2024 Medicaid Behavioral Health Care Provider Manual

Colorado Rocky Mountain Health Plans

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United Healthcare | Rocky Mountain Health Plans

Welcome

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

Click to access different manuals:

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

Easily find information in this manual using the following steps:

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

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

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

Using this manual

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

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

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

This manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this manual:

- “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- “You,” “your” or “care provider” refers to any health care provider subject to this manual. This includes physicians, clinicians, facilities and ancillary providers, except when indicated

- "Community Plan" refers to UnitedHealthcare's Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "RMHP" refers to Rocky Mountain Health Plans
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan 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.

Table of Contents

Chapter 1: Introduction

Rocky Mountain Health Plans (RMHP), a UnitedHealthcare company, is committed to ensuring providers have the tools and resources necessary to best serve members of Health First Colorado (Colorado's Medicaid program). Rocky Mountain Health Plans is the UnitedHealthcare Community Plan for Colorado.

We created this guide to help RMHP behavioral health providers understand behavioral health covered services, benefits, and provider responsibility to ensure successful delivery of health care services to RMHP members.

Commitment to high-quality health care

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

Our key differentiators include:

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

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

- **Whole-person and member-centric foundation**
  Organize the entire RAE model around the goals and needs of members, as those persons who offer impactful contributions to the community
- **Expansive inclusive network**
  Establish, incentivize and maintain a broad and comprehensive network informed by member choice and includes single-provider practices, large group clinics, specialty providers and facilities, and community mental health centers (CMHC)
- **Diverse, knowledgeable and local leadership**
  Establish the focus of leadership and decision making firmly within a local, multi-disciplinary, multi-sector community governance model
- **Integrated care**
  Achieve the deepest possible degree of coordination and collaboration among physical health, behavioral and human service organizations — and help ensure that resources and talent at every level are put to the most productive use
- **Expertise and resource commitment**
  Deliver significant expertise, technology, research and development, and capital investment within a national enterprise available to local leaders, with the autonomy to close gaps, learn and innovate rapidly
- **Transparency and accountability**
  Establish clear, straight lines of accountability to the Colorado Department of Health Care Policy and Financing (HCPF) that allow for the efficient fulfillment of all deliverables and public reporting duties, with an appropriate separation of controls, checks and balances in a framework that ensures competence and continuity without sacrificing access or transparency

Resources for providers

RMHP's Provider Relations team is available to answer questions about credentialing and contracting at 1-800-421-6204 for RMHP PRIME and RAE providers. Providers can also visit UHCprovider.com to find more information about the RAE as well as common forms and resources for providers. RMHP offers providers an updated and secure provider portal at UHCprovider.com or ProviderExpress.com. These portals provide

information about member eligibility, benefits, copays, claim status and code lookup.

To register for the Provider Portal at UHCprovider.com, please contact your office administrator, who is also referred to in our system as a main office contact, to help ensure your office has an existing account for UHCprovider.com. Your main office contact can add your information to the account and initiate the registration process. The registration process guides you through creating your credentials to log onto UHCprovider.com. If you already have a One Healthcare ID, you can use it to register for and log onto UHCprovider.com.

Get help from RMHP

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

Call –

- CHP+: 1-877-668-5947
- RAE and RMHP PRIME: 1-800-421-6204

Email – RMHPCustomer.Service@uhc.com

Services provided by regional organizations

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

- **Rocky Mountain Health Plans**
  - Phone – 1-800-421-6204
  - Hours – Monday-Friday, 8 a.m.-5 p.m.
  - Web – UHCprovider.com
- **Colorado Access**
  - Phone – 1-303-368-0037 or 1-855-267-2095 (toll free)
  - Hours – Monday-Friday, 8 a.m.-5 p.m.
  - Web – coaccess.com
- **Colorado Community Health Alliance**
  - Phone – 1-303-256-1717 or 1-855-627-4685 (toll free)
    Hours – Monday-Friday, 8 a.m.-5 p.m.
  - Web – cchacares.com
- **Health Colorado, Inc.**
  - Phone – 1-888-502-4185; Care Coordination: 1-888-502-4186
  - Hours – Monday-Friday, 8 a.m.-5 p.m.
  - Web – healthcoloradorae.com
- **Northeast Health Partners**
  - Phone – 1-888-502-4189
  - Hours – Monday-Friday, 8 a.m.-5 p.m.
  - Web – northeasthealthpartners.org

Chapter 2: Covered behavioral health services

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

- Alcohol/drug screen counseling
- Autisum spectrum disorder services
- Behavioral health assessment
- Emergency and post-stabilization care services
- Inpatient psychiatric hospital services
- Medication-assisted treatment
- Medication management
- Outpatient day treatment
- Outpatient hospital services
- Psychotherapy: family, individual, individual brief and group
- Rehabilitative services
- School-based services (for children with Individual Education Programs [IEPs])
- Social ambulatory detoxification
- SUD assessment
- Targeted case management
- Additional benefits known as 1915(b)(3) services, which can be accessed at community mental health centers and other participating community providers
- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential
- Assertive community treatment (ACT)
- Recovery services
- Respite services
- Alcohol/drug screen and counseling – SUD counseling services are provided along with screening to discuss results with a member
- **Behavioral health assessment**
  Face-to-face clinical assessment of a member by a behavioral health professional that determines the nature of the member's problem(s); factors contributing to the problem(s); a member's strengths, abilities and resources to help solve the problem(s); and any existing diagnoses
- **SUD assessment**
  An evaluation designed to determine the most appropriate level of care based on criteria established by the American Society of Addiction Medicine (ASAM); the extent of drug/alcohol use, abuse or dependence and related problems; and the comprehensive treatment needs of a member with a drug or alcohol diagnosis
- Emergency and post-stabilization care services
- Inpatient psychiatric hospital services
  - **For members younger than 21 years old**
    A program of care for members age 20 and younger in which the member remains 24 hours a day in a psychiatric hospital or other facility licensed as a hospital by the state. Members who are inpatient on their 21st birthday are entitled to receive inpatient benefits until discharged from the facility or until their 22nd birthday, whichever is earlier, as outlined in 42 C.F.R. §441.151
  - **For adults ages 21 to 64 years**
    A program of psychiatric care in which the member remains 24 hours a day in a facility licensed as a hospital by the state, excluding state institutes for mental disease (IMDs)
  - **For members age 65 years and older**
    A program of care for members age 65 and older in which the member remains 24 hours a day in an institution for mental diseases or other facility licensed as a hospital by the state

Contractor responsibilities for inpatient care

The contractor's responsibility for all inpatient hospital services is based on the primary diagnosis that requires inpatient level of care and is being managed within the treatment plan of the member.

The contractor shall be financially responsible for the hospital stay when the member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures (including labs and ancillary services). See Capitated Behavioral Health Benefit Covered Services & Diagnoses.

The contractor shall not be financially responsible for inpatient hospital services when the member's primary diagnosis is physical in nature, even when the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis. Note: if member is RMHP PRIME, RMHP is responsible for this benefit as a physical health benefit.

The contractor shall not be financially responsible for inpatient hospital services when the member's primary diagnosis is a SUD that is evident at the time of admission.

The contractor shall be financially responsible for a member's admission to any freestanding inpatient psychiatric facility when the member is presenting with psychiatric symptoms for the purposes of acute stabilization, safety and assessment to determine whether or not the primary diagnosis occasioning the member's admission to the hospital is a mental health disorder or SUD.

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

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

The contractor may cover, but may not require the member to use, IMDs in lieu of short-term inpatient psychiatric hospital care when determined medically appropriate and cost-effective, in compliance with 42 C.F.R. 438.3(e)(2). Short-term stays in an IMD must be for lengths of stay of no more than 15 days during the period of the monthly capitation payment.

MHPAEA

This plan is subject to the protections provided under the Mental Health Parity and Addiction Equity Act (MHPAEA). Coverage provided for mental health and SUDs must be comparable to services covered under the medical benefits available on this plan. If you believe that your patient's rights under MHPAEA have been violated, you or your patient may contact the Office of the Ombudsperson for Behavioral Health Access to Care at 1-303-866-2789 or at ombuds@bhoco.org. Or they can contact the division of insurance at:

Colorado Division of Insurance
Consumer Services
1560 Broadway, Ste. 850
Denver, CO 80202

Phone – 1-303-894-7490 or 1-800-930-3745 (in-state, toll-free)

Email – dora insurance@state.co.us

Mental health parity reports (HCPF website)

The MHPAEA is designed to ensure that Medicaid managed care organizations and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications.

The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitated MH/SUD payment structure to a fee-for-service M/S payment structure. The department chose to design its coverage in this manner to maximize the breadth of MH/SUD services available to its members. The comparison between MH/SUD and M/S benefits seeks to assess whether the written policies and procedures, in design and applied in practice, affect the ability of Medicaid members to access MH/SUD services. hcpf.colorado.gov/regulatory-resource-center

Services requiring prior authorization

Prior authorization is required for inpatient hospitalizations, partial hospitalizations, acute treatment units, short- and long-term residential, day treatment, intensive outpatient programs, testing and electroconvulsive therapy. For notifications by the admitting facility, call 1-800-421-6204 for RAE and RMHP PRIME members.

Behavioral health services requiring prior authorization by RMHP for RAE members can be found at

UHCprovider.com.

The list of covered services requiring prior authorization by RMHP may change from time to time. The most up-to-date prior authorization policies, procedures and list of services subject to authorization and covered by RMHP under the RAE contract can be found at UHCprovider.com.

Submitting prior authorizations

Online tools and resources to help you manage your practice's notifications and prior authorization requests can be found at UHCprovider.com.

RMHP PRIME and RAE Members, prior authorizations and behavioral health prior authorization requests are submitted in one of the following ways:

Email: rmhpbhvm@uhc.com

Call: 1-855-886-2832

Fax: 970-257-3986

Short-term behavioral health services in the primary care setting

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

The following procedure codes are included as short-term behavioral health services:

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

While the intent of the policy is to increase access to behavioral health services that can address a low-acuity condition within 6 visits, we understand that there may be times when a member requires additional services. In these instances, there are 2 options for accessing additional services.

1. A PCMP that has a licensed behavioral health clinician who is contracted as part of the RMHP RAE behavioral health network may submit claims to RMHP for reimbursement of additional visits beyond 6 during a state fiscal year. All additional visits must be provided in accordance with RMHP utilization management (UM) policies and procedures.
2. A PCMP with a licensed behavioral health clinician that is not contracted as part of the RMHP RAE behavioral health network can work with RMHP to transition a member's care to another behavioral health provider. Any additional visits beyond 6 during a state fiscal year will be denied FFS reimbursement.

*This excludes any primary care provider (PCP) that is on the same site as a Medicaid-enrolled CMHC.

Capitated behavioral health benefit covered services and diagnoses

Procedure code modifiers

Procedure code modifiers are required on most behavioral health claims.

For further information about modifiers and coding guidelines, please reference the applicable State Behavioral Health Services Billing Manual and other resources in the Behavioral Health Services section located at hcpf.colorado.gov/ accountable care-collaborative-phase-ii-provider-and-stakeholder-resource-center.

Specialty behavioral health codes
Reimbursed under the behavioral health capitation, when the service is for a covered behavioral health diagnosis and is billed by a behavioral health specialty provider, nonphysician practitioner group or an FQHC or RHC using revenue code 0900.

Short-term behavioral health services in the primary care setting

For short-term behavioral health services, behavioral health codes, evaluation and management consultation codes, and evaluation and management add-on codes, refer to the Uniform Service Coding Standards Manual located on the HCPF website at **hcpf.colorado.gov** and the preauthorization list found at **UHCprovider.com**.

Continuum of services

The RMHP provider network is designed to include a wide array of services that support therapeutic interventions at the level of intensity indicated by the strengths and needs of each unique person served. Many of these services are offered through our CMHC providers. However, routine outpatient assessment, psychotherapy, psychological testing and medication management services are also offered by our network of independent outpatient providers. Hospitalization and residential levels of care are offered by contracted network facilities and some CMHCs.

The care delivery system has been developed to ensure that, from the moment they access services, Health First Colorado members are directed to the most appropriate level and type of behavioral health care, in geographically convenient locations. RMHP providers, facilities and other treatment programs are screened against credentialing standards, qualifications in specialty areas and managed care experience. Authorizations for payment of services are determined through the application of medical necessity criteria and use of clinical judgment.

Clinical services descriptions

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

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

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

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

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

Evaluation/assessment services
Diagnostic assessment of the member who presents for treatment to determine the member's needs and strengths and to recommend the appropriate level of care and focus of treatment

Family preservation services
Time-limited, in-home treatment to maintain the child in the home or to facilitate reunification of the child with the family

Home-based services
Services, which can vary in intensity and duration, provided in the home to assess and stabilize a member's symptoms, and to maintain and/or improve a member's level of functioning

Inpatient hospitalization
Treatment of a mental health condition requiring 24-hour supervision, observation and intervention in

a structured therapeutic medical environment with 24-hour nursing care. This is the most restrictive level of care and generally applies to those members who are experiencing mental health symptoms resulting in behaviors that cause significant danger to themselves or others or cause the member to be significantly disabled and unable to meet their basic needs.

Intensive case management
Services typically provided by community behavioral health center staff for coordination of services, support and advocacy and to assist members with the recovery process

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

Mobile assessment
An assessment of a member's treatment needs by a clinician who travels to the member's location in the community, including an emergency room

Outpatient hospital-based laboratory services
Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the member's behavioral health treatment or condition. Please note all laboratories must be Clinical Laboratory Improvement Amendments (CLIA)-certified.

Outpatient treatment
Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the member's behavioral health treatment or condition. Please note all laboratories must be CLIA-certified.

Partial hospitalization program
A structured, intensive, time-limited program designed to provide diagnosis and treatment for members who require more structure than is provided by outpatient therapy to continue to reside in the community

Post-stabilization services
Services provided in relationship to an emergency medical condition and are provided after a member is stabilized to maintain the stabilized condition

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

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

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

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

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

Vocational services
Services for any member interested in pursuing educational or work opportunities. Services may include assessment, prevocational training, job training, supported employment, social skills training, coaching and referral to related agencies. Help all providers connect members to adjunctive services, including physical health, specialty services and community care. For assistance, call 1-888-282-8801.

SUD benefit

RMHP is responsible for authorizing inpatient and residential SUD treatment stays as part of administering Health First Colorado's capitated behavioral health benefit.

RSATF

A residential substance abuse treatment facility (RSATF) is a facility licensed by the Behavioral Health Administration (BHA) based on the ASAM criteria, which provides treatment for substance (alcohol and drug) abuse to live-in residents. Services rendered at these facilities are reimbursed with a per diem rate. The per diem rate is intended to cover all services provided. There may be unique situations in which additional services are offered and could be billed separately. These allowances are at the discretion of the member's RAE. Room and board are not included in the per diem rate in RSATFs and should be billed to BHA or their designee. When inpatient SUD services are rendered in a hospital and billed using a revenue code, room and board is included in reimbursement. For more details, please see the coding pages that reflect the covered residential benefit effective Jan. 1, 2021. The following ASAM levels of care are Medicaid-covered services:

Treatment services

- Level 1 – Outpatient services
- Level 2.1 – Intensive outpatient services (IOP)
- Level 3.1 – Clinically managed low-intensity residential services
- Level 3.3 – Clinically managed population-specific high-intensity residential services
- Level 3.5 – Clinically managed high-intensity residential services
- Level 3.7 - Medically monitored intensive inpatient services

Withdrawal management services

- Level 3.2 - Clinically managed residential withdrawal
- Level 3.7 WM – Medically monitored inpatient withdrawal management

Room and board

Room and board services are provided to patients residing in a facility. Patients must reside in the facility for at least 24 hours while they are provided with lodging and meals.

Prior authorization notification process

The following services require preauthorization before the member starts treatment:

- Level 2.1 – Intensive outpatient programming (IOP)
- Level 3.1 – Clinically managed low-intensity residential
- Level 3.3 – Clinically managed population-specific high-intensity residential
- Level 3.5 – Clinically managed high-intensity residential
- Level 3.7 – Medically monitored intensive inpatient

To obtain prior authorization for these services, please complete the Initial SUD Authorization Form along with clinical documentation supporting the ASAM level of care and fax it to 1-970-257-3986 or secure email it to **rmhpbhvm@uhc.com**. The Initial SUD Authorization Form and the Concurrent SUD Authorization Form can be found at **UHCprovider.com**.

These services require concurrent review if the member stays longer than 4 days:

- Level 3.7WM – Medically monitored withdrawal management

To notify of an admission:

Email: **rmhpbhvm@uhc.com**

Call: 1-855-886-2832

Fax: 970-257-3986

We will need the member's name, date of birth and the level of care.

ASAM level of care

HD Modifier	Special connections program if certified by BHA and appropriately enrolled with HCPF
H2036 HF U1	ASAM Level 3.1
H0010 HF	ASAM Level 3.2WM (withdrawal manaqement)
H2036 HF U3	ASAM Level 3.3
H2036 HF U5	ASAM Level 3.5
H2036 HF U7 Rev Code 1000	ASAM Level 3.7
H0011 HF Rev Code 1002	ASAM Level 3.7WM (withdrawal management)

Chapter 3: Early and periodic screening, diagnosis and treatment (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under including adults who are pregnant, who are enrolled in Medicaid. It aims to ensure they receive preventive, dental, behavioral health, developmental and specialty services. With EPSDT, any medically necessary health care service is covered. A service may be covered even if it is not a Health First Colorado benefit; no arbitrary limitations on services are allowed. Any person enrolled in the Health First Colorado program can get EPSDT services if they are 20 years old or younger; this age group is automatically enrolled. All Health First Colorado providers can offer EPSDT services.

Regarding copays:

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

EPSDT assessment

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

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

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

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

Medical necessity for EPSDT

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

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

Treatment

Medically necessary health care services must be made available for the treatment of all physical and mental

illnesses or conditions discovered by any screening or diagnostic procedure. Additional health care services may be covered under the federal Medicaid program if they are found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan.

To learn more about Colorado's EPSDT benefit, please call the department at 1-303-866-6167, visit their EPSDT website at **colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt** or call the Member Services at 1-800-421-6204.

The state of Colorado also may provide the following services through the RAE and/or MCO and other programs:

- Educate all eligible members about the EPSDT program
- Describe the available benefits in greater detail
- Help find a PCP or other medical providers as needed
- Arrange for an appointment if the member needs help
- Communicate options for non-emergency medical transportation (NEMT) assistance, if necessary
- Follow-up on screening appointments
- Follow-up includes assistance to reschedule the missed appointment

EPSDT care providers

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

Behavioral health providers are required to:

- Assess new members to determine that EPSDT screenings have been occurring
- Refer members to their PCMP, if screenings are not being conducted
- Provide behavioral health assessment/treatment upon referral from a PCP who desires
- Perform additional behavioral health services, in which medical necessity has been determined
- Communicate with the PCMP regarding any pertinent findings/actions
- Document all actions in the member's clinical record

Because assessing physical health is an important component of providing comprehensive behavioral health care, we require all behavioral health providers to ensure that their Health First Colorado clients who are younger than age 21 have had an EPSDT well-child exam, according to the well-child check-up schedule listed. You must contact the member's PCMP or talk with the child's parent or guardian to determine if this has happened. If the child or youth does not have a PCMP or has not been screened according to the recommended schedule, you should contact the family health coordinators in your community to facilitate the screening process. A list of family health coordinators can be found at **colorado.gov/pacific/hcpf/family-health-coordinator-list**.

If additional assistance is needed, or if you have questions about EPSDT resources, you can call Member Services at 1-800-421-6204 for RAE and RMHP PRIME members.

Care coordination

Care coordination services for RAE and RMHP PRIME members are provided through RMHP with support from participating PCMP providers and integrated community care teams (where available). Care coordination services focus on the whole person and assess, and address areas of need related to physical health, behavioral health and social determinants of health. RMHP also serves as a bridge and connector of our members to needed services and care. Care coordinators are here to help all providers connect members to adjunctive services, including physical health, specialty services and community care. For assistance, call Member Services at 1-800-421-6204 for RAE and RMHP PRIME members.

Chapter 4: Provider responsibilities

Join the PRIME RAE network

Credentialing and contracting

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

- Developing and maintaining a credentialed and contracted statewide network of behavioral health providers (both individual providers and facilities) to provide covered behavioral health services
- Providing UM of covered behavioral health services
- Reimbursing behavioral health providers for services covered under the capitated behavioral health benefit
- Providing training and support to behavioral health providers

Steps to participate

Step 1: Enroll/revalidate as a Health First Colorado provider
Providers that have not yet enrolled and revalidated with Health First Colorado through the Colorado interchange must complete this process to contract with RMHP's RAE behavioral health network. Information about this requirement can be found on the department's **website**.

Step 2: RMHP credentialing
Behavioral health providers that wish to participate with RMHP must complete RMHP's standard credentialing process and agree to accept RMHP's RAE fee schedule agreement to be a participating RMHP RAE provider.

Current RMHP credentialed behavioral health providers are not required to complete additional credentialing by RMHP; however, they must agree to accept RMHP's RAE fee schedule agreement to be a participating RMHP RAE provider. For credentialing information, submit all credentialing requests online to Optum Behavioral Health for all Rocky Mountain Health Plans behavioral health care professionals through the **Optum Provider Express portal.**

Letters of agreement

RMHP may enter into letters of agreement with some behavioral health providers to encourage and foster continuity of care for members. These letters of agreement are also known as single case agreements.

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

Verification of eligibility and enrollment

Providers are responsible for confirming Health First Colorado eligibility and RAE enrollment eligibility of members before providing services. Determination of eligibility and enrollment with RMHP as the regional organization is based on the state of Colorado's eligibility standards developed and applied by the department. Health First Colorado eligibility should be verified by using the system available through the State of Colorado, the Colorado interChange.

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

The department's web portal is **colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx.**

ID cards

RMHP does provide ID cards to RAE members. The state does also not distribute ID cards to Health First Colorado members. Eligibility verification through Colorado interchange does not require a member's ID number and can be verified by using identifiers such as date of birth and name. RMHP will continue to distribute an RMHP member ID card to RMHP PRIME members.

Collection of copayments/ deductibles

Members covered through Health First Colorado are **not subject to copays or deductibles** for behavioral health services. Collection of fees directly from an RMHP Medicaid member may result in termination as a participating provider. This includes charges for noncovered services, including missed appointments.

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

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

RMHP RAE and PRIME members copayment

All RMHP RAE and PRIME members, when applicable, will pay copayments directly to the provider at the time of service. As a provider, you can choose to waive copayments, but you cannot deny care if a member is unable to pay. The member may not be billed for any costs that are not covered by either RMHP or Health First Colorado. The member should never pay more than their minimal PRIME copay, if any.

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

In most cases, RMHP PRIME members will pay copayments directly to the provider at the time of service. Certain members are considered to be copay exempt. The most common copayments are:

- Members who are copay-exempt ($0 copay)
- Children 18 and younger
- Pregnant members
- American Indian or Native American
- Living in a skilled nursing facility
- Living in a traditional care facility or mental institution
- Former foster care children ages 18 through 26
- Living in a household that has paid more than 5% of household income in copays for the month

Behavioral health providers

A member may request that a provider be considered to join the relevant RAE. In cases of a member already in treatment with a provider at the time the member obtains RMHP enrollment, for the purpose of continuity of care, the member's provider may request a single case agreement, and treatment may be continued. In cases involving special needs, RMHP may offer a single case agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria. Under certain circumstances, members may request an out-of-network provider. These circumstances may include:

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

Provider availability for member access to care

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

All RMHP providers must have appointments available for Health First Colorado members as follows, according to state/federal regulation and the provider contract:

1. **Routine access**
   A routine appointment must be available within 7 business days of a member's request. If a provider offers a member a routine appointment within 7 business days, and the member declines and chooses an appointment outside of 7 business days, the access requirement is met. Members must be offered the same hours of availability as all other insurance members.
2. **Routine outpatient appointment following an inpatient or residential discharge**
   A routine appointment must be available within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility
3. **Urgent access**
   Urgent care (appointments) shall be available within 24 hours from the initial identification of need. "Urgent" definition: A request from a member or designated member representative for situations or circumstances for which there is the potential for placing the health of the individual (or, with respect to a pregnant member, the health of the person or their unborn child) or the health of another in serious jeopardy without treatment, OR potential for serious impairment to bodily functions without treatment, OR potential for serious dysfunction of any bodily organ or part without treatment. The appointment should be scheduled within 24 hours of the initial request.
4. **Emergency access**
   Emergency services shall be available by phone, including by TTY accessibility, within 15 minutes of the initial contact, in person within 1 hour of contact in urban and suburban areas, in person within 2 hours of contact in rural and frontier areas. "Emergency" definition: Conditions, situations or circumstances for which there is the risk for placing the health of the individual (or, with respect to a pregnant member, the health of the person or their unborn child) or the health of another in serious jeopardy without treatment, OR for serious impairment to bodily functions without treatment, OR for serious dysfunction of any bodily organ or part without treatment.
5. **Inpatient and residential treatment post-discharge follow-up appointments**
   Outpatient follow-up appointments are required within 7 business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within 7 business days after discharge from a residential treatment facility.
6. **Hours of operation**
   Providers who serve Health First Colorado members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Providers are encouraged to offer flexible appointment times or after-regular business-hours appointments to members whenever possible.
7. **Extended hours of operation**
   Extended hours of operation and covered service coverage must be provided at least 2 days per week at clinic treatment sites, which should include a combination of additional morning, evening or weekend hours, to accommodate members who are unable to attend appointments during standard business hours.
8. **Waiting room time for scheduled member appointments**
   A Health First Colorado member who arrives on time for their scheduled appointment shall wait no longer than 15 minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by having the wait time policy reviewed with the member at the initiation of treatment. Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access

standards for urgent/emergency requests.

9. **Evening and/or weekend support services**
   Members and families should have access to clinical staff over evenings and weekends, not just an answering service or referral service staff
   - Ongoing mental health and SUD services: Services shall be scheduled and continually provided for within 2 weeks from an initial assessment or intake appointment. Ongoing services include, but are not limited to, assignment to a therapist and individual/group therapy
10. **Routine outpatient appointments**
    Following intake/initial assessment, routine outpatient appointments shall occur at least 3 times within 45 days

Members access to behavioral health care

A member can access behavioral health care in 4 ways:

1. A member, family member, provider or advocate for the member can call Member Services toll-free, Monday-Friday, 8 a.m-5 p.m., for nonemergency situations, clinical assessment and referral to the most appropriate provider. Any emergency situation should call 911.
2. The member can call or walk into any one of the Colorado CMHCs or contact a network provider office and receive a face-to-face clinical evaluation and request services
3. The member can be referred by their PCP, social services caseworker, court system or other community agency through the access points described
4. The member can go to or be brought to any emergency room. A face-to-face evaluation may be arranged with an area crisis evaluator. The crisis evaluator participates in disposition recommendations.

RAE behavioral health telemedicine

In alignment with the Colorado HCPF, RMHP adopted an expanded allowance of telemedicine for most services covered under the Medicaid RAE behavioral health benefit (See **Telemedicine Services Exception Codes**.) not previously allowed to be delivered by telemedicine for RAE members.

RMHP behavioral health telemedicine guidelines:

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

Provider requirements:

1. Practitioners using intensive outpatient psychiatric services (IOP) to treat SUD 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 and/or weight measurements monitored by a professional.
2. Providers are responsible to provide telemedicine services in accordance with Office for Civil Rights (OCR) Notice **hhs.gov/ocr/index.html**

In addition, providers should:

- Be consistent with directives from the Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMSHA), health services that are not urgent should be postponed where possible
- Weigh potential benefits from rendering needed care against the potential weakened validity and reliability of assessment results if choosing to conduct testing via telemedicine or virtual visit care
- Ensure the integrity of the psychometric properties of the tests or assessment procedures used to include:
  - Modifying the test environment as necessary to prevent access to cell phones, the internet

or coaching from other persons during administration
  - Minimizing any potential distractions which could affect performance
- Ensure that additional consideration is given to issues that arise with testing diverse populations that could further lower reliability and validity of scores due to changes in administration procedures and the test environment
- Ensure the quality of the technologies being used and the hardware requirements needed are considered prior to starting testing. Consideration should be given to the availability of 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 enable all available encryption and privacy modes when using such applications.
- Ensure that documentation of the following issues is 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
  - Potential limitations of all assessment results or conclusions when test norms used for interpretation are not based on a telemedicine administration

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

Billing and coding guidance

- Providers are required to abide by all Medicaid billing and coding policy as outlines in the State Behavioral Health Services (SBHS) Billing Manual and requires all services billed in accordance with the USCSM, SBHS Billing Manual 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 depending on the members location
- All codes outlined in the SBHS Billing Manual are allowed with the exception of those codes listed 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

Providers may only bill procedure codes which they are already eligible to bill per their contract and not outlined in the Telemedicine Services Exception Code table.

Telemedicine services exception codes

Code	Description
90870	Electroconvulsive therapy
99217	Observation care discharge day management
99218	Initial observation care, per day, for the evaluation and management of a patient
99219	Initial observation care, per day, for the evaluation and management of a patient
99220	Initial observation care, per day, for the evaluation and management of a patient
99221	Initial hospital care (30 min.)
99222	Initial hospital care (50 min.)
99223	Initial hospital care (70 min.)
99224	Subsequent observation care (15 min.)
99225	Subsequent observation care (25 min.)
99226	Subsequent observation care (35 min.)
99233	Subsequent hospital care (35 min.)

Code	Description
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.)
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	Behavioral health residential without room/board
H0018	Behavioral health short-term residential without room/board
H0019	Behavioral health long-term residential without room/board
H0020	Methadone admin/service
H0033	Oral med admin direct observation
H0035	Mental health partial hospitalization less than 24 hours
H0036	Community psychiatric supportive treatment, face to face, per 15 min.
H0037	Community psychiatric treatment, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H2001	Rehab program 1/2 day
H2030	Mental health clubhouse, per 15 min.
H2031	Mental health clubhouse, per diem
H2032	Activity therapy, per 15 min.
S3005	Performance measurement, depression
S5150	Unskilled respite care, not hospice, per 15 min.
S5151	Unskilled respite care, not hospice, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care service, 15 min.
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification
T1019	Personal care services, per 15 min.

Expectations of providers for emergency access

After initial emergency department triage, authorization for further inpatient evaluation and/or treatment must be obtained from RHMP. At most hospitals, an independent assessment by a CMHC or another outpatient behavioral health provider is required to assist in diversion, crisis stabilization and referral to follow-up.

To comply with emergency access standards under the provider's contract, our expectations for independent providers are:

- If an independent provider is contacted by a member in crisis, the provider will conduct an assessment to determine whether the member's situation can be handled outside of the emergency room. This assessment should follow the standards as indicated in item 4, Emergency Access.
- If the member goes directly to the ER, or if the provider determines the member in crisis is best

assessed in the ER, the provider will be available to the CMHC emergency services team to provide background information, diagnosis and other pertinent details on the member in crisis. This will assist the CMHC emergency services clinician in conducting the member's evaluation and may result in the most appropriate disposition for the member.

- Providers are required to give contact information to members on their voicemail to include one of the following: the provider's pager, the provider's cell phone number or how to reach a covering clinician with whom the provider contracts to provide coverage when the treating provider is not reachable.
- Quarterly test calls are performed at random by the RMHP Quality Improvement staff to monitor provider compliance with these standards. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider's nonresponse to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services.

Outpatient providers are expected to offer 24-hour personal emergency access to their members or have formal arrangements for emergency coverage by another practitioner. An answering service/machine which refers all callers to an emergency room, community mental health center, crisis or other agency is not acceptable unless the provider has established a formal contract for emergency coverage with the agency. In all cases, providers must obtain prior authorization for inpatient care by calling RMHP 24 hours a day, 7 days a week, at 1-888-282-8801.

Coordination of care requirements

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

- Outpatient behavioral health provider
- RMHP clinical coordinators from utilization management
- RAE (or proxy) transition of care planner
- A member of the clinical team familiar with the care of the member

Coordination of care discussions include aftercare planning and should occur at least 48 hours prior to discharge. If the hospital plans to recommend a step down to any level of care other than outpatient, it must involve a referral to the RMHP clinical coordinator managing the inpatient admission and discussion with the outpatient behavioral health provider and transition of care planner. The referral must occur prior to discharge to ensure that a decision can be made prior to the member discharge from inpatient care. Referrals for partial hospitalization, intensive outpatient, acute treatment unit or other services should be made to RMHP at least 2 days prior to discharge to ensure a timely decision can be reached.

Additional requirements include:

- Frequent coordination of care and unrestricted communication with the outpatient behavioral health provider and transition of care planner, including contact by a practitioner involved with the member's care (i.e. an active representative of the treatment team, such as the member's assigned social worker, therapist or prescriber)
- Communication with the outpatient behavioral health provider within 24 hours of admission:
  - Exchange of pertinent history
  - Establishing connection discharge planning
- Updates by the attending physician or other treatment staff on progress, medications, family sessions/needs and aftercare referrals

Examples of coordination of care:

- Progress updates with a focus toward discharge readiness
- Medication feedback or discussion of previous medications
- Development of transition plan to outpatient receiving team, especially for any patient on a mental health certification with or without court-ordered medications
- Barriers to discharge (resource needs, family and placement)
- Aftercare referrals to services other than outpatient need to be given to the RMHP UM clinical coordinator staff and discussed with the discharge planner
- Contact at least 24 hours prior to discharge to ensure aftercare plans are in place

- The hospital must be responsive to the RAE and/or outpatient behavioral health provider and return calls within 24 hours
- Face-to-face meetings with the member when requested by the outpatient behavioral health provider and/or discharge planner to be facilitated by the hospital staff in a timely manner
- Calls/emails from the outpatient behavioral health provider and/or discharge planner returned within 24 hours or by the next business day

All members should have a PCMP. RMHP can assist members in finding a PCMP. Coordination with the PCMP is necessary to promote integrated care, particularly related to medication management. Coordination with primary care is the responsibility of the primary behavioral health provider.

Facilitating improved integration of services and coordination of care

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

Mental health inpatient care requirements

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

Clinical requirement assessment

An initial visit with a psychiatrist, or other psychiatric practitioner with prescriptive authority (e.g. physician assistant, nurse practitioner, resident physician) and psychiatrist consultation, for evaluation and treatment planning within 24 hours of admission.

- A comprehensive bio-psychosocial history including, at a minimum:
  - History of presenting illness
  - Psychiatric history, substance use history
  - Medical history
  - Family history
  - Social history
  - Current medications
  - Allergies
- Comprehensive review of systems
- Full mental status examination
- Initial psychiatric assessment/formulation including current Diagnostic and Statistical Manual (DSM)-based diagnoses risk assessment
- Individualized overall assessment/formulation of key issues and recommended interventions
- Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate

Clinical requirements: subsequent treatment

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

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

Clinical requirements: discharge

Documentation of the discharge plan including follow-up appointments per handbook guidelines, discharge medications, and emergency contacts delivered to the patient in writing with a face-to-face review.

Provision of a 30-day prescription for discharge medications with confirmation that the member has the resources to obtain medications or documentation that a new prescription is not required.

Any prescribed medications requiring pre-authorization to be filled must have the pre-authorization obtained by the hospital staff prior to the member being discharged.

Transfer of certification to outpatient level of care with or without court-ordered medications requires advance notification and discussion with receiving CMHC.

The liaison can coordinate direct communication with the CMHC treatment team a treatment plan that bridges a certified patient from inpatient to outpatient receiving team must be developed before discharge The prescriber's dictated discharge summary must be faxed to the outpatient provider within 72 hours of discharge.

UM procedures

Authorization decisions are based on medical need, appropriateness of the level of care requested, benefit coverage and administrative requirements such as submitting complete clinical documentation. We are only able to authorize covered services for covered diagnoses per our contract with HCPF. Providers are expected to cooperate fully with RMHP clinical coordinators and medical staff to provide accurate and timely clinical information to assist with this process. This may include submission of verbal reports or written documentation (including clinical notes and treatment plans). All documentation needs to be submitted in English, even if records in the member's chart are kept in another language. Participation in telephonic or face-to-face staffing may be required for complex cases. UM staff will make every effort to make decisions in a manner that allows providers to focus on the care of members and will not ask for more information than is necessary to make an appropriate decision regarding medical necessity of the service in question.

As defined by the department, "medical necessity" is a medical assistance program, good or service that:

- Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering or the physical, mental, cognitive or developmental effects of an illness, condition, injury or disability. This may include a course of treatment that includes mere observation or no treatment at all.
- Is provided in accordance with generally accepted professional standards for health care in the United States Is clinically appropriate in terms of type, frequency, extent, site and duration
- Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker or provider
- Is delivered in the most appropriate setting(s) required by the client's condition
- Is not experimental or investigational
- Is not more costly than other equally effective treatment options

Clinical criteria utilized for decision-making include the department's definition of medical necessity and MCG criteria, which are evidence-based clinical care guidelines that support what level of care will best support a member's needs.

Additional criteria used to make authorization decisions are comprised of admission criteria, exclusion criteria, continued stay criteria and discharge criteria for the specific level of care requested.

UM is the responsibility of the RMHP utilization department. Clinical coordinators perform clinical reviews for all levels of care that require prior authorization through telephonic discussions and review of written clinical records. The frequency of review varies with the intensity of the level of care being provided and the clinical needs of the member.

Member consent is not required for provider participation in UM activities except for those UM activities related to SUD services, when it is specifically required by law (42 C.F.R., part 2).

RMHP clinical coordinators are responsible for the following functions:

- Conducting reviews with treatment providers to verify medical necessity based on the department's and MCG's medical necessity criteria at admission, continued ongoing care and aftercare
- Ensuring that the evaluation of the member includes pertinent biopsychosocial, medical and psychiatric/behavioral health information to support the diagnosis and impairments determined by the provider
- Ensuring that service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the provider, are coordinated with other service delivery persons or agencies and are consistent with the department's medical necessity criteria
- Ensuring good coordination of care, prompting providers to involve all appropriate treatment team members in the delivery of integrated care designed to assist the member in overall health. To this end, to listen for needs that may be unrelated to the behavioral health authorization decision but may be having a significant impact by creating barriers to discharge or contributing to readmissions (e.g. physical health needs, housing, transportation, other social determinants of health needs and/or waiver services)
- Ensuring that level-of-care and treatment decisions are based on medical appropriateness and necessity, as described in the medical necessity criteria and guidelines, and are designed to achieve desired member outcomes within an optimal time frame
- Encouraging providers that discharge planning begins at admission
- Providing consultation to treatment team members when needs of a member are complex

Provider responsibilities in UM

RMHP-contracted providers are required to:

- Complete a comprehensive assessment of the member at the start of treatment that clearly provides rationale for the diagnosis and the mix of services provided to the member
- Provide accurate clinical information that is consistent with the member's written documentation in the chart to support authorization requests
- Keep track of authorizations and use of authorized services and make timely requests for reauthorizations. Begin discharge planning at the time of admission for all levels of care.
- Submit complete and accurate discharge and aftercare plans to RMHP and all related aftercare provided within 72 hours of discharge. Member care and quality treatment are significantly impacted following inpatient treatment without this data.
- For inpatient and residential levels of care, complete a discharge plan for each member within 48 hours of admission and have this plan signed by the member and guardian/family member, as appropriate. This plan must be included in the member's chart.
- For any discharge plan not completed within 48 hours, the chart needs to contain documentation of the clinical reason why this was not possible
- Provide services in the least restrictive environment possible for the member
- Follow all documentation requirements, including updated and accurate written treatment plans that guide services to RMHP members
- Provide clinical information verbally, when requested, to assist with an authorization decision
- Provide a copy of the member's written treatment plan and treatment notes, when requested
- Respond in a timely manner when UM staff reach out to confirm information (e.g. clarify their authorization request, confirm member's start or end date of treatment or other treatment details)

- If an assessment is needed to determine what services a member needs, authorization requests for those services should occur no later than 30 calendar days after the assessment was completed
- Request concurrent authorizations in a timely manner, typically on the last day covered from the previous authorization
- Request authorization only for services that meet medical necessity guidelines
- Follow the Uniform Service Coding Standards Manual guidelines in providing care at the approved place of service by the appropriately qualified staff person. You may be able to find the latest version on the Colorado official state website.

Outpatient care

A treatment plan is required for all outpatient services and must include time-limited and measurable objectives. It must be formulated with member or guardian input and signed by the member and/or guardian.

Network providers do not need prior authorization of evaluation or most outpatient services; however, there are a few that do require prior authorization. More information can be found at **UHCprovider.com**.

Family therapy is conducted for the treatment of the identified member's covered diagnosis only and billed under the member's RMHP coverage.

Separate billing for other family members who participate in the family therapy sessions is not allowed.

Higher level of care: prior authorization

Prior authorization is required for all inpatient, partial hospital, residential, intensive outpatient services and day treatment services.

RMHP may require an independent assessment by a CMHC crisis evaluator. In most cases, the clinical coordinator will consult with the local CMHC for availability of diversion services prior to authorizing higher levels of care.

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

Collaboration includes the provision of verbal or written treatment information to another provider, if indicated. Inpatient care requires coordination of care with the CMHC for RMHP member admissions to obtain the best treatment outcome for each member and arrange appropriate aftercare services. Care should be coordinated by a social worker or member of the treatment team with firsthand knowledge of the member's symptoms, needs and care. This should begin on the day of admission and occur routinely and regularly throughout the hospitalization.

Pre-authorization of continuing higher levels of care requires a review between the provider and the RMHP UM clinical coordinator. Providers should follow the instructions of the clinical coordinator regarding the clinical information needed. Most authorizations are completed with written clinical documentation faxed or secured email by the provider to the UM team.

RMHP requires active collaboration with the RAE or proxy discharge planner.

To evaluate the higher level of care request, the clinical coordinator will require detailed information concerning the member's need for continuing care (i.e. measurable treatment goals, discharge plans, current condition, treatment notes, prescribed medications, medication changes). It is the responsibility of the provider/facility to provide appropriate concurrent review documentation to the RMHP UM department prior to the expiration of the current authorization.

Hospital professional charges

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

Emergency services

Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

Emergency services do not require prior authorization.

Documentation must accompany claims for emergency services to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.

Authorization when level of care changes

Authorization of care does not extend from one level of care to another. RMHP's UM department must be notified immediately when a member is discharged from any level of care, and a RMHP must receive the discharge and aftercare plan in writing.

Authorization for treatment at a new level of care will be based on medical necessity.

A new authorization will be required with any change in the level of care.

Electroconvulsive therapy (ECT)

All inpatient and outpatient ECT requires pre-authorization. Most ECT requests are reviewed by the RMHP medical director.

For RMHP RAE members:

- Behavioral health claims are submitted to RMHP
- Physical health claims are submitted to DXC, the fiscal agent for the department

For RMHP PRIME members:

- Behavioral health claims are submitted to RMHP
- Physical health claims are submitted to RMHP

Chapter 5: Claims billing and provider appeals

Submission of claims to RMHP

Providers are responsible for submitting claims to UnitedHealthcare for payment.

For services covered by RMHP, including behavioral health services for RMHP RAE members and medical services for RMHP PRIME members.

Electronic delivery

RMHP encourages providers to submit claims electronically. RMHP accepts submissions from most major clearinghouses. To learn more about electronic submission, visit the **EDI Connectivity web page**. For providers that wish to send 8371 and/or 837P transactions, RMHP has more information at **UHCprovider.com**.

Paper delivery

You may also submit claims directly to RMHP at the following address. If claims are submitted on paper, they must be submitted on a CMS 1500 or UB-04/CMS 1450.

Mail for RMHP Medicaid plans:

UnitedHealthcare Community Plan
P.O. Box 5260
Kingston, NY 12402-5260

Submission of claims to DXC

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

Incomplete claims are not clean claims

If RMHP is unable to locate a member, the claim will be rejected in Gateway. The necessary corrections should be made and a new claim should be submitted for consideration. Please send all requested information within the account-specific timely filing guidelines.

Required claim elements

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

Tips for completing the UB-04 (CMS-1450) claim form

All data elements noted as required must be provided, but they must also be current and match what the member has on file. If the member's ID on the claim is illegible or does not match what the client has provided to us, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the member's ID card and validate that it is current at the time of each visit.

There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.

For paper claims, the use of scanning by means of optical character recognition technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the provider does not follow the guidelines, claims will still be processed; however manual intervention will be required which may delay claims processing.

Tips for completing paper claims:

- Use machine print
- Use original red claim forms
- Use black ink

- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8½" x 11" paper
- Use an 8-digit date format (e.g. 10212015)
- Use a fixed-width font (e.g. Courier)

Claims processing

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

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

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

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

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

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

Coordination of benefits

Some members may have health benefits coverage from more than 1 source. In these instances, benefit coverage is coordinated between primary and secondary payers. Providers should obtain information from members as to whether the member has health benefits coverage from more than 1 source, and if so, provide this information to RMHP.

By federal mandate, providers must exhaust all other insurance coverage and payment prior to billing Health First Colorado for covered services. To the extent not otherwise required by applicable laws or regulations, providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

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

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

Overpayment recovery

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

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- Duplicate payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations

- Payments made in excess of amounts due in instances of third-party liability and/or coordination of benefits
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative and medically unlikely edits described in the claims submission guidelines

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

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

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter, RMHP will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out, and the full amount of the overpayment is recovered. RMHP may use automated processes for claims adjustments in the overpayment recovery process. In those instances, in which there is an outstanding negative balance because of claims adjustments for overpayments for more than 90 calendar days, RMHP reserves the right to issue a demand for re-payment.

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

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

UnitedHealthcare
ATTN: Recovery Services
P.O. Box 101760
Atlanta, GA 30392-1760

Requests for review

Providers may request review of a RMHP claims determination. All requests for review must be submitted in writing or made telephonically within 60 calendar days or the time period specified in the provider agreement (if any) from the date of RMHP's original claim determination. Requests for review received beyond the noted time period will not be reviewed and are considered expired.

Claims disputes

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

Claims appeal process

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

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

UnitedHealthcare Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included. Adjustments and reversal requests may be requested by calling Member Services.

Resubmissions

Incomplete claims

1. Claims may be "zero-paid" by RMHP in the case of incorrect or incomplete required data elements
2. RMHP will notify the provider through the provider summary voucher of those data elements requiring completion or correction

Resubmissions

1. Claims that are "zero paid" due to incorrect or incomplete required data elements must be resubmitted for payment consideration within 60 days from the date on the provider summary voucher
2. Providers may resubmit corrected claims by mail or electronic media claims
3. Corrected claims should have a clear indication on the claim that the claim is a corrected claim

Claims billing audits

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

- Members
- External referrals from state, federal and other regulatory agencies
- Internal staff
- Data analysis
- Whistleblowers
- Others who express a concern about potential fraud, waste or abuse

RMHP also conducts random audits. RMHP conducts most of its audits by reviewing records providers either fax or mail to RMHP, but in some instances on-site audits are performed as well. Record review audits, or discovery audits, entail requesting an initial sample of records from the provider to compare against claims submission records. Following the review of the initial sample, RMHP may request additional records and pursue a full/comprehensive audit.

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

Records reviewed may include, but are not limited to:

- Financial
- Administrative
- Current and past staff rosters
- Treatment records

For the purposes of RMHP's audits, the treatment record includes, but is not limited to:

- Progress notes
- Medication prescriptions and monitoring
- Documentation of counseling sessions
- Modalities and frequency of treatment furnished
- Results of clinical tests

It may also include summaries of the:

- Diagnosis
- Functional status
- Treatment plan
- Symptoms
- Prognosis
- Progress to date

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

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

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

In the course of an audit, documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered.

Providers' strict adherence to these guidelines is required. A member's treatment record must include the

following core elements:

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

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

Education/Training
RMHP may require the provider to develop an educational/training program addressing the deficiencies identified. RMHP may provide tools to assist the provider in correcting such deficiencies.

CAP
RMHP may require the provider to submit a CAP identifying steps the provider will take to correct all identified deficiencies. CAPs should include, at a minimum, confirmation of the provider's understanding of the audit findings and agreement to correct the identified deficiencies within a specific time frame.

Repayment of claims
The audit report will specify any overpayments to be refunded. The overpayment amount will be based on the actual deficiency determined in the audit process, or the value of the claims identified as billed without accurate or supportive documentation. RMHP does not use extrapolation to determine recovery amounts. The provider will be responsible for paying the actual amount owed, based on RMHP's findings within 10 business days, unless the provider has an approved installment payment plan.

Monitoring
RMHP may require monitoring of claims submissions and treatment records in 90-day increments until compliance is demonstrated. The participating provider's monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.

Chapter 6: Member appeals and grievances: PRIME and RAE

RMHP RAE and PRIME members have many rights. Providers should be aware of these rights, as members may ask for your assistance in exercising some of them.

Members have the right to complain about RMHP. They have the right to complain about provider care. The member or a designated client representative (DCR) may complain about anything the member is unhappy about or has a problem with. A DCR is someone (including a provider) the member chooses to help them with an appeal or a grievance. The member must sign a form to give their DCR permission to act on their behalf. The form must have the DCR's name, address, and telephone number. If the complaint is about medical care, the DCR will have access to the member's medical records and specific details about the member's medical care.

The member has the right to appeal a decision. This means the member can ask for a review of something RMHP has done. Decisions are just those things listed in Section A.

The member has the right to file a grievance. This means the member can complain about any matter other than a decision. See Section A. Grievances are the kinds of things listed in **Section B**.

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

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

Section A – appeal a decision

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

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

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

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

First level review

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

Within 2 working days of the day RMHP receives the member appeal, RMHP will notify the member in writing acknowledging RMHP received the member's appeal. In that letter, RMHP will tell the member how they may get a copy of RMHP's file about their appeal. RMHP will also give the member a chance to give RMHP any more information about the appeal.

The appeals and grievance coordinator will get all the facts about the case. Within 10 working days after RMHP hears from the member, RMHP will send the company's decision in writing. After this review, RMHP may decide to change its action.

Expedited (fast) review

Expedited or fast appeals are used when RMHP's decision puts the member health in danger. The member or DCR can ask for an expedited or fast appeal. RMHP must complete the fast appeal review within 72 hours of the request. Because of this short 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. An expedited or fast appeal can be downgraded by a medical director if it is determined that working the appeal in standard time frame will not put the member's health in danger.

State fair hearing

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

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

For any type of an appeal, the member may still receive services when the member asks the plan to take a second look at a decision. The same is true when the member has asked for a state fair hearing. See **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 DCR must tell RMHP they want to keep receiving services within 10 days after receiving the notice of the appeal resolution
- Providers may not ask to have benefits continue while the appeal is being reviewed
- An RMHP provider must have ordered the services

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

Section B – file a grievance

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

A grievance is a verbal or written statement that says the member is unhappy. The member will not lose their coverage because of the complaint. The member will be treated the same as any other member.

Here are some things a member can complain about:

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

How grievances are handled

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

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

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

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

Section C – state fair hearing

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

- Write a request for a hearing within 120 calendar days from the date of RMHP's final decision. If needed, RMHP 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:

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

Fax – 1-303-866-2000 or 1-303-866-5909

The member, provider or DCR may file for a state fair hearing on the member's behalf. The provider or DCR must have the member's written permission to file.

The member has the right:

- To represent themselves at the state fair hearing
- To choose someone to represent them at the state fair hearing
- To present information or evidence to the administrative judge during the hearing
- To read or examine all RMHP documents related to the appeal before and during the hearing

For help from RMHP in writing and submitting a request for a state fair hearing, members should call Member Services at 1-800-421-6204 for RAE and RMHP PRIME members.

Chapter 7: General medical record requirements

RMHP has medical record requirements for members receiving services at any level of intensity:

Coordination of care

All providers must coordinate care with any member's PCMP and with other treatment providers to include member's outpatient therapist or prescriber. If a member does not have a PCMP, providers are to assist the member in locating one. Assistance is also available at the RMHP and may be obtained by calling 1-800-421-6204.

Missed appointments

Providers are expected to contact members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the member's medical record.

Discharge plan

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

Medical record and treatment plan

- All documentation must be contained in the member's medical record. Additionally, all member medical records must contain a comprehensive biopsychosocial assessment, measurable treatment goals, signed progress notes and a discharge plan. The treatment plan should indicate involvement of a member's family/significant others when clinically indicated. If not clinically indicated, this should be noted as a part of the plan. Medical and psychological treatment documentation and progress notes must be current, dated and signed, and treatment plans must be updated regularly.
- The provider initiating treatment must formulate an initial treatment plan with input from the member
- The treatment plan should describe the specific target problems or symptoms and identify strengths and supportive resources, as well as the diagnosis, planned interventions at the level of care proposed and clear, time-limited and measurable criteria for discharging the member from treatment that are agreed upon by member and provider
- Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan. The treatment plan must be signed by the member or the member's guardian. If the member refuses to sign, this too should be documented in the record.
- Progress notes must reflect that treatment provided to the member at each session is tied to the goals of the treatment plan
- We require thorough documentation of regular communication with other providers, including physical health providers and an integrated treatment plan
- Medical records are subject to quality of care and financial audits. Client consent is not necessary.

Advance directives

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

- If a member requests additional information on the acts from the provider, the member can be referred to the RAE Office of Member and Family Affairs, the

Member Handbook or the RAE website

- For help writing an advance directive, refer the member to their PCMP or to the Colorado Bar Association. In Colorado, advance directives, as defined in the Patient Self-Determination Act, apply to medical/surgical procedures, not psychiatric conditions.
- Providers are encouraged to assist members to develop crisis plans that define the member's wishes in time of psychiatric crisis
- Providers are required to ask members if they have an advance directive and are encouraged to ask if they would like a copy placed in their mental health record. Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. If the member is incapacitated at the time of admission, the provider shall ask the family or significant other if the member has an advance directive and shall give the family information about advance directives. At such time as the member is able to understand the question, the provider must again ask if the member has an advance directive and, if so, document that in the medical record.
- A provider may not condition a member's care or treatment on whether or not they have executed an advance directive

Providers must inform members how to report a grievance to the appropriate state agency if an advance directive is not followed.

Quality assurance and compliance

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

- CAPs
- Documentation and chart audits
- Colorado Client Assessment Report (CCAR) submissions

CMHC and other large group providers who submit CCAR files directly to the Behavioral Health Administration (BHA) will continue to do so.

Behavioral health quality program

The objective of RMHP is to assess and improve the quality and effectiveness of care delivered to Colorado Health First Colorado members. The program is designed to analyze provider performance so data can be used to recognize quality care, identify provider and facility best practices, improve provider network services and identify areas for continuing education.

Measures of performance and outcome as well as practitioner practice patterns are reviewed.

Other areas reviewed may include treatment record documentation, compliments, grievances/member satisfaction, and quality of care and utilization patterns. Providers will receive formal, written feedback on their performance.

Quality of care

Please contact RMHP to report any quality-of-care issues identified in the provision of services to members by contacting Provider Services for RAE and PRIME members at 1-800-421-6204.

Treatment record audits

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

Confidentiality

To support quality management responsibilities for oversight of member care, RMHP has in place strict confidentiality policies and procedures regarding the protection and disclosure of member information. These policies and procedures ensure that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA, **42 C.F.R. Part 2**) and accreditation requirements. RMHP ensures that all such information obtained is used solely for

the purposes of UM, quality management, disease management, discharge planning, case management and claims payment. In addition, RMHP maintains information systems to collect, maintain and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as well as a plan for secure storage, maintenance, tracking and destruction of member-identifiable clinical information. RMHP staff engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information. Reference to individual providers or members is redacted to safeguard the member's identity. Confidential information may include, but is not limited to:

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

Consents to disclose SUD information

For each member receiving SUD services, providers shall obtain a release of information, compliant with 42 C.F.R. § 2.31, authorizing them to disclose information related to the member and their SUD services to RMHP for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such information by the RMHP to HCPF, as required by and for the purposes set forth in the RMHP's contracts with the department.

Providers shall retain and maintain each such consent for a period of at least 6 years from the last effective date of such consent. If a member refuses to sign such a consent, providers shall document their efforts to obtain such a consent and shall notify RMHP prior to billing for the provision of substance use services for such members.

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

Medical record documentation standard

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

General requirements

- Each record includes the member's identification, including, but not limited to:
  - Age
  - Date of birth
  - Gender
  - Address
  - Employer or school
  - Home and work telephone numbers
  - Emergency contacts
  - Marital/legal status
  - Financial information
- Each record includes appropriate consent forms and guardianship information
- Each record contains a statement as to whether or not a member older than age 18 has an advance directive and contains a statement that you provided advance directive information if requested
- Each record contains a statement as to whether or

not a member younger than age 21 has had a well-child exam (EPSDT requirement) in the last year and results of the exam if related to the mental health condition, or a referral to a PCP if no recent exam has occurred

- Each record contains a copy of Health First Colorado client rights and responsibilities signed by the member
- Each record contains a copy of the member's signed acknowledgement that they received your Notice of Privacy Practices
- Each record contains a copy of your professional disclosure form signed by the client
- Each record contains a copy of any release of information (to PCP or other parties as indicated) signed by the member or a statement that member refused to sign. Releases must meet all HIPAA and 42 C.R.F. Part 2 requirements.
- Each record contains an assessment of transportation needs and documentation that the provider helped to arrange transportation when necessary
- Each record includes an individual bio-psychosocial assessment (e.g. presenting problems; medical history; physical health status; relevant medical conditions; current medications; allergies; mental illness; organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, cultural, and social conditions affecting the member and family; past or present history of abuse; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances)
  - For children and adolescents, the assessment includes a developmental history (e.g. physical, psychological, social, intellectual, academic)
  - For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues
- Each record includes a mental status examination documenting the member's presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others
- Each record includes a clinical formulation describing the reasoning and justification for the diagnosis, and a current DSM diagnosis based on psychiatric, psychological, substance use or medical condition. The formulation includes sufficient description of the criteria per the current DSM to support the diagnosis.
  - Any subsequent changes in diagnosis must be similarly documented and explained
  - The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record

Service/treatment plan

- Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider's intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution
- The treatment/service plan is consistent with the member's diagnosis and needs as identified in the assessment. There is documented evidence in a progress note that the member—and parent/guardian, if applicable—participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates.
- The treatment/service plan must include specific criteria for discharging the member from treatment that are agreed upon by the member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan.
- The treatment plan addresses coordination of care with other relevant providers
- The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the member's condition or service needs occurs. The plan is revised as necessary. For members involuntarily receiving services pursuant to Section 27-65-101 et seq., C.R.S., the plan must be reviewed monthly. The treatment plan for substance use diagnoses is completed every 6 months, unless individuals receive medication/psychiatric services as only as described in Section 21.190.7 of the BHA standards. The member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.

Progress notes

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

Miscellaneous

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

Compliance

UnitedHealthcare, a subsidiary of UnitedHealth Group 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.

Fraud, waste and 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 fraud, waste and abuse in the health care system.

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