 1 month after the request; unless appointment is required sooner to ensure the provision of screenings in accordance with the department's accepted EPSDT schedules.	
Behavioral health		
Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility.	
	Urban and suburban, in person: within 1 hour of contact.	Rural and frontier, in person: within 2 hours after contact.

RAE Region 1 and RAE Region 2 networks

Service type	Standard
Nonurgent, symptomatic behavioral health services	Within 7 days after member's request. * Care provider shall not consider administrative intake appointments or group intake processes as a treatment.
Medication-assisted treatment evaluation	Within 72 hours after the request.

* Care provider shall not place members on waiting lists or initial routine service requests.

CHP+ network

Service type	Standard
Urgently needed services	Within 24 hours of notification of the member's need for those services to the member's PCP.
Outpatient follow-up appointments	Within 7 days after discharge from hospitalization.
Nonemergent, nonurgent medical	Within 30 calendar days. * Does not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 calendar days.
Nonurgent, symptomatic care	Within 7 calendar days of the member's request for services.
Nonsymptomatic well care physical exams	Within 30 calendar days month after the request; unless appointment is required sooner to ensure the recommended screenings in accordance with the Academy of Pediatrics (AAP) accepted Bright Futures schedule.

Behavioral health

Emergency behavioral health care	By phone: within 15 minutes after the initial contact, including TTY accessibility.	
	Urban and suburban, in person: within 1 hour of contact.	Rural and frontier, in person: within 2 hours after contact.
Nonurgent, symptomatic behavioral health services	Within 7 days after member's request. *Care provider shall not consider administrative intake appointments or group intake processes as a treatment.	

*Care providers shall not place members on waiting lists for initial routine service requests.

Products and networks

RMHP has covered Colorado – and only Colorado – for more than 50 years. We know what makes our state unique, including what our members need to remain healthy, happy and secure. We continue to help Coloradans find plans that fit their Colorado lifestyle.

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

Access to care

HMO Individual Plans, RMHP PRIME, CHP+

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

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

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

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

Types of products and programs

Individual and Family Plan products

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

Government programs

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

Plan information and details

PCP selection

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

PCP referrals

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

Prior authorization

Obtaining prior authorization for certain services is the responsibility of the participating care provider. The participating care provider cannot bill the member for services requiring prior authorization if the care provider failed to obtain such prior authorization from RMHP for those services.

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

Covered services

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

Individual plans

- **Colorado Doctors Plan**
Offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick and Weld counties
- **Monument Health HMO**
Offered in Delta, Mesa, Moffat and Rio Blanco counties
- **Monument ONE**
Offered in Delta, Mesa, Moffat and Rio Blanco counties
- **Rocky Mountain Valley**
Offered in Alamosa, Archuleta, Chaffee, Conejos, Costilla, Custer, Dolores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, La Plata, Lake, Mineral, Montezuma, Montrose, Ouray, Pitkin, Pueblo, Rio Grande, Routt, Saguache, San Juan, San Miguel, and Summit counties

Member eligibility

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

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

Understanding ID cards

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

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

Medicaid ID cards

RMHP does not provide ID cards to RAE members. The state does provide ID cards to all Health First Colorado members, which includes both RAE and PRIME members. Members can access their Health First Colorado ID card through their PEAK account. 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 a RMHP member ID card to PRIME and CHP+ members.




Health Plan (80840) 911-87726-04

Member ID: 121212121 Group Number: CORMCHP

Member:
Member Name Payer ID: 87726
State ID: Y123456



RxBin: 610494
RxGrp: RMHCAID
Rx PCN: 4444

DOI -0501 CO CHP High Copay Underwritten by Rocky Mountain HMO

In an emergency go to nearest emergency room or call 911. Printed: 04/23/24

Website: www.myuhc.com/communityplan

For Members: 877-668-5947 TTY 711

Para asistencia en español llame al: 877-668-5947 TTY 711

For Providers/Preauthorization: 877-668-5947 UHCprovider.com
Medical Claims: UHCCP, PO Box 5260, Kingston, NY 12402-5260
Referrals to participating providers not required.

Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952




Health Plan (80840) 911-87726-04

Member ID: 121212121 Group Number: CORMCA

Member:
Member Name Payer ID: 87726
State ID: Y123456



RxBin: 610494
RxGrp: RMHCAID
Rx PCN: 4444

DOI -0501 CO RAE Prime Underwritten by Rocky Mountain HMO

In an emergency go to nearest emergency room or call 911. Printed: 04/23/24

Website: www.myuhc.com/communityplan

For Members: 800-421-6204 TTY 711

Para asistencia en español llame al: 800-421-6204 TTY 711

For Providers/Preauthorization: 800-421-6204 UHCprovider.com
Medical Claims: UHCCP, PO Box 5260, Kingston, NY 12402-5260
Referrals to participating providers not required.

Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952



Member ID: xxxxxxxx Name: xxxxxxxx xxxxxxxx

Your PCP is available to help.
Primary Care Provider (PCP): xxx-xxx-xxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Emergencies or medical advice
If you aren't sure if it's an emergency, call your PCP or the Nurse Advice Line. If it's an emergency, call 911 or go to the emergency room.
24/7 Nurse Advice Line: 800-283-3221
24/7 Mental health crisis: 844-493-TALK (8255)
ColoradoCrisisServices.org text TALK to 38255

If you need help getting an appointment call xxx-xxx-xxxx.
See if you're active on the  PEAK Health App



Member ID: xxxxxxxx Name: xxxxxxxx xxxxxxxx

Eligibility/Am I Active?: (720) 944-4347 or CO.gov/PEAK
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Find a provider or get help with care. Call your Regional Organization.
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DentaQuest: 855-225-1729 or DentaQuest.com
Benefits, Co-pays, Bills: 800-221-3943
Free ride to services: xxx-xxx-xxxx
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Allergies and important information about me:

Providers: This card is not proof of coverage. Verify benefits at CO.gov/hcpt/our-providers

									
Member: _____ Member Name _____									
Member ID: 000100071		Group Number: COXXXX							
		Plan Name _____							
PCP Required _____		Payer ID: 87726							
Copy: _____		<table border="0"> <tr> <td>Rx Bin:</td> <td>610279</td> </tr> <tr> <td>Rx PCN:</td> <td>7777</td> </tr> <tr> <td>Rx Grp:</td> <td>EXCCO</td> </tr> </table>		Rx Bin:	610279	Rx PCN:	7777	Rx Grp:	EXCCO
Rx Bin:	610279								
Rx PCN:	7777								
Rx Grp:	EXCCO								
PCP:\$XX UC:\$XX	Spec:\$XXX ER:\$XXX	OCPM IND/FAM \$XXXX/\$XXXX							
Med INN	DED IND/FAM \$XXXX/\$XXXX								

Print: 11/01/02



Members: Sign in at myuhc.com/exchange to pay your bills, see your claims and more. A referral is needed from a PCP to see specialists. Prior authorization of some services and notice of hospital admission is required. Please call 800-854-4338.

UHC Online Account: myuhc.com/exchange
Member Services + Care Support: 888-809-6539

Providers: 888-478-4760 or UHCprovider.com
Medical Claims: PO Box 5290, Kingston, NY, 12402-5290

Pharmacists: 844-569-4143
Pharmacy Claims: OptumRx PO Box 650540, Dallas, TX 75265-0540

  	
Member: _____ Member Name _____ Member ID: 000100001 _____ Group Number: COXXXX _____ Plan Name _____	
PCP Required _____ Copay: _____ PCP:\$XX UC:\$XX	Spec:\$XXX ER:\$XXX OOPM IND/\$MAM \$XXXX/\$XXXX
Med INN _____ \$XXXX/\$XXXX	Payer ID: 87726 Rx Bin: 610279 Rx PCN: 7777 Rx Grp: EXCCO
HMO CO-DOI _____ PCP Referral Required _____ Monument ONE HMO Network Underwritten by Rocky Mountain HMO, Inc.	

Printed: 11/01/2005



Members: Sign in at myuhc.com/exchange to pay your bills, see your claims and more. A referral is needed from a PCP to see specialists. Prior authorization of some services and notice of hospital admission is required. Please call 800-834-4558.

UHC Online Account: myuhc.com/exchange
Member Services + Care Support: 888-809-6539

Providers: 888-478-4760 or UHCprovider.com
Medical Claims: PO Box 5290, Kingston, NY, 12402-5290

Pharmacists: 844-569-4143
Pharmacy Claims: OptumRx PO Box 650540, Dallas, TX 75265-0540

 Colorado Doctors Plan  UnitedHealthcare	 ROCKY MOUNTAIN HEALTH PLANS® A UnitedHealthcare Company	 Optum Rx®
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Member:	MEMBER NAME	
Member ID:	111111292	Group ID: COXXXX

	PLAN NAME
Payer ID: 87726	

Copay: PCP: XXX UC: XXX	InPt/Hosp: XXX Spec: XXX ER: XXX	<table border="1"> <tr> <td>Rx Bin:</td> <td>610279</td> </tr> <tr> <td>Rx PCN:</td> <td>7777</td> </tr> <tr> <td>Rx Grp:</td> <td>EXCCO</td> </tr> </table>	Rx Bin:	610279	Rx PCN:	7777	Rx Grp:	EXCCO
Rx Bin:	610279							
Rx PCN:	7777							
Rx Grp:	EXCCO							
Med INN XXXXX/XXX	OOPM IND/IFAM XXXXX/XXXXX							

No PCP Referral Required
 Colorado Doctors Plan HMO Network
 Underwritten by Rocky Mountain HMO, Inc.

CO-DOI-508

Printed: 11/01/2025



Members: Sign in at myuhc.com/exchange to find network care, pay your bills, see your claims, ask a question and more. Prior authorization or notice of admission; 800-854-4558. Prior authorization of some services and notice of hospital admission is required.

UHC Online Account: myuhc.com/exchange
Member Services + Care Support: 888-809-6539

Providers: 888-478-4760 or UHCprovider.com
Medical Claims: PO Box 5290, Kingston, NY, 12402-5290

Pharmacists: 844-569-4143
Pharmacy Claims: OptumRx PO Box 650540, Dallas, TX 75265-0540

Rocky Mountain Health Plan PRIME, RAE and CHP+ plans

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

RMHP PRIME counties

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

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

RMHP PRIME member eligibility

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

Please verify eligibility using the [department's eligibility system](#), this system is updated frequently in real time and serves as the most accurate method for determining eligibility. It is important to retain all documents related to eligibility verification, as they will be required if a claim is denied and appealed. If the department retroactively adjusts eligibility, claims payment may also be retracted if you are unable to demonstrate eligibility was verified at the time of service. Care providers must use a member's Medicaid ID Letter followed by 6 digits to verify eligibility in the Medicaid Provider Portal.

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

CHP+

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

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

CHP+ counties

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

Colorado's Accountable Care Collaborative program

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

RMHP coordinates care and partners with Health First Colorado to ensure access for the ACC members. Care providers are to bill Health First Colorado for all Physical Health services rendered. You can verify eligibility through the Medicaid Provider Portal or by calling UnitedHealthcare Provider Portal Member Services at 1-833-468-0362. Follow the prompts for verification of member eligibility. Additionally, members receive a letter from the department confirming their participation in the program.

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

RMHP ACC/RAE Region 1

- Alamosa
- Archuleta
- Chaffee
- Conejos
- Costilla
- Custer
- Delta
- Dolores
- Eagle
- Fremont
- Garfield
- Grand
- Gunnison
- Hinsdale
- Huerfano
- Jackson
- La Plata
- Lake
- Las Animas

- Mesa
- Mineral
- Moffat
- Montezuma
- Montrose
- Ouray
- Pitkin
- Pueblo
- Rio Blanco
- Rio Grande
- Routt
- Saguache
- San Juan
- San Miguel
- Summit

NHP ACC/RAE Region 2

- Baca
- Bent
- Cheyenne
- Crowley
- Elbert
- Kiowa
- Kit Carson
- Larimer
- Lincoln
- Logan
- Morgan
- Otero
- Phillips
- Prowers
- Sedgwick
- Washington
- Weld
- Yuma

Cost-share collection

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

Colorado law (C.R.S. 25.5-4-301(1)) states that no Medicaid member shall be liable for the cost—or the cost remaining after payment by Medicaid or a private insurer—of medical benefits authorized under Title XIX of the Social Security Act.

This law applies whether or not Medicaid has reimbursed the care provider, whether claims are rejected or denied by Medicaid due to care provider error, and whether or not the care provider is enrolled in the Colorado Medical Assistance Program. This law applies even if a Medicaid member agrees to pay for part or all of a covered service.

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

Rocky Mountain Health Plan CHP+ members

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

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

Following federal rules, CHP+ members who are American Indians or Alaskan Natives do not have to pay any copays or cost-sharing.

American Indians are members of a federally recognized Indian tribe, band or group, or a descendant in the first or second degree of any such member. Alaskan Natives are an Eskimo, Aleut or other Alaska Native enrolled by the Secretary of the Interior. In addition, prenatal members do not have a copay.

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

Rocky Mountain Health Plan PRIME members

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

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

Statewide care providers

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

Balance billing

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

Supplemental networks

Chiropractic coverage

Optum Physical Health manages plans that have chiropractic benefits on behalf of Rocky Mountain Health Plans. Please visit myoptumhealthphysicalhealth.com for more information.

Behavioral or mental health

- Effective Jan. 1, 2021, the Department of HCPF ensured a full continuum of Substance Use Disorder (SUD) benefits for Health First Colorado RAE and RAE PRIME members. Residential and inpatient SUD treatment and withdrawal management services were added to the SUD benefit.
- The treatment provider will conduct an assessment and determine the appropriate level of care for the member based on American Society of Addiction Medicine (ASAM) Criteria. The care provider will then submit a request for prior authorization to RMHP. RMHP will review the recommendation for treatment and ensure that it is consistent with ASAM criteria.
- Services will be covered as long as they are medically necessary. Medical necessity will be based on the ASAM criteria. Length of stay will be determined by progress in treatment and continued medical necessity. There will be no limit on length of stay.
- If a member receives a denial of their prior authorization request for a level of treatment from RMHP, they have the right to appeal the decision. See appeals and grievance processes – RAE, RMHP PRIME, CHP+.
- Special Connections (a program for pregnant members on Colorado Medicaid who have alcohol or drug use problems) is part of the capitated behavioral health benefit managed by RMHP. The Office of Behavioral Health will continue to certify those programs.

Benefit exclusions

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

Guidelines

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

Codes

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

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

CPT/HCPCS procedure code: H2036

Procedure code description: Alcohol or other drug treatment program, per diem.

Service description: Structured alcohol or drug treatment program to provide therapy and treatment toward rehabilitation. A planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol or drug addiction disorders.

Minimum documentation requirements

Technical documentation requirements: See Appendix B of the Provider Manual for Residential and Inpatient Substance Use Disorder (SUD). Services from the Department of Health Care Policy & Financing (HCPF).

Service content: Shift notes or daily note (summary of shift notes).

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

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

Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.1 services are as follows:

- First position: HF
- Second position: U1 Special Connection services use an additional modifier
- Third position: HD room and board is billed separately to the Office of Behavioral Health or their designee

Example activities:

This per diem could include services such as:

1. SUD assessment.
2. Individual and family therapy.
3. Group therapy.
4. Alcohol/drug screening counseling.
5. Service planning.
6. Discharge planning.

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

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

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.1 Specialty Provider Type (871) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: • HF (SUD) (first position) • U1 (second position) For special connections ONLY: HD (third position).
Place of service: RSATF (55).	

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

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

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

Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.3 services are as follows:

- First position: HF
- Second position: U3 Special Connection services use an additional modifier
- Third position: HD room and board is billed separately to the Office of Behavioral Health or their designee

Example activities:

This per diem could include services such as:

1. SUD assessment.
2. Individual and family therapy.
3. Group therapy.
4. Alcohol/drug screening counseling.
5. Service planning.
6. Discharge planning.

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.3 Specialty Provider Type (872) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

Program service categories:

- HF (SUD) (first position)
 - U3 (second position)
- For special connections ONLY: HD (third position).

Place of service: RSATF (55).

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

CPT/HCPCS Procedure Code: H2036.

Procedure code description: Alcohol or other drug treatment program, per diem.

Service description: 24-hour supportive treatment environment to assist with the initiation or continuation of a patient's recovery process. Daily clinical services are provided as outlined in an individualized treatment plan to address the member's needs.

Minimum documentation requirements

Technical documentation requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF.

Service content: Shift notes or daily note (summary of shift notes).

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

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

Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.5 services are as follows:

- First position: HF
- Second position: U5 Special Connection services use an additional modifier
- Third position: HD room and board is billed separately to the Office of Behavioral Health or their designee

Example activities:

This per diem could include services such as:

1. SUD.
2. Individual and family therapy.
3. Group therapy.
4. Alcohol/drug screening counseling.
5. Occupational therapy.
6. Recreational therapy.
7. Vocational therapy.
8. Service planning.
9. Discharge planning.

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

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

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.5 Specialty Provider Type (873) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

Program service categories:

- HF (SUD) (first position)
- U5 (second position)

For special connections ONLY: HD (third position).

Place of service: RSATF (55).

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

CPT/HCPCS procedure code: H2036.

Procedure code description: Alcohol or other drug treatment program, per diem.

These services will also be billed using revenue code 1000 by hospitals (general or specialty).

Service description: Inpatient services for patients whose medical, cognitive or psychiatric problems are so severe that they require inpatient care but do not require the full resources of an acute care general hospital. Services offered include physician monitoring, nursing care and observation. 24-hour professionally directed evaluation, care and treatment services are available.

Minimum documentation requirements

Technical documentation requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF.

Service content: Shift notes or daily note (summary of shift notes).

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

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

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

Notes: Procedure code H2036 is used to bill for ASAM level 3.1, 3.3, 3.5, and 3.7 services. Modifiers will be used to distinguish between these levels of care. Modifiers used for level 3.5 services are as follows:

- First position: HF
- Second position: U7 Special Connection services use an additional modifier
- Third position: HD room and board is billed separately to the Office of Behavioral Health or their designee

Example activities:

This per diem could include services such as:

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

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid under the 3.7 Specialty Provider Type (874) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

Program service categories:

- HF (SUD) (first position)
 - U7 (second position)
- For special connections ONLY: HD (third position).

Place of service:

- RSATF (55)
- Inpt Hosp (21)
- Inpt PF (51)

**SUD Residential Treatment – Clinically Managed Residential Withdrawal Management: ASAM level 3.2WM
(formerly referred to as Social Detox)**

CPT/HCPCS procedure code: H0010

Alcohol or drug services, acute detoxification (residential addiction program inpatient).

Service description: An organized clinical service that provides 24-hour structure, support and supervision for patients who are intoxicated or experiencing withdrawal symptoms. Services are supervised by a qualified medical professional who must be available by telephone or in person 24 hours per day.

Minimum documentation requirements

Technical documentation requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF.

Service content: Shift notes or daily note (summary of shift notes).

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

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

Notes: Procedure code H0010 should be used with the HF modifier.

First position: HF

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

Example activities:

This per diem could include services such as:

1. SUD assessment.
2. Physical examination.
3. Individual and group therapy.
4. Peer recovery support services.
5. Medical and nursing care, including daily medical evaluation.
6. Medication management and administration.
7. Health education.
8. Service planning.
9. Discharge planning.

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

SUD Residential Treatment – Clinically Managed Residential Withdrawal Management: ASAM level 3.2WM (formerly referred to as Social Detox)

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid as under the 3.2WM Specialty Provider Type (875) and SUD Clinic Provider Type (64). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.	Program service categories: HF (SUD) (first position).
Place of service: • CMHC (53) • Outp hospital (22) • Independent clinic (49)	

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

CPT/HCPCS procedure code: H0011 These services will be billed as revenue code 1002 by hospitals (general or specialty).	Alcohol or drug services; acute detoxification (residential addiction program inpatient).
Service description: Inpatient care in which services are delivered by medical and nursing staff to address a patient’s withdrawal from substances. 24-hour observation, monitoring and treatment are available.	Minimum documentation requirements Technical documentation requirements: See Appendix B of the Provider Manual for Residential and Inpatient SUD Services from the Department of HCPF. Service content: Shift notes or daily note (summary of shift notes). 1. Patient’s current clinical status, (e.g. symptoms or pertinent mental status and functioning status). 2. Participating in treatment. 3. Pertinent physical health status information. 4. Progress toward treatment/service plan goals or discharge. 5. Any other patient activities or patient general behaviors in milieu. 6. The therapeutic intervention(s) used and the individual’s response to the intervention(s). All individual and group services, provided by residential staff, (e.g. skills training group, individual therapy, med administration services should be identified separately). These services can all be included in the same documentation as the daily/shift notes or in a separate note. Refer to appropriate service procedure code minimum documentation for each service.

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

Notes: Procedure code H0011 should be used with the HF modifier.

First position: HF.

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

Example activities:

This per diem could include services such as:

1. SUD assessment.
2. Physical examination.
3. Individual and group therapy.
4. Peer recovery support services.
5. Medical and nursing care, including daily medical evaluation.
6. Medication management and administration.
7. Health education.
8. Service planning.
9. Discharge planning.

Applicable population:

- Child (0-11 years)
- Adolescent (12-17 years)
- Young adult (18-20 years)
- Adult (21-64 years)
- Geriatric (65+ years)

Unit: Day

Duration:

- Min: N/A
- Max: 24 hours

Facility type: Facility must be licensed by the Colorado Department of Human Services, Office of Behavioral Health and enrolled with Medicaid as under the 3.7WM Specialty Provider Type (876) and SUD Clinic Provider Type (64) or as a hospital (general or specialty). Refer to the Provider Enrollment Manual for enrollment requirements and procedures.

Program service categories: HF (SUD) (first position).

Place of service:

- RSATF (55)
- Inpt hospital (21)
- Inpt PF (51)

Physical, occupational and speech therapy

Rocky Mountain Health Plan Individual and Family Plan physical therapy/occupational therapy/speech therapy

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

Rocky Mountain Health Plan PRIME physical therapy/occupational therapy/speech therapy

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

CHP+ physical therapy/occupational therapy/speech therapy

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

Home health services

Individual and Family Plan/CHP+

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

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

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

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

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

Rocky Mountain Health Plan PRIME – What is covered?

RMHP PRIME home health services are covered without prior authorization.

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

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

When is it covered?

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

How long is it covered?

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

What is the required documentation?

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

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

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Protection Act (TCPA) Opt Out form**. The Provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and it will be processed within 10 business days and your phone number will be removed from the do not call registry. For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24 hours, 7 days a week from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit UHCprovider.com/contactus.

Chapter 2: Claims

Forms and filing requirements

Claim forms

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

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

Mail claims to:

UnitedHealthcare Individual and Family Plans

P.O. Box 5290
Kingston, NY 12402-5290

**UnitedHealthcare Community Health
UnitedHealthcare Regional Accountable
Entities (RAE)**

UnitedHealthcare PRIME
P.O. Box 5260
Kingston, NY 12402-5260

Claim filing requirements

How to file a claim

All participating care providers must submit claims in accordance with their contractual requirements.

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

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

Payment and reimbursement policies

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

Electronic submission

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

Advantages of transmitting claims electronically:

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

Hospital/obstetric claims

Please bill obstetric (OB) claims for all CHP+ and Individual Exchange member's (with the exception of PRIME) as 2 separate claims: the member's claim(s), and the baby's claim(s).

The CHP baby claim will be processed under the baby's ID if the baby has been enrolled in the RMHP CHP program. The Individual Exchange well baby claim will be processed under the mother's ID. If the member is discharged, and the baby remains an inpatient, submit a new claim for the baby's entire stay under the baby's member number. The admission date on the baby's claim should be the baby's date of birth.

Lab charges – billing guidelines

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

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

See CLIA Regulations for additional information or visit their website at [fda.gov/medical-devices/ivd-regulatory-assistance/clinical-laboratory-improvement-amendments-clia](https://www.fda.gov/medical-devices/ivd-regulatory-assistance/clinical-laboratory-improvement-amendments-clia).

Hospitals

Hospitals acting as a reference laboratory or conducting diagnostic testing for non-patients cannot bill for such non-patient diagnostic laboratory tests under that hospital's facility Participation Agreement.

Hospitals wishing to participate in a UnitedHealthcare commercial network as a reference laboratory may apply with UnitedHealthcare to be credentialed and contracted as a reference laboratory.

To contract your hospital as a reference laboratory, please contact your network representative to begin the credentialing and contracting process.

Payments for medical services

RMHP contracting care providers will accept the amount of reimbursement agreed to in the contract for each procedure or service as full payment. The RMHP member cannot be billed for the difference, if any, between the billed amount and the amount allowed. The care provider may bill the RMHP member for noncovered services or specialty services such as personal convenience items. Payment for services may be collected from or billed to RMHP PRIME member only if the specific service rendered is not covered by Medicaid.

In this situation, the department requires that care providers obtain a statement prior to service, signed by the Medicaid member, acknowledging that the specific service is not a Medicaid-covered benefit and agreeing to pay.

Payment errors

Duplicate payments or payment errors should be reported to Member Services immediately, at [UHCprovider.com/payment](https://uhcprovider.com/payment). It is the policy of RMHP to retract credited amounts from the care provider remittance.

Care provider remittance

Electronic funds transfer registration

Payments are administered through Optum Pay®. To learn more about Optum Pay visit providerexpress.com > Admin Resources > Claim Tips > Optum Pay.

Please note: RMHP PRIME claims for Medicare denied, non-covered or exhausted benefits are not considered Medicare crossover claims and must be filed within 120 days of the date of service or 60 days after the Medicare denial. In some instances, there may be enrollees with dual coverage under RMHP PRIME and an Individual and Family Plan plan. Those claims will also be coordinated and be reported as 2 claims.

Surgery guidelines

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

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

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

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

RMHP will follow guidelines within the clinical editing program. These are based on a combination of Medicare guidelines and recommendations by the American College of Surgeons.

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

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

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

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

Spanning year end

Outpatient claims that span the calendar year should be split accordingly. Please do not submit a claim that includes both December and January dates-of-service.

Timely filing limit

Timely filing limits are designated in each provider's specific agreement. Nonparticipating timely filing limit is 365 days.

Rocky Mountain Health Plan PRIME timely filing limit

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

- Standard RMHP PRIME claims – 120 days, if not specified in provider's agreement. Nonparticipating timely claims limit is 365 days.
- If a member's eligibility is backdated, timely filing is 120 days from the date the enrollee is added to the eligibility system. Eligibility must be verified using the department's website. A letter from the county Department of Human Services or Single Entry Point verifying backdating must accompany the claim.

Electronic process for claim correction

- Submit corrected claims electronically as an EDI 837 transaction with the appropriate frequency code. For more details, go to UHCprovider.com/ediclaimtips > Corrected Claims.

- Use the claims tool in the **UnitedHealthcare Provider Portal** to resubmit corrected claims that have been paid or denied
- If you received a letter asking for additional information, submit it using the claims tool in the UnitedHealthcare Provider Portal
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, replacement of prior claim. Do not submit corrected or additional charges using bill type xx5, late charge claim
- When correcting or submitting late charges on a 1500 professional claim, use the following frequency code in Box 22 and use left justified to enter the code. Include the 12-digit original claim number under the Original Reference Number in this box.
 - Frequency code 7 replacement of prior claim: Corrects a previously submitted claim
 - Frequency code 8 void/cancel of prior claim: Indicates this bill is an exact duplicate of an incorrect bill previously submitted. This code will void the original submitted claims.

Refunding Rocky Mountain Health Plans

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

When refunding RMHP for claims overpayments, please submit the full overpayment, for unsolicited overpayment refunds, please submit this form with your refund, so we can properly apply the check and record the receipt. If a check is included with this correspondence, please make it payable to UnitedHealthcare and submit it with any supporting documentation. Solicited overpayment refunds can be submitted electronically through Optum at UHCprovider.com/content/dam/provider/docs/public/claims/Claims-Overpayment-Refund-Form.pdf.

Request for reconsideration

Claims reconsideration and appeal process

If you disagree with a claim reimbursement decision, you can challenge it by providing comments, documents or other information to explain why you think the decision should be changed. You can submit a claim reconsideration request through the UnitedHealthcare Provider Portal:

- Go to UHCprovider.com and click Sign In at the top-right corner
- In the menu, select claims & payments > look up a claim and enter your search criteria
- Find your claim and click on the claim number to see details
- Scroll down to the act on a claim section and select explore available actions. Select claim lines > click next > select create a reconsideration (if available) > click next
- Complete the fields, attach supporting documents and submit. For step-by-step training, visit our claims interactive guide.

If electronic submission isn't possible, use the following form found at UHCprovider.com/content/dam/provider/docs/public/claims/UHC-Single-Paper-Claim-Reconsideration-Form.pdf. This form is for submitting 1 claim at a time, not for bulk or multiple claims.

Claims involving other insurance

Coordination of benefits

Sometimes an RMHP member may have other insurance coverage. Regarding coordination of benefits (COB), examples include a group policy through their spouse's employer. Examples for third-party liability (TPL) include on-the-job injuries that may be covered by workers' compensation, and auto-related injuries covered by automobile insurance.

Double coverage

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

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

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

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

Injuries – auto-related

RMHP will coordinate benefits against any "medical payments" and uninsured/underinsured coverage that may be available to our members for claims sustained as a result of an automobile accident. All medical claims subrogation is administered by Optum For all automobile accident-related claims, RMHP requires automobile insurance and accident information from our members.

Injuries – on-the-job

Colorado employers must provide workers' compensation coverage. RMHP cannot consider claims for services related to on-the-job illness or injuries. This includes aggravation of existing conditions as a result of working, unless they are denied by workers' compensation.

If you have any doubt about whether the claim may be work-related, please notify our TPL team so additional research can be performed.

Injury – other accidents

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

Occasionally there may be a lawsuit filed in these cases resulting in a member being compensated for their injuries and being reimbursed for medical expenses. If you are aware the member has contacted an attorney and plans to file suit, please notify RMHP so we can contact the insurance company and the attorneys involved as soon as possible. A sample of the injury information form is available at [UHCprovider.com](https://www.uhcprovider.com).

Other coverage

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

Chapter 3: Appeals and grievances

Individual and Family Plans

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

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

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

PRIME, RAE and CHP+

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

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

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

RMHP RAE, PRIME, and CHP+ members have the right to file a complaint about access to behavioral health care. The member's health plan is subject to the Mental Health Parity Addiction Equity Act of 2008.

This means that the member's covered behavioral health benefits cannot be more difficult to access than physical health benefits. A denial, restriction, or withholding of behavioral health services could be a potential violation of the parity act. To file a complaint with the Behavioral Health Ombudsman Office of Colorado with a parity concern, please contact Behavioral Health Ombudsman Office of Colorado:

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

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

Section A. Appeal a decision

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

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

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

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

First level review

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

Expedited (fast or quick) review

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

State fair hearing/state review

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

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

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

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

- An RMHP care provider must have ordered the services. The member or DCR must tell RMHP if they want to keep getting services within 10 days of the notice of the appeal decision. Care providers may not ask to have benefits continued while the state fair hearing is being reviewed.
- If the member loses the appeal, the member will have to pay for the care they received

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

Section B. File a grievance

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

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

- **IFP:**
 - Member Portal
 - Fax: 1-888-404-0949
 - Mail: P.O. Box 6111
MS CA-0197
Cypress, CA 90630
- **PRIME, RAE, and CHP+:**
 - Member Portal
 - Standard fax: 1-801-994-1082
 - Urgent fax: 1-801-994-1261
 - Mail: P.O. Box 31364
Salt Lake City, UT 84131-0364

Here are some things a member can complain about:

- The member is unhappy with their doctor, clinic, or any RMHP care provider
- The member cannot find a doctor or get in to see their doctor
- The member has a problem with RMHP Member Services
- The member is unhappy with how their doctor took care of them

- The member feels they have been treated in a different way by RMHP or one of its care providers. This could be because of race, color, national origin, disability, sex, sexual orientation or gender identity.
- The member is unhappy because a care provider or RMHP employee was rude to them

How grievances are handled

The member or DCR may call or write to file the grievance at any time. There is no deadline to file a grievance. In 2 working days, RMHP will notify the member in writing acknowledging RMHP received the member's grievance. RMHP will review the grievance and send a response within 90 working days of the day the grievance was received. RMHP may respond to the grievance sooner than 2 working days. If this happens, the member will not receive a separate letter telling them that RMHP received the grievance.

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

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

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

Quality of care grievances

All grievances that have anything to do with the care experience are investigated as a quality of care grievance and follow the procedure and timeline noted for grievances.

For care providers wanting to submit a possible quality of care concern, you can find the referral form at [UHCprovider.com](https://www.uhcprovider.com) > Tools and resources > Forms > Provider forms.

Section C. State fair hearing/ state review

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

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

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

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

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

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

The member has the right to:

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

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

Care provider appeal

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

Examples of care provider appeals: please note this is not an exclusive list.

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

How to request a care provider appeal

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

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

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

Any request received from the care provider that is not a written request will be returned to the care provider with a request to complete the care provider dispute resolution form.

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

Care provider notification

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

In the event the determination is not in favor of the care provider, written notification will be sent to the care provider.

The notification shall include the principal reasons for the determination.

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

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

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

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

Levels of appeal

First level – informal review

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

Second level – review appeal

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

Arbitration

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

Face-to-face

If a care provider requests to present their rationale for the dispute resolution in person, the care provider must contact the provider dispute resolution coordinator to initiate the process.

The care provider dispute resolution coordinator will coordinate with the care provider relations department manager and based on the nature of the appeal, the appropriate departments and representatives will be selected to participate in the dispute process.

Benefits questions

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

Representatives filing appeals for enrollees

Individuals who represent enrollees may either be appointed or authorized. (For purposes of this manual [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as “representatives.”)

An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney or any physician) to act as their representative and file an appeal on their behalf.

Also, a representative (surrogate) may be authorized by the court or act in accordance with state law to file an appeal for an enrollee. A surrogate could include, but is not limited to, a court-appointed guardian, an individual who has durable power of attorney, a health care proxy or a person designated under a health care consent statute.

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

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

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

Chapter 4: Rocky Mountain Health Plan

PRIME, RAE, and CHP+

Regional Accountability Entity

RMHP is the Regional Accountability Entity (RAE) for 34 counties in Colorado. The RAE administers the behavioral health benefit and coordinates care for members for all services. RMHP also acts as the administrative services provider for NHP RAE Region 2, please refer to **page 9** for more information.

Behavioral health providers will bill the RAE to whom the Member is assigned. All other services are billed to State Fee for Service (Health First Colorado), with the RAE supplying the primary care network.

COMING SOON quality measurement Provider Performance Quality Measurement (PPQM)/ Electronic Data Warehouse (EDW). We will provide PPQM and EDW support as needed.

First Health Colorado Prescriber Tool

The Prescriber Tool is a multi-functional platform accessible to prescribers through most electronic health record (EHR) systems. It provides patient-specific benefit and cost information to prescribers at the point of care and eases administrative burden and rework for prescribers while improving service to patients as well. The first Health Colorado Prescriber tool can be found at hcpf.colorado.gov/prescriber-tool-project.

Value- Based Payment Models/ Alternative Payment Models

RMHP offers a variety of Value Based Payment Models for qualifying providers. The Prescriber Tool Alternative Payment Model (APM) is an upside-risk-only program designed to increase consistent use of the Prescriber Tool, specifically the Real-Time Benefits Inquiry (RTBI) module, and prescription of preferred medications where clinically appropriate.

For more information contact our clinical quality improvement (practice transformation) team at hcpf_pharmacyapm@state.co.us.

RAE 1 offers comprehensive support to our providers for accessing and utilizing the Health First Prescriber Tool and its associated alternative payment model. The clinical program manager team is also available for one-on-one meetings with our care provider partners. These meetings are designed to address any questions or concerns regarding the HCPF Prescriber Tool. In addition to direct support, RAE 1 utilizes the CQI Newsroom to provide updated trainings and resources. This ensures that our care providers are always informed about the latest developments and best practices.

Rocky Mountain Health Plan PRIME

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

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

In-network services

All members should select a PCMP/PCP as their medical home. Members of the RMHP PRIME network are able to obtain consultation and treatment from in-network specialist physicians and mid-level care providers without a referral from the PCMP/PCP.

The member must be eligible to receive services through RMHP at the time services are provided and the services that the member receives must be covered services as specified in the RMHP PRIME Member Handbook.

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

Members may obtain covered services from out-of-network/out-of-plan care providers at the in-network benefit level, subject to obtaining RMHP's approval.

Such approval shall be in a timely manner relative to the member's condition. Such services include those in which:

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

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

Early and Periodic Screening, Diagnostic and Treatment

Through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program RMHP works closely with the state of Colorado to ensure all RMHP PRIME and RAE enrolled children and youth, from birth through age 20 and adults who are pregnant receive the appropriate screening, diagnosis, treatment and immunizations needed to develop or maintain a healthy life. This is a benefit program designed to enhance primary care, with emphasis on prevention, diagnosis and timely treatment.

The program includes periodic screenings for children and youth, which are often included in "well-child exams." These exams are the foundation of the EPSDT program, and RMHP encourages all PCMP care providers for RMHP PRIME and RAE enrolled children and youth to participate in the program.

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

RMHP has developed and annually updates the EPSDT guidebook for care providers. This annual publication is distributed each fall but is available on the RMHP website for reference at any time. Colorado has adopted the American Academy of Pediatrics Bright Futures periodicity schedule for screening services. The frequency of the periodic screening is as follows:

Infancy periodicity schedule

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

Early childhood periodicity schedule

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

Middle childhood periodicity schedule

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

Adolescence periodicity schedule

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

Comprehensive screening must include:

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

It is imperative that EPSDT screenings are coded properly to reflect accurately the services delivered. RMHP captures and reports data based on your accurate coding. If you have any questions, please refer to the Health First Colorado website to locate the EPSDT billing manual.

Once in the state's website:

- Select "For our providers" from the horizontal tool bar at the top of the page
- Select "Provider Services"
- Select "Billing manuals"
- Once in "Billing manuals" select CMS 1500 and scroll down to EPSDT
- Click on the hyperlink to allow popups in your browser, if needed
- The complete EPSDT manual will appear

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

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

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

Vaccines for Children program

RMHP does not reimburse for PRIME member (ages 18 and under) vaccines as they are available through the Vaccines for Children (VFC) program. The state of Colorado, Department of Public Health and Environment, supplies care providers with free vaccine for their Medicaid patients.

This program is open to all care providers who have completed the necessary paperwork. RMHP reimburses care providers for the administration of each state-supplied vaccine.

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

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

Health First Colorado sterilization consent

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

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

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

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

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

A copy of this form is available at our website, [UHCprovider.com](https://uhcprovider.com), as well as colorado.gov/pacific/hcpf/provider-forms.

Rocky Mountain Health Plan PRIME copay

Effective July 1, 2022, RMHP PRIME members do not have copays for any medical or behavioral health services.

RMHP PRIME copay summary

Service	Copayment
Physician office visit	No copay.
Hospital	
Emergency room	
Lab work	
X-ray	
Durable medical equipment	No copay.
Second opinions	
Mental health and substance use disorder services	
Pharmacy - generic drugs	No copay.
Pharmacy - brand-name drugs	No copay.

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

Wrap-around services

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

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

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

More information about these wrap-around services can be found in the [PRIME member handbook](#) and in Colorado Medicaid Rules and Regulations. The member handbook also includes information about how to access these services. Wrap-around services include, but not limited to the following:

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

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

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

- Delta – 1-970-874-2030
- Garfield – 1-970-625-5282
- Gunnison – 1-970-641-3244
- Larimer - 1-970-498-7000
- Mesa – 1-970-241-8480
- Montrose – 1-970-252-5000
- Morgan - 1-970-542-3530
- Ouray – 1-970-626-2299
- Pitkin – 1-970-920-5235
- Rio Blanco – 1-970-878-9645
- San Miguel – 1-970-728-4411
- Sedgwick- 1-970-474-3397
- Yuma - 1-970-332-4877

Rocky Mountain Health Plan timely filing limit

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

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

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

CHP+

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

Members who are women have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.

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

In-network services

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

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

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

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

In each of these cases, RMHP will arrange for authorization of services from a provider with the necessary expertise and ensure that the member obtains the same benefit level as if the benefit was obtained from a plan care provider. Refer to the continuity of care section for specific parameters.

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

CHP+ copay summary

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

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

Regional Accountable Entity behavioral health telemedicine

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

RMHP behavioral health telemedicine guidelines:

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

Care provider requirements

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

In addition, care providers should:

- Be consistent with directives from the Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMSHA), health services that are not urgent should be postponed where possible. Care providers should weigh potential benefits from rendering needed care against the potential weakened validity and reliability of assessment results if choosing to conduct testing by telemedicine or virtual visit care.

- Ensure the integrity of the psychometric properties of the tests or assessment procedures used to include:
 - Modifying the test environment as necessary to prevent access to cell phones, the internet or coaching from other persons during administration
 - Minimizing any potential distractions which could affect performance
- Ensure that additional consideration are given to issues that arise with testing diverse populations that could further lower reliability and validity of scores due to changes in administration procedures and the test environment
- Ensure the quality of the technologies being used and the hardware requirements needed are considered prior to starting testing—consideration should be given to the availability of backup technologies should technical problems be encountered during administration
- Use HIPAA-approved telemedicine technologies as well as temporarily allowed popular applications that allow for video chats to provide telemedicine in accordance with the OCR Notice. Notify patients that telemedicine applications potentially introduce privacy risks, and care providers should enable all available encryption and privacy modes when using such applications.
- Ensure that documentation of the following issues are included in the member record:
 - Potential difference in obtained scores due to telemedicine administration
 - Any accommodations or modifications that were made to standard administration procedures, and
 - Potential limitations of all assessment results or conclusions when test norms used for interpretation are not based on a telemedicine administration

Care providers are responsible for using a HIPAA-approved telemedicine technology platform that allows asynchronous communication with video. Care providers will continue to be responsible for ensuring compliance with all local, state and federal regulations for the delivery of services through a telemedicine modality (including but not limited to rules and regulations from HCPF, Office of Behavioral Health, Colorado Division of Insurance, CDC, SAMSHA and CMS).

3. Billing and coding guidance:

- Care providers are required to abide by all Medicaid billing and coding policy as outlined in the State Behavior Health Services Manual (SBHS) manual and requires all services billed in accordance with the SBHS, including services delivered through telemedicine. In addition, the following claim guidance must be followed to receive a reimbursement and to allow identification of services as provided through telemedicine during the COVID-19 State of Emergency:
 - CMS 1500 professional claims: Place of Service code 02 or 10 must be indicated on all CMS 1500 professional claims for telemedicine; All codes outlined in the SBHS are allowed with the exception of those codes listed as follows in the Telemedicine Services Exception Code table
 - UB-04 institutional claims: The GT modifier must be appended to the UB-04 institutional claim form with the service’s procedure code
- Care providers may only bill procedure codes which they are already eligible to bill per their contract and not outlined in the below Telemedicine Services Exception Code table

4. Medical record standards and documentation:

- Care providers must obtain and document the member’s consent to receive services through telemedicine prior to rendering services
- Clinical records must be maintained in a timely and accurate manner, ensuring effective and confidential member care and quality review. RMHP will continue to monitor medical records, claim submissions and compliance to policies and procedures to ensure quality patient care is achieved through behavioral health services.

Telemedicine services exception codes

Code	Description
90870	Electroconvulsive therapy.
99217	Observation care discharge day management.

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

Code	Description
99253	Inpatient consultation for new or established patient (55 min.)
99254	Inpatient consultation for new or established patient (80 min.)
99255	Inpatient consultation for new or established patient (110 min.)
99281	Emergency department visit, focused.
99282	Emergency department visit, expanded, low complexity.
99283	Emergency department visit, expanded, moderate complexity.
99284	Emergency department visit, detailed.
99285	Emergency department visit, comprehensive.
G0176	Activity therapy, such as music, dance, art or play therapies (45 min or more).
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems.
H0017	BH residential without room/board.
H0018	BH short term res without room/board.
H0019	BH long term res without room/board.
H0020	Methadone admin/service.
H0033	Oral med admin direct observation.
H0035	MH partial hospitalization less than 24 hr.
H0036	Community psychiatric supportive treatment, face to face, per (15 min).
H0037	Community psychiatric treatment, per diem.
H0043	Supported housing, per diem.
H0044	Supported housing, per month.

Code	Description
H0045	Respite care services, not in the home, per diem.
H2001	Rehab program 1/2 day.
H2030	Mental health clubhouse per (15 min.)
H2031	Mental health clubhouse per diem.
H2032	Activity therapy per (15 min.)
S3005	Performance measurement, depression.
S5150	Unskilled respite care, not hospice; per (15 min.)
S5151	Unskilled respite care, not hospice; per diem.
S9485	Crisis intervention mental health services, per diem.
T1005	Respite care service (15 min.)

Chapter 5: Utilization and care management

About utilization and care management - philosophy and purpose

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

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

Annual evaluation

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

Staff availability

RMHP staff are available during normal business hours Monday–Friday, 8 a.m.–5 p.m. for calls, faxes and secure emails including UM and CM issues. Behavioral health UM and CM staff are available after hours 24/7, please call **1-800-346-4643**, option 6. You may also make arrangements in advance to speak to CM staff after normal business hours by calling your care provider relations representative at **1-970-244-7798**, option 4.

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

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

Confidentiality

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

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

Goals and objectives

The UM and CM program goals and objectives:

- Promote quality of care for all RMHP members
- Facilitate access and delivery of care at the appropriate level, using resources relevant to the individual needs of members
- Identify over/underutilization of health care resources

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

Liability

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

Medical records

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

Delegated activities

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

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

An evaluation of the delegated UM activities is performed prior to delegation and the signing of the contract and then at least annually by reviewing and approving the delegated agency's UM program. Reports with specific UM data will be analyzed at least semi-annually. All other necessary data for tracking purposes will be extracted from the RMHP database as needed.

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

Collaboration with quality improvement

RMHP maintains its tradition and commitment to constantly seeking improvement of the quality of care and level of services for our members.

To request a copy of the quality improvement program description, the quality improvement work plan, as well as performance of the quality improvement program, please contact the RMHP quality improvement team by calling **1-970-263-5552** or **1-855-830-1565**.

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

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

Use of clinical practice guidelines

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

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

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

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

Review activities

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

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

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

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

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

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

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

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

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

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

- Admission and continued stay review for medical necessity
- Appropriateness of setting, severity of illness/intensity of service
- Potential case management referrals
- Identified quality management issues
- Medical appropriateness of services

- Extended lengths of stay
- Some behavioral health services and admissions
- Potential quality of care issues, e.g. adverse events, are referred to and are investigated thoroughly by the quality improvement process

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

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

UM provides a framework for managing and monitoring the utilization of resources to maximize the effectiveness of care provided to our members. The UM program includes prospective review, concurrent review, retrospective review, case management, quality improvement, disease state management referral and monitoring of physician under-/over-utilization. The program consists of those activities that focus on ensuring quality of care, evaluation of appropriateness and efficacy of health care services, and evaluation of appropriate level of services. All UM processes are performed to evaluate the medical necessity and medical appropriateness of health services, procedures, quality of care and level of care.

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

Review criteria

Professional medical judgment guides all aspects of health care delivery and management. RMHP's UM and CM teams consist of registered nurses and behavioral health practitioners, supported by the CMO and associate medical directors, to review care across all settings. All RMHP medical directors and the CMO have a medical license, without restrictions.

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

If InterQual or other evidence-based criteria do not address a particular area, RMHP utilizes other nationally established criteria in making determinations. UnitedHealthcare clinical guidelines are based on literature evidence.

If no nationally established criteria are available, UnitedHealthcare develops medical guidelines and policies through the Medical Technology Assessment Committee (MTAC).

Provider/practice performance for adherence is monitored through multiple mechanisms. If care providers are identified as requiring further analysis, RMHP will conduct a care provider specific medical record review to include an assessment of adherence to specified clinical practice guidelines. The primary function of MTAC is to utilize a systematic approach in the review of new health care technologies and the new application of existing technology, including medical procedures, behavioral health procedures and devices for inclusion in benefit plans. The local delivery system is evaluated to determine availability of services at sub-acute facilities and home care to support the patient after discharge, the ability of the local acute hospitals to provide all recommended services within the estimated length of stay and availability of behavioral health services and community resources. The local delivery system and practitioner practice patterns also are considered in the adoption of criteria for procedures performed in the outpatient setting.

The InterQual criteria, UnitedHealthcare medical guidelines/policies and ASAM criteria are reviewed and updated at least annually by the CMO and associate medical directors. RMHP involves appropriate, licensed practitioners with professional knowledge of clinical expertise in the relevant area when developing, adopting and reviewing clinical policies used by RMHP or delegated entities in UM decision-making. InterQual criteria, EviCore policies and UnitedHealthcare policies and updates are reviewed annually by MTAC and these updates are provided to the UM department.

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

Rocky Mountain Health Plans

Attn: Care Management

P.O. Box 10600

Grand Junction, CO 81502-5600

Utilization management

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

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

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

Examples of specific components of the evaluation process include:

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

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

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

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

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

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

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

Utilization management decision-making

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

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

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

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

Scope of activities

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

Unfair discrimination

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

Affirmative statement

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

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

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

Care management

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

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

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

In addition, we offer:

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

RMHP offers formal CM programs in the following areas:

• **Oncology case management**

A specially trained nurse provides support and coordinates services that help your patients better understand their treatment plans

• **Special needs case management**

Our nurse case manager's help your RMHP PRIME patients and their families negotiate the health care system by improving continuity of care and facilitate communication

• **Catastrophic case management**

Patients experiencing a catastrophic event can become overwhelmed. Our nurse case managers will work with you and your members to develop a comprehensive and coordinated approach to their care.

• **High-risk OB case management**

Qualified RNs assist you with coordination of care to ensure member receives adequate support, education and resources to minimize risk during pregnancy and the postpartum period

• **Transplant case management**

The program is designed to reinforce the care and treatment you provide to your patients. The focus of this program is to educate and help your patients take a more active and responsible role in managing their health.

Additional coordination and continuity of care

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

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

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

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

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

A continuity of care request can only be granted when:

1. The care provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to RMHP for that member as provided in the original care provider contract, or by the new payment and terms agreed upon and executed between the care provider and RMHP.

2. The care provider agrees in writing not to seek any payment from the member for any amount for which the member would not have been responsible if the care provider were still a participating care provider.
3. Any decisions regarding continuity of care are subject to the internal and external member appeal procedures as set forth in the evidences of coverage.

To request case management for a member:

- Call RMHP case management referral line at **1-970-248-8718** or **1-800-793-1339**
- You may also call Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE or **1-877-668-5947** for CHP+ and ask for a case manager, or
- Send an email to RMHPCareManagementReferrals@uhc.com to request a case manager

Disease management programs

RMHP offers comprehensive disease management (DM) program for its members to promote self-management skills, provide disease-specific education, and encourage communication between member and provider. RMHP currently offers a Diabetes Disease Management programs targeting all RMHP members with diabetes who are referred in to the program. RMHP actively outreaches members with newly diagnosed diabetes to offer the program.

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

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

Goals of disease management program

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

Measurement and reporting

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

Clinical guidelines and tools are available on the RMHP website.

Member outreach

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

Communication with care providers

During each intervention with the member the RN health educator reinforces the importance of regular and appropriate communication with their health care provider.

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

Guidelines for communicating with treating provider:

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

Notification of admission

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

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

For members of RMHP PRIME, CHP+ and individual and family plans, prior authorization is required for any services provided by nonparticipating care providers; prior authorization is not required by nonparticipating care providers for medical emergencies and urgent care services or specified codes on the behavioral health prior authorization list.

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

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

To expedite the review process, please include medical records to justify the reason for requesting approval to obtain services from a nonparticipating care providers.

Chapter 6: Prior authorization and notifications

Prior authorization policies and procedures

The physician's/care provider's staff may request prior authorization online by answering a few questions regarding your patient's condition and obtain a response regarding approval or denial. Submit requests online at [UnitedHealthcare Provider Portal](#). If you haven't received training, log in to learn how to sign up.

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

To gain access to submit prior authorization requests through the UnitedHealthcare Provider Portal, send an email to RMHPEssetteSupport@uhc.com.

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

If you currently do not have access to the [UnitedHealthcare Provider Portal](#), please contact Provider Services. Once you have access, you can submit authorizations online.

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

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

The decision to deny or reduce the services requested will be made by a health care professional with the appropriate clinical experience in treating the member's condition.

- Please note: RMHP will not be financially responsible for services if the patient is not eligible on the treatment date or if the member has not been properly prior authorized for the services. RMHP will make reasonable efforts to verify a member's eligibility in advance of the treatment date.
- Prior authorization policies and procedures are subject to change. Criteria used in decision-making are available, free of charge, to physicians, practitioners, facilities and members can be found at [UHCprovider.com/policies](https://uhcprovider.com/policies), or upon request to RMHP by calling Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE or **1-877-668-5947** for CHP+. Call a CM nurse with any questions regarding clinical criteria.
- Advanced imaging procedures performed within Colorado, must be made through eviCore online at evicore.com or by telephone at 1-800-792-8750.
- Genetic testing for PRIME, RAE and CHP+ must be submitted through eviCore online at evicore.com or by telephone at 1-800-792-8750.
- Genetic testing for individual and family plans must be submitted at [UnitedHealthcare Provider Portal](#).
- Radiation oncology prior authorizations are managed by the cancer guidance program, please login to [UnitedHealthcare Provider Portal](#) and follow the prompts to be routed to MBMNow to submit.

Specific behavioral health requests require completion of specific behavioral health prior authorization form. Please see commonly used forms for care providers at [UHCprovider.com/priorauth](https://uhcprovider.com/priorauth). To submit a behavioral health service prior authorization request for RMHP Individual and Family Plan and CHP+ members:

- Email all clinical notes and requests to rmhpbhvm@uhc.com
- Fax all clinical notes and requests to 1-888-240-2689
- Contact RMHP at **1-855-886-2832** for hospital notification

Guidelines and responsibilities of care providers

Care providers must follow the prior authorization guidelines. All out-of-plan services that are nonemergent must be authorized by RMHP prior to service being rendered for RMHP PRIME, CHP+, RAE 1, RAE 2 and HMO members. It is the responsibility of the care provider to verify eligibility and limitation of benefits. The care provider must also verify coordination of benefits for members with other insurance.

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

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

Helpful hints for the prior authorization process – office staff

Please use the [UnitedHealthcare Provider Portal](#). If you haven't received training, log in to learn how to sign up.

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

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

- **Use of a surgical assist**
Specify if an M.D. or non-M.D. assist will be used and provide the assistant's name or group affiliation and tax ID
- **Use of intraoperative neuromonitoring**
Specify both the physician and the technician who will perform this service, including tax ID
- **Clinical information**
Submit clinical information with every prior authorization request: include what treatment has been provided to the member including medications, lab results, radiology imaging reports or past and current therapies in progress, and the proposed plan for the member.

When requesting prior authorization for a diagnostic procedure, please include current notes to facilitate the review process. Requests submitted without clinical information will result in a delay in the prior authorization determination.

- **Contact person and phone number**

Please provide this information in the event additional information is necessary or questions arise. Please add this information in the additional notes field when submitting your prior authorization online.

Also:

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

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

Standard pre-service review time frames:

- Individual and Family Plan members: 5 calendar days
- RMHP PRIME & CHP+ members: 7 calendar days

Expedited review time frames:

- Individual and Family Plan members: 24 hours
- RMHP PRIME & CHP+ members: 72 hours

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

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

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

Durable medical equipment and supplies

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

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

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

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

Notification of inpatient admission

Admitting facility should notify RMHP of inpatient admission, by calling **1-800-416-2157**, option 4 or **1-970-248-5197**. We may also receive notification of inpatient admission from the health information exchange.

Chapter 7: Optum pharmacy

Formulary - prior authorizations

Some drugs in the formulary require prior authorization. Prescriptions presented to a pharmacy that require prior authorization will reject. More information about these requirements can be found and completed through CoverMyMeds or SureScripts.

For information on how to submit online, go to UHCprovider.com/pharmacy for Medicaid and CHP+, and UHCprovider.com/en/health-plans-by-state/exchange-plans.html for IFP.

Once filled out and submitted to the review team, the request will be evaluated within 24 hours and a decision made within turnaround-times based on the member's benefit. You will be notified, by fax, of an approval. If the prior authorization is denied, you will be copied on the denial letter sent to the member.

Optum Rx, our pharmacy benefit manager, processes prior authorization and exception requests on behalf of UnitedHealthcare Individual Exchange Plans.

Healthcare providers can submit a request:

- Online: business.optum.com/en/pharmacy-services/electronic-prior-authorization.html
- Phone: **1-800-711-4555**
- Faxing a request form to: 1-844-403-1027

State-specific request forms are at UHCprovider.com/plans.

Additional current prior authorization forms for individual drugs are available at:

- Online: UHCprovider.com/priorauth
- Phone: **1-800-788-4863**
- Fax: 1-800-491-7997

Formulary - copay tiers

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

The RMHP outpatient drug formulary offers comprehensive drug coverage to allow for shared decision making between the members and their prescribers. Individual and Family Plan Formularies are named the Essential Plus Six-Tier Prescription Drug List and Colorado Options Prescription Drug List. Self-administrable injectables are a prescription drug benefit. Since these injectables are considered a prescription drug benefit, they will not be covered if billed through a physician's office. Nonself-administered injectables (also known as physician-administered drugs) billed through a physician's office will be subject to the medical benefit cost-sharing.

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

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

Formulary - requesting exceptions

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

Specialty pharmacy network

Optum Specialty Pharmacy is the resource for RMHP members to receive specialty drugs. A complete listing of specialty drugs is available at UHCprovider.com/pharmacy for Medicaid and CHP +, and UHCprovider.com/en/health-plans-by-state/exchange-plans.html for IFP.

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

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

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

Mail order prescriptions

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

Medication therapy management

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

MTM services combine a thorough review of the member's medication history by a UnitedHealthcare employed or contracted clinical pharmacist with a written summary of findings and suggestions for alternative therapy.

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

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

Chapter 8: Care provider rights and responsibilities

Accommodations for people with disabilities

Members enrolled in federally funded programs that have communication disabilities have a right to interpreter services to render effective communication in connection with the provision of covered services.

As a RMHP participating physician or care provider, it is your responsibility to provide interpretive services for RMHP members enrolled in federally funded programs, at no cost to the member.

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

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

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

Accommodations for non-English-speaking members

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

If your office is unable to accommodate requests, RMHP provides access to a language line for care providers seeing RMHP members.

Translators representing multiple languages are available and can be arranged by calling RMHP Member Services at **1-888-809-6539** for Individual and Family Plans, **1-800-421-6204** for RMHP PRIME and RAE or **1-877-668-5947** for CHP+.

Advance directives policy

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

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

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

- A person's right under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to have advance directives
 - RMHP's written policy with respect to the person's right to make health care and advance directive decisions and the way such rights may be carried out
- RMHP's policy regarding advance directives requires that:
- RMHP ensures compliance with state laws regarding advance directives
 - Documentation is maintained in the member's medical record about the existence of advanced directives
 - Provision of health or medical care is not conditioned on whether or not the member has signed an advanced directive or otherwise judge a member based on whether or not the member has signed an advance directive
 - Staff to be trained concerning its policies on advance directives
 - Community education be provided regarding advance directives

Practitioner requirements related to advance directives

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

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

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

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

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

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

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

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

Verifying eligibility, benefits and your network participation status

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

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

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

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

Eligibility grace period for Individual Exchange Plan members

When individuals enroll in a health benefit plan on the exchange, Connect for Health Colorado, they are required to provide a 3-month grace period before terminating coverage. The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least 1 full month's premium within the benefit year. Additionally, for individuals who do not receive federal subsidy assistance, plans are required to provide a grace period consistent with state law (typically 30 or 31 calendar days) before terminating coverage.

You can verify if the member is within the grace period when you verify eligibility. Refer to the **Chapter 4: Individual Exchange Plans** for more information.

Understanding your network participation status

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

Commercial only

For more information about tiered benefit plans, visit [UHCprovider.com/plans](#) > Select your state > Commercial > UnitedHealthcare Tiered Benefit Plans.

Benefits questions

Address all benefits questions to RMHP Member Services by calling:

Members

- Individual and Family Plans at **1-888-809-6539**
- RMHP PRIME and RAE at **1-800-421-6204**
- CHP+ at **1-877-668-5947**

Care providers

- Individual and Family Plans at **1-888-478-4760**
- RMHP PRIME and RAE at **1-800-421-6204**
- CHP+ at **1-877-668-5947**

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

Clinical Laboratory Improvement Amendments regulations

Care providers with laboratory testing facilities must hold a valid Clinical Laboratory Improvement Amendments (CLIA) certification or Waiver of a CLIA Certificate of Registration in 1992, phased in through 1994, and amended in 1993, 1995 and 2003. Labs will not be eligible for reimbursement from RMHP without a valid certification for the type of testing performed. See lab charges – billing guidelines for additional information.

Closing a practice to new members

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

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

Rocky Mountain Health Plan member dismissal process

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

In this instance, you must do the following:

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

Send a copy of the letter to RMHP care management team by secure email or mail, if needed:

Rocky Mountain Health Plans

Attn: Care Management Team

P.O. Box 10600

Grand Junction, CO 81501-5600

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

Circumstances that may result in member dismissal

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

- A documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet other member responsibilities

- The member fails repeatedly to follow the recommended treatment plan or medical instructions
- The care provider cannot provide the level of care necessary to meet the member's needs
- The care provider moves out of the service area
- The member or member's family is abusive to the care provider or practice staff, or poses a serious threat of harm to the care provider, staff or other patients

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

A member cannot be dismissed due to:

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

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

Credentialing, re-credentialing, and delegated credentialing

UnitedHealthcare/RMHP does not retroactively terminate participating network clinicians/ facilities in Colorado. UnitedHealthcare/RMHP accepts the Colorado (CO) Health Care Professional Credential Application (CO Revised Statutes Sect. 25-1-108.7) which is on the CAQH application database. National database checks are completed for clinicians and organizational care providers through the Office of Inspector General List of Excluded Individuals and Entities (OIG/LEIE), the General Services Administration Systems for Awards Management (SAM), the National Plan and Provider Enumeration System (NPPES), the National Practitioner Data Bank (NPDB), and the State Medicaid Agency at credentialing and recredentialing.

- Timely credentialing of physicians (in accordance with [Colorado Revised Statutes 10-16-705.7](#))
- Within 7 calendar days after a carrier receives an application, the carrier is required to provide a receipt to the physician applicant in written or electronic form
- Upon receiving an application, a carrier shall promptly determine whether the application is complete. If the carrier determines that the application is incomplete, the carrier shall notify the physician applicant in writing or by electronic means within 10 calendar days. The notice must describe the items that are required to complete the application.
- If a carrier receives a completed application but fails to provide the physician applicant with a written or electronic receipt as required (above) the carrier is required to consider the physician applicant a participating physician effective no later than 53 calendar days following the carrier's receipt of the application

The carrier is required to conclude the process of credentialing a physician applicant within 60 calendar days after receipt of the completed application.

- The carrier is required to provide each physician applicant with written or electronic notice of the outcome of the physician applicant's credentialing within 10 calendar days after the conclusion of the credentialing process
- After concluding the credentialing process for a physician applicant and making a determination regarding the physician applicant's credentialing application, the carrier shall provide, at the physician applicant's request, all nonproprietary information pertaining to the physician's application and to the final decision regarding the application as outlined in the UnitedHealthcare Credentialing Plan, Section 8.2 – Applicant Rights

The carrier is required to make the following nonproprietary information available to all physician applicants and shall post the information on its website:

- Credentialing policies and procedures
- A list of the information required to be included in a physician application
- A checklist of materials that must be submitted in the credentialing process

- Designated contact information, including a designated point of contact, an email address, and a telephone number to which the physician applicant may address any credentialing inquiries
- The authority of the Insurance Commissioner to enforce requirements and impose penalties for violations

A carrier may recredential a participating physician if such recredentialing is:

- Required by federal or state law or by the carrier's accreditation standard
- Permitted by the carrier's contract with the participating physician
- A carrier shall not require a participating physician to submit an application or participate in a contracting process in order to be recredentialled

Except as described in subsection 8 of [Colorado Revised Statutes 10-16-705.7](#), and as may be provided in a contract between a carrier and a participating physician, a carrier shall allow a participating physician to remain credentialed and include the participating physician in the carrier's network unless the carrier discovers information indicating that the participating physician no longer satisfies the carrier's guidelines for participation, in which case, the carrier shall satisfy the requirements described in section 10-16-705(5) before terminating the participating physician's network participation.

Requirements specific to Medicaid care providers only

- UnitedHealthcare/RMHP shall complete the credentialing and contracting processes or deny network admission within 90 days for at least 90% of all care provider applications. The 90 days begins upon the submission of a care provider's written request to contract with the contractor.
- The contracting and credentialing measurement period ends on the actual date of a signed and fully executed contract or when UnitedHealthcare/RMHP sends a formal document denying the care provider admission to the network. The practice of contract back-dating does not constitute compliance to this process

- The measurement period shall be tolled in the event UnitedHealthcare/RMHP and the care provider are in active contract negotiations, and UnitedHealthcare/RMHP has sent written notice to the care provider that the care provider's credentialing application has been approved
- UnitedHealthcare/RMHP shall deny the application from the contracting process if a care provider's application is not complete within 80 days
- UnitedHealthcare/RMHP shall notify the care provider if the application is not complete prior to denial of the application
- UnitedHealthcare/RMHP shall respond to all care provider inquiries related to their credentialing and contracting within 2 business days

For additional credentialing, re-credentialing, and delegated credentialing information, please go to UHCprovider.com/join.

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

Visit UHCprovider.com/attestation to view ways to update and verify your provider demographic data.

To update your practice or facility information

You can make demographic updates every 90 days to your practice information through the [UnitedHealthcare Provider Portal](#) > Sign In > My Practice Profile. Or submit your change by:

- Using Provider Directory Snapshot within Council of Affordable Quality Healthcare, Inc. (CAQH) ProView
- Visiting UHCprovider.com/attestation to view ways to update and verify your provider demographic data electronically
- Connecting with us through chat 24 hours, 7 days a week in the [UnitedHealthcare Provider Portal](#)

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

Health care provider office site quality review

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

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

Emergency care and on-call physician

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

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

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

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

Office emergency services

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

Behavioral health secure transport

- Behavioral health secure transport (BHST) services information can be found at [Behavioral Health Secure Transportation \(BHST\) Billing Manual | Department of Health Care Policy and Financing](#)
- Behavioral health secure transport must be provided by care providers who are specifically enrolled with HCPF as a BHST care provider

On-call physician

When a PCP is off-duty, they must provide 24-hour coverage through a colleague with comparable qualifications who is also a participating physician (or who has a covering physician agreement) with RMHP. The on-call (covering) physician is authorized and responsible for providing care to RMHP members to the same extent as the PCP. When covering for another care provider, the on-call (covering) physician agrees to accept as full payment for services rendered to the member, the amounts which RME pays to the care provider being covered for (based upon the fee schedule in effect at the time the services are rendered). They may refer and order labs, X-rays and other diagnostic tests. The on-call physician may bill RMHP directly, indicating the on-call situation and the name of the physician for whom he/she was taking calls. A nonparticipating physician may provide coverage only if it is an emergency, unless an RMHP CM nurse has authorized the visit.

Compliance

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

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

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

To report a known or suspected violation or concern to UnitedHealthcare, call the compliance & ethics help center – available 24 hours a day, 7 days a week at **1-844-359-7736**.

Noncovered services

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

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

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

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

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

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

Primary care provider

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

Additional primary care provider responsibilities

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

Provide official notice

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

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

Provide timely notice of demographic changes- primary care provider

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

We have developed specific definitions for open, closed or existing-only practices to promote consistency throughout the participating health care provider network related to acceptance of new or transferring members.

For purposes of this section, a new member may be a member who has switched health plans or coverage plans, such as a member who switches from a Fee-For-Service (FFS) plan to a Commercial HMO/MCO plan. Follow these definitions:

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

Notification of changes must be proactive

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

You and the delegates are required to update all health care provider information, such as the following:

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

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

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

Mutual obligations- UnitedHealthcare and care provider professional conduct

Professional conduct

When we conduct business together, you will work with us to ensure that your employees, agents, and any personnel operating in our facilities or yours comply with the following:

- **Collaborate for member outcomes:** Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism:** At all times, treat other care providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.
- **Prohibit threats and harassment:** Create a safe and respectful environment. Any form of threats, harassment, or intimidation is strictly prohibited, including verbal, physical, and written forms.
- **Prohibit violence:** Prohibit acts of violence against other care providers, UnitedHealthcare members, and UnitedHealthcare and your employees.
- **Protect confidential employee information:** Not publicly disclose any confidential personal information about UnitedHealth Group's or your employees, including home address, personal telephone numbers, personal and professional email addresses, medical, or employment-related details, to any third party without express written consent from the other party, unless legally required to do so.
- **Inaccurate statements:** Not make any misleading, inaccurate or untrue statements, whether oral or written, that disparage or intentionally harm the reputation or safety of the other party, its affiliates, or its employees. This includes statements made on social media, in public forums, or any other medium of communication.

If the requirements above are not met, we will collaborate and fully cooperate to address the matters.

If you fail to fully cooperate with UnitedHealthcare to address any violation of these requirements, such conduct is a material breach under the Agreement. UnitedHealthcare may:

- Refuse to interact with any individual engaging in such conduct
- Terminate any professional's participation in UnitedHealthcare's network, without terminating the Agreement between the parties
- Terminate the Agreement between the parties upon 30 days' prior written notice
- Any other remedies available to the parties under the participation agreement or at law

Any threat, attempted violence, or acts of violence will be reported to the appropriate authorities including, but not limited to, UnitedHealth Group Corporate Security, appropriate care provider security, law enforcement, state and federal regulatory bodies.

Primary care provider changes - member requested

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

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

Primary care provider - consultant relationship

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

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

Confidentiality - member

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

- Employees of Rocky Mountain Health Management Corporation agree at the time of hiring and on an annual basis to maintain the confidentiality of protected health information

- Most RMHP members are asked to read and sign the Application for Enrollment form when they enroll. The application includes information authorizing any physician, health care provider, hospital, other medical facility, insurance company or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage to give RMHP such information and to supplement such information as RMHP requests. This is referred to as the member's routine consent.
- Members have the right to approve the release of information through special consents. RMHP may request a unique medical records release form when necessary to receive information from entities as previously mentioned.
- RMHP is a "covered entity" under HIPAA and is subject to the HIPAA Privacy Rule found at 45 CFR, parts 160 and 164
- RMHP does not generally keep completed medical records regarding our members. A member may access their medical records through the PCP, or other care providers. RMHP provides access to its members to the records that RMHP does keep consistent with HIPAA. RMHP has a policy regarding the use of member data for measurement purposes. Except when agreements to protect confidentiality are in place, information requested is given in de-identified or aggregate form and is only provided upon request. All requests from external entities to use de-identified or aggregate member data are reviewed by RMHP personnel.

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

Cultural competence

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

Culture shapes how people experience their world. Decisions on quality of work and family life and how to relate to others are determined in part by culture. Culture is the shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people.

It is a vital factor in both how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by race and ethnicity but also by factors such as geography, age, religion, gender, sexual orientation and socioeconomic status.

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

Providing patients with quality health care and helping people to change risky behavior patterns and understand the benefits of healthy living are all hallmarks of the kind of good practices health care professionals in the United States strive to achieve.

Unfortunately, practitioners in this country also face many unique obstacles to the level of care they would like to deliver. Some of these obstacles involve cultural misunderstandings and miscommunications with patient populations whose languages, experiences and backgrounds differ from those of their care providers. Public health studies consistently show improved health outcomes as care providers bridge cultural gaps between themselves and their patients.

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

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

RMHP values diversity and encourages all participating care providers to be aware and sensitive to the cultural differences that exist in our diverse communities. In support of this philosophy, RMHP advocates for continued education and diversity training. For more information on how you may obtain subject matter pertaining to cultural competency programs, please contact the U.S. Department of Health & Human Services, Office of Minority Health:

- Phone – 1-844-899-8057
- Website – [thinkculturalhealth.hhs.gov](https://www.thinkculturalhealth.hhs.gov)

Cultural competency training and information

Free continuing medical education (CME) and non-CME courses are available on our [Cultural Competency page](#) as well as other important resources. Cultural competency information is stored within your care provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our [data attestation process](#).

Equal opportunity policy statement

It is the policy of RMHP to provide equal opportunity and to prevent discrimination based on race, color, national origin, disability, or sex which includes sex characteristics, including inter-sex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law.

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

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

Care provider tools and resources

Online resources

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

UHCprovider.com

This [public website](#) is available 24 hours, 7 days a week and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, quality programs and more.

We encourage you to bookmark the following frequently referenced pages for quick access:

- **Policies and protocols**
[UHCprovider.com/policies](#) > **For Community Plans**
library includes UnitedHealthcare Community Plan policies and protocols
- **Health plans by state**
This is the fastest way to review all of the health plans UnitedHealthcare offers in each state. Go to [UHCprovider.com/plans](#) > Choose a Location > View Plans to review specific plans offered in that market.
- **UnitedHealthcare Provider Portal**
This secure portal is accessible from [UHCprovider.com](#). It allows you to access patient information such as eligibility and benefit information and digital ID cards.
 - You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting [UHCprovider.com/portal](#).
 - You can also access [self-paced user guides](#) for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
Bookmark [UHCprovider.com/networknews](#). It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
 - Get news related to your role, specialty, health plan and state. When you [subscribe](#) to Network News, you can update your preferences to select what news you receive.

Chapter 9: Fraud, waste, and abuse

Fraud, waste, and abuse in health care

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

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

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

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

Report suspected fraud or abuse

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

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

False Claims Act

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

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

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

The state of Colorado has specific laws regarding false claims. Under the Colorado False Medicaid Claims statute (25.5-4-306), the state may bring a civil action against any person who has intentionally or with reckless disregard submitted a false Medicaid claim. An individual may be ordered to pay to the state full restitution in addition to a civil penalty of up to \$50,000 or 2 times the amount of medical assistance paid.

Hold harmless policy

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

“No Recourse Against Covered Persons or Colorado. In no event, including, but not limited to, nonpayment by Rocky Mountain Entities (RME), RME’s insolvency, or breach of this Agreement, shall Contractor or a Group Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person, the state of Colorado, any federal health care program or state health care program or persons (other than the RME) acting on the covered person’s behalf, for services provided pursuant to this Agreement. This provision does not prohibit the contractor or a group physician from collecting copayments, coinsurance and deductibles as specifically provided in the covered person’s health care plan or fees or supplemental charges for uncovered services delivered on a fee-for-service basis to covered persons.

This provision shall survive the termination of this Agreement, regardless of the reason for termination, including insolvency of RME, and shall be construed to be for the benefit of covered persons, the state of Colorado and any federal health care program or state health care program. This provision supersedes any oral or written contrary Agreement now existing or hereafter entered into between the contractor or a group physician and a covered person or persons acting on a covered person’s behalf insofar as such contrary Agreement relates to liability for payment for or continuation of services provided pursuant to this Agreement. No changes, modifications, additions or deletions shall be made to the provisions of this paragraph without the prior written consent of the Secretary of the United States Department of Health and Human Services and such changes, modifications, additions or deletions shall become effective on a date no earlier than 30 days after the Colorado Commissioner of Insurance has received written notice of such proposed changes, modifications, additions, or deletions with regard to health care plans which are not self-insured health care plans. This paragraph shall not apply in the event of the insolvency of a self-insured employer who offers a self-insured health care plan administered by RME.”

Locum tenens

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

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

Mid-level care providers

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

Chapter 10: Medical records

Release of information and transfer of records

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

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

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

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

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

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

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

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

Office records - primary care

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

All records should include:

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

Office visit information

- The primary problem for which the physician was consulted
- Any pertinent history or physical examination data
- A diagnosis, impression, or assessment and subsequent data
- A plan, including any medications or tests ordered
- EKGs mounted, labeled and interpreted
- Interpretation of office X-rays

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

Reports and summaries

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

Official records - specialist

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

All records should include:

- General information
- A basic information sheet containing name, date of birth and sex
- A medical history, a family history, personal history and current medications list
- Allergies or drug reactions
- An up-to-date list of the patient's medical problems
- An up-to-date list of the patient's current medications
- Each page in the record contains the patient's name or ID number

- All entries are dated and contain the author's identification
- Consultation reports and any material provided by the referring or PCP
- Dated laboratory and radiology reports
- Hospital discharge summaries, history, physical examination and operative notes where applicable
- Care provider signature

Office visit information

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

Reports and summaries

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

Consent to disclose substance use disorder information

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

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

Chapter 11: Member rights and responsibilities

The following text is reproduced from the Member Handbook.

Individual and Family Plan members

It is your right to:

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

It is your responsibility to:

- Tell your doctor about any advance directives about your health care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Follow the plans and instructions for care that you and your health care provider have agreed on
- Assume responsibility for your own health and well-being
- Learn about your health care benefits, procedures, and limitations
- Be helpful and considerate with health care providers and staff

- Tell Member Services of any changes to your membership
- Let us know if you move. RMHP will change your address in our records if it receives notice from the U.S. Postal Service of a different address for you.
- Assume responsibility for copays and costs for certain health care services, including copays for both your health plan and any services that are not covered
- Give RMHP and your care provider all necessary information to offer you correct health care

Rocky Mountain Health Plan PRIME, RAE and CHP+ members

It is your right:

- To get information about RMHP and its services, doctors, and health care providers and to get information about your rights and responsibilities
- To be treated with respect and with recognition of your dignity and right to privacy
- To accept or refuse medical treatment to the extent provided by Colorado state law and to participate in making decisions about your health care
- To have open discussions with health care providers about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage, and presented in a manner appropriate to your condition and ability to understand
- To make appeals, and to bring complaints to RMHP, the insurance commissioner of the state of Colorado, or the Department of HCPF
- To be furnished health care services in accordance with federal health care regulations for access and availability, care coordination and quality
- To expect all communications regarding your care to be kept confidential as required by law
- To freely exercise your rights without being treated differently
- To be free from the use of physical restraint or being isolated. These methods may not be used to make you cooperate, to punish you, for the ease of the caregiver, or as a way of getting back at you.

- To get family planning services from an Health First Colorado provider, in or out of RMHP network with no referral
- To request and receive your medical records and to have them changed according to federal law
- To get a second opinion with no referral and at no cost to the member
- To be free from discrimination based on race, color, national origin, age, disability, sex, sexual orientation or gender identity
- To make recommendations regarding RMHP rights and responsibilities policy
- To use any hospital or other setting for emergency care

It is your responsibility:

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

Member responsibilities

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

Chapter 12: Definitions

Abuse

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

Active course of treatment

An ongoing course of treatment for a life-threatening condition

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

Ancillary product providers

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

Ancillary service providers

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

Case management

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

Counties with extreme access considerations (CEAC)

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

Department

References to the “department” means Health First Colorado.

Emergency medical condition

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

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

Emergency services

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

Emergent care

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

Essential community provider (ECP)

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

Fraud

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

Frontier county

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

High-impact specialist

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

High-volume specialist

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

High-volume behavioral health care providers

A type of behavioral health, mental health and substance abuse disorder specialist who treats a significant portion of an organization's membership (determined annually).

Institutional care providers

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

Mental health, behavioral health, and substance use disorder care providers

To include psychiatrists, psychologists and peers, licensed clinical social workers, psychiatric nurses, licensed addiction counselors and licensed professional counselors.**Network**

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

Pharmacy

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

Primary Care Physicians (PCP)

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

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

Rural county

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

Specialist

A physician or nonphysician health care professional who:

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

Urban county

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

Urgent care

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

Urgent care center

A medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of nonlife- and limb threatening illnesses and injuries. Urgent care centers are enhanced by on-site radiology and laboratory services and operate in a location distinct from a freestanding or hospital-based emergency department. Care is rendered under the medical direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-ins patients seeking medical attention during all posted hours of operation.

Waste

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