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SECTION I: WELCOME!

Dear Provider,

Welcome! Thank you for becoming a participating Provider with the Denver Health Medical Plan, Inc. (DHMP) and/or Denver Health Medicaid Choice (DHMC). Please note Denver Health Medical Plan, Inc. (DHMP) and Denver Health Medicaid Choice (DHMC) may be hereinafter referred to individually as separate entities, such as “DHMP” or “DHMC”, or collectively as “the Company”.

Background Information of Denver Health Medical Plan, Inc.
Denver Health Medical Plan, Inc. was incorporated on January 1, 1997 in Colorado as a not-for-profit corporation for the purpose of providing or arranging for the delivery of health care services and related functions through, among other activities, the establishment and operation of a managed care organization to deliver quality, accessible, and affordable health care services in and around the City and County of Denver, Colorado. DHMP is a wholly-owned subsidiary of Denver Health and Hospital Authority (DHHA), an academic, community-based, integrated health care system that serves as Colorado’s primary “safety net” system.

Denver Health Medical Plan, Inc. offers many different plans and networks. Among the commercial products are Denver Health Medical Plan (Large Group) and Elevate (Exchange product). Additionally, Denver Health Medical Plan, Inc. offers two Medicare Advantage Plans. Unless otherwise noted herein, DHMP will refer broadly to all products falling under the DHMP umbrella.

Background Information of Denver Health Medicaid Choice
Denver Health and Hospital Authority (DHHA), the parent company of DHMP and DHMC, is contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to operate a Medicaid Managed Care Program. Denver Health Medicaid Choice provides or arranges for covered health care benefits and related services to Medicaid-eligible residents of the City and County of Denver, Colorado and surrounding counties. The Denver Health Medicaid Choice contract is managed by the Denver Health Managed Care Division of DHHA.

This manual explains company network Provider rights and responsibilities in an accessible, user-friendly format. Providers can contact the Company for general information, policy clarification, or any other information related to this program at the numbers listed below. This manual is an extension of the Provider and Practitioner Contract.

THE COMPANY CONTACT LIST:

UTILIZATION/CASE MANAGEMENT
Phone: 303-602-2170
Fax: 303-602-2126

PHARMACY SERVICES
Phone: 303-602-2070
Fax: 303-602-2081

PROVIDER RELATIONS
Phone: 303-602-2003
Fax: 303-602-2516
SECTION II: PROVIDER RESPONSIBILITIES

OVERVIEW
A Company Member will choose a specific Provider to be their Primary Care Provider (PCP). The PCP is the manager of the Member’s total health care needs; this includes all routine and preventive medical services as well as referrals for medically necessary diagnostic, specialist and hospital services. A formal referral process is typically required for those services, with the exception of some limited specialty services that can be obtained without a referral. Please refer to the Company Prior Authorization List that can be found on our website to determine if a service requires Prior Authorization. See the Utilization Management Section for the Prior Authorization Lists and instructions.

The primary care concept emphasizes keeping members well. The goal of the Company and the PCP is to educate members with respect to healthy lifestyles and prevention of serious illness. Regular and appropriate PCP visits, including routine checkups and annual exams, are important in achieving a healthier lifestyle.

Practitioners and Providers may communicate with Patients about all treatment options regardless of benefit coverage limitations.

PCP RESPONSIBILITIES
The PCP has the responsibility to provide all routine and preventive primary care services to Members of Company health programs who have designated the PCP as such. The PCP, as the manager of a Patient’s care, initiates referrals for specialty care, if applicable. In addition, the PCP is responsible for coordinating medically necessary care with other Providers. Additional responsibilities include: having timely appointments available, participating in quality assurance utilization management programs, cooperating with quality improvement activities, complying with credentialing requirements, maintaining confidentiality of medical information in compliance with all state and federal regulatory entities, maintaining a separate medical record for each Member, maintaining legible and comprehensive medical records for each encounter, allowing the Company
use of clinical and access performance data, and participating in the referral and Prior Authorization processes, as applicable.

SPECIALTY CARE PROVIDERS (SCP)
SCPs are responsible for verifying Member eligibility on the date of service before rendering the service, providing specialty consultation care as approved by a Member’s PCP or the health program, providing additional services after discussing care with the PCP, and obtaining Prior Authorization from the health program for such services, as applicable. The SCP is also responsible for coordinating the Member’s care with the PCP (including providing feedback to the PCP on services rendered and diagnoses identified within five business days of providing the service). Where applicable, the SCP is responsible for obtaining written Prior Authorization from the Company before making secondary referrals to other specialists or medical professionals for procedures or admissions. The SCP is also responsible for communicating, in writing, their findings and recommendations to the Patient’s nursing home, where applicable. Record-keeping requirements include maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies; maintaining a separate medical record for each Member; maintaining legible and comprehensive medical records for each encounter; participating in documenting the referral and Prior Authorization processes, as applicable; cooperating with quality improvement activities; and allowing the Company use of clinical and access performance data.

VERIFYING ELIGIBILITY, BENEFITS, AND NETWORK PARTICIPATION STATUS
Please check the Member’s eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted to the correct payer, and notifies the Provider of any member financial responsibility, such as copayments. It helps determine if a referral and Prior Authorization or notification is required and reduces denials for coverage. To obtain this information, please check our websites at www.denverhealthmedicalplan.org or www.denverhealthmedicaid.org.

Medicaid: Check the state Medicaid website or call the number on the back of the ID card.
Medicare: Check the state Medicare website or call the number on the back of the ID card.
DHMP Commercial Plans: Call the number on the back of the ID card.

For information on Real Time Eligibility (RTE), visit www.denverhealthmedicalplan.org/rte-transactions.

UNDERSTANDING NETWORK PARTICIPATION STATUS
It is important to confirm Provider network status and tier status while checking eligibility. If the Provider is not participating in the Member’s benefit plan or is outside of the network service area for the benefit plan, the Member may have a higher cost share or no coverage.

OVERPAYMENTS
Provider must report to the Company any overpayments that are for more than specified in the contract.

COMPLIANCE WITH FEDERAL AND STATE LAWS AND RULES AND REGULATIONS
The Company operates in a highly regulated health insurance environment. It is our policy to comply at all times with applicable federal, state and local laws, all rules and regulations established by regulatory agencies related to Company business. Additionally, the Company prohibits discrimination on the basis of race, color, national origin, sex, gender identity, sexual orientation, age mental or physical disability, medical condition, claims experience, evidence of insurability, genetic information or source of payment in certain health programs and activities.
Contracting Providers are required to also comply with all applicable federal, state and local laws, rules, and regulations applicable to Company business. Below is a list of regulations relative to our business activities, but is not an exhaustive list. Please note there may be additional laws and regulations not expressly captured here.

2. American Disabilities Act of 1990 (ADA)
3. Section 504 of the Rehabilitation Act of 1973
4. Civil Rights Act of 1964
5. Deficit Reduction Act of 2005 (DRA)
6. Equal Pay Act of 1963
7. Federal and State False Claims Acts
8. Anti-Kickback Statute
9. Health Insurance Portability and Accountability Act (HIPAA)
10. Colorado Fraud Statute
11. Colorado Revised Statutes, Title 10
12. Colorado Division of Insurance Regulations and Bulletins
14. All sub-regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS) for Medicare Advantage and Medicare Part D, such as manuals, training materials, and guidance
15. Applicable Civil Monetary Penalties and Exclusions
17. Patient Protection and Affordable Care Act (ACA)

Providers are responsible for protecting the confidentiality, privacy and security of the Company’s Member information. Providers must follow the rules and standards laid out in The Health Insurance Portability and Accountability Action (HIPAA) Act. The Company has a specific policy and procedure for the proper handling of Protected Health Information (PHI); Medicaid Choice HIP_901 is available by calling Provider Relations at 303-602-2003.

The Company has specific policies and procedures related to its compliance with federal and state laws, rules and regulations. To obtain a copy of the policy and procedure, please contact Managed Care Provider Relations at 303-602-2003.
Providers are explicitly prohibited from collecting payment or attempting to collect payment through recipient for the cost or the cost remaining after payment by the Company for covered items or services rendered. Reference: 8.012.2.A. www.sos.state.co.us.

**MORAL OR RELIGIOUS OBJECTIONS**

A company Provider must notify the Company if they object to providing a service on moral or religious grounds. Please call Provider Relations at 303-602-2003.

Company Providers should know that the Company will not prohibit, or otherwise restrict any health care professionals from acting within the lawful scope of their practice, from advising or advocating on the behalf of a Member who is the Provider’s Patient for the following:
- The Member’s health status, medical care or treatment options, including alternative treatments that may be self-administered
- Any information the Member needs in order to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The Member’s right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment options

**SECTION III: PROVIDER RELATIONS**

The Provider Relations Department is responsible for building and maintaining positive and strong relationships with Providers. This department will work with Providers to resolve issues and help prevent issues by serving as a liaison between the Company and Providers to facilitate positive communication and provide excellence in service; conduct routine and follow-up visits to all priority Providers as directed; and ensure Providers are up to date with the most current information available.

The team is looking forward to a long, successful relationship with each Provider, and is committed to providing excellent service in any issue that a new or existing Providers may have. The Company is dedicated to providing health care Providers that see Company members with the necessary tools, resources and information needed to understand the Company program and be able to bill claims correctly.

Provider Relations has a dedicated website to ensure that Providers are informed of all changes related to the Company: www.denverhealthmedicalplan.org/providers.

For questions or concerns, please call 303-602-2003.

**SECTION IV: CREDENTIALING AND RE-CREDENTIALING OF PRACTITIONERS**

The Company has policies and procedures that meet the National Committee for Quality Assurance (NCQA) standards and Center for Medicare and Medicaid Services (CMS) requirements regarding credentialing, re-credentialing and ongoing monitoring.

The Company’s Provider selection policies and procedures include provisions that the Company does not:
- Discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within
the scope of their license or certification under applicable state law, solely on the basis of that license or certification

- Discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Company does not prohibit or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the Member who is the Provider’s Patient for the following:

1. The Member’s health status, medical care or treatment options, including any alternative treatments that may be self-administered
2. Any information the Member needs in order to decide among all relevant treatment options
3. The risks, benefits and consequences of treatment or non-treatment
4. The Member’s right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions

INSURANCE

A Colorado-licensed Physician must maintain commercial professional liability insurance coverage with an insurance company authorized to do business in Colorado. Effective July 1, 2010, the law requires a minimum indemnity amount of $1,000,000 per incident and $3,000,000 annual aggregate per year, or an acceptable alternative, as set forth in Board Rule 220.

The articles of incorporation stipulate, and all shareholders of the Corporation agree, that all shareholders of the corporation are jointly and severally liable for all acts, errors and omissions of the employees of the corporation or that all shareholders of the corporation are jointly and severally liable for all acts, errors and omissions of the employees of the corporation. This is except during periods of time when each licensee who is a shareholder or any employee of the corporation has a professional liability policy insuring himself or herself and all employees who are not licensed pursuant to this article who act at his or her direction, in the amount of $50,000 for each claim and an aggregate top limit of liability per year for all claims of $150,000, or the corporation maintains in good standing professional liability insurance that meets the following minimum standards: (I) The insurance insures the corporation against liability imposed upon the corporation by law for damages resulting from any claim made against the corporation arising out of the performance of professional services for others by those officers and employees of the corporation who are licensees. (II) The policies insure the corporation against liability imposed upon it by law for damages arising out of the acts, errors, and omissions of all nonprofessional employees. (III) The insurance is in an amount for each claim of at least $50,000 multiplied by the number of licensees employed by the corporation. The policy may provide for an aggregate top limit of liability per year for all claims of $150,000 also multiplied by the number of licensees employed by the corporation, but no firm shall be required to carry insurance in excess of $300,000 for each claim with an aggregate top limit of liability for all claims during the year of $900,000.

PRACTITIONER RIGHTS

- The applicant has the right to review the information obtained to evaluate their credentialing or re-credentialing application upon request. The Company must notify the Practitioner if there is a substantial variation in information regarding actions on licensure, malpractice claims history and board certification. The Practitioner may not review references or recommendations or other information that is peer-review-protected, and the Company is not required to reveal the source of information if law prohibits disclosure.
- The applicant has the right to correct erroneous information from other sources. In the event the credentialing information obtained from other sources varies substantially from that provided by the applicant, the Credentialing Department will notify the applicant of the process to correct the erroneous
information submitted by another party.

- The applicant has the right to be informed of the status of their credentialing or re-credentialing application upon request.

The Company credentials the following Practitioners:
- Physical Health
- Allopathic Physician (MD)
- Osteopathic Physician (DO)
- Doctor of Dental Sciences (DDS)*
- Doctor of Dental Medicine (DMD)*
- Podiatrist (DPM)
- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Chiropractor (DC)
- Non-Physician Practitioners who are licensed or certified by the state, have an independent relationship with the organization, and provide care under the organization’s medical benefits.

*Dentists who provide care under the medical benefit program only (i.e., Oral Surgeons)

**BEHAVIORAL HEALTH**
- Psychiatrist (MD, DO)
- Psychologist (PsyD, PhD, EdD)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage Family Therapist (LMFT)
- Clinical Nurse Specialist (CNS)

Certain Practitioners that are exempt from the credentialing process are listed below. However, the Company does credential and re-credential hospital-based Practitioners who provide care in an outpatient setting (i.e., anesthesiologist offering pain management services and hospital-based university faculty who also have private practices).
- Covering Practitioners
- Locum tenens
- Emergency Department Physicians
- Hospitalists
- Telemedicine consultants
- Practitioners who practice exclusively within free-standing facilities (e.g., mammography centers, urgent care centers, surgery centers, ambulatory behavioral healthcare facilities and psychiatric and addiction disorder clinics)
- Dentists who provide primary dental care only under a dental plan

The Company may delegate any or all elements of credentialing and re-credentialing responsibilities to a contracted entity, but will perform oversight, and is ultimately responsible to see that credentialing activities are performed according to the Company’s standards. If these activities are delegated, there will be a mutually agreed-upon document attached to the contract that describes the delegated activities and the responsibility for these activities. The Company will perform a documented annual evaluation of each delegated entity’s credentialing activities.
The Company utilizes CAQH ProView. Providers can enter their information free of charge and access, manage and revise their credentialing applications at their convenience. CAQH ProView eliminates duplicative paperwork with organizations that require professional and practice information. It helps reduce inquiries for administrative information and can save time when the CAQH ProView profile is complete and current. If utilizing CAQH, please ensure the Company is authorized to have instant access to information. If interested in utilizing CAQH ProView, please contact a credentialing representative at 303-602-2124.

The credentialing process for Practitioners includes review and verification of the following elements:

- Accurate completion and attestation to correctness of the most current Colorado Health Care Professional Credentials Application, which contains questions regarding reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license, license sanctions or felony convictions, history of loss or limitation of clinical privileges or disciplinary actions, and current malpractice insurance coverage amounts
- Current, unrestricted license to practice medicine in the State of Colorado, and any other state in which the Provider sees the Company’s Members
- If board-certified, current certification in field of practice; non-physicians must have a certificate, diploma or degree from an accredited program
- Current DEA prescription number as applicable
- Current professional liability insurance policy as stipulated in the Provider Agreement
- Good standing with Medicare and Medicaid in any state in which the Provider renders services to Company Members

RE-CREDENTIALING REQUIREMENT

The re-credentialing process takes place at least every three years, during which the elements listed under credentialing requirements are again reviewed and verified. The re-credentialing decision-making process may also incorporate information from the following sources:

- Member Grievances
- Provider complaints
- Quality of care concerns
- Monthly monitoring activities
- Practitioner office site quality issues
- Reports from Managed Care Provider Relations

ONGOING MONITORING OF PRACTITIONERS

The Company monitors for, identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

Organizational Providers must maintain compliance with all applicable criteria as a condition of continued participation. Contracts with Organizational Providers shall require that Providers notify DHMC of any failure to maintain compliance as applicable. DHMC may take action against Organizational Providers when it identifies occurrences of poor quality, and acts on quality and safety issues in a timely manner during the three-year interval between formal credentialing.

The Company will review reports on a monthly basis regarding:

- Medicare/Medicaid sanctions
- Sanctions or limitations on licensure
- Member complaints
- Practitioner adverse events
• Complaints related to office site quality

When the Company identifies such issues, it shall determine if there is evidence of poor quality that could affect the health and safety of its Members and, depending on the nature of the event, implement appropriate interventions.

PRACTITIONER RIGHTS
Each applicant seeking credentialing through the Company has the right to receive notification of their rights regarding the Credentialing program. These are detailed in Denver Health Policy & Procedure CRE01. A copy of this policy and procedure can be sent upon request by contacting the Provider Relations Department at 303-602-2003.

PRACTITIONER OFFICE SITE QUALITY
The Company has a process to ensure that Practitioner offices meet the Company office site standards. The Company will monitor Member complaints regarding the following:
• Physical accessibility: includes, but is not limited to, ease of entry and accessibility of space within the building, including standards for physically disabled Patients
• Physical appearance: includes, but is not limited to, cleanliness, lighting and safety
• Adequacy of waiting and examining room space: includes, but is not limited to, adequate and appropriate size of seating for waiting rooms
• Adequacy of treatment record keeping: includes, but is not limited to, file/record orderliness, security, confidentiality and documentation practices

The Company has set an acceptable threshold of two complaints received within 24 months regarding the elements listed above, and will perform a site visit once that threshold has been met.

PROACTIVE NOTIFICATION OF CHANGES
The Provider must send official notice to the Company at the address noted in the agreement with the Company and deliver by the method required within 10 calendar days of knowledge of the occurrence of any of the following: material changes to, cancellation or termination of liability insurance; any indictment, arrest or conviction for a felony or any criminal charge related to the practice or profession; any suspension, exclusion, debarment or other sanction from a state or federally funded health care program; or loss suspension, restriction, condition, limitation or qualification of license to practice. Physicians need to disclose any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home or other facility; relocation or closing of your practice; and, if applicable, transfer of Member records to another Physician/facility.

NOTIFICATION OF CHANGES MUST BE PROACTIVE
The Provider or an entity delegated to conduct credentialing activities on your behalf are expected to review updated care Provider records and attest to the information available to members including the inflation listed here, at least quarterly. If the Provider or the delegate cannot attest to the information the Provider or the delegate must supply corrections to the Company and must disclose affiliations, ownership and control of any prohibited affiliation, these chances must be in writing at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information as well as updating the following information. If the Provider or a delegate fail to update records or give 30 days prior notice of changes, or fail to attest to the information available to our Members, the Provider or the participating Providers credentialed by the delegate may be subject to penalties. The Provider and the delegates are required to update all Provider information including, but not limited to:
• Office address
• Office phone number
• Participating Provider’s email address
• If the Provider is still participating
• Participating Provider’s hospital affiliations
• Participating Provider’s specialty
• Office hours

Provider must send written disclosure of any prohibited affiliation with any individuals disbarred by federal agencies. Provider must disclose any ownership and control interest in the disclosing entity, fiscal agent or managed care entity.

SECTION V: CLAIMS SUBMISSION

For claims submission information, please refer to the billing manuals on the website at: www.denverhealthmedicalplan.org/provider-forms.

WHAT IS A CLEAN CLAIM?

A “clean” claim is defined as one that does not require the payer to investigate or develop on a pre-payment basis. Clean claims must be filed in the timely filing period.

It is the Provider’s obligation to submit medical record documentation upon request. The Company has the right to recoup funds for missing or inadequate documentation.

Most payers consider clean claims as:
• Claims that pass all edits
• Claims that do not require external development (i.e., are investigated within the claims, medical review, or payment office even if the investigator does not need to contact the Provider, the beneficiary, or other outside source)
• Claims subject to medical review but complete medical evidence is attached by the Provider
• Additional requests for information are developed on a post-payment basis
• Having all basic information necessary to adjudicate the claim, and all required supporting documentation is attached
• Clean paper claims are resolved within 45 calendar days of receipt and electronically submitted clean claims are resolved within 30 calendar days of receipt.
• Provider must make sure dates of service, Provider name and Patient name match on the claim

TIMELY FILING

Every insurance company has a time window during which the Provider can submit claims from the date of service. If filed later than the allowed time, the claim will be denied and the Provider will not be allowed to balance bill the Patient.

Timely filing guidelines are as follows:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial plans</td>
<td>120 days</td>
</tr>
<tr>
<td>Non-contracted Providers</td>
<td>1 Year</td>
</tr>
<tr>
<td>Medicare plans</td>
<td>1 Year</td>
</tr>
<tr>
<td>Medicaid plans</td>
<td>120 days</td>
</tr>
</tbody>
</table>
UB-04 Billing Manual
Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB-04. Please see below for a list of required fields. Providers must include the information as required.

Box 1 – Billing Provider Name, Address, Phone Number
Inpatient – Required
Outpatient – Required
Enter the Provider or agency name and complete mailing address of the Provider billing for the services: Street/post office box, city, state, zip code. Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 2 – Pay-to Name, Address, City, State
Inpatient – Required if different from Box 1
Outpatient - Required if different from Box 1
Enter the Provider or agency name and complete mailing address of the Provider who will receive payment for the services: Street/post office box, city, state, zip code. Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 3a – Patient Control Number
Inpatient – Required
Outpatient – Required
Up to 20 characters: Letters, numbers or hyphens
Enter information that identifies the Client or claim in the Provider’s billing system. Submitted information appears on the Provider Claim Report.

Box 3b – Medical Record Number
Inpatient - Required Outpatient - Required
Enter the 17-digit number assigned to the Patient to assist in retrieval of medical records.

Box 4 – Type of Bill
Inpatient - Required Outpatient - Required
Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):

Digit 1 Type of Facility:
1. Hospital
2. Skilled Nursing Facility
3. Home Health
3. Religious Non-Medical Health Care Institution, Hospital, Inpatient
4. Religious Non-Medical Health Care Institution, Post-hospital extended care services
5. Intermediate Care
6. Clinic-(Rural Health/FQHC/Dialysis Center)
7. Special Facility (Hospice, RTCs)

Digit 2 Bill Classification (except clinics and special facilities):
1. Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only)
2. Outpatient
3. Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
4. Intermediate Care Level I
5. Sub-acute Inpatient (revenue code 19X required with this bill type)
6. Swing Beds
7. Other
Digit 2 Bill Classification (Clinics only):
1. Rural Health/FQHC
2. Hospital-based or Independent Renal Dialysis Center
3. Free-standing
4. Outpatient Rehabilitation Facility (ORF)
5. Comprehensive Outpatient Rehabilitation Facilities (COFRs)
6. Community Mental Health Center

Digit 2 Bill Classification (Special Facilities Only):
1. Hospice (Non-hospital based)
2. Hospice (Hospital based)

Box 5 – Federal Tax Number
Inpatient – Required
Outpatient – Required

Box 6 – Statement Covers Period – From/Through
Inpatient – Required
Outpatient – Required
Enter the “From” (beginning) date and “Through” (ending) date of service covered by this bill using MM/DD/YY format.
From MM/DD/YY – Through MM/DD/YY
For Example: January 1, 2008 = 010108
(Note: OP claims cannot span over a month’s end)

Inpatient
“From” date is the actual admission date, or first date of an interim bill. “From” date cannot be prior to the date reported in Box 12 (Admission Date). “Through” date is the actual discharge date, or final date of an interim bill. If Patient is admitted and discharged on the same date, that date must appear in both form locators. Interim bills may be submitted for Prospective Payment System (PPS)-DRG claims, but must meet specific billing requirements.

Outpatient
This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete Box 45 (Service Date). Providers not wishing to span bill following these guidelines must submit one claim per date of service. “From” and “Through” dates must be the same. All line item entries must represent the same date of service.

Box 8a – Patient Identifier
Submitted information is not entered into the claim processing system.

Box 8b – Patient Name
Inpatient - Required
Outpatient - Required
Enter the Client’s last name, first name and middle initial from the medical card.

Box 9a – Patient Address-Street
Inpatient - Required
Outpatient - Required
Enter the Client’s street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.
Box 9b – Patient Address-City
Inpatient - Required
Outpatient - Required
Enter the Client’s city exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9c – Patient Address-State
Inpatient - Required
Outpatient - Required
Enter the Client’s state exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9d – Patient Address-Zip
Inpatient – Required
Outpatient – Required
Enter the Client’s zip code exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9e – Patient Address-County Code
Inpatient – Optional
Outpatient – Optional

Box 10 – Birth date Inpatient - Required Outpatient - Required
Enter the Client’s birth date, using two digits for the month, two digits for the date, and four digits for the year (MM/DD/CC/YY format)
Example: 01012008 for January 1, 2008
Use the birth date that appears on the eligibility verification or at the time of admission.

Box 11 – Patient Sex Inpatient - Required Outpatient - Required
Enter an M (male) or F (female) to indicate the Client’s sex

Box 12 – Admission Date
Inpatient – Required
Enter the date client was admitted to the hospital. Use MM/DD/YY format for inpatient hospital claims
Outpatient – Conditional
Required for observation holding beds only

Box 13 – Admission Hour
Inpatient - Required
Enter the hour the Client was admitted for inpatient care.

Code Time
00  12:00-12:59 am
01  1:00-1:59 am
02  2:00-2:59 am
03  3:00-3:59 am
04  4:00-4:59 am
05  5:00-5:59 am
Box 14 – Admission Type

Inpatient - Required
Outpatient - Optional

Enter the following to identify the admission priority:

1 – Emergency
Client requires immediate intervention as a result of severe, life-threatening or potentially disabling conditions.
Exempts inpatient hospital & clinic claims from copayment and PCP referral.
Exempts outpatient hospital claims from copayment and PCP only if revenue code 450 or 459 is present.
This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.

2 – Urgent
The Client requires immediate attention for the care and treatment of a physical or mental disorder.

3 – Elective
The Client’s condition permits adequate time to schedule the availability of accommodations.

4 – Newborn
Required for inpatient and outpatient hospital.

5 – Trauma Center
Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

Box 15 – Source of Admission

Inpatient - Required
Outpatient - Required

Enter the appropriate code for copayment exceptions on claims submitted for outpatient services (to be used in conjunction with Box 14, Type of Admission).

1 Physician referral
2 Clinic referral
3  Referred from HMO
4  Transfer from a hospital
5  Transfer from a skilled nursing facility (SNF)
6  Transfer from another health care facility
7  Emergency Room
8  Court/law enforcement
9  Information not available
A  Transfer from a Critical Access Hospital
B  Transfer from another Home Health Agency
C  Readmission to same Home Health Agency

Newborns
1  Normal Delivery
2  Premature Delivery
3  Sick Baby
4  Extramural Birth (birth in a non-sterile environment)

Box 16 – Discharge Hour
Inpatient - Required
Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in Box 13 (Admission Hour).

Box 17 – Patient Discharge Status
Inpatient – Required
Outpatient – Conditional
Enter Patient status as of discharge date.
01  Discharged to home or self-care (dialysis is limited to code 01)
02  Discharged/transferred to another short-term hospital
03  Discharged/transferred to a Skilled Nursing Facility (SNF)
04  Discharged/transferred to an Intermediate Care Facility (ICF)
05  Discharged/transferred to another type institution
06  Discharged/transferred to home under care of organized Home and Community-Based Services Program (HCBS)
07  Left against medical advice or discontinued care
08  Discharged/transferred to home under care of a Home Health Provider
09  Admitted as an inpatient to this hospital
20  Expired
30  Still a Patient or expected to return for outpatient services
31  Still a Patient - Awaiting transfer to long-term psychiatric hospital
32  Still a Patient - Awaiting placement by Colorado Medical Assistance Program
50  Hospice – Home
51  Hospice – Medical Facility discharged/transferred within this institution to hospital-based
61  Medicare-approved swing bed
62  Discharged/transferred to an inpatient rehabilitation hospital
63  Discharged/transferred to a Medicare-certified long-term care hospital
71  Discharged/transferred/referred to another institution for outpatient services
72  Discharged/transferred/referred to this institution for outpatient services
Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.

Condition Codes:
01 Military service-related
02 Employment-related
04 HMO enrollees
05 Lien has been filed
06 ESRD Patients - first 18 months entitlement
07 Treatment of non-terminal condition/hospice Patient
17 Patient is homeless
25 Patient is a non-U.S. resident
39 Private room(s) medically necessary
60 DRG (day outlier)

Renal dialysis settings:
71 Full-care unit
72 Self-care unit
73 Self-care training
74 Home care
75 Home care - 100 percent reimbursement
76 Backup facility

Special Program Indicator Codes:
A1 EPSDT/CHAP
A2 Physically Handicapped Children’s Program
A3 Family Planning
A4 Family Planning
A6 PPV/Medicare
A7 Induced abortion - Danger to Life
A8 Induced abortion - Victim Rape/Incest
A9 Second Opinion Surgery
B3 Pregnancy indicator

PRO Approval Codes:
C1 Approved as billed
C2 Automatic approval as billed - based on focused review
C3 Partial approval
C4 Admission/services denied
C5 Post-payment review applicable
C6 Admission pre-authorization
C7 Extended authorization

Box 29 – Accident State Inpatient
Optional Outpatient – Optional

Box 31 - 34 – Occurrence Code/Date
Inpatient – Conditional
Outpatient – Conditional
Complete both the code and date of occurrence.
Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.
Occurrence Codes:
01 Accident/Medical Coverage
02 Auto Accident - No Fault Liability
03 Accident/Tort Liability
04 Accident/Employment Related
05 Other Accident/No Medical Coverage or Liability Coverage
06 Crime Victim
20 Date Guarantee of Payment Began
24 Date Insurance Denied
25 Date Benefits Terminated by Primary Payer
26 Dates SNF Bed Available
27 Date of Hospice Certification or Recertification
40 Scheduled Date of Admission (RTD)
50 Medicare Pay Date
51 Medicare Denial Date
53 Late Bill Override Date
55 Insurance Pay Date

A3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer A.
B3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer B.
C3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer C.

NOTE: Other Payer Occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third-party information.

Box 35 - 36 – Occurrence Span Code From/Through
Inpatient – If applicable
Outpatient – If applicable

Box 38 – Responsible Party Name/Address Submitted information is not entered into the claim processing system.

Box 39 - 41 – Value Code-Code Value Code - Amount
Inpatient – Conditional Outpatient - Conditional
If a value code is entered, a dollar amount or related numeric value must be entered.

Enter the appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers which are necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

01 Most common semi-private rate (Accommodation Rate)
06 Medicare blood deductible
14 No fault including auto/other
15 Workers Compensation
31 Patient Liability Amount
32 Multiple Patient Ambulance Transport
37  Pints of Blood Furnished
38  Blood Deductible Pints
40  New Coverage Not Implemented by HMO
45  Accident Hour - Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in Box 18 (Admission Hour)
49  Hematocrit Reading - EPO-related
58  Arterial Blood Gas (PO2/PA2)
68  EPO-Drug
80  Covered Days
81  Non-covered Days

Enter the deductible amount applied by indicated payer.
A1 Deductible Payer A
B1 Deductible Payer B
C1 Deductible Payer C

Enter the amount applied to client’s co-insurance by indicated payer.
A2 Coinsurance Payer A
B2 Coinsurance Payer B
C2 Coinsurance Payer C

Enter the amount paid by indicated payer:
A3 Estimated Responsibility Payer A
B3 Estimated Responsibility Payer B
C3 Estimated Responsibility Payer C

Box 42 – Revenue Code Inpatient - Required Outpatient - Required
Enter the revenue code which identifies the specific accommodation or ancillary service provided.

List revenue codes in ascending order:
A revenue code must appear only once per date of service. If more than one of the same services is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS/CPT code cannot be repeated for the same date of service. Refer to instructions under Box 44 (HCPCS/CPT/Rates).

Box 43 – Revenue Code Description
Inpatient – Required
Outpatient – Required
Enter the revenue code description or abbreviated description.

When reporting an NDC:
- Enter the NDC qualifier of “N4” in the first two positions on the left side of the field
- Enter the 11-digit NDC numeric code
- Enter the NDC unit of measure qualifier (examples include):
  »  F2 – International Unit
  »  GR – Gram
  »  ML – Milliliter
  »  UN – Units
- Enter the NDC unit of measure quantity
Box 44 – HCPCS/Rates/HIPPS Rate Codes
Inpatient – Optional
Outpatient – Conditional
Enter only the HCPCS/CPT code for each detail line. Use approved modifiers listed in this section for hospital-based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital-based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed.

Services Requiring HCPCS/CPT
- Anatomical Laboratory: Bill with TC modifier
- Hospital-Based Transportation
- Outpatient Laboratory: Use only HCPCS 80000s – 89000s
- Outpatient Radiology Services

Enter HCPCS/CPT and revenue codes for each radiology line. The only valid modifier for OP radiology is TC.

With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services.

HCPCS/CPT codes must be identified for the following revenue codes:
- 32X Radiology – Diagnostic
- 33X Radiology – Therapeutic
- 34X Nuclear Medicine
- 35X CT Scan
- 40X Other Imaging Services
- 61X MRI

NOTE: HCPCS/CPT codes cannot be repeated for the same date of service.

Combine the units in Box 46 (Service Units) to report multiple services. When CPT/HCPC is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.

- 251 Generic Drugs
- 252 Non-Generic Drugs
- 253 Take-Home Drugs
- 255 Drugs Incident to Radiology
- 257 Non-prescription
- 258 IV Solutions
- 259 Other Pharmacy
- 260 IV Therapy General Classification
- 261 Infusion Pump
- 262 IV Therapy/Pharmacy Services
- 263 IV Therapy/Drug/Supply Delivery
- 264 IV Therapy/Supplies
- 269 Other IV Therapy
- 631 Single-source Drug
- 632 Multiple-source Drug
- 633 Restrictive Prescription
- 634 Erythropoietin (EPO) <10,000
• 635 Erythropoietin (EPO) >10,000
• 636 Drugs Requiring Detailed Coding

Box 45 – Service Date Inpatient - Leave blank Outpatient - Required
For span bills only.
Enter the date of service using MM/DD/YY format for each detail line completed.
Each date of service must fall within the date span entered in the Statement Covers Period.
Not required for single date of service claims.

Box 46 – Service Units Inpatient - Required Outpatient - Required
Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and
do not show a decimal point followed by a 0 to designate whole numbers (e.g., do not enter 1.0 to signify one unit). The grand total line (Line 23) does not require a unit value.

For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in Box 45.

Box 47 – Total Charges Inpatient - Required Outpatient - Required
Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the
unit charge. Do not subtract Medicare or third-party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.

Box 48 – Non-covered Charges
Inpatient – Conditional
Outpatient – Conditional
Incurred charges that are not payable by the Company’s non-covered charges must be entered in both Box 47 (Total Charges) and Box 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.

Box 50 – Payer Name Inpatient - Required Outpatient - Required
Enter the payment source code followed by name of each payer organization from which the Provider might expect payment.

Source Payment Codes
• B - Workers Compensation
• C - Medicare
• D - Colorado Medical Assistance Program
• E - Other Federal Program
• F - Insurance Company
• G - Blue Cross, including Federal Employee Program
• H - Other - Inpatient (Part B Only)
• I - Other
• Line A - Primary Payer
• Line B - Secondary Payer
• Line C - Tertiary Payer

Box 51 – Health Plan ID Inpatient - Required Outpatient - Required
Enter the Provider’s Health Plan ID for each payer name. Enter Health Plan ID.
Box 52 – Release of Information
Submitted information is not entered into the claim processing system.

Box 53 – Assignment of Benefits
Submitted information is not entered into the claim processing system.

Box 54 – Prior Payments Inpatient - Conditional Outpatient - Conditional
Complete when there are third-party payments.

Box 55 – Estimated Amount Due
Inpatient – Conditional
Outpatient – Conditional
Complete this box when there are third-party payments.
Beginning May 23, 2008, all identifiers submitted on the Form UB-04 requires National Provider Identifiers (NPI) on all claims.

Box 56 – National Provider Identifier (NPI)
Inpatient – Required
Outpatient – Required
Enter the billing Provider’s 10-digit National Provider Identifier (NPI)

Box 57 – Other Provider ID Inpatient - Required Outpatient - Required

Box 58 – Insured’s Name Inpatient - Required Outpatient - Required
Enter the Client’s name from medical card.

Other Insurance
Complete additional lines when there is third-party coverage. Enter the policyholder’s last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 60 – Insured’s Unique Member ID
Inpatient – Required
Outpatient – Required
Enter the insured’s unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes shown on the card.

Box 61 – Insurance Group Name
Inpatient – Conditional
Outpatient – Conditional
Complete when there is third-party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.

Box 62 – Insurance Group Number
Inpatient – Conditional
Outpatient – Conditional
Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
Box 63 – Treatment Authorization Code
Inpatient – Conditional
Outpatient – Conditional
Complete when the service requires authorization. Enter the authorization number in this box when Patient has been approved for the services.

Box 64 – Document Control Number
Inpatient – If applicable
Outpatient – If applicable

Box 65 – Employer Name
Inpatient - Conditional
Outpatient - Conditional
Complete when there is third-party coverage. Enter the policyholder’s last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 66 – Diagnosis Version Qualifier
Submitted information is not entered into the claim.

Box 67 – Principal Diagnosis Code
Inpatient – Required
Outpatient – Required
Enter the exact ICD-9-CM ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.

Box 67a - 67q – Other Diagnosis
Inpatient – Required
Outpatient – Required
Enter the exact ICD-9-CM ICD-10-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.

Box 69 – Admitting Diagnosis Code
Inpatient – Required
Outpatient – Optional
Enter the ICD-9-CM ICD-10-CM diagnosis code as stated by the Physician at the time of admission.

Box 70 – Patient Reason Diagnosis
Inpatient – If applicable
Outpatient – If applicable

Box 71 – PPS Code
Submitted information is not entered into the claim.

Box 72 – External Cause of Injury Code (E-code)
Inpatient – Required
Outpatient – Required
Enter the ICD-9-CM ICD-10-CM diagnosis code for the external cause of an injury, such as poisoning, or adverse effect. This code must begin with an “E”.
Box 74 – Principal Procedure Code/Date
Inpatient – Conditional
Outpatient – Conditional
Enter the ICD-9-CM ICD-10-CM procedure code for the principal procedure performed during this billing period and the date on which the procedure was performed. Enter the date using MM/DD/YY format.
Apply the following criteria to determine the principle procedure:
The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment.
The principal procedure is most related to the primary diagnosis.

Box 74a – Other Procedure Code/Date
Inpatient – Conditional
Outpatient – Conditional
Complete when there are additional significant procedure codes.
Enter the ICD-9-CM ICD-10-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MM/DD/YY format.

Box 76 – Attending NPI Inpatient - Required Outpatient - Required
Enter the 10-digit NPI.

Box 77 – Operating - NPI/QUAL/ID
Inpatient – Required
Outpatient – Required
Enter the 10-digit NPI.

Box 78 - 79 – Other NPI Inpatient - Required Outpatient - Required
Enter the 10-digit NPI.

Box 78 - 79 – Other ID Last/First Name (Continued)
Inpatient – Required
Outpatient – Required
Enter the attending Physician’s last and first name.

Box 80 – Remarks
Enter specific additional information necessary to process the claim or fulfill reporting requirements.

Box 81 – Code-Code QUAL/CODE/VALUE (a-d)
Submitted information is not entered into the claim.

Providers must file all claims for professional services, including laboratory services performed by independent laboratory, on the current CMS HCFA 1500 form. Please see below for a list of required fields. Providers must include the information marked “Required”.

1500 Claims Processing Manual
CMS-1500 form.
Box 1 – Medicare, Medicaid, Group Health Plan or other insurance Information
Show the type of health insurance coverage applicable to this claim by checking the appropriate box. This is a required field.

Box 1a – Insured’s ID Number
Enter the Patient’s Health Insurance ID Number. This is a required field.

Box 2 – Patient’s Name (Last Name, First Name, Middle Initial) Enter the Patient’s last name, first name, and middle initial, if any, as shown on the Patient’s card. This is a required field.

Box 3 – Patient Birth Date
Enter the Patient’s 8-digit birth date (MM/DD/CCYY) and sex. This is required field.

Box 4 – Insured’s Name (Last Name, First Name, Middle Initial) List the name of the insured here. When the insured and the Patient are the same, enter the word “SAME”. This is required field.

Box 5 – Patient’s Address (Number, Street)
Enter the Patient’s mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the zip code and phone number.

Box 6 – Patient Relationship to Insured
Check the appropriate box for Patient’s relationship to insured when Box 4 is completed. This is a required field.

Box 7 – Insured’s Address (Number, Street)
Enter the insured’s address and telephone number. When the address is the same as the Patient’s, enter the word “SAME”. Complete this item only when Boxes 4, 6 and 11 are completed.

Box 8 – Patient Status
Check the appropriate box for the Patient’s marital status and whether Single or Married and Employed or Student. This is a required field.

Box 9 – Other Insured’s name (Last Name, First Name, Middle Initial)
Enter the last name, first name, and middle initial of the enrollee if policy is different. This field may be used in the future for supplemental insurance plans.

Box 9a – Other Insured’s Policy or Group Number
Enter the other policy and/or group number of the other insurance. This box must be completed if applicable.

Box 9b – Other Insured’s Date of Birth
Enter the other insured’s 8-digit birth date (MM/DD/CCYY) and sex. This box must be completed if applicable.
Box 9c – Employer’s Name or School Name
Enter employer’s name or school name.
This box must be completed if applicable.

Box 9d – Insurance Plan Name or Program Name
Name of the insurance plan.
This box must be completed if applicable.

Boxes 10a - 10c – Is Patient’s condition related to:
Check “YES” or “NO” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Box 24.
This is a required field.

Box 10d – Reserved for local use

Box 11 – Insured’s Policy Group Number
This box must be completed if applicable.

NOTE: Enter the appropriate information in item 11c if insurance primary to the Company is indicated in Box 11. If there is insurance primary to the Company, enter the insured’s policy or group number and proceed to Boxes 11a - 11c. Boxes 4, 6 and 7 must be completed. If there is no insurance primary to the Company, enter the word “NONE” and proceed to Box 12.

If the insured reports a terminating event with regard to insurance which had been primary to the Company (e.g., insured retired), enter the word “NONE” and proceed to Box 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word “NONE” in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to the Company
Circumstances under which the Company payment may be secondary to other insurance:
• Group Health Plan Coverage through spouse working aged
• Disability (large group health plan)
• End-stage renal disease
• No fault and/or other liability
• Work-related illness/injury
• Workers compensation
• Black lung
• Veterans’ Benefits

NOTE: For a paper claim to be considered for the Company’s secondary payer benefits, a copy of the primary payer’s EOB notice must be forwarded along with the claim form.

Box 11a – Insured’s Date of Birth
Enter the insured’s 8-digit birth date (MM/DD/CCYY) and sex if different from Box 3.
Box 11b – Employer’s Name or School Name
Enter employer’s name, if applicable. If there is a change in the insurance status, such as retired, enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word “RETIRED.”

Box 11c – Insurance Plan Name or Program name
Enter the 9-digit Payer ID number of the primary insurer. If no Payer ID number exists, then enter the complete primary payer’s program or plan name. If the primary payer’s EOB does not contain the claims processing address, record the primary payer’s claims processing address directly on the EOB. This is required if there is insurance primary to the Company which is indicated in Box 11.

Box 11d – Is there another Health Benefit Plan?
This box must be completed if applicable.

Box 12 – Patient’s or Authorized Person’s Signature
The Patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alpha-numeric date (e.g., January 1, 2008) unless the signature is on file.

NOTE: This can be “Signature on File” and/or a computer-generated signature.
The Patient’s signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the Provider of service or supplier when the Provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter their name and address next to the mark.
This is a required field.

Box 13 – Insured’s or Authorized Person’s Signature
The Patient’s signature or the statement “Signature on File” in this box authorizes payments of medical benefits to the Physician or supplier.

The Patient or their authorized representative signs this item or the signature must be on file separately with the Provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating Physician or supplier, a Patient’s signature or a “Signature on File” is not required in order for the Company payment to be made directly to the Physician or supplier.

NOTE: This can be “Signature on File” signature and/or a computer generated signature.
This is a required field.

Box 14 – Date of Current
Enter either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date of current illness, injury, or pregnancy.
This is a required field.

Box 15 – If Patient has had the same or similar Illness
This box must be completed if applicable.

Box 16 – Dates Patient unable to work in current occupation
If the Patient is employed and is unable to work in their current occupation, enter an 8-digit (MM/DD/CCYY)
or 6-digit (MM/DD/YY) date when Patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Box 17 – Name of Referring Provider or Other Source
Enter the name of the referring or ordering Physician if the service or item was ordered or referred by a Physician.

Box 17a – Leave blank
NOTE: Effective May 23, 2008, 17a is not to be reported, but 17b must be reported when a service was ordered or referred by a Physician.

Box 17b Form CMS-1500 – NPI
Enter the NPI of the referring/ordering Physician listed in Box 17.
All Physicians who order services or refer the Company’s beneficiaries must report this data.
This is a required field.

Box 18 – Hospitalization Dates Related to Current Services
Enter either an 8-digit (MM/DD/CCYY) or a 6-digit (MM/DD/YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Box 19 – Reserved for Local Use
This box must be completed if applicable.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and “mod” represents all modifiers applicable to the referenced line item.

Box 20 – Outside Lab
Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the “YES” block is checked. A “YES” check indicates that an entity other than the entity billing for the service performed the diagnostic test. A “NO” check indicates “no purchased tests are included on the claim.” When “YES” is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.
NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Box 21 – Diagnosis or Nature of Illness Injury
Enter the Patient’s diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all Physician and non-Physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-10-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.
This is a required field.

Box 22 – Medicaid Resubmission Code
Not applicable.
Box 23 – Prior Authorization Number
Enter the Company Prior Authorization number for those procedures that require the Company’s prior approval.

Box 24a – Date(s) of Service
Enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date for each procedure, service or supply. This is a required field.

Box 24b – Place of Service
Enter the appropriate place of service code(s) from the list provided.
Identify the location, using a place of service code, for each item used or service performed:
- 11 - Clinic
- 12 - Home
- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room
- 24 - Ambulatory Surgery
- 41 - Ambulance
- 50 - FQHC
- 65 - End-stage renal disease treatment
This is a required field.

Box 24c – EMG
This box must be completed if applicable.

Box 24d – Procedures, Services, or Supplies - CPT/HCPCS Modifiers
Enter the procedures, services, or supplies using the Healthcare Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS). When applicable, show CPT/HCPCS modifiers with CPT/HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers. Enter the specific CPT/HCPCS procedure code without a narrative description.

However, when reporting an “unlisted procedure code” or “not otherwise classified” (NOS), include a narrative description in Box 19, if a coherent description can be given, within the confines of that box. Otherwise, an attachment should be submitted with the claim.
This is a required field.

Box 24e – Diagnosis Pointer
Enter the diagnosis code reference number as shown in Box 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service (i.e., a 1, or a 2, or a 3 or a 4).

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the Provider shall reference only one of the diagnoses in Box 21.
This is a required field.

Box 24f – $ Charges
Enter the charge for each listed service.
This is a required field.
Box 24g – Days or Units
Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral “1” must be entered. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided. For anesthesia, show the elapsed time (minutes) in Box 24g. Convert hours into minutes and enter the total minutes required for this procedure. This is a required field.

NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default to “1” unit when the information in this field is missing to avoid returning claims as unprocessable.

Box 24h – EPSDT Family Plan
Not applicable.

Box 24j – Rendering Provider NPI
Enter the rendering Provider’s NPI number in the lower unshaded portion. This is a required field.

NOTE: Effective May 23, 2008, the shaded portion of 24j is not to be reported.

Box 25 – Federal Tax ID Number
Enter the service Provider’s or supplier’s Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Providers are required to complete this box for crossover purposes. Tax identification information is used in the determination of accurate NPI reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed. This is a required field.

Box 26 – Patient’s Account Number
Enter the Patient’s account number assigned by the service Provider’s or supplier’s accounting system. This is a required field to assist the Provider in Patient identification.

Box 27 – Accept Assignment? Yes or No?
Check the appropriate block to indicate whether the service Provider or supplier accepts assignment of the Company benefits. The service Provider or supplier shall also be a participating service Provider or supplier with the Company and accept assignment of the Company benefits for all covered charges for all Patients. This is a required field.

Box 28 – Total Charge
Enter total charges for the services (i.e., total of all charges in Box 24F). This is a required field.

Box 29 – Amount Paid
Enter the total amount the Patient paid on the covered services only. This box must be completed if applicable.

Box 30 – Balance Due
This box must be completed if applicable.
Box 31 – Signature of Physician or Supplier
Enter the signature of service Provider or supplier, or their representative, and one of the following: the 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed on.

NOTE: This is a required field. However, the claim can be processed if the following occurs: if a Physician, supplier, or authorized person’s signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has “Signature on File” and/or a computer generated signature.

Box 32 – Service Facility Location Information
Enter the name, address and zip code of the facility if the services were furnished in a hospital, clinic, laboratory or facility other than the Patient’s home or Physician’s office.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier’s personnel performs the work at the Physician’s office or at another location.

Complete this box for all laboratory work performed outside a Physician’s office. If an independent laboratory is billing, enter the place where the test was performed. This is a required field.

Box 32a – Service Facility Location Information
Required by the Company for claims processing policy. Enter the NPI of the service facility if applicable.

Box 32b – Effective May 23, 2008, Box 32b is not to be reported.

Box 33 – Billing Provider Info & PH Number
Enter the service Provider’s or supplier’s billing name, address, zip code and telephone number. This is a required field.

Box 33a – Billing Provider Info & PH Number
Enter the NPI of the billing Provider or group. This is a required field.

Box 33b - Effective May 23, 2008, Box 33b is not to be reported.

**OVERPAYMENT RECOVERY**
The Company strives for 100% payment quality but recognizes that a percentage of financial overpayments may occur while processing claims. An overpayment is defined as any funds a person or entity has received or retained to which the person is not entitled. An overpayment can occur due to many reasons, such as retroactive Member termination, Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefits, through retrospective medical record review that is not supported by the medical record, and other reasons. An overpayment can be initially identified by the Provider during the course of their business operations or it can be identified by the Company. Providers are responsible for notifying the Company within 60 calendar days of identification of an overpayment. The Company has a regulatory obligation to report any overpayments to the applicable regulatory agency and recoup those funds that the Provider is not entitled to.
The Company will proactively identify and attempt to correct inappropriate payments. With respect to the Medicare line of business, in situations when the inappropriate payment caused an overpayment, the Company will follow the same methodology used by CMS Recovery Audit Contractor (RAC) program by limiting its recovery to 3 years from the date of service. For more information on the CMS RAC, refer to the CMS website. In all cases, the Company, or its designee, will provide a written notice to the Provider explaining the overpayment reason and amount, contact information, and instructions on how to send the refund. If the overpayment results from Coordination of Benefits, the written notice will specify the name of the carrier and coverage period for the Member. The overpayment request notification provides 30 calendar days for the Provider to send in the refund, request further information, or dispute the overpayment. Failure of the Provider to respond within the allotted timeframe will constitute acceptance of the terms in the letter and will result in claim offsets to future payments. The Provider will receive an Provider Remittance Advice (RA) indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than 3 months and a claims offset cannot be made, the Provider may be contacted by the Company, or its designee, to arrange payment.

**If the Provider independently identifies an overpayment, the Company requires that they submit:**
1) a letter explaining the overpayment, within 60 days of identification,
2) a copy of the claim that was affected or copy of the Provider Remittance Advice highlighting the claim information,
3) a refund check made payable to Denver Health Medical Plan or Denver Health Medicaid Choice, depending on the line of business,
4) instructions to the Company to offset against future payments, if a refund check is not included in the submission.

**Please send information to:**
Denver Health Medical Plan/Denver Health Medicaid Choice  
ATTN: Finance Department  
938 Bannock Street  
Denver, CO 80204

**SECTION VI: RESUBMISSION OF CLAIMS**

**PROVIDER INQUIRIES REGARDING CLAIMS ADJUDICATION AND PAYMENT**

Providers having questions about claims adjudication should review the Company’s RA received with their payment. RA questions can be directed to the Company’s Customer Service Department at 303-602-2100, or faxed to 303-602-2138.

**RESUBMISSION OF A CLAIM**

If a claim has been pended or denied for lack of proper coding or other additional information needed to comprise a clean and compete claim, a Provider may re-submit the corrected claim with the necessary information to have it reconsidered for adjudication purposes. Colorado Revised Statutes 10-16-106.5(4)(b) states that Providers receiving a request for additional information shall submit all additional information requested within 30 calendar days after receipt of such a request.

To re-submit a claim, re-date and re-sign a copy of the original claim and mark “RESUB” on the face of the claim. Include a copy of the RA from the Company with the original claim. Send re-submitted claims, along with a letter of explanation as to why the claim is being re-submitted, to:
Should a Provider and the Company not be able to resolve issues regarding claims adjudication, the Company has established a Provider Carrier Dispute Resolution Process in accordance with Division of Insurance regulations. Providers who cannot resolve a disagreement in the normal course of business, as noted directly above, can use this process to request resolution. A Provider Carrier Dispute Resolution Form can be found in this Provider Manual (Attachment 1) or the Provider may contact Provider Relations at 303-602-2042. This form must have all required fields completed. Incomplete forms will be returned to the Provider. Include all supporting documentation and evidence to support the request. The completed forms and documentation can be faxed to 303-602-2096 or mailed to:

Denver Health Medical Plan, Inc.  Elevate Health Plans
PO Box 24922  PO Box 24631
Seattle, WA 98124-0992  Seattle, WA 98124-0631
Electronic Payer ID: 84-135  Electronic Payer ID: 84-135

The Company will respond to a request within 30 calendar days of receipt with the disposition of the request. This process does not apply to Utilization Review.

SECTION VII: ADMINISTRATIVE RESPONSIBILITIES

APPOINTMENT STANDARDS
Member satisfaction is very important to the Company. Excessive waiting times for appointments are a major cause of Member dissatisfaction with their health care Provider and health program. The Company has established the following appointment standards for all contracted Providers:

<table>
<thead>
<tr>
<th>Access to Services Standard</th>
<th>Timeframe</th>
<th>Compliance Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care – Medical, Behavioral, Substance Abuse</td>
<td>24 hours a day, 7 days a week</td>
<td>100% of the time</td>
</tr>
<tr>
<td>Urgent Care – Medical, Behavioral, Substance Abuse</td>
<td>Within 24 hours</td>
<td>100% of the time</td>
</tr>
<tr>
<td>Primary Care — Routine, Non-urgent Symptoms</td>
<td>Within 7 calendar days</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Behavioral Health, Mental Health and Substance Abuse – Routine, Non-urgent, Non-emergency</td>
<td>Within 7 calendar days</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 7 calendar days</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Primary Care — Access to After-hours Care</td>
<td>Office number answered 24 hrs/7 days a week by answering service or instructions on how to reach a physician</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Preventive/Well Visits</td>
<td>Within 30 calendar days</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Specialty Care — Non-urgent</td>
<td>Within 60 calendar days</td>
<td>&gt;=90% of the time</td>
</tr>
</tbody>
</table>
WAIT TIMES
Wait times should be no longer than 30 minutes from the scheduled appointment time (except when Provider is unavailable due to an emergency).

The Company will monitor Providers and assess compliance to these standards in the following manner:
• Periodic office visits
• Conduct secret or open shopper surveys
• Review grievances and complaints related to the Company’s Providers for access issues

The Company reserves the right to adjust or modify appointment standards based on Member and Provider needs.

AFTER-HOURS CALLS AND COVERAGE STANDARD
PCPs and SCPs must assure that coverage is available 7 days a week, 24 hours a day for Member emergency services and to provide medical advice and direction. Backup coverage must be arranged when a Provider is not available during regular office hours. It is the responsibility of the backup Provider to know and follow the Policies and Procedures of the referral and authorization processes. Providers are required to respond to after-hours and/or emergency calls within 30 minutes. The Denver Health Nurse Line is available at 303-739-1211 24 hours a day, 7 days a week for health advice and questions.

EMERGENCY SERVICES
If a Member seeks treatment in a hospital emergency department for a medical emergency, the emergency department should provide screening or treatment without PCP authorization. Prior approval or authorization is not required for emergency services. The Member has the right to use any hospital or other setting for emergency care. The Company will cover and pay for emergency services regardless of whether the Provider that furnishes the services has a contract with the Company.

However, the PCP should be informed of the services rendered after the Member has been stabilized, or by the next business day by the hospital, if possible.

An emergency medical condition is defined herein as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy.
• Serious impairment to bodily functions.
• Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:
• Furnished by a Provider that is qualified to furnish these services under 42 C.F.R. §438.114
• Needed to evaluate or stabilize an emergency medical condition

If a Member contacts their PCP with an emergency, the PCP may instruct the Member to seek immediate medical services through the 911 system or go to the nearest emergency room. Hospital staff should try to contact the Company’s UM Department within 48 hours of the encounter. This can be accomplished by telephone or fax, with the emergency room encounter note attached.
The Company is financially responsible for any care given, in-network or out-of-network, which is necessary to stabilize the Member’s emergency medical condition. Prior Authorization or referral is not required for stabilization care services.

The admitting Physician and/or the hospital should inform the PCP of emergency admissions at the time of admission or the next business day. PCP notification must be documented in the hospital medical record and in the PCP’s medical record. Documentation must include the date of admission, name and title of the person notifying the PCP, and the date of the contact.

Ambulance services are covered when medically necessary. Emergency department visits and emergency transportation claims are reviewed retrospectively. The health program, according to this policy regarding notification and the established rules, will reimburse all bonafide medical emergencies. This review does take into consideration the “prudent layperson” definition of an emergency.

**POST-STABILIZATION CARE SERVICES**

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member’s condition. The Company is financially responsible for post-stabilization care services within or outside the network that are not pre-approved by the Company, but are administered to maintain, improve, or resolve the Member’s stabilized condition if:

- The Company does not respond to the request of a facility providing post-stabilization care for pre-approval within 1 hour of request;
- The Company cannot be contacted; or
- The Company and the attending Provider at the requesting facility cannot reach an agreement concerning the Member’s care.

In this situation, the Company must give the treating Physician the opportunity to consult with a plan Physician. The treating Physician may continue the Member’s treatment until they are able to consult a Company Physician or until the criteria below are met so that the Company is no longer financially responsible for the post-stabilization care.

The Company’s financial responsibility for post-stabilization care services that it has not pre-approved ends when:

- A Company Physician with privileges at the treating hospital assumes financial responsibility for the Member’s care
- A Company Physician assumes responsibility for the Member’s care through transfer
- The Company and the treating Physician reach an agreement concerning the Member’s care
- The Member is discharged

The Company is financially responsible for any post-stabilization care services that are provided at Denver Health or a non-Denver Health hospital if the post-stabilization care was pre-approved by the Company.

**NON-EMERGENT SERVICES**

Non-emergent services provided in an emergency department are not a benefit. The emergency department can determine if an emergency exists. Reimbursement for a medical screening exam, as opposed to an emergency visit, will be authorized for payment to Providers in such cases where the emergency department determines an emergency did not exist.
NON-EMERGENT AIR AMBULANCE
While it is expected that these actions will rarely be necessary, please remember that there is protocol and this does need to be reviewed; please call the UM Department before proceeding with any further plans.

URGENTLY NEEDED SERVICES
Urgently Needed Services, as defined in 42 C.F.R. § 422.113(b)(1)(iii), means covered services that are not emergency services as defined above, provided when a Member is temporarily out of the Company’s service area, or when the Company’s Provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required:
- As a result of an unforeseen illness, injury or condition; and
- Given the circumstances, it was not reasonable to obtain the services through the Company’s Provider network.

Prior approval or authorization is not required for urgent care services. The Company is responsible for payment for urgent care services even if the facility is not contracted with the Company or out-of-area.

If urgent care is required, the Member should be instructed to 1) call their PCP or clinic during hours of operation, 2) call the Denver Health Nurse Line at 303-739-1211 if unable to access the PCP or clinic or 3) go to the nearest urgent care center, whether or not the urgent care center is within the Company’s network.

SECTION VIII: PREVENTIVE HEALTH CARE
We encourage PCPs to coordinate and request preventive health care services for their Patients. These include annual check-ups, regular screening procedures and appropriate immunizations.

See Attachment 2 for the U.S. Preventive Service Task Force (USPSTF) recommendations.

Guidelines are subject to change. For clarification, please call the Company at 303-602-2003. New and revised guidelines will be sent periodically.

SECTION IX: BENEFITS AND LIMITATIONS
Please refer to these websites for current benefits and limitations for all plans:
www.denverhealthmedicalplan.org
www.denverhealthmedicaid.org

SECTION X: UTILIZATION MANAGEMENT (UM)
The goal of the UM Department is to encourage the highest quality of care, in the most appropriate setting, from the most appropriate Provider. Through the UM program, the Company seeks to avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. The organization distributes a statement to all Members and to all Practitioners, Providers and employees who make UM decisions, affirming the following: 1) UM decision-making is based only on
appropriateness of care and service and existence of coverage; 2) the organization does not specifically reward practitioners or other individuals for issuing denials of coverage; and 3) financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The Company uses both internally approved guidelines and the following National Criteria Sets:

A. MCG Modules:
   i. Ambulatory Care
   ii. Inpatient and Surgical Care
   iii. General Recovery Care
   iv. Multiple Condition Management
   v. Recovery Facility Care
   vi. Home Care
   vii. Chronic Care
   viii. Behavioral Health Care

B. InterQual modules:
   i. Acute Adult
   ii. Acute Pediatric
   iii. Durable Medical Equipment
   iv. Imaging
   v. Molecular Diagnostics
   vi. Procedures
   vii. Sub-acute/SNF
   viii. BH: Adult and Geriatric Psychiatry
   ix. BH: Child and Adolescent Psychiatry
   x. BH: Substance Use Disorders
   xi. BH: Procedures

The Company also uses the Medicare Coverage Database, HCPF Benefits Collaborative, and Hayes Knowledge Center to determine the medical necessity of requested services.

For copies of any of the specific criteria, or for questions about the UM program, please call 303-602-2140.

The following table provides a summary of the timeliness requirements for UM decisions for behavioral health and non-behavioral health determinations as of January 1, 2015.

<table>
<thead>
<tr>
<th>TYPE OF REVIEW</th>
<th>COMM/ELEVATE (ALL)</th>
<th>MEDICAID &amp; CHP+</th>
<th>MEDICARE (ALL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service/Prospective</td>
<td>15 calendar days</td>
<td>10 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Expedited/Urgent Pre-service</td>
<td>72 hours</td>
<td>72 hours</td>
<td>72 hours</td>
</tr>
<tr>
<td>Urgent Extension due to lack of info from Member</td>
<td>Notify 24 hours; Extend Member time 48 hours</td>
<td>14 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>24 hours</td>
<td>24 hours</td>
</tr>
<tr>
<td>Urgent Concurrent Extension</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Retrospective/Post-service</td>
<td>30 calendar days</td>
<td>10 calendar days</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
If the UM staff receives insufficient information to make a coverage determination, the staff will notify the Provider of the specific information that is needed to make the determination. The extension timeframe in the above chart may be used in those cases wherein the Provider needs additional time to provide sufficient information to make a determination.

The Company has posted a Prior Authorization List on the website. It can be found here: www.denverhealthmedicalplan.org/prior-authorization-list

Please refer to the website for UM Prior Authorization forms:
www.denverhealthmedicalplan.org/2017-um-outpatient-provider-referral-form
www.denverhealthmedicalplan.org/2017-um-outpatient-provider-procedure-form

Look for the forms titled “UM Outpatient Provider Referral Form” and “UM Outpatient Provider Procedure Form”. Use the Company’s Prior Authorization Forms and fill them out completely in order to expedite the process. Please also submit any documentation needed to support medical necessity for the request.

Prior Authorizations should be faxed to the following numbers:
Inpatient Admissions: 303-602-2127
Outpatient Services and Elective Admissions: 303-602-2128
Durable Medical Equipment (DME): 303-602-2160

When submitting a request for Prior Authorization, please remember that there are specific rules to determine if a Prior Authorization request is urgent. The Colorado Department of Regulatory Agencies defines an urgent request as: a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or, for a person with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or

b) In the opinion of a Physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

If submitting an urgent request, supporting documentation must be provided to show why the request meets the above definition of urgent. Urgent requests that do not meet the above definition will be downgraded to a routine request, and will be completed within the timeframe for making a non-urgent (standard) request.

**Timeframes to Make Determination on Non-Urgent (Standard) Care Requests**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid and CHP +</td>
<td>10 calendar days</td>
</tr>
<tr>
<td>Medicare</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Commercial/Employee Group Plans/Elevate</td>
<td>15 calendar days</td>
</tr>
</tbody>
</table>
**Timeframes to Make Determinations on Urgent/Expedited Care Requests**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid and CHP +</td>
<td>72 hours</td>
</tr>
<tr>
<td>Medicare</td>
<td>72 hours</td>
</tr>
<tr>
<td>Commercial/Employee Group Plans/Elevate</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

Please do not send duplicate requests for services that are within the appropriate determination timeframe. This causes duplicate work and slows down the authorization process. For questions about an authorization request or submitted request with no response within the above timeframes, please call the Medical Management Department Provider number at 303-602-2140.

**ADVANCE NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS**

Physicians, healthcare professionals and ancillary care Providers are responsible for providing Advance Notification or requesting Prior Authorization for services on the Prior Authorization List as further explained below.

Members may be required to obtain Prior Authorization for out-of-network services. Physicians, health care professionals and ancillary care Providers are responsible for directing Members to care Providers within the Members’ health plan network.

Facilities are responsible, prior to the date of services, for confirming coverage approval is on file as further explained below.

Facilities are responsible for admission notification for inpatient services even if coverage approval is on file as further explained below.

If Advance Notification or Prior Authorization requirements are not followed, claims may be denied in whole or in part and, as required under the Provider’s agreement with the Company, and the Member cannot be billed for the service.

Advance Notification or Prior Authorization is valid only for the date of service or date range stated on the notification or Prior Authorization. If that specified date of service or date range has passed and the service(s) has not been delivered, a new Advance Notification or Prior Authorization request must be submitted. Subject to state and federal regulations, including regulations pertaining to a care Provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain the Ownership System (PECOS)* list, the provision of Advance Notification or receipt of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon:

- Coverage within an individual Member’s benefit plan
- Whether the care Provider is eligible for payment
- Any claim processing requirements, and
- Provider’s participation agreement with Denver Health

**WHEN TO SUBMIT ADVANCE NOTIFICATION OR PRIOR AUTHORIZATION**

Physicians, health care professionals and ancillary care Providers are responsible for Advance Notification for planned services on the Advance Notification list. Additionally, Members may be required to obtain Prior Authorization for out-of-network services. Advance Notification with supporting clinical documentation should be submitted as far in advance as possible, but at least 2 weeks before the planned service date is recommended to allow enough time for coverage review. Prioritization of case review is based on the specifics...
of the case, the completeness of the information received, CMS requirements and/or other state or federal requirements. Time may be extended if additional information is needed.

**FACILITIES: STANDARD NOTIFICATION REQUIREMENTS**

Confirming Coverage Approvals:
For any inpatient or outpatient service on the Advance Notification/Prior Authorization List, and prior to rendering the service, the facility must confirm the coverage approval is on file. The purpose of this protocol is to enable the facility and the Member to have an informed pre-service conversation. In cases where the service is not covered, the Member can then decide whether to receive and pay for the service out-of-pocket.

Facilities are responsible for Admission Notifications for the following types of inpatient admissions:
- All planned and elective admissions for acute care
- All SNF admissions
- All admissions following outpatient surgery
- All admissions following observation
- All newborns admitted to Neonatal Intensive Care Unit (NICU)
- All emergency department admissions

All admissions will require concurrent review and will only be approved for medical necessity.

**SECTION XI: PHARMACY BENEFITS FOR DHMP**

Pharmacy website content can be found at www.denverhealthmedicalplan.org/provider-pharmacy-information. Copies of all information available on the website are available by request at no charge.

**PHARMACY DEPARTMENT CONTACT INFORMATION:**
Phone: 303-602-2070
Fax: 303-602-2081
Email: ManagedCarePAR@dhha.org

**FORMULARY**
The formularies contain:
- A list of covered drugs, including restrictions and preferences
- Copayment information, including tiers
- Drugs that require Prior Authorization
- Limits on refills, doses or prescriptions

**FORMULARY UPDATES**
- The Medicare formularies are updated monthly and updated documents are posted when updates occur
- For all other plans (Large Group Commercial, Medicaid, CHP+, and Healthcare Exchange), formularies and updated formulary documents are updated quarterly
- The most current version can be found on the pharmacy webpages

**GENERIC SUBSTITUTION**
Generic drugs are preferred on the formulary. Brand name drugs may be dispensed if the Provider or Member specifies the brand is required. When the brand is requested, the Member must pay their copay (if applicable)
plus the price difference between the brand and the generic drug. If a Prior Authorization is completed and approved for the brand, the Member is responsible for the exception tier copay. For more information, see the formulary or call the DHMP Pharmacy Department at 303-602-2070.

PRIOR AUTHORIZATION AND STEP THERAPY CRITERIA
- DHMP Prior Authorization and step therapy criteria can be found on the respective pharmacy webpages
  » Medicare criteria are updated monthly
  » For all other plans (Large Group Commercial, Medicaid, CHP+, and Healthcare Exchange), criteria are updated quarterly
- The most current version can be found on the pharmacy webpages
- If a drug is non-formulary, at least 2 formulary drugs to treat the same condition must be tried first
- Generic non-formulary drugs are preferred over brand non-formulary drugs

PROCESS FOR SUBMITTING A PRIOR AUTHORIZATION
(ALSO KNOWN AS AN EXCEPTION REQUEST)
- Prior Authorization forms are located at:
  http://www.denverhealthmedicalplan.org/provider-forms-and-materials
- Completed forms should include all pertinent medical necessity information
  » Incomplete requests may be pended while the Pharmacy Department attempts to reach the Provider to obtain the required information. If the required information cannot be obtained, the request may be denied.
- Prior Authorization forms may be submitted by:
  » Fax
  » Email
  » Phone
  » Online upload from the Provider forms webpage by clicking “Upload a Pharmacy Prior Authorization Form Here”
- A request may be marked urgent to expedite the review:
  » Medicare: When the standard timeframe may jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function
  » Commercial: In situations where a delay could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; would subject the Member to severe pain without the treatment that is the subject of the request; or could create substantial limitation to the Member’s ability to live independently
  » Medicaid/CHP+: A Member has acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman and/or her unborn child;
    2. Serious impairment to bodily functions; or
    3. Serious dysfunction of any bodily organ or part
- Members and Providers are notified of the decision at minimum via written communication

THIRD-PARTY PHARMACY ADMINISTRATOR FOR OUTPATIENT PRESCRIPTIONS
MedImpact is the pharmacy benefit manager for DHMP. Emergency and after-hours overrides are available 24 hours a day, 365 days a year at 1-800-788-2949.
SECTION XII: INTENSIVE CASE MANAGEMENT

It often takes a coordinated effort to make sure that services are delivered accurately and that Members get the most out of the resources that are available to them. The Company’s Intensive Case Managers have expertise in case management and care coordination and focus solely on managing the more challenging and complex situations.

This department includes three case management programs and a team dedicated to outreach and care coordination, each of which is an opt-out program available at no cost to any individual enrolled in any of the Company’s insurance plans. Services and programs are designed to support the Company’s mission by promoting Members’ efforts to play active and effective roles in their care and addressing the social and behavioral determinants of health care outcomes. By providing case management services in an insurance (payer-based) setting, the Company’s focus is on the health and wellness of its Members as well as being a liaison between care Providers.

More specifically, the Intensive Case Management (ICM) Department includes the following:

1. Care Support Services: A team of non-clinical, bilingual staff (Case Manager Assistants) dedicated to providing basic care coordination services (i.e., help with arranging appointments and transportation, Patient education, community referrals), performing scripted assessments, providing outreach interventions to address gaps in care, and assisting case managers in file reviews and implementation of appropriate interventions

2. Complex Case Management (CCM): Provides comprehensive case management services to high-risk Members with multiple and complex needs

3. Intensive Care Transitions (ICT): Provides short-term, 30-45 day, intensive management and support for Members identified as high-risk during an acute inpatient hospital admission

4. Targeted Case Management (TCM): Provides intensive, personalized support, monitoring, outreach, and engagement for individuals with medical and behavioral care needs and who are also high-cost/high utilizers of the health care system

The case management staff works with Members, families and health care Providers to make sure Members receive the best care possible, in the most cost-effective way, with the best possible outcome. Interventions may include, but are not limited to:

- A comprehensive needs assessment and periodic re-assessment
- Coordination of primary and specialty care
- Support in following treatment plans
- Promote self-awareness and self-management through development and maintenance of care plans
- Resource connection and coordination
- Improve understanding and management of benefits
- Patient education

Referrals to the ICM Department can be made either through Denver Health’s internal Appointment Request List (ARL) referral system or by emailing a referral form to caresupport@dhha.org. Providers can also obtain more information by calling 303-602-2080 or visiting www.denverhealthmedicalplan.org.
SECTION XIII: BEHAVIORAL HEALTH AND WELLNESS SERVICES

HEALTH COACHING PROGRAM
Health coaching offers self-management support, motivation, encouragement and compassion to individuals as they address chronic health care needs or make health behavior changes. The services offered through the program are voluntary and are provided at no cost to the Company’s Members.

Health coaches work with Members who have a variety of health conditions or wellness goals including:
- Asthma
- Congestive heart failure
- Depression/anxiety
- Diabetes
- Eating healthier
- High blood pressure
- Medication adherence
- Pain management
- Physical activity
- Smoking cessation
- Stress management
- Weight management

Health coaches are trained in motivational interviewing and are skilled at helping guide people into action. They conduct bio-psychosocial assessments to gain a better understanding of the whole person and the barriers that might be preventing them from achieving their health goals. They assess readiness to change and employ a diverse array of psychological and behavioral change tools to empower individuals to become better self-managers of their health.

Health Coaching supports you and your Patients by helping them:
- Understand their diagnoses
- Become motivated to actively manage their health
- Make short-term and long-term goals to improve health
- Implement new lifestyle changes to reduce health risks
- Identify and address barriers to care
- Get connected to appropriate resources
- Learn self-care skills and strategies that follow Provider treatment plans
- Feel more prepared for clinic visits

For more information or to refer a Member for health coaching, please contact Care Support Services at:
Phone: 303-602-2080
Fax: 303-602-2194
Email: caresupport@dhha.org
Web: www.denverhealthmedicalplan.org

THE NATIONAL DIABETES PREVENTION PROGRAM (DPP) AT DENVER HEALTH
Since 2013, over 2,000 Patients have enrolled in these rolling, year-long classes. On average, Patients completing the program lose 5% of their body weight, and some individuals have lost up to 60 pounds! The DPP is an effective intervention for Patients with pre-diabetes or other risk factors like overweight/obesity. The Company encourages long-lasting lifestyle changes for weight loss and improved overall health. There are
22 weekly-to-monthly group classes over a year, plus 1-on-1 support. Classes are in both English and Spanish. There is also a text message program for Patients who cannot attend classes.

Most adults who need to lose weight, but don’t yet have diabetes, are eligible; eligibility will be verified as needed:
• BMI of ≥ 24
• Pre-diabetes (e.g., A1c 5.7-6.4) in the past year or history of gestational diabetes
• Sedentary lifestyle

How do Providers refer Patients?
• Providers can refer through the Appointment Request List (Denver Health only) to Diabetes Prevention Program (http://pulseapp/PatientWaitList/Default.aspx); or
• Email: DiabetesPrevention@dhha.org

Diabetes Self-Management Education Classes
This 6-week class is intended to help Patients learn about their diabetes diagnoses and feel more confident about their health. By the end of the program, they will know:
• How to monitor blood sugar
• Target blood sugar levels
• How to eat a healthy diet
• Tips for dealing with the stress and emotions of diabetes
• Ideas for staying active
• The basics of medication

Call 303-602-2117 for more information.

TELEPHONIC COUNSELING FOR DEPRESSION AND ANXIETY
Participants will get to choose from 12 different modules geared toward treating symptoms of depression and/or anxiety. Each of the modules will have up to 3 therapy calls. The module topics include: Managing Stress and Anxiety, Behavioral Activation, Coping with Illness, Managing Chronic Pain, Changing Negative Thoughts, Improving Sleep, Eating Healthy, Increasing Exercise, Improving Interpersonal Relationships, Grief and Loss, and Problem Solving.

For more information on the Telephonic Counseling for Depression and Anxiety program, please contact Christine Garcia at:
Phone: 303-602-2185
Email: Christine.Garcia@dhha.org

LEARN AND BURN PROGRAM
Behavioral Health and Wellness Services offers a monthly mixed health education and physical activity seminar series which is open to anyone with an interest in learning more about health and wellness. Topics vary, but have included mind-body connection, diabetes care, taking care of your heart, how to sleep better at night, dealing with stress and health family eating, to name a few.

When: First Thursday of each month from 10 a.m. to 11 a.m.
Where: Glenarm Recreation Center, 2800 Glenarm Place, Denver, CO 80205 (across from the Denver Health Eastside Clinic)
EDUCATION CLASSES
Behavioral Health and Wellness Services offers free education classes to the Company’s members. Topics vary, but have included weight management, family nutrition, chronic pain, diabetes, mood/emotional health, heart health and smoking cessation, to name a few.

SECTION XIV: QUALITY IMPROVEMENT

The Quality Improvement (QI) Program is designed to support the mission of the Company by promoting the delivery of high-quality accessible healthcare services that will enhance or stabilize the health of its Members. The QI Program provides a formal structure and process designed to monitor and evaluate the quality and safety of care and service through defined performance metrics, which are derived from a variety of data sources, including:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider satisfaction surveys
- Health Plan Services call data
- Medical record review
- Claims data
- Open shopper studies
- Pharmacy data
- Case management data
- Utilization data
- Behavioral Health and Wellness data

These sources allow the Company to collect the data necessary to improve the appropriateness, efficiency, effectiveness, availability, timeliness, and continuity of care delivered to its Members. This approach also allows the Company to focus on opportunities for improving operational processes, increasing Member and Practitioner satisfaction, and effectively providing care and managing health outcomes. The Company’s mission is to deliver the right care or service, at the right time, by the right staff in a safe and suitable setting.

The Company uses a continuous improvement cycle where designated staff conduct a measurement of performance indicators, assess and prioritize the indicators, and then plan, implement, and evaluate interventions to improve the quality of care, quality of service, and Patient safety. Data are collected on a prospective, concurrent, and/or retrospective basis, dependent on which type best meets the measurement need. Data are analyzed, summarized, and presented in a clear manner with trending and comparison against benchmarks, when available, to the Quality Management Committee (QMC). The QMC provides recommendations for improving quality efforts. QI works collaboratively with various departments within the Company to develop and implement initiatives targeted at improving clinical care, outcomes, safety and service.

The Company’s network Providers must agree to cooperate with QI activities and allow the Company to use Provider performance data.

GOALS AND OBJECTIVES
The QI Program seeks to accomplish the following objectives: 1) to assess the quality of care delivered to the Company’s Members, and 2) to evaluate the manner in which care and services are delivered to these individuals. The QI team is committed to maintaining a standard of excellence and enacts/monitors programs,
The QI Program strives to achieve the following goals for all Members:

- Measure, analyze, evaluate and improve the plan’s administrative services
- Measure, analyze, evaluate and improve the health care services delivered by contracted practitioners
- Promote medical and preventive care delivered by contracted Practitioners that meets or exceeds the accepted standards of quality within the community
- Achieve outcome goals related to Member health care access, quality, cost, and satisfaction
- Empower Members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic conditions, community outreach efforts and coordination with public and private community resources
- Encourage safe and effective clinical practice through established care standards and best-practice guidelines
- Educate Members about Patient safety through health promotion activities, member newsletters and community outreach efforts

The QI Program strategy for meeting these goals incorporates the following actions:

- Design and maintain the QI structure and processes that support continuous quality improvement (CQI). The summarized approach to achieve this aim is as follows: 1) analysis of available data, 2) trending and barrier/root cause analysis of measures, 3) implementation of intervention(s), and 4) re-measurement of targets
- Assure compliance with all federal and Colorado state statutes and regulatory/contractual requirements
- Objectively and systematically measure and analyze HEDIS, CAHPS 5.0 H, and other access/customer service data to promote improvement in Member satisfaction
- Monitor Member satisfaction and identify/address areas of dissatisfaction through an annual review of the following data: 1) CAHPS 5.0 H, 2) Member feedback, 3) Grievance and Appeals data and 4) quality of care complaint(s)
- Monitor and maintain safety measures and address identified problems
- Design and maintain a chronic care improvement program that objectively and systematically measures and analyzes its health outcomes and enrollee satisfaction data
- Conduct an annual Practitioner survey to evaluate satisfaction with the medical management process and services
- Monitor access reports and identify improvement opportunities for implementation
- Monitor and analyze targeted HEDIS measures for health disparities and develop appropriate interventions
- Empower Members to lead a healthy lifestyle through health promotion activities, community outreach efforts, and coordination with public and private community resources
- Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines
- Facilitate the participation of Providers, the interdisciplinary care team and Members in the QI Program
- Communicate improvements in the QI Program to all stakeholders
- Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis
- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
- Participate in the annual external independent review of quality outcomes, which includes, but is not limited to, any or all of the following: 1) medical record review, 2) performance improvement projects and studies, 3) surveys, 4) calculation and audit of quality and utilization indicators, 5) administrative data analyses, and 6) review of individual cases. For external review of activities involving medical record review, the Company will be responsible for obtaining copies of records from the sites in which services occurred.
• Participate in the development and design of any external independent studies to assess and assure quality of care.

PROGRAM SCOPE
To effectively formulate projects, the QI Department uses clinical and service performance benchmarks established by the State of Colorado and best-practices literature. QI structures activities to offer optimal quality and cost-effectiveness by ensuring CQI of healthcare services. Areas targeted for CQI include:
• Cultural and linguistic Member needs
• Behavioral Health and Wellness Promotion
• Preventive health promotion
• Patient safety
• Complex health needs
• Adequacy and availability of services
• Clinical and practice guidelines
• Continuity and coordination of care
• Quality of care complaints
• Member satisfaction
• Practitioner satisfaction
• Credentialing and delegated credentialing
• Delegation activities and oversight

CLINICAL PRACTICE GUIDELINES
The Company’s clinical and practice guidelines are developed, analyzed and posted annually. They are also distributed free-of-charge upon request. The Company consults with Practitioners to develop and apply evidence-based clinical practice guidelines and involves Practitioners in the annual review and updating of established guidelines.

Preventive guidelines:
• Pediatric, adolescent and adult immunizations
• Care of well newborn
• Prenatal care
• Routine cervical cancer screening
• Smoking cessation
• Well-child visit
• Adolescent health
• Clinical preventive health recommendations for adults
• Fall prevention for 65+ and above

Clinical guidelines:
• Treatment of depression in adults in primary care
• Pharmacologic management of congestive heart failure
• Management of high-risk newborns after discharge
• Management of asthma in adults and children
• Diabetes management
• ADHD in children and adolescents

All of the guidelines can be found at www.denverhealthmedicalplan.org at the bottom of the home page under the link titled “Quality Improvement”.
EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under 21 who are enrolled in Medicaid. EPSDT is the key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

- Early: Assessing and identifying problems early
- Periodic: Checking children’s health at periodic, age-appropriate intervals
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostic: Performing diagnostic tests to follow-up when a risk is identified
- Treatment: Control, correct or reduce health problems found

EPSDT Services

States are required to provide comprehensive services and furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening, which is a requirement for all Medicaid-eligible children at 12 and 24 months or between the ages of 36 and 72 months if not previously tested)
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Diagnostic Services

When a screening examination indicates the need for further evaluation of an individual’s health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses and conditions discovered by any screening and diagnostic procedures. If the screening Provider is not licensed or equipped to render the necessary treatment or further diagnosis, the Provider shall refer the individual to an appropriate enrolled Practitioner or facility utilizing one of the following resources:

- For benefits covered by DHMC, place a referral in EPIC to the appropriate Practitioner or facility to be reviewed for authorization by the Company’s UM Department at 303-602-2140 (See UM policy MCD_CHP_UM01, Utilization Review Determinations Including Approvals and Actions, for more information)
- For Wrap Around Benefits not covered by DHMC Medicaid Choice, place a referral through ColoradoPAR (see Pediatric and Adolescent Preventive Healthcare Guidelines, PolicyStat ID 2212803, for more information)
- Healthy Communities is a comprehensive community-based outreach program designed to assist families, children, and pregnant women to find appropriate services. Healthy Communities can help provide, or arrange for, the provision of screening services for all children; arrange (through referral) for corrective treatment as determined by child health screenings; missed appointment follow-up; and refer for transportation assistance. Providers can also contact Healthy Communities to obtain assistance with EPSDT-related Wrap Around services, or may refer members to Healthy Communities for any questions related to EPSDT Wrap Around services by calling 303-602-6770
• Contact Health Plan Services for questions regarding Care Management or to refer a child for Care Management services by calling 303-602-2140
• The EPSDT Outreach Coordinator for the State of Colorado is available to help Providers and families of Medicaid children (ages zero through 20) by assisting families with completing paperwork for Medicaid and CHP+; guiding families to appropriately use Medicaid benefits; assisting with finding a Medicaid dentist; and assisting with coordination of transportation through the local Health and Human Services Department. Contact Gina Robinson at 303-866-6167

**Periodicity Schedule**
Periodicity schedules for periodic screening, vision and hearing services must be provided at intervals that meet reasonable standards of medical practice. Colorado used nationally recognized pediatric periodicity schedule (i.e., Bright Futures; see Attachment 6.)

**Medical Necessity**
“Medical necessity for EPSDT services” is defined as:
• A service that is found to be equally effective treatment among other less conservative or more costly treatment options
• Meets one of the following criteria:
  » The service is expected to prevent or diagnose the onset of an illness, condition, or disability
  » The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability
  » The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability
  » The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living
• May be a course of treatment that includes observation or no treatment at all
• The Contractor’s UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements:
  » The service is medically necessary
  » The service is in accordance with generally accepted standards of medical practice
  » The service is clinically appropriate in terms of type, frequency, extent, and duration
  » The service provides a safe environment or situation for the child
  » The service is not for the convenience of the caregiver
  » The service is not experimental and is generally accepted by the medical community for the purpose stated

**Members may self-refer for the following EPSDT services:**
• Well-child checks
• Immunizations
• Vision screening/eyeglasses
• Hearing screening

**EPSDT services that require a PCP referral and/or Prior Authorization (PAR):**
• Speech (PCP referral)
• Physical therapy/occupational therapy (PCP referral)
• Home Health (PCP referral and Prior Authorization)
• Substance use disorders treatment (PCP referral and Prior Authorization)
Wrap Around Benefits

Wrap Around Benefits are additional treatments or services that are not part of the DHMC covered benefits, but are covered by Medicaid and payable by the state’s fiscal agent when medically necessary. It is the Provider’s responsibility to make a referral to another Provider or to Healthy Communities.

Wrap Around Benefits associated with EPSDT:

- Hearing devices and auditory training
- Dental/hygienist care and treatment
- Orthodontia for severe, handicapping malocclusions
- Transportation for non-emergency medical, dental, or behavioral/mental health care
- Hospice services
- SNF care
- Intestinal transplants
- Private-duty nursing
- Expanded benefits - benefits that the state chooses to provide a child that are above and beyond the EPSDT benefit package (e.g., chiropractic care, extraordinary home care, etc.)

EPSDT Provider Responsibility

- Provide health screening services, including immunizations, according to EPSDT guidelines and Bright Futures Periodicity Schedule
- Promptly diagnose, treat or provide a referral for problems identified during the screening process
  - If a Provider is not licensed or equipped to render necessary treatment, the Provider is responsible to make a referral to another Provider, make a referral to Healthy Communities, and/or make a referral to the UM Case Managers to assist with a referral
- Utilize the ColoradoPAR Provider Portal for Wrap Around services available through Colorado Health First for delivery of medically necessary services to EPSDT-eligible Members

Tracking of EPSDT-required services

Initiation of treatment, if required, must occur within an outer limit of six months after a referral has been placed. To ensure the delivery of EPSDT-required services, the following tools should be utilized as needed:

- EPIC reports
- ACS data and analytics reports
- ColoradoPAR Provider Portal Reports

SECTION XV: HEALTH PLAN SERVICES DEPARTMENT

Providers should be aware that Member Service Representatives are available for program Members and Providers Monday through Friday from 8 a.m. to 5 p.m. for Commercial, Medicaid and CHP+ plans and 8 a.m. to 8 p.m. for Medicare plans to help solve problems, answer questions and provide information about benefits, services, eligibility, how a Member can join the Company’s consumer Advisory Committee and other available resources. They can be reached at 303-602-2100 or 1-800-700-8140 (TTY line for the hearing impaired at 711).
MEMBER INFORMATION

Members are provided a Member Handbook at the time of enrollment (and at any time following enrollment, upon request from Health Plan Services), a resource that assists Members in understanding the rules and benefits of their plan with the Company. Members of the Company have a right to obtain all information provided within the Member Handbook at any time upon request. The company also makes available, upon request, additional information about the plan such as the structure and operation of the Company and information about Physician Incentive Plans.

Members are mailed a Company Member newsletter on a quarterly basis. This newsletter contains important information and updates about the plan. Additionally, the Company will provide each Member written notice of any significant change to the following information, and will provide written notice at least 30 days before the intended effective date of change:

- Member disenrollment rights
- Provider information
- Member rights and protections
- Grievance, Appeal and State Fair Hearing processes
- Benefits available to Members through the Company
- Benefits available to Member that are not through the Company
- How to obtain benefits, including authorization requirements and family planning benefits
- Emergency, urgent, and post-stabilization care services
- Referrals for specialty care
- Cost-sharing
- Moral and religious objections

GRIEVANCES AND APPEALS

The Health Plan Services Department coordinates the intake and disposition or resolution of Member Grievances and Appeals. Please refer to Section XVI of this Provider Manual to learn more about Member Grievances and Appeals.

TERMINATION OF PCP/PATIENT RELATIONSHIP

PCPs may request a Member’s discharge from their practice by contacting the Health Plan Services Department at 303-602-2100. Reasons for the discharge could include, but are not limited to, abusive behavior by the Member, non-compliance and failure to keep or cancel scheduled appointments.

When the request is made due to abusive behavior or non-compliance, it may be grounds for disenrollment of the Member from this program. If a Member refuses to accept or comply with medical advice, treatment or procedures, and no acceptable alternative exists according to the judgment of two or more participating Physicians and the Company Medical Director, the Member will be advised of the situation and compliance will be formally requested by the Company.

If the Member still refuses to accept or comply with medical advice, treatment or procedures, then the Company, hospital and/or Provider will have no further liability or responsibility to provide care for the condition under treatment and/or the Member may be terminated after not less than 31 days’ written notice.

A Member may be terminated if the their behavior is disruptive, unruly, abusive or uncooperative to the extent that the ability of the Company and/or the PCP to supply services to the Member or other Members is impaired. The Company will make a good faith effort to resolve the problem, including the use or attempted use of the Grievance procedure or mediation services. Behavior resulting from mental illness, reaction to
treatment or medication will be taken into consideration. If oral communication with the Member regarding the possible consequences of the Member’s actions does not solve the problem, the Member may be terminated after not less than 31 days’ written notice.

ELIGIBILITY VERIFICATION
Providers are responsible for determining that a Patient is eligible for services. Call the Company Health Plan Services Department at 303-602-2100 to verify that a Patient is eligible to receive services. For information on Real Time Eligibility (RTE), visit www.denverhealthmedicalplan.org/rte-transactions.

NEWBORN ELIGIBILITY

**Commercial Plans: Pre-enrollment**
- Newborn children of Commercial Members are covered for the first 31 days after birth.
  - If the mother of the newborn child is a Dependent child of the Participant, the newborn is not provided benefits.
- Services provided during the first 31 days of coverage are subject to the cost sharing requirements and any applicable benefit maximums.
- The family deductible and family out-of-pocket maximum will apply to the newborn (and all other Members) for the first 31-day period following birth, regardless of whether the newborn is or is not enrolled beyond the first 31 days of coverage.

**Commercial Plans: Enrollment**
- The family deductible and family out-of-pocket maximum will continue to apply to the newborn (and all other Members) after the first 31 days, if the newborn is actively enrolled in the plan.
  - The Member must actively enroll the newborn in the plan within the first 31 days and pay the required premiums for coverage to continue beyond the first 31 days.
  - The Member must complete and submit an enrollment change form to their employer within the first 31 days.

**Medicaid and CHP+ Newborn Eligibility:**
- If the mother is a DHMC Member when newborn is born, then the newborn is guaranteed coverage for the first year under “Eligible Needy Newborn”.
- If the mother is a CHP+ Member when newborn is born, then the newborn is guaranteed coverage for the first year, unless the member has other coverage. If the Member has other coverage, then the Member would be dis-enrolled from CHP+.
- When a baby is born, the mother or the Provider must notify the State regarding the delivery so the newborn can be added to the mother’s case and a State ID can be generated for the newborn.

**Medicaid and CHP+ Newborn Billing:**
- If the mother and the newborn are discharged at the same time, the mother will be billed for both under the mother’s State ID.
- If the mother and the newborn are discharged separately, the newborn will be billed separately under the newborn’s own State ID.

**PRIMARY CARE PROVIDER CHANGES**
The Company’s Members can change their PCP at will or for cause by calling the Health Plan Services Department at 303-602-2100. The change takes effect the first day of the following month. Any reissued specialist referrals must be by the new PCP.
MEDICAL INTERPRETATION AND TRANSLATION SERVICES
The Company’s Members and Providers can access medical interpretation and translation services by contacting Health Plan Services at 303-602-2100. All oral non-English language interpretation services are available at no charge to the Member. Health Plan Services can provide the proper contact number for the interpretation services hot-line as well as help Providers access a medical interpreter.

The Company makes all written Member information available in prevalent non-English languages and in alternative formats such as Braille, large print and audiotapes. To request Member information in alternative formats, Members and Providers should contact Health Plan Services.

HEARING IMPAIRED
Advance scheduling of American Sign Language Interpreters is necessary to assure their availability when needed. Please contact Health Plan Services at 303-602-2100 so that they can contact the Care Support Services during regular business hours to schedule an American Sign Language Interpreter.

In addition, a TTY is located in each Denver Health Community Health Service facility and in the Emergency Department. Staff or Patients may use these devices. A TTY is also located in the Nursing Supervisor’s office and is available to the hospitalized Patients.

Hearing-impaired Patients also have access to TTY located at the Rocky Mountain Poison Center, Nurse Line, Clinical Social Work Department, Managed Care and the Patient Representative’s Office.

A TTY is also located in the Health Plan Services area and that telephone number is 711.

SECTION XVI: MEMBER GRIEVANCES, DENIALS, AND APPEALS

ACTING ON BEHALF OF A MEMBER
Providers may, acting on behalf of a Member and with a Member’s written consent, file an Appeal or Grievance and act as the Member’s authorized representative. A Member can appoint a Provider as their Designated Personal Representative (DPR) by filling out a Designation of Personal Representative Form (Attachment 4). The Member’s DPR may do any of the following actions within this section.

GRIEVANCES (COMPLAINTS)
A Grievance is an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including, but not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of Provider or employee, or failure to respect the Member’s rights.

A quality of care complaint shall mean any grievance made in regards to the professional competence and/or conduct of a Physician or other health care Provider, which could adversely affect the health, or welfare of, a Member.

Members have the right to file grievances. Commercial Members/DPRs have 180 calendar days from the date of the incident to inform the Company of their Grievance. Medicare Part C and D Members/DPRs have 60 calendar days from the date of the incident to inform the Company of their grievance. CHP+ Members/DPRs have 60 calendar days from the date of the incident to inform the Company of their grievance. They may call the Grievance and Appeal department at 303-602-2261 (toll-free at 1-800-700-8140) or they may contact the
Grievance Team in writing. A written Grievance must include the Member’s name, health plan ID number, address, and phone number. Members/DPRs may also fill out the Grievance Form located in the back of the Company’s Member Handbook or Attachment 5 of this manual. Members/DPRs have the option to fax a copy of a written Grievance to the Company’s secure fax line at 303-602-2078.

Address for Concerns and Grievances:
Denver Health Medical Plan, Inc.
Attn: Members Grievance and Appeal Department
938 Bannock Street
Denver, CO 80204

AFTER FILING A GRIEVANCE
The Company will send the Member/DPR a written acknowledgment letter within 5 business days for Commercial and Medicare plans, or within 2 business days for Medicaid and CHP+ plans, to confirm that the Grievance was received. As expeditiously as the Member’s health condition requires, but not to exceed 30 calendar days for Commercial and standard Medicare plans; 15 business days for Medicaid and CHP+ plans; or 72 hours for expedited Medicare Grievances, the Company will send the Member/DPR a letter with the results of the outcome of the Grievance and the date it was completed. The Member/DPR may request an extension of 15 calendar days for Commercial plans, or 14 calendar days for Medicare, Medicaid and CHP+ plans, for the Company to dispose of the Grievance. The Company may also extend the grievance disposal timeframe by up to 15 calendar days for Commercial plans, or 14 calendar days for Medicare, Medicaid and CHP+ plans, if more information is needed, and if the extension is in the Member’s best interest. The Company will send a letter informing the Member/DPR of the extension and the reason for the extension.

IF MEMBER NEEDS HELP FILING A GRIEVANCE
The Company will give Members/DPRs reasonable assistance in completing forms and taking other procedural steps necessary for the Member to fully exercise their Grievance filing rights. This assistance includes, but is not limited to, providing interpreter services and a toll-free number that has adequate TTY/TDD and interpreter capability. Members/DPRs can call the Company Grievance and Appeal Department at 303-602-2261, toll-free at 1-800-700-8140, or TTY at 711.

NOTICE OF ADVERSE BENEFIT DETERMINATION LETTER
A Notice of Adverse Benefit Determination letter is a letter that the Company sends the Member/DPR if the Company makes an Adverse Benefit Determination on any part of the Member’s current or requested services.

An Adverse Benefit Determination could be considered any of the following:
• The denial or limited authorization of a requested service, including the type or level of service
• The reduction, suspension, or termination of a previously authorized service
• The denial, in whole or in part, of payment for a service
• The failure to provide services in a timely manner
• The failure to act within the timeframes for resolution of Grievances and Appeals as provided in 10 C.C.R. 2505-10, Section 8.209.
• The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

A Notice of Adverse Benefit Determination Letter must include:
• The Adverse Benefit Determination that the Company plans to take
• The reason for the Adverse Benefit Determination
• The Member’s/DPR’s right to Appeal this Adverse Benefit Determination
• The date when the Appeal is needed
• When they may ask to expedite the Appeal process
• How to continue receiving services while the Appeal is being decided
• When the Member might have to pay for those services obtained while a final ruling was pending

ADVANCE NOTICE OF ADVERSE BENEFIT DETERMINATION
The Company must let the Member/DPR know about an Adverse Benefit Determination before the action happens. If the Company plans to stop paying for or reducing any services they have been getting already, the Company must send a Notice of Adverse Benefit Determination letter 10 calendar days before the date it stops paying for or reducing services. The Company can shorten the timeframe to 5 calendar days if:
• There is fraud
• The Member has passed away
• The Member is institutionalized
• The Member’s whereabouts are unknown and there is no forwarding address
• The Member has moved out-of-state or outside metropolitan Denver
• The Member’s Doctor orders a change in the level of care
• Pre-admission screening of the Social Security Act
• The Member’s safety or health is endangered
• The medical care is urgently needed

APPEALS
An Appeal is a request that the Member/DPR makes to review an Adverse Benefit Determination that the Company has made. If the Member/DPR thinks an Adverse Benefit Determination taken by the Company is not right, the Member/DPR has the right to call or write the Company to Appeal the Adverse Benefit Determination.

Medicare Provider Appeals: Contract Providers do not have appeal rights; payment disputes and Appeals submitted by contracting Providers are governed by the Provider contract. Providers have 60 calendar days from the initial organization determination date to file a written request for an Appeal. The Company has 60 calendar days from receipt of the written request and necessary documentation to resolve the Appeal. No extensions are allowed. If the Company requires information that is missing, the Provider is allowed 60 calendar days to submit the information.

HOW TO FILE AN APPEAL
Commercial Members/DPRs have 180 calendar days from the date of the Notice of Adverse Benefit Determination to file an Appeal. Medicaid, CHP+ and Medicare Members/DPRs have 60 calendar days from the date of the Notice of Adverse Benefit Determination to file an Appeal. All Appeals must be received in writing except for Medicare plans. If a Commercial, Medicaid or CHP+ plan Member/DPR verbally requests to file an Appeal, the Appeal process will not begin until the date of receipt of the written Appeal and receipt of related personal representative documents, if applicable. Medicare Appeals may be received verbally.

To Appeal an Adverse Benefit Determination the Member/DPR may fill out the Appeal form in the back of the Company’s Member Handbook (and Attachment 5 of this manual), and fax to 303-602-2078, or mail to:

Denver Health Medical Plan, Inc.
Attn: Grievance and Appeal Department
938 Bannock Street
Denver, CO 80204
FILING AN EXPEDITED APPEAL
The Company maintains an expedited review process for appeals, used when the Company determines, or the Provider indicates, that taking the time for standard resolution could seriously jeopardize the Member’s life or health or ability to attain, maintain or regain maximum function. The Company ensures that punitive action may not be taken against a Provider who requests an expedited resolution of an Appeal or supports a Member’s Appeal.

If the Member’s life or health is in danger and a decision needs to be made on an Appeal right away, the Member/DPR can call the Company’s Medical Management at 303-602-2140 or toll-free at 1-800-700-8140. If an expedited Appeal is approved, the Company will make a decision on the Appeal and send written notice of the decision as expeditiously as the Member’s health condition requires, not to exceed 72 hours for Commercial and Medicare plans, or 72 hours for Medicaid and CHP+ plans, after the Company receives the Appeal. The Company will also try to let the Member/DPR know of the decision by phone.

If the Company denies a request for an expedited Appeal, the Company will give the Member/DPR prompt oral notice of the denial and send the Member/DPR a written notification within 2 business days. The Company will process the request as a standard Appeal rather than an expedited Appeal. The Member/DPR can call or write the Grievance and Appeal Department to file a Grievance if they feel the Company should not have denied the expedited Appeal request.

AFTER FILING AN APPEAL
The Company will send the Member/DPR a written notice that the Appeal was received within 5 business days of receipt for Commercial and Medicare Part C plans, or 2 business days of receipt for Medicaid and CHP+ plans, unless the Member/DPR has filed an expedited Appeal. This does not apply for Medicare Part D plans.

APPEAL DECISIONS
The Company ensures that the individuals who make decisions on Appeals are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the Member’s condition or disease if deciding any of the following: an Appeal of a denial that is based on lack of medical necessity, an Appeal regarding denial of expedited resolution of an Appeal, or an Appeal that involves clinical issues.

During the decision/resolution process of the appeal, the Member/DPR may present evidence and allegations of fact or law about the Appeal in writing or in person (in the case of expedited Appeal decisions, Members/DPRs have less time to do so). The Member/DPR has the opportunity to look at their Appeal case file before and during the appeal process by calling the Grievance and Appeal Department at 303-602-2261 or toll-free at 1-800-700-8140. The Appeal case file includes medical records and any other records used during the Appeal process that are not considered private under state and federal law. Included as parties to the Appeal are 1) the Member and their DPR; or 2) the legal representative of a deceased Member’s estate.

The Company must resolve each appeal and provide written notice of the disposition to affected parties as expeditiously at the Member’s health condition requires, but not to exceed the following timeframes:
- For standard Appeal decisions, within 30 calendar days for Commercial plans from the date the Company receives the Appeal
- For standard Appeal decisions, within 30 calendar days preservice or 60 calendar days postservice for Medicare Part C plans from the date the Company receives the Appeal
- For standard Appeal decisions, within 7 calendar days for Medicare Part D plans from the date the Company receives the Appeal
• For standard Appeal decisions, within 10 business days for Medicaid and CHP+ plans from the date the Company receives the Appeal
• For expedited Appeal decisions, 72 hours for Commercial and Medicare plans after the Company receives the Appeal (unless the timeframe has been extended). For notice of expedited Appeal resolution decisions, the Company will also provide oral notification to Members/DPRs
• For expedited Appeal decisions, 72 hours for Medicaid and CHP+ plans after the Company receives the Appeal (unless the timeframe has been extended). For notice of expedited Appeal resolution decisions, the Company will also provide oral notification to Members/DPRs

The written notice of the Appeal resolution will contain the results of the resolution process and the date it was completed. If the outcome is not wholly in the Member’s favor, the letter will also provide information on the right to file a second-level Appeal and how to do so.

APPEAL TIMEFRAME EXTENSIONS
The Company may extend the timeframe for resolution of expedited and standard appeals by up to 15 calendar days for Commercial plans; 14 calendar days for Medicare Part C plans; 24 hours pre-service expedite, or 72 hours pre-service standard, or 14 calendar days post-service for Medicare Part D plans; and 14 calendar days for Medicaid and CHP+ plans if the Member requests the extension or if the Company shows there is a need for additional information, and that the delay is in the Member’s best interest. If the Company lengthens the time, it must have a legitimate reason and must explain this reason to the Member/DPR in an extension letter. The extension letter must include information on the Member’s/DPR’s right to file a Grievance regarding the extension and how to file a Grievance.

GETTING HELP FILING AN APPEAL
The Company will give a Member/DPR reasonable assistance in completing forms and taking other procedural steps necessary for the Member to fully exercise their Appeal filing rights. This assistance includes, but is not limited to, providing interpreter services and a toll-free number that has adequate TTY and interpreter capability. Members/DPRs can call the Company Grievance and Appeal Department at 303-602-2261, toll free at 1-800-700-8140, or TTY at 711 to request assistance.

SECOND-LEVEL APPEAL
Second-level Appeals apply to Commercial plans only. If the Member/DPR is not satisfied with the first-level Appeal decision, they have the right to file a second-level Appeal with the Company. The Member/DPR may file a second-level Appeal within 30 calendar days of the first-level Appeal determination. Providers, acting on behalf of the Member and with the Member’s written consent, may request a second-level Appeal and act as the Member’s authorized representative throughout the second-level Appeal process and at the Appeals Committee review.

The Member/DPR may request a second-level appeal when:
• Services the Member seeks are denied or the ruling to approve services is not acted upon in a timely manner
• The Member/DPR believes the action taken is wrong

To request a second-level Appeal, the Member/DPR must send a letter to the Company’s Grievance and Appeal Department. The writing should contain:
• Member name, address and Member identification number
• The action, denial or failure to act quickly on which the request Appeal is based
• The reason for appealing the action, denial or failure to act quickly

For Medicare plans:
Instead of a second-level Appeal, the next steps for Medicare Members are to go through:
• The Independent Review Entity (IRE)
• Administrative Law Judge (ALJ)
• Appeals Council
• Judicial Review

The Medicare Member will be informed of their rights at the end of each stage of the appeal process.

For Medicaid and CHP+ plans:
If the Member disagrees with the decision the Company makes in the Appeal, they can request a State Fair Hearing once they have exhausted the Company appeal process. The Member has 120 days from the date of notice of adverse action to request a hearing.

SECOND-LEVEL APPEALS COMMITTEE
The Company utilizes an Appeals Committee for the second-level Appeal. The Committee will usually consist of at least three people - a nurse reviewer, a non-clinician and a Physician reviewer with the clinical expertise in the same or similar specialty to evaluate the requested service. All committee members will not have been involved in any prior decision of the matter, nor be subordinates of any previous decision-makers, nor have a financial interest in the Appeal or outcome of the review. The Grievance and Appeal Director, and/or designee, shall serve as the coordinator for the Appeal Committee unless they were involved in any lower-level decisions. At the second-level Appeals Committee hearing, the Member can represent themself, or can select a legal guide, a relative, a friend, the Provider, or other spokesperson at the hearing. The Appeals Committee will meet to review all evidence related to the case and decide to either uphold or overturn the Appeal.

EXPEDITED SECOND-LEVEL APPEALS
For expedited second-level Appeal requests, at least two people will conduct the Appeals Committee review - a Physician reviewer and at least one non-clinician. The reviewers will take into consideration all comments, documents, records and other information regarding the request without regard to whether the information was submitted or considered in making the initial adverse determination. Additionally, all expedited pre-service Appeal requests will be evaluated by a Physician with the clinical expertise in the same or similar specialty and their input will be taken into consideration when the Company renders a decision. Expedited second-level Appeals will be processed within 72 hours of the receipt date.

SECOND-LEVEL APPEAL TIMEFRAME EXTENSIONS
There is no timeframe extension for second-level Appeals.

For help filing a second-level Appeal, the Company will assist. Call the Grievance and Appeal Department at 303-602-2261.

REQUEST FOR EXTERNAL REVIEW
If the Member/DPR is not satisfied with the decision made at the second-level Appeal, they have the right to file a request, in writing, for an external review. The request for an external review must be made within 4 months of the first-level Appeal decision and within 60 days of the second-level Appeal decision. Members/DPRs must first exhaust the internal appeal process before requesting an external review. Once the request for external review is received, the Company will notify the Colorado Commissioner of Insurance of the request.
and submit it to them within 2 business days of the receipt of the request. The Colorado Commissioner of Insurance will then assign an independent external review entity to the case and notify the Company. Within 5 business days of notification, the Company will submit all related case information to the assigned independent external review entity to provide a ruling. The independent external review entity has 45 days to provide a ruling on the submitted Appeal.

An external review decision is binding on the Company and the Member/DPR except to the extent the Company and the Member have other remedies available under federal or state law. A Member/DPR may not file a subsequent request for external review involving the same adverse determination for which the Member/DPR has already received an external review decision.

**CONTINUATION OF BENEFITS DURING AN APPEAL**

In some cases, the Company will keep covering services while the Member waits for the ruling of an Appeal. A Member/DPR must call UM at 303-602-2140 to make known that they want the Company to keep covering their services. If the final resolution of the Appeal upholds the Company’s Adverse Benefit Determination, the Member may be held responsible for the cost of the services furnished to the Member while the Appeal was pending.

**EFFECTUATION OF APPEAL RESOLUTIONS**

For Services not furnished while the appeal is pending: If the Company reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Company must authorize and/or provide the disputed services promptly and as expeditiously as the Member’s health condition requires.

For services furnished while the appeal is pending: If the Company reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Company must pay for those services in accordance with regulations.

<table>
<thead>
<tr>
<th>COMPLAINT OR GRIEVANCE</th>
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<tbody>
<tr>
<td>(does not involve an organizational determination)</td>
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<th>Line of Business</th>
<th>Member Timely Filing Requirement</th>
<th>Quality of Care Concern Timely Filing Requirements</th>
<th>Written Acknowledgement Letter</th>
<th>Plan Decision Timeline</th>
<th>Extension Allowed</th>
<th>Peer to Peer Conversation</th>
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<tr>
<td>Commercial (DOI &amp; NCQA)</td>
<td>Within 180 calendar days</td>
<td>Within 180 calendar days</td>
<td>Within 5 business days</td>
<td>30 calendar days</td>
<td>15 calendar days if criteria are met</td>
<td>Prospective Review Determination within 5 days of request</td>
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<td>Colorado DOI Reg 4-2-17 and 4-2-21</td>
<td>Sec. 10.D</td>
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<td>Timeframe</td>
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<td>Medicare Advantage (Part C)</td>
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<td>5 business days</td>
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<td>Expedited = 72 hours</td>
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<td>CMS 100-16 Medicare Managed Care Manual, Chapter 13</td>
<td>20.2 20.3</td>
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<td>Plan business decision within 5 business days</td>
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<td>20.3</td>
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<td>Medicare Prescription Drug (Part D)</td>
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<td>May be submitted to Plan or QIO after 60 days</td>
<td>5 business days</td>
<td>Standard = 30 calendar days</td>
<td>14 calendar days</td>
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<td>Expedited = 72 hours</td>
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<td>No time limit Eff 7/1/17 - Mbr can file a Grievance at any time (no limit)</td>
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<td>15 business days</td>
<td>14 calendar days</td>
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<td>CCR 2505-10 8.200</td>
<td>HCPF Contract 3.1.2.2.3, CMS Medicaid Managed Care Regulations 42 CFR 438.402 (c) (2)(i)</td>
<td>HCPF Contract 3.1.2.2.5 CCR 2505-10 8.209.5D</td>
<td>8.209.5.B</td>
<td>8.209.5.D</td>
<td>8.209.5.E</td>
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<td>No time limit Eff 7/1/17 - Mbr can file a Grievance at any time (no limit)</td>
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<td>15 business days</td>
<td>14 calendar days</td>
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<td>Written Acknowledgement Letter</td>
<td>Plan decision timeline Preservice</td>
<td>Plan decision Timeline Postservice</td>
<td>Plan decision timeline Expedited</td>
<td>Extension</td>
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<tr>
<td>Commercial (DOI &amp; NCQA)</td>
<td>180 calendar days</td>
<td>within 5 business days</td>
<td>30 calendar days</td>
<td>DOI - 30 calendar days</td>
<td>72 hours</td>
<td>15 calendar days if extension criteria are met</td>
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<td>Colorado DOI Reg 4-2-17 and 4-2-21</td>
<td>Sec. 10.D</td>
<td>Business decision to send Acknowledgement Letter (not required by DOI for written Appeals)</td>
<td>Sec 10-G.2</td>
<td>Sec 10-G.3 30 days</td>
<td>Sec 12.G</td>
<td>DOI - N/A</td>
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<td>NCQA</td>
<td>UM 8A</td>
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<td>UM 8A.7</td>
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<td>UM 8A.9</td>
<td>UM 9 Explanation Section</td>
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<td>60 calendar days written (may accept after 60 days if good cause is shown)</td>
<td>5 business days</td>
<td>30 calendar days</td>
<td>60 calendar days</td>
<td>72 hours written/oral</td>
<td>Member or Plan may extend by 14 days if criteria are met</td>
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<td>CMS 100-16 Medicare Managed Care Manual, Chapter 13</td>
<td>70.1.1, 70.2, 70.3</td>
<td>Written appeal required business decision to send letter within 5 days</td>
<td>70.7.1, 70.7.2</td>
<td>70.7.3</td>
<td>80.1</td>
<td>70.7.1</td>
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<td>Plan decision Timeline Preservice</td>
<td>Plan decision Timeline Post-service</td>
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<td>Extension Allowed</td>
<td>Effectuation of Decision Reversals</td>
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<td><strong>Commercial (DOI &amp; NCQA)</strong></td>
<td>Ind Plan - 180 days; Group Plan - 30 calendar days from first-level decision</td>
<td>60 days to schedule Appeal Committee review from receipt of request - decision req. 7 days post review</td>
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<td>Sec. 10.D Sec 11.D.2</td>
<td>Sec. 11.G.1 (67 Days Max)</td>
<td>Sec. 11.G.1 (67 Days Max)</td>
<td>Sec. 12.G</td>
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<td>Medicare Prescription Drug (Part D)</td>
<td>Medicaid Choice</td>
<td>CCR 2505-10 8.200</td>
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<td>dimension</td>
<td>60 calendar days</td>
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<td>Mbr must exhaust health plan appeal process before requesting a State Fair Hearing. Mbr has 120 days from date of notice of ad adverse appeal resolution</td>
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<td>columns</td>
<td>30 calendar days; automatically send file to IRE</td>
<td>Send file to IRE (if member filed) within 48 hours IRE decision within 30 days</td>
<td>N/A</td>
<td>N/A</td>
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<td>rows</td>
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<td>Send file to IRE within 24 hours</td>
<td>Send file to IRE if member filed) within 24 hours. IRE decision within 72 hours</td>
<td>N/A</td>
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<td>context</td>
<td>Provide service within 14 calendar days, 72 hours expedited; payment within 30 calendar days</td>
<td>Provide benefit within 72 hours, 24 hours if expedited; payments within 30 calendar days</td>
<td>N/A</td>
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<td>CMS 100-16 Medicare Managed Care Manual, Chapter 13</td>
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<td>Commercial (DOI &amp; NCQA)</td>
<td>Request in writing within 4 months of first-level decision, within 60 days of second-level decision</td>
<td>Plan to notify DOI within 2 calendar days of receipt of written request</td>
<td>45 days</td>
<td>Plan to notify DOI within 1 day if criteria are met (Requires Physician Certification)</td>
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**THIRD-LEVEL REVIEW**

Applicable to Medicare only

**ALJ Hearing**

- **Commercial (DOI & NCQA)**
  - Member Timely Filing Requirement: N/A
  - ALJ Timeline: N/A
  - Expedited: N/A
- **Colorado DOI Reg 4-2-17 and 4-2-21**
  - Member Timely Filing Requirement: N/A
  - ALJ Timeline: N/A
  - Expedited: N/A
- **NCQA**
  - Member Timely Filing Requirement: N/A
  - ALJ Timeline: N/A
  - Expedited: N/A
- **Medicare Advantage (Part C)**
  - Member Timely Filing Requirement: Within 60 calendar days
  - ALJ Timeline: Not specified
  - Expedited: Not specified
- **CMS 100-16 Medicare Managed Care Manual, Chapter 13**
  - Member Timely Filing Requirement: 100.0 100.1
  - ALJ Timeline: N/A
  - Expedited: N/A
- **Medicare Prescription Drug (Part D)**
  - Member Timely Filing Requirement: 60 calendar days
  - ALJ Timeline: 90 calendar days
  - Expedited: 10 calendar days
- **CMS Prescription Drug Benefit Manual 100-18**
  - Member Timely Filing Requirement: 90.1
  - ALJ Timeline: 90.4
  - Expedited: 90.4
- **Medicaid Choice**
  - Member Timely Filing Requirement: N/A
  - ALJ Timeline: N/A
  - Expedited: N/A
- **CCR 2505-10 8.200**
  - Member Timely Filing Requirement: N/A
  - ALJ Timeline: N/A
  - Expedited: N/A
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SECTION XVII: ADVANCE CARE DIRECTIVES

PURPOSE
This section is meant to outline the Policy and Procedures to be utilized by the Company to be in compliance with federal and Colorado state regulation regarding Advance Medical Directives (AMDs) passed by Congress (COBRA, 1990, PL 101-508 et. seq.).

POLICY
A. Competent adults (age 18 and over) have the right under state law to make decisions regarding health care, including the right to accept or refuse treatment and the right to formulate Advance Directives.
B. Pursuant to the Patient and Self-Determination Act, the Company will provide all competent adult Members with written information about Advance Directives. This information will be available for Members on the Company website. The informative materials will contain basic information concerning a Member’s rights under state law to make decisions regarding health care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Network Providers will assist Members in executing Advance Directives when requested.

C. Network Providers will comply with Members’ valid, apparent, and available Medical Durable Power of Attorney (MDPOA) and Living Will directives, as described in this Policy.

D. In the event that a Member suffers a cardio/pulmonary arrest, network Providers will honor Members’ CPR Directives if they are valid, apparent, and immediately available to the care Providers. In all other circumstances, appropriate resuscitation efforts will be initiated. For Members undergoing anesthesia or invasive ambulatory procedures who have No CPR or Limited CPR status, a decision should be reached with the Member prior to the procedure as to whether the designated CPR status will be temporarily suspended during the procedure. If no clear consensus as to CPR status is reached prior to the procedure, the Limited or No CPR status will be suspended during anesthesia/the procedure and during immediate recovery, but typically not longer than 24 hours following the procedure.

E. Members are not required to have an Advance Directive and the existence or lack of an Advance Directive does not determine a Member’s access to care, treatment, and services. A Member will not be discriminated against based on whether or not they have executed an Advance Directive.

F. In the event the Member’s attending Physician cannot comply with the terms of an Advance Directive valid on its face on the basis of conscience, the attending Physician shall transfer the care of the Member to another Physician who is willing to comply with the terms of the directive. In this situation, the Member’s attending Physician shall provide a clear and concise statement of limitation to the Member/Member’s decision-maker.

DEFINITIONS:

ADVANCE DIRECTIVE:
The general term used to describe written instructions from the Member concerning their wishes about medical treatment to be followed in the event the Member becomes unable to make health care decisions for him/herself. Colorado law recognizes three Advance Directives: Medical Durable Power of Attorney (MDPOAs), Living Wills, and CPR Directives.

CARDIOPULMONARY RESUSCITATION (CPR) DIRECTIVE:
CPR Directives are authorized under the Colorado Medical Treatment Decision Act, C.R.S. 15-18.6-101, et seq. A CPR Directive is a legal document, executed by a competent adult/legal representative over 18 years of age and countersigned by a Physician, providing direction concerning the administration of CPR. CPR refers to measures taken to restore cardiac function or to support breathing in the event of cardiac or respiratory arrest or malfunction. CPR includes, but is not limited to, chest compressions, delivering electric shock to the chest, and/or placing tubes in the airway to assist breathing. Denver Health classifies CPR status as one of the following:
1. Complete CPR: all medically appropriate efforts to maintain or restore cardiopulmonary function will be made. In the event of a cardiopulmonary arrest, the CPR team will be notified.
2. No CPR: no cardiopulmonary resuscitation will be performed. Therapeutic efforts and drugs which provide or maintain Member comfort and support human dignity (e.g., suctioning, oxygen, narcotics, anxiolytic agents, IV fluids, and medications) may be used. This category does not mean no care.
3. Limited CPR: CPR efforts will be made, limited by pre-event written orders, including but not limited to:
   i. Airway and breathing: withhold artificial ventilation, or withhold endotracheal intubation.
ii. Circulation: withhold defibrillation, withhold administration of acute CPR drugs (e.g., antiarrhythmic, vasopressors), withhold chest compressions, or withhold blood or blood products – may set limits, e.g., four (4) units.

iii. Withhold other: e.g., withhold emergency surgery (e.g., tracheotomy, thoracotomy, chest tube, etc.).

DECISIONAL CAPACITY:
A person who has the functional ability to:
1. Comprehend information relevant to the particular decision to be made
2. Consider the available choices, their own values and goals; and communicate, verbally or nonverbally, their decisions

LIVING WILL:
Living Wills are authorized by the Colorado Medical Treatment Decision Act, C.R.S. 15-18-101, et seq. A Living Will is a signed, dated, and witnessed (two independent witnesses required) declaration by which a competent adult instructs certain life-sustaining procedures be withheld or withdrawn in the even the Member is in a terminal condition and either unconscious or otherwise incompetent to make medical treatment decisions.

MEDICAL DURABLE POWER OF ATTORNEY (MDPOA):
MDPOAs are authorized by the Colorado Patient Autonomy Act, C.R.S. 15-14-506. A MDPOA is a signed and dated document that allows a competent adult to specify an agent to make health care decisions on his/her behalf in the event he/she lacks decision-making capacity. The Member can also provide instructions to the agent about his/her wishes.

RESPONSIBILITY:
A. Admissions, registration, clinical social work, and the Patient care team shall be responsible for providing information to Members on Advance Directives and assisting the Member in executing Advance Directives if requested.
B. It shall be the responsibility of the Member/Member’s legal representative to inform Provider of the existence of any previously executed Advance Directives.
C. It shall be the responsibility of the Company’s Product Line Manager to notify Members and Providers of any changes to State law relevant to Advance Directives within 90 days following the change in the law.
D. Notification shall be provided to Members in the Member Newsletter and the Member Handbook. Providers will be notified of any changes via the Provider Manual and the Provider Newsletter. Applicable Policies and Procedures relevant to Advance Directives will also be updated as necessary.

PROCEDURES:
A. Admissions will provide written information about Advance Directives to all adult Members at the time of admission, and will document that the information was given. If the Member is incapacitated at the time of initial enrollment or is unable to understand the information, the information may be given to the Member’s family or surrogate. When the Member is no longer incapacitated and is able to understand information, the information will be provided to the Member directly at that time. In the outpatient setting, registration will provide written information about Advance Directives to Members annually at the time the General Consent for Treatment form is signed.
B. Upon admission, Physicians and nursing personnel on the medical care team should 1) ask the Member whether he/she has any Advance Directives and 2) check for the existence of an Advance Directive in the Member’s medical record. If the Member has an existing Advance Directive, the Member must provide the nurse or Doctor with a copy.
C. If the Member wishes to execute a new Advance Directive, staff shall assist the Member and may refer the Member to social work for additional assistance in executing Advance Directives. Once the directive has
been fully executed, staff must ensure that a copy of the directive is in the Member’s medical record. If the unit maintains a paper chart, staff shall file the original copy of the directive in the Member’s paper chart. A copy of the directive should be given to the Member for their records as well.

D. In all cases, the medical and nursing staff is responsible for documenting the existence of an Advance Directive in the Member’s medical record.

E. An Advance Directive is a permanent part of the medical record. All properly executed Advance Directives, including CPR Directives, are valid from admission to admission, and remain valid until they are specifically revoked by the Member (or by the guardian, if originally executed by the guardian). Therefore, to ensure that the Member’s Advance Directive(s) continues to reflect that Member’s wishes, staff should review a competent Member’s Advance Directives with the Member at each admission, upon Member request, or if a significant change in the Member’s condition warrants discussion. However, unless the Member makes a change to their Advance Directive(s), the existing directive remains valid and a new document should not be created on each admission.

F. A detailed discussion about Advance Directives is primarily the responsibility of the Member’s outpatient PCP. However, hospital staff will assist in the development of Advance Directives for Members who desire to do so. Assistance will be provided by:

- Having Advance Directive forms available for the Member to review or complete
- Providing for availability of nursing staff, clinical social work staff, and chaplains to assist the Member in accessing the Advance Directives process, counseling, and assistance in executing Advance Directives, if desired
- Providing the Nursing administrator with a list of the on-duty clinical social worker and/or chaplain for nights or weekends from which appropriate referral can be made, if necessary
- Encouraging the Member to direct questions to their PCP

G. An Advance Directive may be revoked at any time by the person making the directive.

H. MDPOAs

- A MDPOA authorizes another person (an “agent”) to make decisions on behalf of a Member specifically with regard to the administration of health care when and if the Member lacks decisional capacity. An agent has the authority to consent to, or refuse, medical treatment, including artificial nourishment and hydration, on behalf of a Member who lacks decisional capacity.
- In all cases, the Member retains the right under state law to consent to, or refuse, any proposed medical treatment as long as they possess the capacity to make decisions. A MDPOA does not become effective until the Member has been deemed to lack decisional capacity.
- The MDPOA shall act in accordance with the terms, directives, conditions or limitations stated in the MDPOA, and in conformance with the Member’s wishes that are known to the agent. If the MDPOA contains no directives, conditions or limitations relating to the Member’s medical condition, or if the Member’s wishes are not otherwise known to the MDPOA, the MDPOA shall act in accordance with the best interests of the Member as determined by the MDPOA (C.R.S. 1514-506(2).)
- A MDPOA may NOT consent to or refuse treatment over the Member’s objection (even if the Member has been deemed incompetent). In the event that an MDPOA wishes to make major health decisions over the objections of a Member that lacks capacity, the MDPOA should consider pursuing a court-appointed guardianship.
- An MDPOA shall have the same rights of access to the Member’s medical records as the Member themself and may confer with the Member’s Physician concerning the Member’s medical condition.
- If a MDPOA is unable or unwilling to serve in that capacity, the appointment will be revoked. If a Member appointed a spouse as their MDPOA, a subsequent divorce, legal separation, or annulment automatically revokes the agent’s appointment, unless otherwise expressly provided for in the MDPOA document.
I. Living Wills

- Under Colorado law, any competent adult may execute a Living Will directing that life-sustaining procedures be withheld or withdrawn if, at some future time, the Member is in a terminal condition and either unconscious or incompetent to decide whether a medical intervention should be accepted or rejected.

- When a Member wishes to execute a Living Will during a hospital stay, the following individuals cannot serve as witnesses:
  » The attending or any other physician
  » Any nurse or other employee of hospital
  » Any Patient at hospital
  » Persons likely to inherit from the Member’s estate (such as family members or close friends) or anyone known to have a claim against the Member’s estate (hospital volunteers are permitted to witness Living Wills)

- Pursuant to C.R.S. 15-18-107, a Physician is legally required to withhold or withdraw all life-sustaining medical procedures (or transfer care of the Member to another Physician who is willing to comply with the declaration) if a signed and witnessed Living Will is presented and all of the following conditions are met:
  » The Member is unconscious or incompetent. The duration of incapacity may or may not be specified in the Living Will, and Colorado law does not require any specified length of time.
  » The Member is diagnosed as being in a terminal condition, which is defined as an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death.
  » The attending Physician has obtained a confirming consultation from another Physician certifying that the Member is in a terminal condition, and both Physicians have certified in the medical record that the Member has a terminal condition, and the notation is dated and timed.
  » The attending Physician or designee has made a reasonable attempt to notify one of the following in the stated order: 1) the Member’s spouse; 2) any of the Member’s adult children; 3) a parent; 4) MDPOA.

No action to challenge the validity of the Living Will has been filed within 48 hours after certification by the two physicians of the terminal condition.

- In the case of a terminally ill Member who is pregnant, a medical evaluation must be made as to whether the fetus is viable and could, with a reasonable degree of medical certainty, develop to live birth with continued application of life-sustaining procedures. If such is the case, the Living Will must be disregarded.

- If the Physician objects to, or cannot abide by the declarations of the Living Will, he/she must immediately withdraw from the case and transfer care of the Member to another Physician who is willing to comply with the Living Will.
  » In this situation, the Member’s attending physician shall provide a clear and concise Statement of Limitation to the Member’s decision-maker. Such statements should:
    i. Clarify any differences between institution-wide conscience objections and those that may be raised by individual Physicians
    ii. Identify the state legal authority permitting such objection
    iii. Describe the range of medical conditions or procedures affected by the conscious objection
    iv. Inform the Member of their right to file a complaint with the Colorado Department of Public Health and Environment by mail: 4300 Cherry Creek Drive South HFEMSC-A2, Attn: Complaint Department Denver, Colorado 80246-1530, by phone: 303-692-2000 or 1-800-886-7689 (in-state), or by email: hfdintake@cdphe.state.co.us with concerns regarding non-compliance with the Member’s Advance Medical Directives; and identify the attending Physician to whom the Member’s care will be transferred
» Refusal of the Physician to comply with the terms of a valid Living Will and failure to transfer the care of the Member to another Physician that will comply constitutes unprofessional conduct and must be reported under the Medical Practice Act, C.R.S. 12-36-117.

» If any other health care Provider objects to, or cannot abide by, the conditions of the Living Will, he/she should notify his/her immediate supervisor for resolution.

Note: As long as a Member is competent and somehow able to communicate their treatment decisions, their Living Will is inapplicable even though they may, in fact, be in a terminal condition.

J. CPR Directives

• Any adult over the age of 18 who has decisional capacity to consent to or refuse medical treatment may execute a CPR Directive. An adult Member’s legal guardian, MDPOA, or proxy decision-maker may execute a CPR Directive for that adult if they lack decisional capacity. The following persons may execute a CPR Directive for a minor: the parents of a minor, if married and living together; the custodial parent or parent with decision-making responsibility for such a decision; or the legal guardian of a minor. CPR Directives must be countersigned by the Member’s Physician to be valid.

• A CPR Directive must contain the following information:
  » The person’s name, date of birth and sex
  » The person’s eye and hair color and race or ethnic background
  » If applicable, the name of the hospice program in which the person is enrolled
  » The name, address, and telephone number of the person’s Physician
  » The person’s signature or mark or that of a person authorized to sign the CPR Directive on behalf of the person, and the date the CPR Directive form was signed
  » The person’s directive concerning the administration of CPR, which must be countersigned by the person’s Physician
  » If applicable, the person’s directive regarding tissue donation

• Provider can provide a form that meets these requirements to the Member upon request. In addition, the Member shall be encouraged to obtain a State of Colorado-issued CPR Directive identification necklace or bracelet for the Member’s permanent use.

• Every Member admitted to the hospital shall have a designated CPR status. The CPR status of each Member shall be considered to be in the complete CPR status category unless the Member/guardian has executed a CPR Directive or as otherwise ordered by the attending Physician or their Physician designee. No or Limited CPR status is to be documented in the Member’s medical record and a copy of the CPR Directive must be kept immediately accessible within the Member’s medical record. No order limited CPR status may be written unless the Member/Member’s decision-maker consents to having that order written.

• In the absence of a valid, apparent, and immediately available CPR Directive, a person’s consent to CPR shall be presumed.

• When a Member’s CPR status is classified in the Limited CPR or No CPR category, the attending Physician or their designee should write an explanatory note outlining the reasons for this decision. The note should state the Member’s wishes, when known. It is also appropriate to mention any consultative opinions (e.g., neurology, neurosurgery, etc.), discussions with Nursing and/or Reparatory Therapy, and discussions with family members or other interested parties, if applicable. The attending Physician should countersign the note and the order declaring the No CPR or Limited CPR status within 24 hours.

• A valid CPR Directive for any person who is admitted shall be implemented as a Physician’s order concerning resuscitation as directed by the person in the CPR Directive, pending further Physician’s orders.

• When a Member is admitted with Limited or No CPR status (or changes their status to Limited or No CPR), the Member’s Physician shall also enter an order Limited or No CPR in CPOE, according to the Member’s wishes. If a Member later revokes a CPR Directive, the CPOE order must also be changed.
• CPR status shall be reviewed by the treating team on a regular basis for Members in intensive care units, and as appropriate for other hospital Members.
• During any CPR, the Physicians responsible for the Member’s medical care will make the final judgment as to what procedures are carried out.
• A CPR Directive may be revoked at any time by a person who is the subject of the directive. Only those CPR Directives originally executed by a guardian, agent, or proxy decision-maker may be revoked by a guardian, agent, or proxy decision-maker.
• Colorado law requires health care Providers to comply with a person’s CPR Directive that is apparent and immediately available. Colorado law also provides that any health care Provider, facility, and/or any other person who, in good faith, complies with a CPR directive shall not be subject to civil or criminal liability or regulatory sanction for such compliance.
• If any disagreement exists between the Member, Member’s representative, or their family and a member of the medical care team about the CPR status, the attending Physician or their designee may convene, as soon as possible, a group meeting of all interested parties and medical team members. The main purpose of this meeting shall be to resolve the CPR status disagreement. If, after such a meeting, major disagreement of the CPR status still exists, the attending Physician or their designee may seek consultation with the Director of Service (DOS), Legal Services, or with the hospital Ethics Committee. Under Colorado law, a competent adult Member has a right to direct his/her CPR status, and Physicians have a duty to comply with a Member’s wishes as expressed in a valid CPR Directive that has not been revoked. Providers are immune from liability if they so comply. However, if there is a reasonable question about the validity of a CPR Directive or the identity of the Member, resuscitation shall be initiated (see 6-CCR-10152(4.4)(f)(3)). Whether a reasonable question as to the validity of a CPR Directive exists depends upon the circumstances and shall be determined by the attending Physician in consultation with the medical care team, the DOS, Legal, and/or the Ethics Committee.
• Surgical Procedures and Invasive Ambulatory Procedures for Members with CPR Directives: Members with No CPR or Limited CPR orders may present a dilemma regarding appropriate therapy when undergoing anesthesia care or invasive ambulatory procedures. Anesthesia care inherently involves depression of, and/or potential loss of, central nervous system, cardiovascular and respiratory functions. Therefore, this type of care frequently implies a form of resuscitation. The following procedures are intended to provide guidance in the care of these Members during the preoperative period and prior to, during and following invasive ambulatory procedures:
  » The anesthesiologist, attending Physician, or designee should discuss with the Member and medical care team which specific resuscitation modalities are appropriate to maintain adequate cardiopulmonary function during the administration of, and recovery from, the anesthetic and/or the procedure.
  » A decision should then be reached pre-operatively as to whether or not the designated CPR status will be temporarily changed or suspended. This should be documented in the medical record.
  » If the above is not feasible (e.g., emergency surgery), care of the Member should be carried out with reasonable adherence to the Member’s directives, being mindful of the Member’s goals and values.
  » In the event that no clear consensus as to CPR status is reached with the Member prior to anesthesia, the Limited or No CPR status will be suspended during anesthesia and while the Member recovers from anesthesia, but typically not longer than 24 hours following surgery. For example, a Member’s status may be returned to No CPR status upon discharge from PACU.
• Tissue Donation: The CPR Directive form includes a section for the Member to provide a directive regarding tissue donation. This section allows a competent Member to make his/her wishes known in advance, should he/she be unable to do so at a later time. While a Physician may explain to the Member what tissue donation may involve, the Physician may not approach the Member regarding tissue donation.
REFERENCES:
• Patient and Self-Determination Act, P.L. 101-508, 42 USC §§ 4206, 4751.
• Colorado Medical Treatment Decision Act, C.R.S. 15-18-101, et seq.
• Department of Public Health and Environment Rules Pertaining to Implementation and Application of Advance Medical Directives for CPR, 6 CCR 1015-2.
• Colorado Patient Autonomy Act, C.R.S. 15-14-503, et seq.
• Department of Health and Human Services, Centers for Medicare and Medicaid Services, Advance Directives, 42 C.F.R. § 489.102.
• The Joint Commission, Comprehensive Accreditation Manual for Hospitals, Standards R.I.2.20 and R.I.2.80.

SECTION XVIII: COORDINATION OF BENEFITS AND SUBROGATION

Coordination of Benefits occurs when the Company arranges for payment from an alternative insurance, which may either be “primary” or “secondary” for the claim. When a Member is covered under two different plans, the Company coordinates benefits under each plan according to rules issued by the State of Colorado Division of Insurance.

For example, a Member of the Company may also be covered as a dependent on his/her spouse’s health insurance plan. In addition, a Member’s auto insurance may provide personal injury protection (PIP) or medical payment benefits which cover medical expenses incurred as a result of injuries sustained in an automobile accident. Workers’ Compensation insurance provides coverage for medical care received as a result of a work-related injury or condition. There is no primary or secondary insurer for Workers’ Compensation claims; Workers’ Compensation insurance pays if the claim results from a work-related condition. The Company covers claims for services covered by the Member’s benefit plan when claims are denied by the Workers’ Compensation insurer.

SUBROGATION

The Company may pay medical bills for which another person (or their insurer) is legally responsible. The Company then has the right to make a claim against the third party to recover payment for the benefits and services provided. In most cases, based on state laws or ERISA laws, the Company has the right to put a legal hold or lien on any court judgment or settlement. Subrogation occurs when the Company assumes a Member’s right to recover from a third party who caused the Member’s injury or illness. In this case, the Company pays its Member’s claims and files legal documents to collect funds from the third party’s insurer. If a Provider is aware that a third party is liable for the cost of a Member’s services, they should notify the Company’s Claim Department.

SECTION XIX: MEMBER ELIGIBILITY AND IDENTIFICATION

The Company’s Members are issued an ID card upon enrollment into a benefit plan. Members are instructed to present their ID card when seeking medical services. The ID card alone does not guarantee eligibility. Providers are responsible for determining that a Patient is eligible for services. Call the Company Health Plan Services Department at 303-602-2100 to verify that a Patient is eligible to receive services. Refer to the Member’s ID card to identify any Member copayment amounts for office visits, urgent/emergency care, prescriptions, etc. For information on Real Time Eligibility (RTE), visit www.denverhealthmedicalplan.org/rte-transactions.
SECTION XX: HIPAA PRIVACY AND SECURITY

The Company has established a comprehensive Privacy and Security policy to protect Members from inappropriate use or disclosure of their PHI. Under this policy, the Company has implemented appropriate administrative, physical, and technical safeguards to ensure the security of electronic PHI. Its Notice of Privacy Practices is posted on the Company’s website. A copy of the notice is also available upon request.

CONFIDENTIALITY OF AND ACCESS TO MEDICAL RECORDS

The Company is committed to protecting the privacy of Members at all times and in all settings. As part of that commitment, the Company requires that all Providers protect the confidentiality of Member records in accordance with state and federal law. The Company requires that medical records be stored securely, so that access is granted to only those individuals who are authorized to do so in the performance of their duties, that they are organized and stored that allows for easy retrieval and that the practice periodically conducts training centered on member confidentiality requirements.

The Company uses Member information for many different purposes, including:

- For general plan administration purposes, including processing and paying claims, verification of enrollment and eligibility, Coordination of Benefits with other benefit plans, subrogation, re-insurance, financial auditing and Member satisfaction processes
- For quality management
- For UM
- For disease management activities
- To furnish information to Providers who are treating Company Members
- When required by law, such as to respond to a court order or subpoena
- Other purposes allowed by law

Some Physicians have expressed concern about whether they may disclose medical record information to the Company in light of the Privacy Rule requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows covered entities, which includes Physicians and health plans, to use or disclose PHI without an individual authorization from the Patient for treatment, payment and some health care operations purposes and for certain other specific purposes outlined by the HIPAA Privacy Rule (45 C.F.R. §§ 164.502, 164.506). The definition of health care operations includes QI, accreditation and licensing activities (45 C.F.R. § 164.501). Covered entities may disclose PHI to other covered entities for the other covered entity’s treatment, payment and limited health care operations purposes, as defined by the Privacy Rule, as long as the request relates to current or former Patients or Members (45 C.F.R. § 164.506(c)(4)). The Company’s utilization review activities and claims review practices are considered payment activity, and the Company’s QI, accreditation, case management and care coordination activities are considered health care operations activities.

Therefore, the disclosure of health information by Physicians to the Company without an individual authorization from the Patient for these purposes is permissible under the HIPAA Privacy Rule. The Company recognizes that Physicians are concerned with compliance to applicable privacy laws. The Company shares those same concerns and will proceed only in a manner that is consistent with applicable laws.
SECTION XXI: CORPORATE COMPLIANCE PROGRAM
(INCLUDING FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM)

A. COMPLIANCE STATEMENT AND CODE OF CONDUCT
It is the Company’s policy to conduct its business in compliance with the laws and regulations of the United States and the State of Colorado and to assure that the Company operates in a manner consistent with the letter and the spirit of the law. The Company is committed to compliance with such laws and regulations and intends to assure that the Company’s activities and operations, as carried out by the employees and other agents of the Company, are conducted in compliance with such laws and regulations. In recognition of this commitment, the Company has developed a Corporate Compliance Program and a Code of Conduct that has been adopted and endorsed by the Company’s Board of Directors. Every employee, subcontractor, agent, and Provider of the Company is expected to respect and adhere to the Corporate Compliance Program and Code of Conduct; failure to do so may lead to formal disciplinary action, including termination of a contract and relationship with the Company.

GOALS
The goals of the Corporate Compliance Program are to:
• Provide a structure for compliance oversight and direction by management and the Company’s Board of Directors
• Define, demonstrate, and communicate the organization-wide commitment to sustaining an ethical corporate culture
• Provide for the prevention and detection of illegal or unethical conduct by employees, subcontractors, Providers, and agents
• Provide a retaliation-free system for reporting and investigation of compliance violations or concerns
• Educate employees, subcontractors, Providers, and agents of the Company on pertinent federal and state laws and regulations.

SCOPE
The scope of the Corporate Compliance Program covers all Company employees, temporary employees, volunteers, and other work force members, subcontractors, vendors, and agents, including participating Providers and including any related entities, of the Company promoting compliance with applicable federal and state law and regulations while adhering to the highest ethical standards. The Company’s Corporate Compliance Program also includes the Privacy and Security Program, promoting the confidentiality, privacy and security of Member PHI, as well as the Company Fraud, Waste, and Abuse Prevention Program.

All Company employees, temporary employees, volunteers, subcontractors, vendors, and agents, including participating Providers and any related entities, are advised as follows:
• No employee or agent of has any authority to act contrary to the provisions of the Code of Conduct, or to authorize, direct or condone violations by any other employee or agent of the Company.
• Any employee or agent of the Company who has knowledge of facts or incidents that they believe may violate the Code of Conduct or the Corporate Compliance Program has an obligation to promptly report the matter.
• Any employee or agent who violates the Code of Conduct or the Corporate Compliance Program, or who orders or who knowingly permits a subordinate to violate the Code of Conduct or the Corporate Compliance Program, shall be subject to appropriate disciplinary action, which may include discharge or termination of their relationship with the Company.
B. REPORTING CONCERNS
Please report compliance concerns via the toll-free, anonymous Compliance Hotline (Values Line), email the Company, or send the Company a letter via fax or mail.

When making a report, please provide as much detail as possible. Names, dates, and a description of the issues in question are helpful. For example, when applicable, please describe why an activity may be a cause for concern. If possible, please include the reporting party’s name and telephone number. That way, the Company can contact the reporting party with any questions during the investigation. If using email to report a concern, please use secure messaging, if available, to protect confidentiality of information. When making an anonymous report to the Compliance Hotline (Values Line), a call identification number and a call back date will be provided. This will allow the reporting party to provide additional information (if needed) and receive status updates on the investigation.

Reports can be made anonymously:
Compliance Hotline: 1-800-273-8452 (available 24/7)
Email: compliancedhmp@dhha.org
Fax: 303-602-2074
Mailing Address: Denver Health Medical Plan, Inc.
ATTN: Compliance Officer
938 Bannock Street
Denver, Colorado 80204

C. CONFIDENTIALITY AND NON-RETALIATION FOR GOOD FAITH REPORTING
Reasonable efforts will be made to protect the confidentiality of those who are reporting. However, confidentiality cannot be guaranteed and will not be possible in some circumstances. Compliance issues will be discussed only with persons with an absolute “need to know”. The Company does not discriminate or retaliate against any employee, agent, subcontractor, or Provider for reporting a compliance concern or for cooperating in any government or law enforcement authority’s investigation or prosecution.

D. PROMPT RESPONSE AND CORRECTIVE ACTION
All reports of suspected or actual compliance violations and/or reports of suspected or actual suspected fraud, waste, or abuse are taken seriously and investigated by the Company’s Compliance Department. The Company takes appropriate actions to mitigate any harmful effects and works to identify opportunities for improvement and corrective actions designed to correct any underlying problems.

E. ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES
The Company encourages its Providers to report compliance concerns and resolve issues through discussion and cooperation (between the Company and the Provider) even prior to requiring the implementation of formal remedies. When the Company becomes aware of information concerning a Provider (or the office staff working on behalf of the Provider) that warrants further review and possible corrective action, including both non-disciplinary and disciplinary action, the Company will further investigate and render a formal determination in the matter.

F. FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM
The Company is committed to ensuring that staff members, subcontractors and network Providers perform administrative services and deliver health care services in a manner reflecting compliance with all laws, regulations, and contractual obligations. Further, the Company is committed to fulfilling its duties with honesty,
integrity, and high ethical standards. The Company supports the federal and state governments in its goal to decrease financial loss from false claims and has, as its own goal, the reduction of potential exposure to criminal penalties, civil damages, and administrative actions.

In the context of the Company’s Corporate Compliance Plan, fraud is considered an act of purposeful deception or misrepresentation committed by any person to gain an unauthorized benefit. Abuse committed by a health care Provider means activities that are inconsistent with standard fiscal, business, or medical practices that result in unnecessary cost to a government health care program or other health care plan, or that fail to meet professionally recognized standards for health care. Abuse can also include beneficiary practices that may result in unnecessary cost to the Commercial and Health Exchange program. Audits are performed on a routine, scheduled basis to monitor for compliance with requirements associated with regulatory requirements, including documentation practices, the Company Provider Manual and the Provider Agreement.

The Company uses data analytic software for post-payment and pre-payment reviews to evaluate claim payments and to verify the clinical accuracy of processing claims in accordance with clinical editing criteria. This coding program contains complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy and literature, and CCI (Correct Coding Initiative) edits and rules. Providers are required to submit claims in accordance with these rules. Routine monitoring activity includes comparative data analysis on areas such as service utilization and outcomes. Routine reviews focus on identified high-risk or problem areas and ensuring documentation supports submitted claims data. Audits are also performed following the identification of an area of concern which may suggest possible abusive or fraudulent activity. Such referrals may come from internal and external sources, unusual trends in claims or other data, Provider self-disclosures, and other ongoing monitoring activity. The Company seeks to ensure the integrity of the claims billing and payment process by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Billing more than once for the same service
- Falsifying records
- Performing inappropriate or unnecessary services
- Misrepresenting the diagnosis of the Member to justify the services or equipment furnished
- Altering claim forms or medical records to obtain a higher payment amount
- Deliberately applying for duplicate payment (for example, billing the Company and the Member for the same service or billing both the Company and another insurer in an attempt to get paid twice)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of Patients in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Unbundling or billing for separate portions rather than for the whole procedure (for example, the billing of a multi-channel set of lab tests to appear as if the individual tests had been performed)
- Characterizing the service differently than the service actually rendered or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services or dates of services (for example, falsely indicating that a particular healthcare professional attended a procedure)
- Billing or charging Members for covered services that are outside of the Member’s copayment, coinsurance, and deductible financial responsibility
- Provider and/or staff misrepresenting credentials
- Any other Provider action that places a Member in jeopardy
- Any other Provider action that violates federal/state or other applicable regulations

In working with its Providers, the Company will identify opportunities for improvement and will assess compliance with coding and billing requirements and utilization Policies and Procedures. When opportunities for improvement are noted, the Company will work with the specific Provider at its own discretion. If the
process identifies issues with program integrity, the Company will follow-up with Providers, utilize corrective action plans when indicated, request a refund if an overpayment was made erroneously due to billing and coding errors, recoup overpayments from future claims payments, institute any other remedy available, or report abusive or fraudulent claim activity to the appropriate regulatory or law enforcement agency.

The Company provides a toll-free Compliance Hotline (Values Line) 24 hours a day, 7 days a week to ensure the immediacy of Provider reporting of suspected fraud and abuse. The Hotline number is 1-800-273-8452. Callers may remain anonymous, if preferred. However, it is the Company’s policy that neither the Company nor the Provider may retaliate against anyone who identifies oneself and reports any incidence or suspicion of fraud or abuse.

NON-DISCRIMINATION
Covered services are provided to Members with the same degree of care and skill as customarily provided to Provider’s Patients who are not Members, according to generally accepted standards of Provider practice. Members and non-Members should be treated equitably. Discrimination against Members on the basis of race, gender, creed, ancestry, age, religion, marital status, health status, sexual orientation, mental or physical disability, color, national origin, source of payment for services, gender identity, or any other grounds is prohibited by law.

SUSPENSION AND TERMINATION
Please note: If the Company determines that Member health, safety, or welfare is endangered by the conduct of any participating Provider, or if the participating Provider’s license, admitting privileges, or both are limited, suspended, or revoked, the Company may immediately terminate the Provider from participation with the Company. The Company also may suspend such Provider’s participation pending any Appeal to which the Provider is entitled or by applicable agreement with the Company.

ATTACHMENTS
1. Provider Request for Dispute Resolution
2. U.S. Preventive Services Task Force (USPSTF) Recommendations
3. Prior Authorization Form
4. Designation of Personal Representative (DPR) Form
5. Member Grievance and Appeal Form

SECTION XXII: MEMBER RIGHTS AND RESPONSIBILITIES

DHMC/DHMP CHP+’s expectation is that health plan staff members, Providers, and Members maintain a mutually respectful relationship. Member rights and responsibilities assist staff, Providers, and Members in understanding their roles and expectations in the process of delivering and receiving health care. DHMC/DHMP CHP+ informs Members of their specific rights and responsibilities through the Member Handbook. As a DHMC/DHMP CHP+ Provider, you are to understand and provide all care with respect to the rights and responsibilities of Members in the DHMC/DHMP CHP+ plan.

MEMBERS OF DHMC/DHMP CHP+ HAVE THE FOLLOWING RIGHTS:
Health First Colorado Administered by DHMC/DHMP CHP+ provides access to medical care for all its Members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual orientation, gender identity or age.
We give care through a partnership that includes your Provider, DHMC/DHMP CHP+, other health care staff, and you – our member. DHMC/DHMP CHP+ is committed to partnering with you and your Provider. As a DHMC/DHMP CHP+ Member, you have all of the following rights:

- To be provided with health care services in accordance with requirements for access, coverage, and coordination of medically necessary services.
- To be treated with respect and with consideration to your dignity and privacy.
- To get information from your Provider about all of the treatment options and alternatives for your health condition in a way that makes sense to you.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To get a second opinion (have some other Provider review your case) at no cost to you. DHMC/DHMP CHP+ will arrange a second opinion with an out-of-network Provider if a DHMC/DHMP CHP+ Provider is not available.
- To make an Advance Directive.
- To get detailed information about Advance Directives from your Provider and to be told up front if your Provider cannot follow your Advance Directives because of their beliefs.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. (This means that DHMC/DHMP CHP+ Providers and staff cannot hold you against your will to punish you, get you to do something they want, or get back at you for something you have done).
- To get health care services from Providers within the DHMC/DHMP CHP+ appointment standards timeframes (in the handbook).
- To see Providers who make you comfortable and who meet your cultural needs.
- To use any hospital (inside of or outside of the Denver Health network) or other facility for emergency and urgent care services. Emergency and urgent care services do not require prior approval or referral.
- To get health care services outside of the Denver Health Network if you are not able to get them in the Denver Health Network (DHMC/DHMP CHP+ must approve non-emergency and non-urgent care services first).
- To get family planning services directly from any family planning Provider, in-network or out-of-network, without DHMC/DHMP CHP+ approval or referral.
- Request a copy of your medical records, and request that they be amended or corrected.
- To file a Grievance, Appeal or ask for a State Fair hearing.
- To join the DHMC/DHMP CHP+ Consumer Advisory Committee.
- To get complete benefit information from DHMC/DHMP CHP+. This information includes covered services, how to get all types of care like emergency care, detailed information about Providers, and your disenrollment rights.
- To use your rights above, without fear of being treated poorly by DHMC/DHMP CHP+, network Providers, or the State Agency.

**MEMBERS OF DHMC/DHMP CHP+ HAVE THE FOLLOWING RESPONSIBILITIES:**

DHMC/DHMP CHP+ wants to give every Member outstanding care and a great experience every time they come to Denver Health. That is why we expect our Members, staff, and Providers to treat each other with dignity and respect.

As a DHMC/DHMP CHP+ member, you are also responsible for:

- Selecting a PCP or Medical Home that is in the Denver Health Network.
- Following all of the rules in the Member Handbook.
- Getting an approval from your PCP before you see a Specialist (unless one is not needed).
- Following the rules of the DHMC/DHMP CHP+ Appeal and Grievance process.
- Calling Health Plan Services to change your PCP.
• Paying for any health care that you get without referral from your PCP (unless the services are emergency or urgent care services, or if they are Wrap Around Benefits).

• Paying for any services that are not covered by DHMC/DHMP CHP+ or Health First Colorado (Colorado’s Medicaid Program).

• Telling DHMC/DHMP CHP+ about any other insurance you have besides Health First Colorado.

• Calling the Appointment Center 24 hours before your appointment date if you need to cancel your appointment.

MEMBERS OF DENVER HEALTH MEDICARE CHOICE AND DENVER HEALTH MEDICARE SELECT HAVE THE FOLLOWING RIGHTS:

• **DHMP must provide information in a way that works for the Member (in languages other than English, in Braille, in large print, or other alternate formats, etc.)**

To get information from DHMP in a way that works for the Member, please call Health Plan Services.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking Members. Most of our Plan materials are also printed in Spanish. We can also give the Member information in Braille, in large print, or other alternate formats at no cost if the Member needs it. We are required to give the Member information about the Plan’s benefits in a format that is accessible and appropriate for the Member. To get information from us in a way that works for the Member, please call Health Plan Services or contact the U.S. Department of Health and Human Services.

If Members any trouble getting information from our Plan in a format that is accessible and appropriate for them, please call to file a Grievance with our Grievance and Appeal Department at 303-602-2261. The Member may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in the Evidence of Coverage or with this mailing, or the Member may contact Health Plan Services for additional information.

• **We must treat the Member with fairness and respect at all times.**

Our plan must obey laws that protect Members from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If Members want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or the Member local Office for Civil Rights.

If the Member has a disability and need help with access to care, please call Health Plan Services. If the Member has a complaint, such as a problem with wheelchair access, Health Plan Services can help.

• **We must ensure that the Member gets timely access to their covered services and drugs.**

As a Member of our plan, he/she has the right to choose a PCP in the plan’s network to provide and arrange for the Member-covered services. Call Health Plan Services to learn which Doctors are accepting new Patients. The Member also has the right to go to a women’s health specialist (such as a gynecologist) without a referral.

Members have the right to get appointments and covered services from the Plan’s network of Providers within a reasonable amount of time. This includes the right to get timely services from specialists when the Member needs that care. The Member also has the right to get their prescriptions filled or refilled at any of our network pharmacies without long delays.

If the Member thinks that the Member is not getting their medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of the ANOC/EOC booklet tells what the Member can do. (If we have
denied coverage for their medical care or drugs and the Member does not agree with our decision, Chapter 9, Section 4 ANOC/EOC tells the Member what the Member can do).

- **We must protect the privacy of the Member’s PHI.**

  Federal and state laws protect the privacy of the Member’s medical records and PHI. We protect the Member’s PHI as required by these laws. The Member’s PHI includes the personal information the Member gave us when the Member enrolled in this plan as well as the Member’s medical records and other medical and health information.

  The laws that protect the Member’s privacy give the Member rights related to getting information and controlling how the Member’s health information is used. We give the Member a written notice, called a “Notice of Privacy Practice”, that tells about these rights and explains how we protect the privacy of the Member’s health information.

- **How do we protect the privacy of the Member’s health information?**

  We must make sure that unauthorized people don’t see or change the Member’s records.

  In most situations, if we give the Member’s health information to anyone who isn’t providing the Member’s care or paying for the Member’s care, we are required to get written permission from the Member first. Written permission can be given by the Member or by someone the Member have given legal power to make decisions for the Member.

  There are certain exceptions that do not require us to get the Member’s written permission first. These exceptions are allowed or required by law. For example, we are required to release health information to government agencies that are checking on quality of care.

  As a Member of our plan through Medicare, we are required to give Medicare the Member’s health information including information about the Member’s Part D prescription drugs. If Medicare releases the Member’s information for research or other uses, this will be done according to federal statutes and regulations.

- **The Member can see the information in the Member’s records and know how it has been shared with others.**

  Members have the right to look at their medical records held at the Plan, and to get a copy of these records. We are allowed to charge the Member a fee for making copies. The Member also has the right to ask us to make additions or corrections to the Member’s medical records. If the Member asks us to do this, we will work with the Member’s healthcare Provider to decide whether the changes should be made.

  Members have the right to know how the Member’s health information has been shared with others for any purposes that are not routine. If the Member has questions or concerns about the privacy of the Member’s PHI, please call Health Plan Services.

- **We must give the Member information about the plan, its network of Providers, and covered services.**

  As a Member of Medicare Select/Choice HMO, each person has the right to get several kinds of information from us. (As explained above, the Members have the right to get information from us in a way that works for the Member. This includes getting the information in languages other than English and in large print or other alternate formats.) Most of our plan materials are also available in Spanish.

  If the Member wants any of the following kinds of information, please call Health Plan Services (phone numbers are printed on the back cover of the ANOC/EOC):

  - **Information about our plan.** This includes, for example, information about the Plan’s financial condition. It also includes information about the number of Appeals made by Members and the Plan’s performance ratings, including how it has been rated by Plan Members and how it compares to other Medicare health plans.
**Information about our network Providers including our network pharmacies.** For example, the Members have the right to get information from us about the qualifications of the Providers and pharmacies in our network and how we pay the Providers in our network. For a list of the Providers or pharmacies in the Plan’s network, see the Provider/Pharmacy Directory.

For more detailed information about our Providers or pharmacies, the Member can call Health Plan Services (phone numbers are printed on the back cover of the ANOC/EOC) or visit our website at www.denverhealthmedicalplan.org.

**Information about the Member’s coverage and the rules the Member must follow when using the Member’s coverage.** In Chapters 3 and 4 of the ANOC/EOC, we explain what medical services are covered for the Member, any restrictions to the Member’s coverage, and what rules the Member must follow to get the Member’s covered medical services.

To get the details on the member’s Part D prescription drug coverage, see Chapters 5 and 6 of the ANOC/EOC plus the Plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell the Member what drugs are covered and explain the rules the Member must follow and the restrictions to the Member’s coverage for certain drugs. If Members have questions about the rules or restrictions, please call Health Plan Services.

**Information about why something is not covered and what the Member can do about it.** If a medical service or Part D drug is not covered for the Member, or if the Member’s coverage is restricted in some way, the Member can ask us for a written explanation. The Member has the right to this explanation even if the Member received the medical service or drug from an out-of-network Provider or pharmacy.

If the Member is not happy or if the Member disagrees with a decision we make about what medical care or Part D drug is covered, the Member has the right to ask us to change the decision. The Member can ask us to change the decision by making an Appeal. For details on what to do if something is not covered for the Member in the way the Member thinks it should be covered, see Chapter 9 of the ANOC/EOC. It gives the Member the details about how to make an Appeal if the Member wants us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

If the Member wants to ask our Plan to pay our share of a bill the Member has received for medical care or a Part D prescription drug, see Chapter 7 of the ANOC/EOC.

**Subscriber Information.** As new technologies or new indications for current technologies are identified that may have broad applicability for DHMP Members, an ad hoc committee is convened that includes experts in the area under evaluation. The committee reviews technology assessments, published studies and deliberations of other expert panels including coverage decisions by other insurance companies to determine appropriate coverage guidelines.

- **We must support the Member’s right to make decisions about his/her care. The Member has the right to know treatment options and participate in decisions about his/her health care.**

Members have the right to get full information from the Member’s Doctors and other health care Providers when the Member goes for medical care. The Member’s Providers must explain the Member’s medical condition and the treatment choices in a way that the Member can understand.

Members also have the right to participate fully in decisions about their health care. To help the Member make decisions with his/her Doctors about what treatment is best for the Member, the Member’s rights include the following:

- **To know about all of the Member’s choices.** This means that Members have the right to be told about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our Plan. It also includes being told about programs our Plan offers to help
Members manage their medications and use drugs safely.

To know about the risks. Members have the right to be told about any risks involved in their care. The Member must be told in advance if any proposed medical care or treatment is part of a research experiment. The Member always has the choice to refuse any experimental treatments.

The right to say “no.” Members have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if the Member’s Doctor advises the Member not to leave. The Member also has the right to stop taking the Member’s medication. Of course, if the Member refuses treatment or stops taking medication, the Member accepts full responsibility for what happens to the Member’s body as a result.

To receive an explanation if the Member is denied coverage for care. Members have the right to receive an explanation from us if a Provider has denied care that they believe they should receive. To receive this explanation, the Member will need to ask us for a coverage decision. Chapter 9 of the ANOC/EOC tells how to ask the Plan for a coverage decision.

• Members have the right to give instructions about what is to be done if they are not able to make medical decisions for themselves. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. Members have the right to say what they want to happen if they in this situation. This means that, if the Member wants to, the Member can:

  Fill out a written form to give someone the legal authority to make medical decisions for the Member if the Member ever becomes unable to make decisions for him/herself.

  Give the Member’s Doctors written instructions about how the Member wants them to handle the Member’s medical care if the Member becomes unable to make decisions for him/herself.

  The legal documents that the Member can use to give the Member’s directions in advance in these situations are called “Advance Directives.” There are different types of Advance Directives and different names for them. Documents called “Living Will” and “Power of Attorney for Health Care” are examples of Advance Directives.

If the Member wants to use an Advance Directive to give the Member’s instructions, here is what to do:

Get the form. If the Member wants to have an Advance Directive, the Member can get a form from the Member’s lawyer, from a social worker, or from some office supply stores. The Member can sometimes get Advance Directive forms from organizations that give people information about Medicare. The Member can also contact Health Plan Services to ask for the forms.

Fill it out and sign it. Regardless of where the Member gets this form, keep in mind that it is a legal document. The Member should consider having a lawyer help the Member prepare it.

Give copies to appropriate people. The Member should give a copy of the form to the Member’s Doctor and to the person the Member names on the form as the one to make decisions for the Member if the Member can’t. The Member may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If the Member knows ahead of time that the Member is going to be hospitalized, and the Member has signed an Advance Directive, take a copy with the Member to the hospital.

If the Member is admitted to the hospital, they will ask whether the Member has signed an Advance Directive form and whether the Member has it with him/her. If the Member has not signed an Advance Directive form, the hospital has forms available and will ask if the Member want to sign one.

Remember, it is the Member’s choice whether he/she wants to fill out an Advance Directive (including whether the Member wants to sign one if the Member is in the hospital). According to law, no one can deny the Member care or discriminate against the Member based on whether or not he/she has signed an Advance Directive.
What if the Member’s instructions are not followed?

If the Member has signed an Advance Directive, and the Member believes that a Doctor or hospital did not follow the instructions in it, the Member may file a complaint with the Colorado Division of Insurance. The Member has the right to make complaints and to ask us to reconsider decisions we have made.

- **If Members have any problems or concerns about their covered services or care**, Chapter 9 of the ANOC/EOC tells what they can do. It gives the details about how to deal with all types of problems and complaints. What Members need to do to follow up on a problem or concern depends on the situation. The Member might need to ask our Plan to make a coverage decision for the Member, make an Appeal to us to change a coverage decision, or make a complaint. Whatever the Member does – ask for a coverage decision, make an Appeal, or make a complaint – we are required to treat the Member fairly.

Members have the right to get a summary of information about the Appeals and complaints that other Members have filed against our Plan in the past. To get this information, please call Health Plan Services.

- **The Member has the right to make recommendations regarding the organization’s Member rights and responsibilities policy.**

Periodically, our Plan updates the Member’s rights and responsibilities policy. The Member has the right to make recommendations to the content of this policy. For more information, please call Health Plan Services.

- **What can Members do if they believe they being treated unfairly or their rights are not being respected?**

If it is about discrimination, call the Office for Civil Rights. If Members believe they have been treated unfairly or their rights have not been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, they should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call the Member’s local Office for Civil Rights.

Is it about something else? If the Member believes he/she has been treated unfairly or the Member’s rights have not been respected, and it’s not about discrimination, the Member can get help dealing with the problem the Member is having:

The Member can call Health Plan Services.

The Member can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3 of the ANOC/EOC.

Or, the Member can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **How to get more information about the Member’s rights.**

There are several places where the Member can get more information about the Member’s rights:

The Member can call Health Plan Services.

The Member can call the State Health Insurance Assistance Program (SHIP). For details about this organization and how to contact it, go to Chapter 2, Section 3 of the ANOC/EOC.

The Member can contact Medicare. The Member can visit the Medicare website to read or download the publication “The Member’s Medicare Rights & Protections.” (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534.pdf.)

Or, the Member can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
MEMBERS OF DENVER HEALTH MEDICARE CHOICE AND DENVER HEALTH MEDICARE SELECT HAVE THE FOLLOWING RESPONSIBILITIES:

Things the Member needs to do as a Member of the Plan are listed below. If the Member has any questions, please call Health Plan Services. We’re here to help.

- **Get familiar with the Member’s covered services and the rules the Member must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for the Member and the rules the Member needs to follow to get the covered services. Chapters 3 and 4 give the details about the Member’s medical services, including what is covered, what is not covered, rules to follow, and what the Member pays. Chapters 5 and 6 give the details about the Member’s coverage for Part D prescription drugs.

  If the Member has any other health insurance coverage or prescription drug coverage in addition to our plan, the Member is required to tell us. Please call Health Plan Services to let us know. We are required to follow rules set by Medicare to make sure that the Member is using all of the Member’s coverage in combination when the Member gets the Member’s covered services from our Plan. This is called “Coordination of Benefits” because it involves coordinating the health and drug benefits the Member gets from our Plan with any other health and drug benefits available to the Member.

  We’ll help the Member coordinate the Member’s benefits. (For more information about Coordination of Benefits, go to Chapter 1, Section 10).

- **Tell the Member’s Doctor and other health care Providers that the Member is enrolled in our Plan.** Show the Member’s Plan membership card whenever the Member gets the Member’s medical care or Part D prescription drugs.

  Help the Member’s Doctors and other Providers help the Member by giving them information, asking questions, and following through on the Member’s care. To help the Member’s Doctors and other health Providers give the Member the best care, learn as much as the Member is able to about the Member’s health problems and give them the information they need about the Member and the Member’s health. Follow the treatment plans and instructions that the Member and the Member’s Doctors agree upon.

  Make sure the Member’s Doctors know all of the drugs the Member is taking, including over-the-counter drugs, vitamins, and supplements.

  If the Member has any questions, be sure they ask. The Member’s Doctors and other health care Providers are supposed to explain things in a way the Member can understand. If Members ask a question they don’t understand, they should ask again.

- **Be considerate.** We expect all our Members to respect the rights of other Patients. We also expect the Member to act in a way that helps the smooth running of the Member’s Doctor’s office, hospitals and other offices.

- **Pay what the Member owes.** As a Plan Member, they are responsible for these payments: Members must pay their Plan premiums to continue being a Member of our Plan.

  In order to be eligible for our Plan, the Member must have Medicare Part A and Medicare Part B. For that reason, some Plan Members must pay a premium for Medicare Part A and most Plan Members must pay a premium for Medicare Part B to remain a Member of the Plan.

  For most of the Member’s medical services or drugs covered by the Plan, the Member must pay the Member’s share of the cost when the Member gets the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what the Member must pay for the Member’s medical services. Chapter 6 tells what the Member must pay for the Member’s Part D prescription drugs.
If the Member gets any medical services or drugs that are not covered by our Plan or by other insurance the Member may have, the Member must pay the full cost. If the Member disagrees with our decision to deny coverage for a service or drug, the Member can make an Appeal. Please see Chapter 9 of the ANOC/EOC for information about how to make an Appeal.

If the Member is required to pay a late enrollment penalty, the Member must pay the penalty to keep the Member’s prescription drug coverage.

If the Member is required to pay the extra amount for Part D because of the Member’s yearly income, the Member must pay the extra amount directly to the government to remain a Member of the Plan.

• **Tell us if the Member moves.** If the Member is going to move, it’s important to tell us right away. Call Health Plan Services. If the Member moves outside of our Plan service area, the Member cannot remain a Member of our plan. (Chapter 1 tells about our service area.) We can help the Member figure out whether the Member is moving outside our service area. If the Member is leaving our service area, the Member will have a Special Enrollment Period when the Member can join any Medicare plan available in the Member’s new area. We can let the Member know if we have a plan in the Member’s new area.

Even if the Member moves within our service area, we still need to know so we can keep the Member’s membership record up to date and know how to contact the Member.

If the Member moves, it is also important to tell Social Security (or the Railroad Retirement Board). The Member can find phone numbers and contact information for these organizations in Chapter 2 of the ANOC/EOC.

• **Call Health Plan Services for help if the Member has questions or concerns.** We also welcome any suggestions the Member may have for improving our Plan. Phone numbers and calling hours for Health Plan Services are printed on the back cover of the ANOC/EOC. For more information on how to reach us, including our mailing address, please see Chapter 2 of the ANOC/EOC.

**MEMBERS OF DHMP HAVE THE FOLLOWING RIGHTS:**

• Have access to Practitioners and staff who are committed to providing quality health care to all Members without regard for race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability, or participation in a publicly financed program.

• Receive medical/behavioral health care that is based on objective scientific evidence and human relationships. A partnership based on trust, respect, and cooperation among the Provider, the staff and the Member will result in better health care.

• Be treated with courtesy, respect, and recognition of your dignity and right to privacy.

• Receive equal and fair treatment, without regard to race, religion, color, creed, national origin, age, sex, sexual preference, political party, disability, or participation in a publicly financed program.

• Choose or change your PCP within the network of Providers, to contact your PCP whenever a health problem is of concern to you and arrange for a second opinion if desired.

• Expect that your medical records and anything that you say to your Provider will be treated confidentially and will not be released without your consent, except as required or allowed by law.

• Get copies of your medical records or limit access to these records, according to state and federal law;

• Ask for a second opinion, at no cost to you.

• Know the names and titles of the Doctors, nurses, and other persons who provide care or services for the Member.

• A candid discussion with your Provider about appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.

• A right to participate with Providers in making decisions about your health care.

• Request or refuse treatment to the extent of the law and to know what the outcomes may be.

• Receive quality care and be informed of the DHMP QI program.
• Receive information about DHMP, its services, its Practitioners and Providers and Members’ rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions and limits on covered service.

• Learn more about your PCP and his/her qualifications, such as medical school attended or residency, go to www.denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web-based Provider directory or call Health Plan Services at 303-602-2100.

• Express your opinion about DHMP or its Providers to legislative bodies or the media without fear of losing health benefits.

• Receive an explanation of all consent forms or other papers DHMP or its Providers ask you to sign; refuse to sign these forms until you understand them; refuse treatment and to understand the consequences of doing so; refuse to participate in research projects; cross out any part of a consent form that you do not want applied to your care; or to change your mind before undergoing a procedure for which you have already given consent.

• Instruct your Providers about your wishes related to advance directives (such issues as durable power of attorney, Living Will or organ donation).

• Receive care at any time, 24 hours a day, 7 days a week, for emergency conditions and care within 48 hours for urgent conditions.

• Have interpreter services if you need them when getting your health care.

• Change enrollment during the times when rules and regulations allow you to make this choice.

• Have referral options that are not restricted to less than all Providers in the network that are qualified to provide covered specialty services; applicable copays apply.

• Expect that referrals approved by the Plan cannot be changed after Prior Authorization or retrospectively denied except for fraud, abuse or change in eligibility status at the time of service.

• Receive a standing referral, from a PCP to see a DHMP network specialty treatment center, for an illness or injury that requires ongoing care.

• Make recommendations regarding DHMP’s Members’ Rights and Responsibilities policies.

• Voice a complaint about or Appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the Grievance/Appeal process.

MEMBERS OF DHMP HAVE THE FOLLOWING RIGHTS FOR PREGNANCY AND SPECIAL NEEDS:

• Receive family planning services from any licensed Physician or clinic in the DHMP network.

• To go to any participating OB/GYN in the DHMP network without getting a referral from your PCP.

• To see your current non-network Provider for prenatal care, until after delivery of the baby if you become a Member of DHMP during your second or third trimester. This is dependent upon the non-network Provider agreeing to accept DHMP’s arrangements.

• To continue to see your non-network Doctor(s) or Provider(s), when medically necessary, for up to 60 days after becoming a DHMP Member. (Dependent upon the non-network Provider accepting DHMP’s arrangements for this transition.)

MEMBERS OF DHMP HAVE THE FOLLOWING RESPONSIBILITIES:

• To treat Providers and their staff with courtesy, dignity and respect.

• To pay all premiums and applicable cost sharing (i.e. deductible, coinsurance, copays).

• To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP ID card available at the time of service and pay for any charges for non-covered benefits.
• To report your symptoms and problems to your PCP and to ask questions, and take part in your health care.
• To learn about any procedure or treatment and to think about it before it is done.
• To think about the outcomes of refusing treatment that your PCP suggests.
• To get a referral from your PCP before you see a specialist.
• To follow plans and instructions for care that you have agreed upon with your Provider.
• To provide, to the extent possible, correct and necessary information and records that DHMP and its Providers need in order to provide care.
• To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
• To state your complaints and concerns in a civil and appropriate way.
• Learn and know about plan benefits (which services are covered and non-covered) and to contact a DHMP Health Plan Services representative with any questions.
• To follow plans and instructions for care that you have agreed upon with your Provider.
• To get a referral from your PCP before you see a specialist.
• To think about the outcomes of refusing treatment that your PCP suggests.

SECTION XXIII: MEDICAID PREVENTIVE HEALTH CARE

PCPs are encouraged to coordinate and request preventive health care services for their Patients. The health care services include an annual check-up, regular screening procedures and appropriate immunizations. See the guidelines behind the tab marked “Preventive Care Guidelines”.

Important preventive care is also indicated for special conditions. DHMC has guidelines for preventive activities, which include such things as diabetes care (eye and foot exams, blood and urine monitoring and regular visits), the care of Patients with heart failure, special immunizations for people with chronic health conditions (pneumonia and influenza vaccines), follow-up of abnormal results such as PAP smears and advising and helping smokers to quit. See these guidelines behind the tab marked “Disease Management”.

Please watch for new and revised guidelines DHMC will send periodically to keep the Provider Manual current.

One “well-child visit” means a PCP visit that includes the following elements: age-appropriate physical exam (but not a complete physical exam unless this is age-appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age-appropriate behaviors, etc.) and growth and development assessment. For older children, this also includes safety and health education counseling.

PEDIATRIC IMMUNIZATION RECOMMENDATIONS NOTES:

1. This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturer’s package inserts for detailed recommendations.

2. Infants born to HBsAg-negative mothers should receive 2.5 gig of Merck vaccine (Recambivax HB®) or 10 gig of SmithKline Beecham (SB) vaccine (Fmerix-B®). The second dose should be administered > one month after the first dose. The third dose should be given at least two months after the second, but not before six months of age.

3. Infants born to HBsAg-positive mothers should receive 0.5mL hepatitis B immune globulin (HBIG) within 12 hours of birth, and either 5 lag of Merck vaccine (Recombivax HB®) or 10 gig of SB vaccine CEngerix-B®
at a separate site. The second dose is recommended at one to two months of age and the third dose at six months of age.

4. Infants born to mothers whose HBsAg status is unknown should receive either 5 gig of Merck vaccine (Recombivax HB®) or 10 lag of SB vaccine (Engerix-B®) within 12 hours of birth. The second dose of vaccine is recommended at one month of age and the third dose at six months of age. Blood should be drawn at the time of delivery to determine the mother’s HBsAg status; if it is positive, the infant should receive HBIG as soon as possible (no later than one week of age). The dosage and timing of subsequent vaccine doses should be based upon the mother’s HBsAg status.

5. Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series during the 11 to 12 year-old visit, and unvaccinated older adolescents should be vaccinated whenever possible. The second dose should be administered at least one month after the first dose, and the third dose should be administered at least four months after the first dose, and at least two months after the second dose.

6. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, Including completion of the series in children who have received > one dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The forth dose (DTP or DTaP) may be administered as early as 12 months of age, provided six months have elapsed since the third dose, and if the child is unlikely to return at 15 to 18 months of age. Td (tetanus and diphtheria toxoids) is recommended at 11 to 12 years of age if at least five years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every ten years.

7. Three H. Influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB®[Merck]) is administered at two and four months of age, a dose at six months is not required.

8. Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable by the ACIE the AAP, and the AAFP. Parents and Providers may choose among these options:
   » Two doses of IPV followed by two doses of OPV
   » Four doses of IPV
   » Four doses of OPV

9. The ACIP recommends two doses of IPV at two and four months of age followed by two doses of OPV at 12 to 18 months and 4 to 6 years of age. IPV is the only poliovirus vaccine recommended for immune compromised persons and their household contacts.

10. The second dose of MMR is recommended routinely at 4 to 6 years of age, but may be administered during any visit, provided at least one month has elapsed since receipt of the first dose, and that both doses are administered at or after 12 months of age. Those who have not previously received the second dose should complete the schedule no later than the 11 to 12 year visit.

11. Susceptible children may receive Varicella vaccine (Var) during any visit after the first birthday, and those who lack a reliable history of chickenpox should be vaccinated during the 11 to 12 year-old visit. Susceptible children > 13 years of age should receive two doses, at least one month apart.

Guidelines are subject to change; for clarification please call DHMC at 303-602-2003. New and revised guidelines will be sent periodically so as to keep the Provider Manual current.

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)
The EPSDT benefit provides comprehensive and preventive health care services for children under 21 who are enrolled in Medicaid. EPSDT is the key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.
• Early: Assessing and identifying problems early
• Periodic: Checking children’s health at periodic, age-appropriate intervals
• Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
• Diagnostic: Performing diagnostic tests to follow-up when a risk is identified
• Treatment: Control, correct or reduce health problems found

**EPSDT Services**

Based on certain federal guidelines, states are required to provide comprehensive services and furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic, and treatment services:

**Screening Services**

• Comprehensive health and developmental history
• Comprehensive unclothed physical exam
• Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
• Laboratory tests (including lead toxicity screening, which is a requirement for all Medicaid eligible children at 12 and 24 months or between the ages of 36 and 72 months if not previously tested)
• Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

**Diagnostic Services**

When a screening examination indicates the need for further evaluation of an individual’s health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

**Treatment**

Necessary health care services must be made available for treatment of all physical and mental illnesses and conditions discovered by any screening and diagnostic procedures.

If the screening Provider is not licensed or equipped to render the necessary treatment or further diagnosis, the Provider shall refer the individual to an appropriate enrolled Practitioner or facility utilizing one of the following resources:

• For benefits covered by DHMC, place a referral in EPIC to the appropriate practitioner or facility to be reviewed for authorization by the Company’s UM Department. Phone: 303-602-2140 (see UM policy MCD_CHP_UM01, Utilization Review Determinations Including Approvals and Actions, for more information)
• For Wrap Around Benefits not covered by DHMC, place a referral through ColoradoPAR (see Pediatric and Adolescent Preventive Healthcare Guidelines, PolicyStat ID 2212803, for more information)
• Healthy Communities is a comprehensive community-based outreach program designed to assist families, children, and pregnant women to find appropriate services. Healthy Communities can help provide, or arrange for, the provision of screening services for all children; arrange (through referral) for corrective treatment as determined by child health screenings; missed appointment follow-up; and refer for transportation assistance. Providers can also contact Healthy Communities to obtain assistance with EPSDT-related Wrap Around services, or may refer Members to Healthy Communities for any questions related to EPSDT Wrap Around services by calling 303-602-6770
• Contact Health Plan Services for questions regarding Care Management or to refer a child for Care Management services by calling 303-602-2140
• The EPSDT Outreach Coordinator for the State is available to help Providers and families of Medicaid children (ages 0 through 20) by assisting families with completing paperwork for Medicaid and CHP+; guiding families to appropriately use Medicaid benefits; assisting with finding a Medicaid dentist; and assisting with coordination of transportation through the local Health and Human Services Department. Contact Gina Robinson at 303-866-6167.

**Periodicity Schedule**
Periodicity schedules for periodic screening, vision and hearing services must be provided at intervals that meet reasonable standards of medical practice. Colorado used nationally recognized pediatric periodicity schedule (i.e., Bright Futures; See Attachment 6).

**Medical Necessity**
“Medical necessity for EPSDT services” is defined as:
• A service that is found to be equally effective treatment among other less conservative or more costly treatment options
• Meets one of the following criteria:
  » The service is expected to prevent or diagnose the onset of an illness, condition, or disability
  » The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability
  » The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability
  » The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living
• May be a course of treatment that includes observation or no treatment at all
• The Contractor’s UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements:
  » The service is medically necessary
  » The service is in accordance with generally accepted standards of medical practice
  » The service is clinically appropriate in terms of type, frequency, extent, and duration
  » The service provides a safe environment or situation for the child
  » The service is not for the convenience of the caregiver
  » The service is not experimental and is generally accepted by the medical community for the purpose stated

**Members may self-refer for the following EPSDT services:**
• Well-child checks
• Immunizations
• Vision screening/eyeglasses
• Hearing screening

**EPSDT services that require a PCP referral and/or Prior Authorization:**
• Speech (PCP referral)
• Physical therapy/occupational therapy (PCP referral)
• Home Health (PCP referral and Prior Authorization)
• Substance use disorders treatment (PCP referral and Prior Authorization)
**Wrap Around Benefits**

Wrap Around Benefits are additional treatments or services that are not part of the DHMC covered benefits, but are covered by Medicaid and payable by the State’s fiscal agent when medically necessary. It is the Providers’ responsibility to make a referral to another Provider or to Healthy Communities.

**Wrap Around Benefits associated with EPSDT:**
- Hearing devices and auditory training
- Dental/hygienist care and treatment
- Orthodontia for severe, handicapping malocclusions
- Transportation for non-emergency medical, dental, or behavioral/mental health care
- Hospice services
- SNF care
- Intestinal transplants
- Private-duty nursing
- Expanded benefits - benefits that the State chooses to provide a child that are above and beyond the EPSDT benefit package (e.g., chiropractic care, extraordinary home care, etc.)

**EPSDT Provider Responsibility**
- Provide health screening services, including immunizations, according to EPSDT guidelines and Bright Futures Periodicity Schedule
- Promptly diagnose, treat or provide a referral for problems identified during the screening process
  - If a Provider is not licensed or equipped to render necessary treatment, the Provider is responsible to make a referral to another Provider, make a referral to Healthy Communities and/or make a referral to the UM Case Managers to assist with a referral
- Utilize the ColoradoPAR Provider Portal for Wrap Around services available through Colorado Health First for delivery of medically necessary services to EPSDT-eligible Members

**Tracking of EPSDT-required services**

Initiation of treatment, if required, must occur within an outer limit of six months after a referral has been placed. To ensure the delivery of EPSDT-required services, the following tools should be utilized as needed:

- EPIC reports
- ACS data and analytics reports
- ColoradoPAR Provider Portal Reports

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**SECTION XXIV: DHMC PROGRAM OVERVIEW - MEDICAL SERVICES, BENEFITS & EXCLUSION SUMMARY**

**OVERVIEW**

DHMC is a health care program offered by Denver Health and Hospital Authority (DHHA). Providers of DHMC are limited to DHHA unless they have been specifically contracted.

**NOTE:** DHMC Members **shall not be held liable** for any of the following:
- DHMC’s debts in the event of DHMC’s insolvency
- Covered services provided to the Member for which the State does not pay DHMC
- Covered services provided to the Member for which the State or DHMC does not pay the health care Provider that furnishes the services under a contract, referral, or other arrangement
• Payments for Covered Services furnished under a contractual, referral, or other arrangement to the extent those payments are in excess of the amount that the Member would owe if DHMC provided the services directly

ADMISSIONS:
Admissions should occur at Denver Health except when prior authorized by the PCP and the Medical Services Department or in the event of a life-threatening emergency when it would be unsafe to transport the Member to Denver Health.

CONCURRENT REVIEW:
The UM/Case Management nurses from the DHMC Medical Services Department will round daily for all in-Patients at Denver Health and perform regular telephone or onsite review for Patients admitted to non-DH facilities. Inpatient facilities are required to provide good clinical information on request to concurrent review nurses.

COVERED SERVICES:
With the exception of EPSDT and Preventive Care Services as specified in this exhibit, covered services and supplies must be medically necessary and provided for the diagnosis or treatment of an illness, pregnancy or accidental injury. A covered person and their Physician decide which services and supplies are given, but Contractors need only pay for the following covered services and supplies (covered services list updated 12/27/2011.)

ABORTION:
Abortions are a covered benefit only in the following circumstances:
When a Physician has found and certified in writing that the life of the mother would be endangered if the fetus were carried to term or when the pregnancy results from acts of rape or incest, when documented in accordance with federal requirements (42 C.F.R.441.203).

NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:
• Ectopic pregnancies (pregnancy occurring in other than a normal position or place)
• Miscarriage (spontaneous abortion)

AMBULANCE SERVICES:
Covered ambulance services shall be provided to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations:

Air ambulance
Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the Client requires medical attention, the Client is transported to the nearest appropriate medical facility, and:
• The point of pick-up is inaccessible by land emergency transport vehicles
• Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential
• The Client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable
• Emergency services which, due to the Client’s medical or psychiatric condition, are immediate in nature and cannot be arranged in advance
• Non-emergency services that are preplanned, but due to the Client’s medical or psychiatric condition, are the only mode that can be utilized safely; must be prior authorized.

If the client is transported from home to hospital by ambulance for treatment of a condition which a prudent layperson would perceive as an emergency, as defined at 10 CCR 2505-10 Section 8.303, the ambulance shall be reimbursed, even if the healthcare services rendered are subsequently determined to be urgent or non-emergent in nature (42 C.F.R. 438.114 (c) (1)( ii)).

AMBULATORY SURGICAL CARE:
The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.

AMNIOCENTESIS:
Amniocentesis performed for medical reasons other than sex determination.

Anesthesia Services:
Administration of anesthetics to achieve general or regional supplementation of local anesthesia related resuscitative and supportive procedures.

AUDIOLOGY AND SPEECH PATHOLOGY:
• Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.
• Speech pathology services include performance of medical/diagnostic procedures including, but not limited to, those communicative problems resulting from medical conditions such as cerebral palsy, cleft palate/lip, or brain dysfunction.

NOTE: The EPSDT benefit covers screening and medically necessary ear exams and audiological testing.

AUTISM:
Autism shall be treated as a physical disorder.

CONSULTATION:
Covered services include medical services rendered by a Provider whose opinion or advice is requested by a Client’s PCP or the health plan Medical Director for further evaluation of an illness or injury. Clients shall be granted a second opinion when requested, subject to referral requirements. Consultations by non-participating Providers may be subject to Prior Authorization.

DETOXIFICATION:
Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

DIALYSIS, HEMODIALYSIS OR PERITONEAL DIALYSIS:
Coverage includes placement or repair of the dialysis route (“shunt” or “cannula”).

The organization providing dialysis shall be responsible for the provision of all supplies and the maintenance of all equipment and necessary fixtures required for home dialysis.
• Inpatient dialysis: Coverage is provided in those cases where hospitalization is required.
• Outpatient dialysis: Coverage is provided when provided by a separate unit within a hospital or a free-standing dialysis treatment center. Coverage is provided for any other medical condition for which the
Medical Assistance Program provides payment when the eligible recipient receives regular medically necessary maintenance treatment on an outpatient dialysis program.

- **Home dialysis:** The participating separate dialysis unit within a hospital or free-standing dialysis treatment center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

**DURABLE MEDICAL EQUIPMENT AND DISPOSABLE SUPPLIES:**
The following DME and supplies are Medicaid benefits for clients of all ages if medical necessity has been established and use outside of a medical facility is considered appropriate. DME shall be covered as described at 10 CCR 2505-10, Section 8.590. This includes:

- Ambulation devices and accessories (canes, crutches, walkers)
- Bath and bathroom equipment
- Bed and bedroom equipment and accessories, including specialized beds and mattress overlays
- Manual or power wheelchairs, seating system orthosis used for wheelchair positioning
- Diabetic monitoring equipment and related disposable supplies
- Elastic supports/stockings
- Monitoring equipment and supplies
- Oxygen equipment for home use, including nursing facility residents
- Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies
- Trapeze/traction/fracture frames
- Lymphedema pumps/compressors
- Rehabilitation equipment (specialized use)
- Enteral formulas and supplies
- Parenteral equipment and supplies
- Repairs and extensive maintenance as needed to keep the DME item functional

An adequate number of disposable supplies, when used in connection with approved DME and/or when related to one of the following categories:

- Surgical, wound and burn care
- Syringes/needles
- Bowel and bladder care
- Antiseptics/solutions
- Gastric feeding sets and supplies
- Tracheostomy and endotracheal care supplies
- Diabetic monitoring

Covered services include the rental or purchase of DME and supplies including repair, maintenance and delivery. The Contractor is only required to provide DME that is covered by Medicaid, but may provide other DME when medically appropriate. Preference should be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the equipment will be operated. Coverage in a particular case is subject to the requirement that the equipment be medically necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. DME and supplies may be recommended by an appropriate licensed Practitioner, but must be prescribed by a Doctor of Medicine or a Doctor of Osteopathy.

Medicaid Clients for whom wheelchairs, wheelchair component parts, and other specialized equipment were authorized and ordered prior to enrollment in the Contractor’s plan, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid program. The
Contractor shall reimburse services approved and ordered by the Contractor, providing the Client remains Medicaid-eligible, regardless of whether enrollment in the Plan continues. All other DME and disposable supplies approved by the Contractor shall be the responsibility of the Contractor.

**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) BENEFITS:**
The Contractor must meet all state and federal requirements for EPSDT benefits under 42 C.F.R. Sections 441.50 through 441.61 and 10 C.C.R. 2505-10, Section 8.280. EPSDT services include comprehensive well-child examinations, immunizations, assessment, diagnosis and treatment necessary to correct or ameliorate conditions, defects and illnesses discovered by EPSDT screening to all covered persons through the age of 21. EPSDT services also include provision benefit information, scheduling assistance and case management and are key to ensuring that children and adolescents receive appropriate preventive, dental, mental health and development, and specialty services.

Additionally, maintenance of a coordinated system to follow the Client through the entire range of screening and treatment (case management) and coordination with other Providers to ensure that Clients receive covered services, must be provided.

Information about EPSDT benefits must be provided to Clients and Parents and is to include:
- The periodicity table
- Scheduling and transportation to make EPSDT appointments
- The full range of EPSDT Wrap Around Benefits and mental health treatment services available through State Medicaid

**Screening Services:**
- Comprehensive health and development history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health Education (anticipatory guidance including child development, health lifestyles, and accident and disease prevention)

**Vision Services:**
At a minimum, this includes diagnosis and treatment for defects in vision, including eyeglasses.

**Dental Services:**
At a minimum, this includes dental services such as relief of pain and infections, restoration of teeth, and maintenance of dental health.

**Hearing Services:**
At a minimum, this includes hearing services such as diagnosis and treatment for defects in hearing, including hearing aids.

**Lead Screening:**
While substantial environmental improvements have been made to reduce exposure to lead, there are still over four million children estimated to reside in housing where they are exposed to lead. If this screening has already been done, the Provider may just document that the screening has been done to avoid duplication of the screening.
EMERGENCY SERVICES:
Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under this contract
- Needed to evaluate or stabilize an emergency medical condition.

Emergency services are exempt from PCP referral or DHMC authorization.

FAMILY PLANNING SERVICES:
Family planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. Contractor shall reimburse out-of-network family planning services at a rate equal to or better than fee-for-service reimbursement rates, or Contractor’s internal reimbursement rates, whichever is higher. No referral is required.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC):
Core services are provided in outpatient settings only, including a Patient’s place of residence. Core services mean covered outpatient services that may include:

- Physician services
- Physician assistant services
- Nurse Practitioner services
- Nurse Midwife services
- Licensed psychologist services
- Licensed social worker services
- Pneumococcal and influenza vaccines and administration
- Services and supplies incident to health professional services
- Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of Home Health Agencies
- Any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan

Notwithstanding a Behavioral Health Organization (BHO) primary diagnosis, services provided to Members by a Physician (not a mental health Practitioner) are covered (and have been included in the rates). The BHO diagnosis code can be found in Exhibit H of the DHMC contract.

HOME HEALTH SERVICES:
Acute Home Health Services and Long-Term with Acute Episode Home Health Services provided pursuant to 10 CCR 2505-10, Section 8.520.K.3.b are covered services. Long-Term Home Health is excluded.

Services provided by other kinds of Providers (i.e., other than a Medicaid-certified Home Health Agency) to Members in their own homes are also covered services; these include:

- Professional services of an RN, LPN, or LVN on an intermittent basis
- Home Health Aide Services for the purpose of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist
- Physical evaluations and therapy, and speech/hearing evaluations and therapy, by licensed therapists
- Medical/surgical supplies delivered to the Member’s home (e.g., DME, prosthetics, disposable supplies) - but not other Wrap Around services (e.g., Oxygen)
- Services provided when the Client’s medical condition requires teaching (e.g., self-care management training), which is most effectively accomplished in the Client’s home on a short-term basis
• Developmental therapies and EPSDT screenings (e.g., neuromuscular re-education, sensory integration, cognitive skills development)

Nurse Home Visitor Program services provided in the Member’s home are Wrap Around services. These services are billed on the 1500 claim form using CPT codes G9006 or T1017.

**IMAGING (RADIOLOGY OR X-RAY SERVICES):**
These are services authorized by a licensed Physician, including:
- Services performed to diagnose conditions and illnesses with specific symptoms
- Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program
- Routine mammograms, as described under Preventative Care Services

**INPATIENT HOSPITAL:**
Hospital services are a benefit of the Medicaid Program and include those items and services that are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a Physician. These include:
- Semi-private room and board
- Private rooms must be covered:
  » When medically necessary
  » When furnished by the hospital as the only accommodation
  » If the hospital has no semi-private room available, Patient must be moved to a semi-private room as soon as available
- Delivery and labor rooms, anesthesia, and equipment
  » Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post-delivery
  » Limitations for a hospital stay following a cesarean delivery may be limited after 96 hours post-delivery
- All other medically necessary services and supplies during the inpatient hospital stay including pharmacy, therapies, blood and blood products, anesthetics, DME and specialty care services
- Discharge oxygen
- Routine newborn care is limited to period of time that the mother remains hospitalized. Inpatient newborn care following the mother’s discharge is a covered benefit only when the child’s medical condition necessitates ongoing inpatient care
- Inpatient substance abuse rehabilitation DRG 936 is a Wrap Around service (see Wrap Around Benefits section)

**LABORATORY (CLINICAL/PATHOLOGICAL):**
These services are authorized by a licensed Physician and include:
- Services performed to diagnose conditions and illnesses with specific symptoms
- Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program
- Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA)

**LIMITATIONS:**
Collection, handling, and/or conveyance of specimens for transfer from the Patient’s home, a nursing home or a facility other than the physician’s office or place of practice is a benefit only if the Patient is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed,
the pick-up is no longer considered medically necessary and therefore is non-reimbursable. The Physician may be required to certify the medical necessity for the pick-up. Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory’s equipment is not functioning or the laboratory is not certified to perform the tests ordered by the Physician.

MEDICAL SERVICES:
For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File, as published in Provider bulletins or available on disc, shall be considered the prevailing guide. The following is a general overview of such services:

- Direct physical examination of the Patient’s body and/or mental or cognitive status
- Examination of some aspect of the Patient’s condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory or electronic monitoring procedures
- Procedures for prescribing, administering, directing or supervising medical treatment
- Manual manipulation; department guidelines, which include manipulation by osteopathic Physicians only, may be applied by the Plan
- Diagnosis and treatment of eye disease or injury.
- Administration of injectables and allergens
- Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity
- Treatment for ear or hearing problems

NEWBORN HOSPITALIZATION:
Newborn hospitalizations shall extend only for the period of the mother’s hospitalization unless medical necessity exists for the infant to remain hospitalized. When medical necessity for the infant to remain hospitalized exists, the additional days shall be covered.

OCCUPATIONAL/PHYSICAL THERAPY:
A Physician may prescribe occupational or physical therapy for Clients when medically necessary.

OUTPATIENT SERVICES:
Covered services include diagnostic, therapeutic, rehabilitative, preventive, and palliative services furnished by or under the direction of a Physician.

OUTPATIENT REHABILITATION SERVICES:
Covered Services include speech therapy, occupational therapy, physical therapy, pulmonary therapy and cardiac rehabilitation when ordered by the Member’s PCP or referring Physician. All medically necessary care and treatment of conditions discovered as a result of EPSDT medical screenings, including habilitation secondary to birth injury or developmental delay and rehabilitation services following illness or injury, shall be provided to Clients covered by the EPSDT Program.

OXYGEN AND OXYGEN EQUIPMENT:
Oxygen-generating equipment prescribed for use in any inpatient setting, or as discharge oxygen, is a covered service if inpatient services are included within the scope of the Medicaid Choice contract.

Oxygen in canisters, whether in gaseous or liquid form, prescribed for use in any inpatient setting, is a covered service if inpatient services are included within the scope of this contract. The Contractor is responsible for nursing facility charges. All other prescribed uses of oxygen in canisters, whether in gaseous or liquid form, are
covered Wrap Around services paid by the department through fee-for-service reimbursement. See Exclusions for portable and liquid oxygen.

**PHYSICAL EXAMINATIONS:**
Physical examinations are for the purpose of:
- Diagnostic evaluation of disease
- Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnosis and treatment

**PHYSICAL/OCcupATIONAL THERAPY:**
Occupational Therapy or Physical therapy are for Clients when medically necessary and ordered by a Physician.

**PHYSICIAN SERVICES:**
For ages 65 and over, this applies to all medically necessary services.

For those under the age of 65, the following scope and range of benefits apply when medically necessary:
- Inpatient hospital services
- Inpatient surgery
- Outpatient surgery
- Outpatient diagnostic services
- Physician services provided to residents in a SNF
- Home and Physician office calls
- Family planning is considered in the same manner as any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of family planning, depending on the preference of the individual Patient. See Family Planning under covered services.
- Dental care is a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones, including dental splints or other devices. With respect to these services, a doctor of dental surgery or dental medicine, appropriately licensed, is classified as a Physician and entitled to payment
- Foot care services
- Vision care services are included as benefits in accordance with the following general policies:
  » Services performed within the scope of the Medical and Optometrist Practice Acts
  » Services for the provision of eyeglasses and contact lenses following eye surgery
  » Corneal transplants
- Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit
- Immunizations

**PODIATRY:**
Foot care services are included as a benefit in the Medical Assistance Program whether provided by a Physician or licensed podiatrist.

**PRESCRIPTION DRUGS:**
The Contractor is responsible for prescription drugs.

**PREVENTIVE MEDICINE:**
Examinations for the purpose of diagnosis and treatment of existing illness or injury are not included in this section. The Client and the PCP will determine exam periodicity for Members with a disability.
**Physical Exams**
- Under age 21, see Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Age 21 - 35, at least once every five years but not more than once a year
- Age 36 - 50, at least once every two years but not more than once a year
- Over age 50, once every 12 months

**Women’s Health**
- Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis
- Routine mammograms as required by statute (C.R.S. 10-16-104): a single baseline mammogram for women from age 35 to 39; at least once every two contract years for women from age 40 to 49, except women with risk factors to breast cancer, as determined by the PCP, shall be at least once per year; and at least once per contract year for women age 50 to 65 years

**Men’s Health**
- Age 40 to 50 in high-risk categories (as determined by the PCP), in accordance with statute (C.R.S. 10-16-104)
- Age 50 years and older, screening for early detection of prostate cancer at least once per year

**Health Education Services**
- Instruction in personal health care measures, including those appropriate for Clients with disabilities
- Instruction for a designated client representative, when the Client is unable to receive or understand such services due to a disability
- Information about services, including recommendations on generally accepted medical standards for use and frequency of such service

**PROSTHETICS AND ORTHOTICS:**
The following prosthetic devices and orthotics, including but not limited to the following list, are Medicaid benefits for Clients of all ages if medical necessity has been established and use in the home setting has been determined to be appropriate. Medical necessity shall be determined based on criteria established by the department, and in accordance with 10 CCR 2505-10, Section 8.590.2.A:
- Ankle-foot/knee-ankle-foot orthotics
- Artificial limbs
- Augmentative communication devices and communication boards
- Colostomy (and other ostomy) bags and necessary accoutrements required for attachment, including irrigation and flushing equipment and other items/supplies directly related to ostomy care
- Facial prosthetics
- Lumbar-sacral orthoses (LSOs)
- Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace
- Recumbent ankle positioning splints
- Rigid and semi-rigid braces
- Specialized eating utensils and other medically necessary activities of daily living aids; and
- Therapeutic shoes
- Thoracic-lumbar-sacral orthoses (TLSOs)

Covered services include the rental or purchase of prosthetic devices and supplies including repair, maintenance and delivery. Preference will be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the devices will be operated. Coverage
in a particular case is subject to the requirement that the devices be medically necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. Prosthetic devices may be recommended by an appropriate licensed Practitioner, but must be prescribed by a Doctor of Medicine or a Doctor of Osteopathy.

RADIOLOGY - see Imaging

RADIATION THERAPY

RURAL HEALTH CLINICS (RHC):
All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the program.

• Services furnished by a Physician
• Services furnished by a Physician Assistant, Nurse Practitioner or Nurse Midwife, under the medical supervision of a Physician
• Services and supplies that are furnished as an incident to professional services for Physician, Physician Assistant, Nurse Practitioner or Nurse Midwife, under the medical supervision of a Physician
• Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals)
• Other ambulatory services that are otherwise a benefit of the program that meets specific programmatic requirements for the furnishing of that service. Such services are not subject to Physician supervision requirements unless such supervision is generally required for such services under the Medicaid program
• EPSDT services furnished by a rural health clinic that are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished

SECOND OPINIONS:
Members have the right to obtain a second opinion. See Consultation.

SPEECH PATHOLOGY - see Audiology and Speech Pathology

SUBSTANCE ABUSE:
This includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

SURGICAL SERVICES:
For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File shall be considered the prevailing guide. Generally, surgical services include:

• Reconstructive surgery
  » Medically necessary reconstructive plastic surgery or surgery to correct disfigurement resulting from trauma or affecting function, regardless of when the injury, illness or defect occurred
  » Reconstructive services following mastectomy, subject to prior approval
• Male genital system
• Female genital system
• Oral surgical services (limited to treat certain conditions, as follows):
  » Accidental injury to jawbones or surrounding tissues
  » Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder
Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and/or floor of mouth

Sterilization
Stipulations: In order to receive sterilization services, the following criteria must be met:
» The Client must be at least 21 years of age
» The Client may not be currently institutionalized for the care and treatment of mental illness
» The Client must be mentally competent
» The MED 178 consent form, as utilized by the Medicaid Program, must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the Physician must certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and 1) in the case of premature delivery, must state the expected date of delivery; or 2) in the case of abdominal surgery, must describe the emergency

TOBACCO CESSATION:
This includes all FDA-approved prescription medications and over-the-counter tobacco cessation products for a maximum of two 90-day sessions per year; it does not include any group or individual counseling services. Medications related to tobacco cessation are provided through a prescription from a PCP.

Group or individual counseling services and all FDA approved medications and over-the-counter products related to tobacco cessation are available to pregnant women as a Wrap Around Benefit.

TELEMEDICINE:
No Medicaid-Managed Care organization, on or after January 1, 2002, may require face-to-face contact between a Provider and a Client for services appropriately provided through telemedicine if the Client resides in a county with a population of 150,000 residents or fewer, and if the county has the technology necessary for the provision of telemedicine. The use of telemedicine is not required when in-person care by a participating Provider is available to an enrolled Client within a reasonable distance.

Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

TRANSPLANT SERVICES:
These include services received in connection with bone, bone marrow/stem cell, cornea, heart, lung, heart-lung, kidney, liver (including living donor or partial liver), pancreas after kidney, simultaneous pancreas-kidney and skin:
• Charges for retrieval or harvest of donor organs or bone marrow, if not provided by any other health care program or insurance, including any necessary compatibility testing and donor search
• Living donor transplant: Contractor is required to cover services to donor for costs directly related to the transplant. Services required due to complications or non-related care will be the responsibility of the donor’s carrier
• Immunosuppressive drugs as supportive therapy for the transplant

VISION SERVICES:
Under age 21, see EPSDT.

Age 21 and over: Clients with certain medical conditions and/or disabilities such as diabetes, retinal dysplasia or glaucoma may require more frequent exams, which shall be determined by the PCP. Vision services include:
• Eye exams
  » One refraction once during any 24-month period for adults age 21 to 47
  » One refraction every 12 months for adults age 48 or older
• Vision correction: one pair of corrective lenses and no less than the Medicaid-allowable contribution for frames ordered as a result of the covered examinations

NOTE: The Contractor may require completion of 6 continuous months of enrollment before providing vision benefits for adults age 21 years and older.

WOMEN’S HEALTH CARE SERVICES:
Female members of DHMC do not need prior approval or authorization to access routine or preventative health care services from a Women’s Health Care Specialist within the Network.

EXCLUSIONS:
The following services are excluded from coverage:

Acupuncture

Air Ambulance Services when a Client could be safely transported by ground ambulance or by means other than ambulance.

Ambulatory Surgical Procedures not listed on the State-approved list.

Ambulance Services when a Client could be safely transported by means other than ambulance.

Audiology and Speech Pathology with the exception of EPSDT covered services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this contract but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.

Autopsy Charges

Biofeedback, stress management, behavioral testing and training, and counseling for sexual dysfunction.

Chiropractic Services unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

Cosmetic Procedures or corrective plastic surgery performed solely to improve appearance. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation procedures, rhinoplasty and associated surgery, and any procedures utilizing an implant which does not alter physiologic functions, unless medically necessary and/or to correct disfigurement.

Counseling for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders; or chronic situational reactions.
**Dental services:**
- Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.
- For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related cost resulting from the services when determined by the Contractor to relate to a dental condition.

**DME** to include wheelchair lifts for vans or automobiles, hot tubs, Jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.

**EPSDT Services** not provided under this contract are:
- Hearing aids and auditory training
- Psychiatric/psychological care that is included and covered through the Mental Health Capitation Program. Community Mental Health Centers formally known as Mental Health Assessment and Service Agencies (MHASAs) are required to cover diagnoses and services as described at 10 CCR 2505-10 §8.212
- Services that are experimental, not safe or cost-effective, or services provided for the convenience of the caregiver need not be covered
- Expanded EPSDT services

**Experimental** or investigational services or pharmaceuticals.

**Government-Sponsored Care:**
- Items and services provided by federal programs, such as a Veteran’s Hospital
- Services provided in facilities that serve a specific population, such as prisoners
- Care for conditions that federal, state, or local laws require to be treated in a public facility
- Services for which treatment is provided under any government law now existing or subsequently enacted or amended, including but not limited to, Workmen’s Compensation Act, Employer Liability Law and Colorado No Fault automobile insurance

**Fertility Procedures or Services** that render the capability to produce children, except when that capability is a side effect of medically necessary surgery for another purpose/diagnosis.

**FQHC Services:** Inpatient hospital stays are not covered under FQHC Services, but may be a benefit under Inpatient Hospital Care.

**HCBS Services:** Includes Wrap Around services such as case management (for Model 200 children), home modification, electronic monitoring, personal care, non-medical transportation and all other waiver services.

**Hearing Aids** with the exception of EPSDT covered services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids, repairs and batteries are not covered under this contract but may be provided to children under the age of 21 as a Wrap Around Benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this contract.

**High colonics**
Holistic or Homeopathic Care including drugs and ecological or environmental medicine.

Home Delivery: Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.

Home Health Services: Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.
- Long-term Home Health as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.
- Home Health Services provided by a person who ordinarily resides in the Client’s home, or is an immediate family member, are not covered.

Hospice Services: Clients need not be disenrolled from their HMO or MCO to receive hospice services, but may continue to get care not related to the terminal illness from the HMO or MCO. Clients may request disenrollment.

Hospital Backup Level of Care: Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470 is excluded.

Hypnosis

Immunizations related to foreign travel.

Imaging (Radiology or X-ray) Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Infertility Treatment, including, but not limited to, embryo transplants, in vitro fertilization, and low tubal transfers, gamete inter fallopian tube transfer and zygote inter fallopian tube transfer.

Inpatient or residential rehabilitation for substance or alcohol abuse.

Inpatient Hospital excluded services include:
- Psychiatric/psychological care included and covered through the Mental Health Capitation Program (MHCP)
- Discharge medications and experimental drugs
- Inpatient hospital services defined as experimental by the Medicare program
- For Medicaid-approved benefits, Medicare Patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities
- Inpatient substance abuse rehabilitation DRG 936 is a Wrap Around service. See Wrap Around Benefits

Institutional Care when provided for the primary purpose of controlling or changing Client’s environment, or if custodial care, domiciliary care, convalescent care (other than extended care), respite care, rest cures or hospice care.

Isometric Exercise

Expenses for Medical Reports, including presentation and preparation.
Laboratory Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Long Term Home Health as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

Mental Health (BHO): Mental health inpatient or outpatient psychiatric or psychological care that is a benefit of the the MHCP. Hospital inpatient or outpatient care with a principal diagnosis listed in Exhibit G is a benefit of the MHCP. All other mental health services are a benefit of the MHCP if both the diagnosis and procedure codes are listed in Exhibit H.

Newborn Hospitalizations: Continued stay of healthy newborns for any other reason after the mother’s discharge is not a benefit under the medical assistance program.

Portable and Liquid Oxygen is now carved out of the DHMC Plan. For specific procedure codes and descriptions of oxygen and oxygen equipment that are not covered by DHMC and that are covered by State Medicaid, please contact DHMC Provider Relations at 303-602-2050.

Paternity Testing: Such services shall be reimbursed by the Medicaid Program and recouped through the court system.

The Prenatal Plus Program, is a Medicaid-funded, collaborative effort between the Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing. Local programs submit billing to Medicaid for direct reimbursement.

Personal Comfort or Convenience Items: Includes items such as hospital television, telephone, private room (except as medically necessary), modifications and alterations in homes, vehicles, or place of residence.

Physical Examinations of the following nature are excluded:

• Examinations required by the county departments for the purpose of qualifying applicants for assistance or for the re-certification of recipients for assistance in the following categories: AND, AB, AFDC, or placement of children in foster care
• Physical examinations for employment, licensing, marriage, insurance, school, camp, sports, or adoption purposes or requests by any institution, agency, or person other than the recipient’s county department or the state department. Examination or treatment ordered by a court except when such treatment may be medically necessary and is provided by a network Provider and/or authorized by the PCP

Private Duty Nursing (PDN): Private duty nursing services are a Wrap Around Benefit.

Psychiatric/Psychological Care as follows:

• Milieu therapy
• Play therapy
• Day care
• Electroshock treatment rehabilitation
• Night care
• Family therapy
• Biofeedback

Reversal of surgically performed sterilization or subsequent re-sterilization. Procedures, services and supplies relating to sex change or transformation.
**SNF Services** are a Wrap Around Benefit.

**Substance or Alcohol Abuse**, inpatient or residential rehabilitation.

**Surrogate Mother Services** or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

**Transportation, Non-Emergent**, to medical appointments. This is a Medicaid benefit provided through the client’s local county Department of Social Services for the purpose of receiving covered medical services.

**Travel**, whether or not recommended or prescribed by a Physician or other medical Practitioner.

**Vision Correction Procedures** for the purpose of vision correction that can be treated by corrective lenses, such as refractive keratoplasty, or radial and laser keratotomies.

**Wrap Around Benefits** are services that are Medicaid benefits not paid by DHMC. Wrap Around Benefits are paid for by the State of Colorado Medicaid program on a fee-for-service basis upon determination of medical necessity. Providers should work with the State Medicaid Customer Service Department at 303-866-3513 to obtain details and requirements of such services. Wrap Around services include, but may not be limited to, the following:

- Auditory services for children. HMO-covered services include screening and medically necessary ear exams and audiological testing. Wrap around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation
- Comprehensive dental assessment, care and treatment for children
- Dental services for adults. These are limited to emergency services and minimal medically necessary dental services for adults with concurrent medical conditions
- Drug/alcohol treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only
- Extra-ordinary Home Health Services – Expanded EPSDT benefit, which includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child’s place of residence
- HCBS Services including case management (for Model 200 children), home modification, electronic monitoring, personal care and non-medical transportation
- Hospice services, however Client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested
- Hospital backup level of care as defined by 10 CCR 2505-10, Section 8.470
- Inpatient substance abuse rehabilitation DRG 936 (Valley View)
- Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department and HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai
- Non-emergency transportation to medical appointments for covered services only, through the Client’s county of residence
- Private-Duty Nursing (PDN), nursing services only
- SNF services (skilled nursing and rehabilitation services) if Client meets level of care certification. Wrap Around SNF services include those services set forth at 10 CCR 2505-10, Section 8.440.1., notwithstanding the list of covered services set forth above. Wrap Around SNF services also include any Medicare cross-over benefits
• Tobacco cessation. Group or individual counseling services and all FDA-approved medications and over-the-counter products related to tobacco cessation are available to pregnant women.

ADDITIONAL INFORMATION:
No pre-existing condition limitations.

Please note that DHMC Benefits and Exclusions can change. If a Provider has any questions or needs additional clarification, call the DHMC Health Plan Services Department at 303-602-2116 or Provider Relations at 303-602-2003.

SECTION XXV: DENVER HEALTH MEDICARE ADVANTAGE

DHMP HAS TWO MEDICARE ADVANTAGE PLANS FOR DENVER COUNTY RESIDENTS:

Medicare Choice is a Medicare-approved HMO plan and has a contract with the Colorado Medicaid program. This plan is for those looking for a comprehensive health plan, and who have Medicare parts A and B and have full Medicaid benefits. In this plan, ‘Extra Help’, also known as Low-Income Subsidy (LIS), may pay for some or all of their drug costs. Enrollment in DHMP depends on contract renewal.

Medicare Select is for those who are looking for a comprehensive health plan and who have Medicare Parts A and B. In this plan, ‘Extra Help’, also known as Low-Income Subsidy (LIS), may pay for some or all of their drug costs. Medicare Select is a Medicare-approved HMO plan. Enrollment in DHMP depends on contract renewal.

Covered Benefits
Like all Medicare health plans, Denver Health Medicare Select and Choice offer all of the benefits covered by Original Medicare. DHMP members also get more than what is covered by Original Medicare.

For a full listing of covered benefits of each plan, Providers should consult the Explanation of Coverage (EOC) on DHMP’s website at https://www.denverhealthmedicalplan.org/medicare-existing-members.

DHMP also covers Part D drugs for Medicare members as well as Part B drugs, such as chemotherapy and some drugs administered by the Provider. For a complete plan formulary and any restrictions, please see https://www.denverhealthmedicalplan.org/medicare-pharmacy.