2025 Medicaid/Child Health Plan Plus Behavioral Health Care Provider Manual

Rocky Mountain Health Plans

Doc#: PMG 20250624-152404

v72.01.2025

United Healthcare Community Plan

Rocky Mountain Health Plans
A UnitedHealthcare Company

Welcome

Welcome to the Rocky Mountain Health Plans (RMHP), an UnitedHealthcare Company, care 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 in 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**.

If you have questions about the information or material in this manual, or about our policies, please call **Care provider Services** at **1-800-421-6204**. For operational policy changes and other electronic transactions on our website at **UHCprovider.com**

Using this manual

This care provider manual is a resource of information designed to assist care provider offices in successfully delivering health care services to patients covered RMHP. This care provider manual includes:

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

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. RMHP 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 care providers, except when indicated
- “Your Agreement,” “Care provider Agreement” or “Agreement” refers to your Participation Agreement with us
- “RMHP” refers to Rocky Mountain Health Plans
- “PRIME” refers to Medicaid PRIME
- “CHP+” refers to Child Health Plan Plus
- “RAE” refers to Regional Accountable Entity
- “Us,” “we” or “our” refers to Rocky Mountain Health Plans on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to “ID card” includes a physical or digital card

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

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Chapter 1: Introduction

RMHP is committed to ensuring care providers have the tools and resources necessary to best serve members of Child Health Plan Plus (CHP+) and Health First Colorado (Colorado's Medicaid Program).

We created this guide to help behavioral health care providers understand behavioral health covered services, benefits, and care provider responsibility to ensure successful delivery of health care services to 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 care providers and at different levels of care through defined, inter-organizational workflows. We facilitate the exchange of member-centered data among care 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 for RAE, PRIME and CHP+:

- **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-care provider practices, large group clinics, specialty care providers and facilities, and Comprehensive Safety Net Care providers (CSNP)
- **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 care providers

RMHP's Care provider Relations team is available to answer questions about credentialing and contracting at **1-800-421-6204** for PRIME and RAE care providers and 1-877-668-5947 for CHP+ care providers. Care providers can also visit **UHCprovider.com** to find more information about the RAE as well as common forms and resources for care providers. RMHP offers care providers an updated and secure care provider portal at **UHCprovider.com** or **Care providerExpress.com**. These portals provide information about member eligibility, benefits, copays, claim status and code lookup.

To register for the Care 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/portal**.

Get help from RMHP

RMHP is here to help. Our local Member/Care provider Services team can provide you with answers you need when you need them.

- **Rocky Mountain Health Plans**
  - **CHP+:** 1-877-668-5947
  - **RAE and PRIME:** 1-800-421-6204
  - **Mail – rmhpbhvm@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 care 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 care 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:

- **Region 1: Rocky Mountain Health Plans (RMHP)**
  - **Phone – Medicaid** 1-800-421-6204
  - **CHP+:** 1-877-668-5947
  - **Hours –** Monday-Friday, 8 a.m.-5 p.m.
  - **Web – UHCprovider.com**
- **Region 2: NHP**
  - **Phone –** 1-800-541-6870
  - **Hours –** Monday-Friday, 8 a.m.-5 p.m.
  - **Web –** nhprae2.org or **UHCprovider.com**
- **Region 3:** Colorado Community Health Alliance (CCHA)
  - **Phone –** 1-303-256-1717 or 1-855-627-4685 (toll free)
  - **Hours –** Monday-Friday, 8 a.m.-5 p.m.
  - **Web –** cchacares.com
- **Region 4: Colorado Access (COA)**
  - **Phone –** 1-303-368-0037 or 1-855-267-2095 (toll free)
  - **Hours –** Monday-Friday, 8 a.m.-5 p.m.
  - **Web –** coaccess.com

RAE Region 2

Thank you for being a valued partner of RMHP serving NHP RAE Region 2 Members.

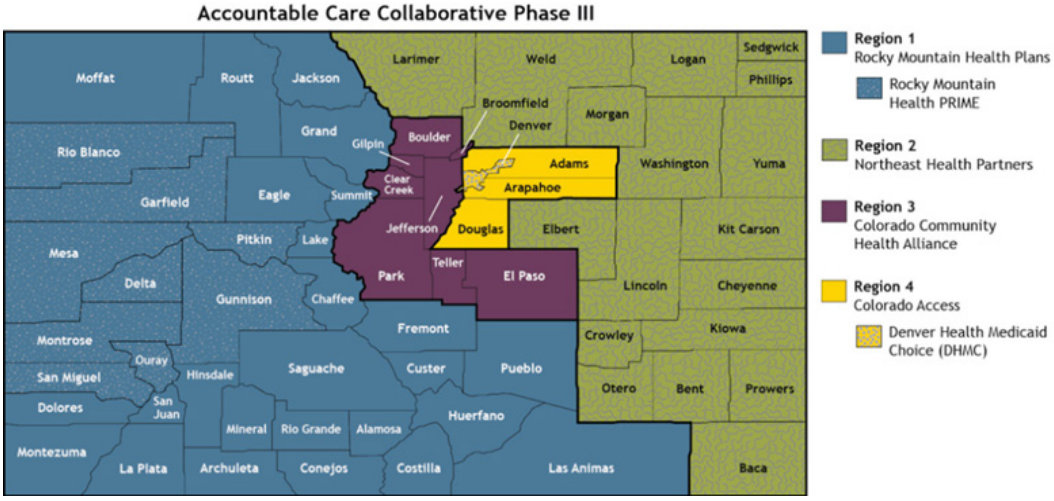
This care provider manual is part of your Medicaid care provider contract. Please note that your Regional Accountable Entity (RAE) Behavioral Health Care Provider Contract with Rocky Mountain Health Plans applies to both RAE Region 1 and Region 2. RAE Region 2, managed by Northeast Health Partners (NHP), has delegated to Rocky Mountain Health Plans (RMHP) to enhance Behavioral Health and Substance Use Disorder administrative services beginning July 1, 2025.

Key services RMHP will provide include:

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

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

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



Chapter 2: Covered behavioral health services

The following mental health and substance use disorders (SUD) services are covered by the RAE, PRIME and CHP+ plans for all ages with exceptions as noted below:

- **Alcohol/drug screen counseling**
  - SUD counseling services are provided along with screening to discuss results with a member
- **Autism spectrum disorder (ASD) services**
  - Effective January 1, 2024, psychotherapy services for ASD are covered as a behavioral health benefit are now covered for Medicaid members, however, other related ASD services may be covered either under the behavioral health benefit or through the fee-for-service benefit. For further information, please reference the applicable State Behavioral Health Services Billing Manual and other resources in the Behavioral Health Services section located at hcpf.colorado.gov/accountablecare-collaborative-phase-ii-care provider-and-stakeholder-resource-center.
- **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
- **Inpatient psychiatric hospital services**
- **For Medicaid 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 CHP+ Members younger than 19 years old**
  - A program of care for members age 18 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.
- **For Medicaid 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 CHP+ adults ages 19+**
  - A program of psychiatric care in which the member remains 24 hours a day in a facility licensed as a hospital by the state.
- **Additional Behavioral Health Services Include for Medicaid and CHP+ 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**
  - 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
- Targeted case management
- Additional benefits known as 1915(b)(3) services, which can be accessed at community mental health centers and other participating community care providers
- Vocational services
- Intensive case management
- Prevention/early intervention activities
- Clubhouse and drop-in centers
- Residential
- Assertive community treatment (ACT)
- Recovery services
- Respite services

RMHP responsibilities for inpatient care

RHMP'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.

RHMP 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** within this Chapter.

RHMP 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 proceduresto treat a secondary covered psychiatric diagnosis. Note: if member is PRIME or CHP+, RMHP is responsible for this benefit as a physical health benefit.

RHMP 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.

RHMP 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.

RHMP shall be financially responsible until a SUD diagnosis is determined to be the primary diagnosis, at which point RHMP 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, RHMP 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.

RHMP 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

These plans are 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 Ombudsman for Behavioral Health Access to Care at:

Phone - 1-303-866-2789

Email- 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

The MHPAEA is designed to ensure that Medicaid and CHP+ 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 and CHP+ 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. HCPF 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 and CHP+ members to access MH/SUD services. View the Regulatory Resource Center.

Services requiring prior authorization

Prior authorization is required for inpatient hospitalizations, partial hospitalizations, acute treatment units, short- and long-term residential (except for QRTP and PRTF), day treatment, intensive outpatient programs, and electroconvulsive therapy. For notifications by the admitting facility, call **1-800-421-6204** for RAE and PRIME and **1-877-668-5947** for CHP+ care providers.

Behavioral health services requiring prior authorization by RMHP for 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 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** and **UHCprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-prior-auth.html**.

For RMHP 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: 1-970-257-3986

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-care 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 care provider, nonphysician practitioner group or an FQHC or RHC using revenue code 0900

Continuum of services

The RMHP care 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 CSNP care providers. However, routine outpatient assessment, psychotherapy, psychological testing and medication management services are also offered by our network of independent outpatient care providers. Hospitalization and residential levels of care are offered by contracted network facilities and some CSNPs.

The care delivery system has been developed to ensure that, from the moment they access services, Health First Colorado and CHP+ members are directed to the most appropriate level and type of behavioral health care, in geographically convenient locations. RMHP care 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 care 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.

Psychiatric Residential Treatment Facility (PRTF)

A PRTF is defined by the Colorado Code of Regulations (10 CCR 2505-10 8.765.2). PRTFs provide services to youth from age 3 up to the age of 21 with a psychiatric diagnosis by treating these issues and restoring the youth to their best possible functional level. Youth who require PRTF level of care have a higher acuity than those youth who require a Qualified Residential Treatment Program (QRTP). Treatment in a PRTF is under the direction of a physician and decisions are made by an interdisciplinary team (IDT). Those on the IDT who certify the need for PRTF level of care includes a psychiatrist or doctoral level psychologist, and a licensed physician as well as a licensed clinical social worker, a registered nurse, a certified occupational therapist and a licensed psychologist. Services at a PRTF may be similar to other levels of care. The distinction lies in the medical background of the treatment care providers and the intensity of services provided. 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

Qualified Residential Treatment Program (QRTP)

A QRTP is defined by Colorado Revised Statute §26-5.4-102(2). This 24-hour, supervised, residential level of care provides trauma-informed treatment designed to address serious emotional or behavioral disorders or other disturbances. As appropriate, QRTP treatment will involve participation of family members, including siblings, in the youth's treatment. Treatment in QRTPs is under a behavioral health model of trauma-informed care led by behavioral health clinicians rather than a medical model led by medical doctors. If the youth is in the Department of Human Services custody, securing an Independent Assessment and authorization for QRTP services is the responsibility of the Department of Human Services.

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 care providers connect members to adjunctive services, including physical health, specialty services and community care. For assistance, call **1-800-421-6204** for PRIME and RAE and **1-877-668-5947** for CHP+.

SUD benefit

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

Behavioral Health Administration (BHA) Resources

RMHP will ensure Behavioral Health Administrative Service Organization (BHASO) contracted providers receive technical support with all data systems required to report their SUD, crisis and mental health data. This includes technical support with the Unity platform and Unified Data Model (UDM) - as it becomes available. Instructions on how to access the Medication Assisted Treatment (MAT) Central Registry go to https://bha.colorado.gov/for-service-providers/technology-and-data-systems#how-to-guides.

- For new Opioid Treatment Provider (OTP) clinics or locations, please contact Ryan Mueller, Colorado's State Opioid Treatment Authority (SOTA) at ryan.mueller@state.co.us
- To add or remove users at existing OTP clinics and locations, please fill out the Central Registry Access Form, or email cdhs_bha_provider_support@state.co.us

Coming Soon - Client Care Search Tool

Client Care Search Tool is a system where inpatient and residential behavioral health care providers track bed availability, and where care navigators can find information for client placements.

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 the 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 2.5 - Partial hospitalization program (PHP)
- 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 WM- Clinically managed residential withdrawal
- Level 3.7 WM – Medically monitored inpatient intensive 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 2.5 - Partial hospitalization program (PHP)
- 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: 1-970-257-3986

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 U1	ASAM Level 3.1
H0010	ASAM Level 3.2WM (withdrawal management)
H2036 U3	ASAM Level 3.3
H2036 U5	ASAM Level 3.5
H2036 U7 Rev Code 1000	ASAM Level 3.7
H0011 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. EPSDT services are not applicable to CHP+ Members. 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 care 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 Member Services at **1-800-421-6204**, visit the online RMHP ESPDT training at **chameleoncloud4.io/review/prod/e44bae6b-c1aa-4268-858d-2f477f8f3e2e**, or HCPF's website at hcpf.colorado.gov/epsdt or call HCPF at 1-303-866-6167.

The state of Colorado also may provide the following services through the RAE and/or Managed Care Organization (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 care 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 care provider who is qualified to provide medical services and is appropriately revalidated and/or enrolled for these services with HCPF.

Behavioral health care 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 care 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 healthfirstcolorado.com.

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.

EPSDT care coordination

Care coordination services for RAE and PRIME members are provided through RMHP with support from participating PCMP care providers and integrated community care teams (where available and applicable). 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 care 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 PRIME members and **1-877-668-5947** for CHP+ members.

Chapter 4: Care provider responsibilities

RMHP behavioral health network care provider responsibilities

Credentialing and contracting

RMHP's responsibility to behavioral health care providers includes:

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

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 behavioral health network. Information about this requirement can be found on hcpf.colorado.gov/provider-enrollment.

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 fee schedule agreement to be a participating RMHP provider.

Current RMHP credentialed behavioral health providers are not required to complete additional credentialing by RMHP; however, they must agree to accept RMHP's fee schedule agreement to be a participating RMHP 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 RMHP region who are providing necessary services to an RMHP member and due to its scope of practice will likely not serve RMHP members often.

Applying for Medicaid/CHP+

Prospective members

Prospective members can apply for Medicaid/CHP+ by going to the Health First Colorado webpage.

Items needed to apply as well as general criteria can be found on this webpage. Additionally a prospective member can get assistance with their enrollment application by contacting their local county office this or locate an assister site.

Verification of eligibility and enrollment

Care providers are responsible for confirming member eligibility and RAE/MCO enrollment of members before providing services. Members' determination of eligibility and enrollment with RMHP as the regional organization or MCO is based on the state of Colorado's eligibility developed and applied by HCPF. Health First Colorado eligibility and enrollment to a RAE or MCO standards should be verified by using the system available through the State of Colorado, the Colorado interchange.

HCPF'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 PRIME as well as CHP+ members should be retained by the RMHP network care provider, as these documents will be required to support a care provider appeal if a claim is

denied due to patient eligibility and enrollment status. If HCPF retroactively adjusts eligibility, claims payment may be retracted if you are unable to demonstrate eligibility was verified at the time of service.

Care providers are required to verify the RAE to whom a member is assigned in order to bill the appropriate RAE for services rendered. The HCPFs web portal is colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/care provider/Home/tabid/135/Default.aspx.

ID cards

RMHP does not provide ID cards to RAE members. The State does provide ID cards to all Health First Colorado members, which includes both RAE and PRIME members. Members can access their Health First Colorado ID card through their PEAK account. Eligibility verification through Colorado interchange does not require a member's ID number and can be verified by using identifiers such as date of birth and name. RMHP will continue to distribute a RMHP member ID card to PRIME and CHP+ members.

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 care provider. This includes charges for noncovered services, including missed appointments.

CHP+ members make their cost-sharing payments (copays when applicable) to the care provider. Your office will be responsible for collecting any applicable cost-sharing at the time of service directly from members.

Colorado law (C.R.S. 25.5-4-301[1]), which can be found at hcpf.colorado.gov/policy-statement-billing-medicaid-members-services, 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 care provider, whether claims are rejected
or denied by Medicaid due to care provider error, and whether or not the care provider is enrolled in the Colorado Medical Assistance program. This law applies even if a Medicaid member agrees to pay for part or all of a covered service.

For CHP+ members, per section 1932(b)(6) of the Social Security Act, CHP+ members are protected from balance billing. CHP+ members may have a copay or out of network liability for services that did not obtain a prior authorization or for noncovered services, or if member was not eligible at the time of service.

Behavioral health care providers

A member may request that a care provider be considered to join the RMHP network. In cases of a member already in treatment with a care provider at the time the member obtains RMHP enrollment, for the purpose of continuity of care, the member's care 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 care 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 care provider. These circumstances may include:

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

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

1. **Routine access**
   A routine appointment must be available within 7 business days of a member's request. If a care 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**
   Care 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. Care 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 are encouraged to 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, care 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 care provider. Any emergency situation should call 911.
2. The member can call or walk into any one of the Colorado CSNPs or contact a network care 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.

Behavioral health telemedicine

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

RMHP behavioral health telemedicine guidelines:

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

Care provider requirements:

1. Practitioners using intensive outpatient psychiatric services (IOP) to treat 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. Care providers are responsible to provide telemedicine services in accordance with Office for Civil Rights (OCR) Notice: hhs.gov/ocr/index.html.

In addition, care providers should:

- Be consistent with directives from the Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMSHA), health services that are not urgent should be postponed where possible
- 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

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

Billing and coding guidance

- Care 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.

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

UB-04 institutional claims

The GT modifier must be appended to the UB-04 institutional claim form with the service's procedure code

Care providers may only bill procedure codes which they are already eligible to bill per their contract and outlined in the SBHS Billing Manual.

Telemedicine services exception codes

RMHP supports the use of telemedicine for the delivery of behavioral health services which can effectively be provided in such a manner. For any questions about if a given procedure is allowed via telemedicine please contact our Care provider Relations area at **RMHPrae_bh_pr@uhc.com**.

Expectations of care 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 CSNP or another outpatient behavioral health care provider is required to assist in diversion, crisis stabilization and referral to follow-up.

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

- If an independent care provider is contacted by a member in crisis, the care 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 care provider determines the member in crisis is best assessed in the ER, the care provider will be available to the CSNP emergency services team to provide background information, diagnosis and other pertinent details on the member in crisis. This will assist the CSNP emergency services clinician in conducting the member's evaluation and may result in the most appropriate disposition for the member.
- Care providers are required to give contact information to members on their voicemail to include one of the following: the care provider's pager, the care provider's cell phone number or how to reach a covering clinician with whom the care provider contracts to provide coverage when the treating care provider is not reachable.
- Quarterly test calls are performed at random by the RMHP Quality Improvement staff to monitor care provider compliance with these standards. Should a care 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 care provider intends to correct any access to care discrepancies and how these will be avoided in the future. A care provider's nonresponse to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services.

Outpatient care 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 care provider has established a formal contract for emergency coverage with the agency. In all cases, care providers must obtain prior authorization for inpatient care by calling RMHP 24 hours a day, 7 days a week, at **1-800-421-6204**.

Coordination of care requirements

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

- Outpatient behavioral health care provider
- RMHP utilization management
- 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 admission. 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 care 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 care 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 care 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/MCO and/or outpatient behavioral health care provider and return calls within 24 hours
- Face-to-face meetings with the member when requested by the outpatient behavioral health care provider and/or discharge planner to be facilitated by the hospital staff in a timely manner
- Calls/emails from the outpatient behavioral health care 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 care 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 all RMHP members. RMHP requires coordination of services for all of our members and offers them care coordination. RMHP requires that the primary outpatient care provider engages in coordination of care with other treating care providers. Member consent is required for coordination of care with other care 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 CSNP or other outpatient behavioral health care 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 CSNPs.

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 care 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 CSNP or community care 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 CSNP.

The liaison can coordinate direct communication with the CSNP 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 care provider within 72 hours of discharge.

Utilization Management procedures (UM)

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.

Additional information from HCPF can be found in the State Behavioral Health Services Billing Manual. This site is updated regularly by HCPF and should be monitored for changes.

Care providers are expected to cooperate fully with RMHP clinical coordinators and 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 care 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 HCPF, "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 care provider or primarily for the convenience of the client, caretaker or care 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 HCPF's definition of medical necessity and InterQual® criteria, which are evidence-based clinical care guidelines that support what level of care will best support a member's needs.

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 requiring prior authorization 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 care 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 care providers to verify medical necessity based on HCPF and InterQual's® medical necessity criteria at admission, continued ongoing care and aftercare
- Ensuring the evaluation of the member includes pertinent biopsychosocial, medical and psychiatric/behavioral health information to support the diagnosis and impairments determined by the care provider

- Ensuring service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the care provider, are coordinated with other service delivery persons or agencies and are consistent with the HCPF's medical necessity criteria
- Ensuring coordination of care, prompting care 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 care providers discharge planning begins at admission
- Providing consultation to treatment team members when needs of a member are complex

Care provider responsibilities in UM

RMHP-contracted care providers are required to:

- Complete a comprehensive assessment of the member at the start of treatment clearly providing rationale for the diagnosis and the mix of services provided to the member
- Provide accurate clinical information 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 additional services. 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 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 the 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 State Behavioral Health Services Billing Manual guidelines in providing care at the approved place of service by the appropriately qualified staff person. You can find the latest version of the manual and additional information from HCPF, at hcpf.colorado.gov/sbhs-billing-manual. This site is updated regularly by HCPF and should be monitored for changes.

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

Some examples include electroconvulsive therapy (ECT) services, intensive outpatient programming (after 15 sessions, notification is required at admission), E-MST/MST (after initial 90 days of treatment, notification is required at admission), E-FFT/FF(after initial 90 days of treatment, notification is required at admission) and partial hospital programming.

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: Authorization

Authorization is required for all inpatient, partial hospital, residential services.

For members seeking QRTP or PRTF level of care, an Enhanced Standardized Assessment may need to be completed by a qualified mental health professional. The Enhanced Standardized Assessment determines whether QRTP or PRTF is recommended, or if the youth's needs can be met in less restrictive setting.

For inpatient care, 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. Care providers are to collaborate with RMHP UM and/or other outpatient behavioral health care providers to assist members in receiving treatment at a lower level of care, if appropriate, to meet the requirement RMHP members receive treatment at the least restrictive level of care.

Collaboration includes the provision of verbal or written treatment information to another care provider, if indicated. Inpatient care requires coordination of care with the CSNP 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.

Authorization of continuing higher levels of care requires a review between the care provider and the RMHP UM Clinical Coordinator. Care providers should follow the instructions of the Clinical Coordinator regarding the clinical information needed. Most authorizations are completed with written clinical documentation faxed or securely emailed by the care 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 care 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 regarding 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 when a member is discharged from any level of care, and 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 when a member transfers to a level of care that requires authorization.

For RAE members:

- Behavioral health claims are submitted to RMHP
- Physical health claims are submitted to Gainwell, the fiscal agent for HCPF

For PRIME and CHP+ members:

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

Transportation

If necessary, the state of Colorado may also provide non-emergency medical transportation (NEMT) for Medicaid members.

NEMT services are covered by IntelliRide/TransDev in the following counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer or Weld counties.

Resources for care providers to help their members

Participating care providers in the RAE 1 and RAE 2 networks (RMHP and NHP) are required to electronically conduct all routine transactions. The following electronic solutions are available to assist participating care providers.

Click on the links below for information and assistance:

- Colorado PEAK–Colorado.gov/PEAK is an online service for Coloradans to screen and apply for medical, food, cash, and early childhood assistance programs
- PEAKHealth mobile app – Members must be a current Health First Colorado or CHP+member to use the secure PEAKHealth mobile app. The app allows Health First Colorado and CHP+ members to view their medical card, update their income and contact information, view benefit information, complete their Medicaid or CHP+ renewals and more.
- Health First Colorado Member Portal – The Department's member portal allows members to select a new PCMP online
  - Members can also change their Primary Care provider (PCP) by calling 1-303-839-2120 or 1-888-367-6557.
- Contexture (formerly known as QHN or CORHIO) - Information about the Colorado health information exchange can be found at contexture.org
- SHIE (Social Health Information Exchange)- Information about the SHIE can be found at https://oehi.colorado.gov/SHIE
- The Colorado interChange (MMIS)/ Care provider Portal – The Department's care provider portal to manage contact information, maintain and update care provider information and check member eligibility, benefits, care provider, and RAE assignment.
- To be added to our monthly training and information sessions, please email rmhppractice.transformation3@uhc.com.

For more information contact:

- IntelliRide at 1-855-489-4999 or 1-303-398-2155 (State Relay: **711**) or visit their webpage at GoIntelliRide.com/Colorado (webpage may present as TransDev Health Solutions - which is the same as IntelliRide)
- For NEMT services in any other county in Colorado, please visit hcpf.colorado.gov/nemtlist to search by county and/or transportation care provider name.
- Emergency/ambulance transportation: Member should call 911. The services are billable under the member's medical benefit.

Behavioral Health Secure Transport

- Behavioral health secure transport (BHST) services information can be found at hcpf.colorado.gov/securetransport
- Behavioral Health Secure Transport must be provided by care providers who are specifically enrolled with HCPF as a BHST care provider

Chapter 5: Claims billing and care provider appeals

Submission of claims to RMHP

Care providers are responsible for submitting claims to UnitedHealthcare for payment.

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

Electronic delivery

RMHP encourages care 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 care 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/RMHP
P.O. Box 5260
Kingston, NY 12402-5260

Submission of claims to Gainwell Technologies

Physical health claims for RMHP RAE members will be processed by Gainwell, the fiscal agent for HCPF, following Health First Colorado billing guidelines.

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 care 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 care providers for covered services rendered to members in accordance with normal claims processing policies and procedures, the payment terms included in the care 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 care provider for covered services or in a request for submission of treatment records.

Care 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 care 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, care providers acknowledge and agree that the payment rates in the care 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. Care 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, care 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, care 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 care 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.

Hold harmless policy

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

"No Recourse Against Covered Persons or Colorado. In no event, including, but not limited to, nonpayment by Rocky Mountain Entities (RME), RME's insolvency, or breach of this Agreement, shall Contractor o r a Group Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person, the state of Colorado, any Federal Health Care Program or State Health Care Program or persons (other than the RME) acting on the covered person's behalf, for services provided pursuant to this Agreement. This provision does not prohibit the contractor or a group physician from collecting copayments, coinsurance and deductibles as specifically provided in the covered person's health care plan or fees or supplemental charges for uncovered services delivered on a fee-for-service basis to covered persons. This provision shall survive the termination of this Agreement, regardless of the reason for termination, including insolvency of RME, and shall be construed to be for the benefit of covered persons, the state of Colorado and any federal health care program or state health care program. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the contractor or a group physician and a covered person or persons acting on a covered person's behalf insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to this Agreement. No changes, modifications, additions or deletions shall be made to the provisions of this paragraph without the prior

written consent of the Secretary of the United States Department of Health and Human Services and such changes, modifications, additions or deletions shall become effective on a date no earlier than 30 days after the Colorado Commissioner of Insurance has received written notice of such proposed changes, modifications, additions, or deletions with regard to health care plans which are not self-insured health care plans. This paragraph shall not apply in the event of the insolvency of a self-insured employer who offers a self-insured health care plan administered by RME."

Overpayment recovery

Care 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 care providers and care 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 care 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 care 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 care provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the care 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: care 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

Care 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 care 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.

Claim disputes

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

- Go to **UHCprovider.com** and click Sign In at the top-right corner
- In the menu, select Claims & Payments > Look up a Claim and enter your search criteria
- Find your claim and click on the claim number to see details
- Scroll down to the Act on a Claim section and select Explore available actions. Select claim lines > click Next > select Create a reconsideration (if available) > click Next
- Complete the fields, attach supporting documents and submit

For step-by-step training, visit our Claims interactive guide. If electronic submission isn't possible, use the following form. This form is for submitting 1 claim at a time, not for bulk or multiple claims.

You can also submit claims reconsiderations and appeals directly through Care provider Express, and here's a helpful **video** to guide you through the process.

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

Claims reconsideration and appeal process

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

- Go to **UHCprovider.com** and click Sign In at the top-right corner
- In the menu, select Claims & Payments > Look up a Claim and enter your search criteria
- Find your claim and click on the claim number to see details
- Scroll down to the Act on a Claim section and select Explore available actions. Select claim lines > click Next > select Create a reconsideration (if available) > click Next
- Complete the fields, attach supporting documents and submit

For step-by-step training, visit our Claims interactive guide. If electronic submission isn't possible, use the following form. This form is for submitting 1 claim at a time, not for bulk or multiple claims.

If the Claim Reconsideration is not successful you may then 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 care 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 care provider summary voucher (EOB) in which the claim was included. Adjustments and reversal requests may be requested by calling Member Services.

Resubmissions

Incomplete claims

Incomplete Claims will be rejected in the EDI Gateway. Care provider must correct the required/rejected elements and resubmit a new claim.

1. Care providers may resubmit corrected claims by mail or electronic media claims.
2. Corrected claims should have a clear indication on the claim that the claim is a corrected claim.

Claim billing audits

RMHP reviews and monitors claims and billing practices of care 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 care 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 care 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

Care 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 care providers are asked to either fax or mail records to RMHP.

For the purpose of on-site audits, care providers must make records available to RMHP staff during the audit. Care 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 care 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 care provider. Claims must be supported by adequate documentation of the treatment and services rendered.

Care 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 care provider signature and/or rendering care 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 care provider. In some instances, such report of the findings may include a request for additional records.

Education/Training

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

CAP

RMHP may require the care provider to submit a CAP identifying steps the care provider will take to correct all identified deficiencies. CAPs should include, at a minimum, confirmation of the care 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 care provider will be responsible for paying the actual amount owed, based on RMHP's findings within 10 business days, unless the care 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 care provider's monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.

Chapter 6: Member appeals and grievances: RAE, PRIME and CHP+

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

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

The member has the right to appeal a decision. This means the member can ask for a review of something RMHP has denied. 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 approve. If it is approved, the member will receive what the doctor ordered. If RMHP does not approve the request, then the request by the doctor has been denied by RMHP. The decision RMHP made is to deny the request.

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

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

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

First level review

The member or DCR must call, write, or go on their secure portal to appeal 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 adverse determination notice or the the notice of the appeal resolution
- Care providers may not ask to have benefits continue while the appeal is being reviewed
- An RMHP care 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 or the secure member portal if they wish to file a grievance. 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 care provider
- The member cannot find a doctor or get in to see their doctor
- The member has a problem with RMHP Member Services
- The member is unhappy with how their doctor took care of them
- The member feels they have been treated in a different way by RMHP or one of its care providers. This could be because of race, color, national origin, disability, sex, sexual orientation or gender identity.

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, if the grievance has to do with quality of care (QOC), a specific QOC investigation will take place. RMHP will send a resolution communication to the member within 90 working days from 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. HCPF will inform the member they received the member's request. HCPF will look into the complaint and send the member a response.

Any grievances that relate to a quality issue, will have a quality of care investigation, called a Quality of Care Grievance (QOCG). Please refer to chapter 7 for additional information.

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, care provider or DCR must:

- Write a request for a hearing within 120 calendar days from the date of RMHP's final decision. If needed, RMHP Member Services of the Office or 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, care provider or DCR may file for a State Fair Hearing on the member's behalf. The care 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 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 care providers must coordinate care with any member's PCMP and with other treatment care providers to include member's outpatient therapist or prescriber. If a member does not have a PCMP, care providers are to assist the member in locating one. Assistance is also available at RMHP and may be obtained by calling **1-800-421-6204**.

Missed appointments

Care 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 care provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the member's medical record.

Treatment Planning with Discharge Criteria/ Plan

Within 48 hours of admission to inpatient or residential care, a discharge planning evaluation must be completed to identify the member's likely need for appropriate post-hospital services, and the member's chart must include a written discharge plan. The evaluation results must be discussed with the member (or the patient's representative), and the care provider must document or provide evidence of this discussion. This plan may include, but is not limited to, a treatment plan with discharge goals and objectives, signed by the member and parent/ guardian/family member, as appropriate. If the discharge 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 care 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 care 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 care providers, including physical health care 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 a care provider, the member can be referred to 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.
- Care providers are encouraged to assist members to develop crisis plans that define the member's wishes in time of psychiatric crisis
- Care 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. Care 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 care 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 care provider must again ask if the member has an advance directive and, if so, document that in the medical record.
- A care provider may not condition a member's care or treatment on whether or not they have executed an advance directive

Care 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:

- Quality Improvement Plan (QuIP)
- CAPs
- Documentation and chart audits
- Colorado Client Assessment Report (CCAR) submissions

CSNP and other large group care 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 care provider performance so data can be used to recognize quality care, identify care provider and facility best practices, improve care 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. Care 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 Care 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 care provider, you are expected to comply with all an 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) care 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 care 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, care 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 RMHP to HCPF, as required by and for the purposes set forth in RMHP's contracts with HCPF.

Care 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, care 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.

Care providers and delegated entities are expected to safeguard the confidentiality of treatment record information related to both active and past clients. Participating care 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 care 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 care 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 care providers lincensed through the Behavioral Health Administration and Behavioral Health Entities follow the applicable Division of Behavioral Health regulations regarding medical records (2 C.C.R. 502-1), all RMHP care 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 care 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 care 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 care 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 care providers
- The treatment/service plan is reviewed by the client and care 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 member's treated by a care provider licensed with the Behavioral Health Administration must be developed as soon as practicable after admission, but no later than the timeframes identified in the endorsement-specific chapters of the BHA rules (i.e., Chapters 4 through 10). The treatment plan must be updated, at a minimum, every 6 months, even if unless individuals are only receiving medication/psychiatric services as specified in Section 4.3.4 Documentation and Timeliness (E)(G) of the BHA standards. The member or guardian must sign the treatment plan as outlined in section 2.13.1 Service plan (5)(b) of the BHA standards. 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 care 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 care 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 care providers and health care institution/care 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 care 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 at **uhc.com/fraud** or by calling **1-844-359-7736**.