



DENVER HEALTH
MEDICAL PLAN INC.™

PROVIDER MANUAL

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FORMS

Visit our website at denverhealthmedicalplan.org/provider-forms-and-materials to access the forms below:

- Provider Request for Dispute Resolution
- U.S. Preventive Services Task Force (USPSTF) Recommendations
- Prior Authorization Form
- Designation of Personal Representative (DPR) Form
- Member Grievance and Appeal Form
- Bright Futures Periodicity Schedule

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 (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:

CONTACT INFO	PHONE	FAX	PREFERRED METHOD
DHHA Enterprise Compliance Services	303-602-3255	303-602-7024	
Credentialing Department			DHMP.Credentialing@dhha.org

Health Plan Services (Member/Provider)	Commercial & CHP+: 303-602-2100 Commercial/Exchange: 303-602-2090 Medicaid: 303-602-2116 Medicare Choice>Select: 303-602-2111	303-602-2138	
Pharmacy Services	303-602-2070	303-602-2081	
Provider Relations	303-602-2100	303-602-2516	
Quality Improvement	303-602-2051	303-602-2064	
Utilization Management	303-602-2100	Urgent/Expedited Fax: 303-602-2160 Outpatient Fax: 303-602-2128 Inpatient Fax: 303-602-2127	
Case Management	303-602-2184		

Please visit us online at www.denverhealthmedicalplan.org

SECTION II: PROVIDER RESPONSIBILITIES

OVERVIEW

Members choose specific Physicians to be their Primary Care Provider (PCP). A Primary Care Provider's responsibility is to manage the total health care needs of the member. This includes routine and preventive medical services, medically necessary diagnostic referrals, and 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 at <https://www.denverhealthmedicalplan.org/provider-forms-and-materials>. 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 is responsible for verifying Member eligibility on the date of service before rendering services, or providing all routine and preventive primary care services per Members benefit program as the designated PCP. The PCP manages the Patient's care initiates referrals for specialty services, as applicable and coordinates medically necessary care with other Providers. PCPs are required to:

- Have timely appointments available
- Participate in Quality Assurance Utilization Management programs
- Comply with Quality Improvement activities
- Meet Credentialing Requirements
- Maintain confidentiality of medical information in compliance with all state and federal regulatory entities,
- Maintain a separate medical record for each Member,
- Ensure legible and comprehensive medical records for each encounter are maintained,
- Authorize the Company use of clinical and access to performance data
- Follow the Referral and Prior Authorization Guidelines Process
- Provider offices must make accommodations for people with disabilities to include offices/ exam rooms and equipment
- Follow the policies and procedures of the Billing Guide

SPECIALTY CARE PROVIDERS (SCP)

Specialty Care Providers are responsible for:

- Verifying Member eligibility prior to and on the date of service before rendering the service
- Providing specialty consultation care as approved by a Member's PCP or the health program
- Establishing additional services after discussing care with the PCP, and obtaining Prior Authorization from the health program for such services, as applicable.
- Coordinating the Member's care with the PCP to include feedback on services rendered and diagnoses identified within five business days of providing the service
- Obtain written Prior Authorization from Denver Health Medical Plan (DHMP) before making secondary referrals to other specialists or medical professionals for procedures or admissions
- Written communication of findings and recommendations
- Record-keeping to include maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies;
 - o Separate medical record for each Member;
 - o Legible and comprehensive medical records for each encounter;
- Documenting the referral and Prior Authorization processes, as applicable;
- Collaborate with quality improvement activities;
- Permitting Denver Health Medical Plan (DHMP) to utilize clinical and access performance data
- Provider offices must make accommodations for people with disabilities to include offices/ exam rooms and equipment
- Follow the policies and procedures of the Billing Guide

VERIFYING ELIGIBILITY, BENEFITS, AND NETWORK PARTICIPATION STATUS

Verifying Member's eligibility and benefits is an important first step prior to rendering services. This will help to ensure that claims are submitted to the correct payer, and will notify the Provider if the member has financial responsibility, such as cost-share or copayments. It also determines if a referral and Prior Authorization notification is required and limits denials for benefits coverage. This information can be found on our websites at denverhealthmedicalplan.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:

denverhealthmedicalplan.org/real-time-eligibility-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.

COMPLIANCE WITH FEDERAL AND STATE LAWS AND RULES AND REGULATIONS

As a licensed health insurer and managed care plan, Denver Health Medical Plan, Inc. (DHMP) operates in a complex, dynamic and highly regulated environment at both the federal and state level. It is our policy to comply at all times with applicable federal, state and local laws, rules, regulations and guidance established by regulatory agencies related to Company business; and to conduct business ethically and with integrity. DHMP requires its providers to do the same. As such, DHMP has established and implemented its Compliance and Fraud, Waste and Abuse Programs.

Key components of these programs include education and training; detection, prevention and correction; and the obligations to report actual or potential compliance or ethics violations, including instances of fraud, waste and abuse.

Providers may report concerns anonymously or confidentially via the following mechanisms:

Values Line:

- Phone: 1-800-273-8452 (available 24/7)
- Web: <https://secure.ethicspoint.com/domain/media/en/gui/47268/index.html>
- Email: ComplianceDHMP@dhha.org or ValuesLine@dhha.org

DHHA Enterprise Compliance Services:

- Phone: 303-602-3255
- Fax: 303-602-2025
- Mail: Denver Health, Enterprise Compliance Services, 601 Broadway St., MC 7776, Denver, CO 80204

All reported concerns are investigated and acted upon, as appropriate. The process to report actual or potential compliance violations is designed to ensure that confidentiality is maintained and anonymity is protected. All persons making a report are assured that confidentiality will be maintained at all times insofar as legal, practical and consistent with a complete investigation. DHMP will not retaliate or take adverse action against persons making good faith reports, regardless of whether the report is ultimately substantiated.

Please contact Health Plan Services at 303-602-2100 to obtain a copy of the Denver Health and Hospital Authority (DHHA) Compliance Plan and Fraud, Waste, and Abuse Policy. The DHHA Code of Conduct can be found on the DHHA website at www.denverhealth.org (see Regulatory Disclosures).

Non-Discrimination

DHMP does not discriminate on the bases of race, color, national origin, sex, gender identity or expression, sexual orientation, age, mental or physical disability, medical condition, claims experience, evidence of insurability, genetic information or source of payment and requires its providers to do the same.

HIPAA

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 Act (HIPAA) Act.

Collecting Payment

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

Provider must notify Denver Health Medical Plan if they object to providing a service due to moral or religious circumstances. Please call Provider Relations at 303-602-2003.

Denver Health Medical Plan will not prohibit, or otherwise restrict any health care professionals from acting within the lawful scope of their practice, and advising or advocating on the behalf of Members who are the Provider's Patient for the following:

- Member's health status, medical care or treatment options, including alternative treatments that may be self-administered
- Information the Member needs in order to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or non-treatment
- 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.

Providers can access Denver Health Medical Plan changes and updates that impact interaction with MCO by accessing the following link: 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 to select and evaluate its contracted Providers that complies 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:

The Company does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation, or on type of procedure or patient (e.g., Medicaid) in which

a practitioner specializes. This does not preclude the Company from including practitioners in the network who meet certain demographic or specialty/cultural needs. The Provider Credentialing Manager does not include gender, age or ethnicity of a practitioner when presenting credentialing or recredentialing files to the Credentialing Committee for review and approval. To ensure practitioners are not discriminated against, the QI Director conducts an annual audit of IDNPs (initially credentialed within the past 12 months) to review the following practitioner information: date of birth, gender and languages spoken. In addition, practitioner complaints received through the Contracting and Provider Relations Department are tracked to identify alleged discrimination occurrences. The results of these audits are presented to the Credentialing Committee annually.

- 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

Revalidation

- HCPF revalidation site: colorado.gov/pacific/hcpf/revalidation

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

1. Review information submitted to support credentialing applications. In the verification process, if any discrepancies are found in the information provided by a practitioner, the Credentialing Department personnel will contact the practitioner by phone or in writing to validate the correct information. The Company must notify the practitioner if there is a substantial variation in information regarding actions on license, 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.
2. Correct any erroneous information in their credentialing application by phone or in writing, prior to the Credentialing Committee meeting date. The practitioner is also notified by mail, email or phone of the deadline for submitting the corrections. The notification includes the following:
 - a. Erroneous information must be corrected within 10 business days
 - b. Submission of corrections must be in the correct format
 - c. Corrections must be submitted to the Credentialing Department personnel
 - d. Receipt of the corrections is documented
3. Receive the status of their credentialing or recredentialing application upon request by contacting the Provider Credentialing Manager at the number listed on the DHMP Initial Practitioner Letter
4. Receive notification of these rights:
 - a. Providers are informed of their rights through the Provider Newsletter which is sent via email annually, and is also available on the Company's website: denverhealthmedicalplan.org/provider-newsletters
 - b. Providers are informed of their rights through the Provider Manual which is available on the Company's website: denverhealthmedicalplan.org/provider-manual
 - c. Providers may also contact the Contracting and Provider Relations Department for their rights.

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.

Practitioners who need to be credentialed:

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 (e.g., 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)

Allied Health

- Acupuncturist
- Audiologist
- Optometry (OD)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Speech and Language Pathologist (SLP)
- Telemedicine Consultant
- Applied Behavior Analyst (ABA)

Certain practitioners that are exempt from the credentialing process are listed below. However, the Company does credential and recredential hospital-based practitioners who provide care in an outpatient setting (e.g., anesthesiologist offering pain management services or University faculty who are hospital based and who also have private practices).

- Covering practitioners
- Locum tenens
- Emergency room physicians
- Hospitalists
- Practitioners who practice exclusively within free-standing facilities (e.g., mammography centers, surgery centers, ambulatory behavioral healthcare facilities and psychiatric and addiction disorder clinics)
- Students, residents and fellows
- Dentists who provide primary dental care only under a dental plan

COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE (CAQH PROVIEW)

Denver Health Medical Plan 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 send email to DHMP.Credentialing@dhha.org.

Credentialing and Recredentialing Application Process

The Company requires all practitioners complete the Colorado Health Care Professional Credentials Application provided on the CAQH website in electronic form so that the Credentialing Department personnel may obtain and validate information attested to by the practitioner. The CAQH Credentialing Application must be currently signed or attested with the most recent information.

IDNPs are required to be recredentialed at least every 36 months for continued participation. The Company assures that the applicant is notified of the recredentialing process and required documentation is provided in a timely manner in order to meet the 36 month timeframe.

The practitioner credentialing and recredentialing processes begin with the completion of an application, signed and dated attestation and submission of requested documentation. The applications include an attestation questionnaire form regarding:

1. Inability to perform essential functions of the position, with or without accommodation
2. Lack of present illegal drug use
3. History of loss of licensure
4. Licensure sanctions
5. Felony convictions
6. Current malpractice insurance coverage
7. Loss or limitation of clinical privileges or disciplinary actions
8. The correctness and completeness of the application

Verification Process

Verification can be obtained verbally, in writing or electronically, as described below:

1. Verbal verification is documented on a contact form and includes the information obtained, the name of the person from the primary source supplying the information, the date the information was received and the initials of the Credentialing Department personnel who took the verbal information.
2. Written verification includes the date the information was queried by the source, the signature of the person at the primary source and/or a letterhead from the primary source supplying the information.
3. Electronic verification (i.e., internet/online) can include WebCrawler verification from approved sources and as well as other hardcopy screen printouts. All electronic verification including but not limited to WebCrawler verification must include the source of the documentation (e.g., WebCrawler update report or activity report), the date the information was generated, the date the information was verified and the name or initials of the verifier.
4. See Attachment B for a list of acceptable verification sources for practitioner credentialing.
5. Initial Credentialing Process
 - a. Licensure: A current, valid Colorado state license must be verified and re-verified from primary sources. Verification must show the license was in effect at the time of the credentialing decision. If there are any adverse actions on the licensure, all of the appropriate documentation is obtained. If the practitioner holds licensures in other states, only the licensures in Colorado must be verified.
 - b. Drug Enforcement Agency (DEA/XDEA): Certificates are verified for practitioners who indicate they prescribe controlled substances through primary source verifications directly through the DEA website, as well as the American Medical Associate (AMA) Physician profile (not applicable to PsyD, PhD, EdD and Master's-level behavioral health providers.). If a practitioner has a pending DEA certificate, the practitioner may be eligible to be credentialed if the provider has in place a designated alternate practitioner to write all prescriptions on their behalf until the practitioner has a valid DEA certificate. The credentialing file must document the absence of the DEA or CDS certificate and the name of the designated practitioner.
 - c. Hospital Affiliation: The practitioner should document on the Colorado state application which hospital(s) they are affiliated with and use as the primary admitting facility. Additionally, the practitioner should also document any coverage arrangements they may have through an affiliated practitioner or hospitalist. Certified Nurse Midwives may or may not hold privileges given the scope of their practice.
 - d. Education Verification: Verification is not necessary for MDs and DOs who, through primary source verification, are confirmed to be board certified. If the practitioner is not board certified, only the highest level of education/training is verified (e.g., residency, graduation from Medical school). Verification of fellowship is not required or accepted as verification of education and training. Verification of education during recredentialing is not required.

The acceptable verification sources for physicians for medical school and residency training are AMA Physician Profile, American Osteopathic Association (AOA) and Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Verification of training or graduation from a graduate school for non-physician practitioner and allied health practitioner is obtained through verification of licensure with the applicable State board (written confirmation of primary source verification from each of the application State licensing boards is obtained annually by the Provider Credentialing Manager). Other acceptable source of verification may include written verification from the institution awarding the degree.

Additional verification sources that are recognized by NCQA include: Federation of State Medical Boards (FCVS) closed residency programs, the recognized residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

- e. **Board Certification:** Board certification is required to be included in the Company network, however information regarding any/all board certifications or appropriate professional specialty certificates must be provided by the applicant. Certifications are primary source verified; expiration dates or board certifications are documented. If a practitioner has a certification that does not expire, DHMP will verify that the board certification is current and document the date of the certification. Board certification is primary source verified during credentialing and recredentialing.

The verification sources for physicians are American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. The ABMS Certified Doctor Verification Program, accessible through the ABMS Web site, is intended for consumer reference only and is not an acceptable source for verifying board certification. AMA Physician Profile, AOA and Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

For other health care professionals, the verification sources are state licensing agency (if they primary source verify board certification) primary source appropriate specialty board or use of a registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.

- f. **Work History:** Work history does not need to be primary source verified. The practitioner is required to either submit a curriculum vitae or resume, or document a minimum of five years of work history following completion of their education on the credentialing application. The practitioner must provide the beginning and ending month and year for each position. Work history verification is not required during recredentialing.

The Credentialing Department personnel review explanations of work gaps provided by providers on the Colorado state application. If clarification is needed, it may be provided verbally or in writing... Explanation of work history gaps greater than one year must be clarified in writing by the practitioner.

- g. **Malpractice Insurance Coverage:** DHMP requires all practitioners to carry minimum malpractice coverage amount of \$1 million per incident and \$3 million aggregate.

Malpractice coverage is confirmed through the signed attestation on the application that includes the dates and amounts of the current malpractice insurance coverage and a copy of the certificate of insurance that includes the practitioner's name, dates and amount of coverage.

Practitioners who have coverage through the Federal Tort Claims Act (FTCA) or Self-Insurance Trust or have governmental immunity are exempt from carrying the minimum amounts of malpractice

- insurance of \$1/\$3 million.
- h. **Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions:** All practitioners complete the attestation questions on the credentialing application regarding their claims history. Per the criteria listed in this policy, the Credentialing Department personnel collects and verifies all sanctions including but not limited to limitations on licensure by way of written narrative is provided by the practitioner to outline the circumstances surrounding any incident(s) identified and any disciplinary action taken.

The NPDB is primary source verified during credentialing and recredentialing. The Credentialing Department personnel reviews the NPDB report to determine if the practitioner has any malpractice suits, adverse actions, sanction or restrictions .. If there are adverse actions that require review by the Credentialing Committee per the criteria listed above in this policy, the Credentialing Department personnel obtains all the necessary information for review at the Credentialing Committee meeting.

- i. **National Provider Identifier (NPI):** The Credentialing Department personnel verify whether the practitioner holds a NPI number in NPPES.
- j. **Office of Inspector General (OIG) and System for Award Management (SAM):** The OIG is queried for each practitioner going through credentialing and recredentialing for information on Medicare/Medicaid sanctions.

The SAM is queried for each practitioner going through credentialing for records of debarments, suspension and other exclusionary actions which would make them ineligible for receiving Federal contracts, subcontracts and Federal assistance and benefits.

6. Recredentialing Process

- a. **Licensure:** A current, valid Colorado state license must be verified and re-verified from primary sources. Verification must show the license was in effect at the time of the credentialing decision. If there are any adverse actions on the licensure, all of the appropriate documentation is obtained.
- b. **Drug Enforcement Agency (DEA/XDEA):** Certificates are verified for practitioners who indicate they prescribe controlled substances through primary source verifications directly through the DEA website, as well as the AMA Physician profile (not applicable to PsyD, PhD, EdD and Master's-level behavioral health providers). If a practitioner has a pending DEA certificate, the practitioner may be eligible to be credentialed if the provider has in place a designated alternate practitioner to write all prescriptions on their behalf until the practitioner has a valid DEA certificate. The credentialing file must document the absence of the DEA or CDS certificate and the name of the designated practitioner.
- c. **Clinical Privileges Hospital Affiliation:** The practitioner should document on the Colorado state application which hospital(s) they are affiliated with and use as the primary admitting facility. Additionally, the practitioner should also document any coverage arrangements they may have through an affiliated practitioner or hospitalist. Certified Nurse Midwives may or may not hold privileges given the scope of their practice. Practitioners exempt from the requirement for clinical privileges include, Psychiatrists, Chiropractors, PhD, PsyD, EdD, and Master's-level behavioral health practitioners.
- d. **Board Certification:** Board certification is required to be included in the Company network, however information regarding any/all board certifications or appropriate professional specialty certificates must be provided by the applicant. Certifications are primary source verified; board certifications are documented,. If a practitioner has a certification that does not expire, DHMP will verify that the board certification is current and document the date of the certification. Board certification is primary source verified during credentialing and recredentialing.

The verification sources for physicians are ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. The ABMS Certified Doctor Verification Program, accessible through the ABMS Web site, is intended for consumer reference only and is not an acceptable source for verifying board certification. AMA Physician Profile,

AOA and Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

For other health care professionals, the verification sources are state licensing agency (if they primary source verify board certification), primary source appropriate specialty board or use of a registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.

- e. **Malpractice Insurance Coverage:** DHMP requires all practitioners to carry minimum malpractice coverage amount of \$1 million per incident and \$3 million aggregate.

Malpractice coverage is confirmed through the signed attestation on the application that includes the dates and amounts of the current malpractice insurance coverage or a copy of the insurance face sheet that includes the practitioner's name, dates and amount of coverage.

Practitioners who have coverage through the FTCA or Self-Insurance Trust or have governmental immunity are exempt from carrying the minimum amounts of malpractice insurance of \$1/\$3 million.

- f. **Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions:** All practitioners complete the attestation questions on the recredentialing application regarding their claims history. Per the criteria listed above in this policy, the Credentialing Department personnel verify that information by way of written narrative is provided by the practitioner to explain the circumstances surrounding any incident(s) identified and/or any disciplinary action taken.

The NPDB is primary source verified during credentialing and recredentialing. The Credentialing Department personnel review the NPDB report to determine if the practitioner has any malpractice suits, adverse actions, sanction or restrictions. If there are adverse actions that require review by the Credentialing Committee per the criteria list in this policy, the Credentialing Department personnel obtain all the necessary information for review at the Credentialing Committee meeting.

- g. **National Provider Identifier (NPI):** The Credentialing Department personnel verify whether the practitioner holds a NPI number in NPPES.
- h. **Office of Inspector General (OIG) and System for Award Management (SAM):** The OIG is queried for each practitioner going through recredentialing for information on Medicare/Medicaid sanctions.

The SAM is queried for each practitioner going through recredentialing for records of debarments, suspension, and other exclusionary actions which would make them ineligible for receiving Federal contracts, subcontracts, and Federal assistance and benefits.

- i. **Quality of Care Concerns (QOCC):** During recredentialing, the Credentialing Department personnel verify through the Utilization Management Department if there have been any Quality of Care Concerns (QOCCs) in the past three years for each practitioner going through the recredentialing process. The verification is included within the credentialing file.

File Completion and Pre-Credentialing Review

Once verification of all elements has been completed, the Credentialing Department personnel review the file for completeness and timeliness of the elements as required by the policy. The Manager of Credentialing completes a second review of all elements before the file is forwarded to the Medical Director or the Credentialing Committee.

Notification of Credentialing and Recredentialing Decision

Practitioners going through credentialing and recredentialing are notified within 60 calendar days of the

Medical Director or the Credentialing Committee's decision (Attachment C). A practitioner is considered to be credentialed as of the date of the Medical Director's decision for a clean file or the Credentialing Committee's decision for a file that is not clean.

Practitioner Appeal Rights

Practitioners may appeal a credentialing or recredentialing decision using the practitioner appeal process as defined in the DHMP Provider Manual or DHMP policy and procedure.

- When an action is taken against a practitioner for quality reasons, the practitioner's appeal rights and the process for notification to authorities is defined in the policy CRE03 - "Practitioner Appeal Rights and Notification to Authorities Based on Issues of Quality of Care".

Listings in Provider Directory and Member Materials

Information contained in member materials, including the Company's provider directory, are consistent with the information obtained during the credentialing process. Any practitioner qualification information given to members should match the information gathered during the credentialing process regarding practitioner education, training, board certification and specialty. The organization and the practitioner(s) are not listed in the directory until the credentialing process is completed and the contract is fully executed.

Termination and Reinstatement

If DHMP terminates a practitioner for administrative reasons such as the practitioner failed to provide complete credentialing information and not for quality reasons, DHMP may reinstate the practitioner with 30 calendar days of termination and is not required to complete an initial credentialing. The practitioner must complete an application for initial credentialing if DHMP reinstates the practitioner more than 30 days after the termination.

If DHMP does not have the necessary information for Recredentialing, it will inform the practitioner that this information is needed at least 30 calendar days before the Recredentialing deadline and that without this information, the practitioner will be administratively terminated. DHMP will include this information in the practitioner's credentialing file. If the practitioners is subsequently terminated for lack of information, the termination notice will also be placed in the practitioner's file.

Initial Sanction Information

The Company collects and reviews all sanction information including limitations on licensure that it receives before making a credentialing decision. Queries are conducted within 180 days prior to the decision date.

1. The NPDB is queried for each provider for verification of malpractice suits, adverse acts, sanctions, exclusions or restrictions against the practice privileges of a practitioner.
2. The LEIE is queried for each provider for information on Medicare/Medicaid sanctions.
3. The SAM is queried for each practitioner for records of debarments, suspension and other exclusionary actions which would make them ineligible for receiving Federal contracts, subcontracts and Federal assistance and benefits.
4. All active state licenses held by a practitioner are queried via the State's web page for verification and sanction information.

Ongoing Monitoring

The Company monitors for, identifies and when appropriate acts upon important quality and safety issues in a timely manner during the interval between formal credentialing. Ongoing monitoring is conducted by the Credentialing Department personnel collects and reviews information from any of the following sources: for all contracted and credentialed providers:

1. Collecting and reviewing Medicare/Medicaid sanction – LEIE is queried on a monthly basis.
2. Collecting and reviewing sanctions or limitation on licensure – Appropriate State Boards are queried for all

licensed health care professionals on a monthly basis.

3. Collecting and reviewing complaints – Member complaints are under the charge of the Appeals and Grievances Department's Grievance Coordinators. All provider complaints are forwarded to the Credentialing Department personnel, who in turn provide the information to the appropriate credentialing office to be considered at the time of the provider's recredentialing. The Credentialing Department personnel include provider complaints in the monitoring log presented to the Credentialing Committee and the QMC at least every six months.
4. Collecting and reviewing practitioner adverse events - Provider adverse events are under the charge of the Medical Director and the QI RN. The Credentialing Department personnel request a report of any adverse events received at least every six months and include this information in the monitoring log presented to the Credentialing Committee and the QMC.
5. Any practitioner identified through the processes of A-D is brought to the attention of the Medical Director, QI Director, Chief Compliance and Audit Officer (or designee), Privacy Officer and Contracting/Provider Relations Director for determination of necessary actions. When the Company identifies such issues, it determines 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 related to possible actions for quality issues for directly credentialed practitioners are described in the policy "Practitioner Appeal Rights and Notification to Authorities Based on Issues of Quality of Care".
6. The Company reviews information released from the appropriate regulatory bodies as referenced above in A-D within 30 calendar days of its release.
7. Monitoring of complaints related to office site quality is addressed in the policy CRE02 "Practitioner Office Site Quality".

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.

NOTIFICATION OF CHANGES MUST ME PROACTIVE

The Provider must send official notice to the Company at the address noted in the agreement and required deliver method within 10 calendar days of knowledge of the occurrence for any of the following: material changes, 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.

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.

CREDENTIALING

Participating Providers are required to give DHMP 10 business days prior written notice of any change, addition or terminations as specified in DHMP Credentialing Policies. All written notices must be sent consistent with the requirements detailed in Article 4 of this Agreement. Examples of changes, addition or terminations where Participating Providers must provide notice, include but are not limited to the following:

- a. Legal Name
- b. NPI 1 or 2
- c. Tax ID
- d. Taxonomy code
- e. Change, addition or termination of practitioners whether employed or subcontracted
- f. Ownership, including but not limited to if Participating Provider is acquired by, acquires or merges with another entity, and such entity. In the event that DHMP already has an Agreement with said entity, DHMP will determine in its sole discretion, which Agreement will prevail
- g. Name change of practitioner
- h. Addition or termination of an Office/Clinic/Facility Physical Address
- i. Changing, adding or deleting a Telephone/Fax/Email/hours of operation
- j. Billing Address/telephone/fax/email
- k. Credentialing Address/telephone/fax/email
- l. Administrative Correspondence/Address/telephone/fax/email
- m. Change, additions, or terminations of facility or outpatient locations if applicable; and
- n. Any practitioner or organizational demographic information required under Applicable Law or DHMP policies and procedures or DHMP Provider Manual that must be provider to DHMP in order to maintain status as credentialed Participating Providers

SECTION V: 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:

ACCESS TO SERVICES STANDARD	TIMEFRAME	COMPLIANCE GOAL
Emergency Care – Medical, Behavioral, Substance Use Disorder	24 hours a day, 7 days a week	100% of the time
Urgent Care – Medical, Behavioral, Substance Use Disorder	Within 24 hours	100% of the time
Primary Care — Routine, Non-urgent Symptoms	Within 7 calendar days	>=90% of the time
Behavioral Health, Mental Health and Substance Use Disorder – Routine, Non-urgent, Non-emergency	Within 7 calendar days	>=90% of the time

Prenatal Care	Within 7 calendar days	>=90% of the time
Primary Care — Access to After-hours Care	Office number answered 24 hrs/ 7 days a week by answering service or instructions on how to reach a physician	>=90% of the time
Preventive/Well Visits	Within 30 calendar days	>=90% of the time
Specialty Care — Non-urgent	Within 60 calendar days	>=90% of the time

MEDICAID & CHP+ ACCESS TO CARE STANDARDS	
APPOINTMENT TYPE	APPOINTMENT STANDARD TIMEFRAME
Emergency care	<ul style="list-style-type: none"> Available twenty-four (24) hours a day, Seven (7) days a week, 365 days a year Comprehensive plan for triage of requests for services on a twenty-four (24) hour seven (7) days per week, 365 days per year basis includes: Immediate medical screening exam by PCP or hospital emergency department. Access to a qualified care practitioner via live telephone coverage either on-site, call sharing, or answering service
Urgent care	Within twenty four (24) hours of patient's notification to the Company
Outpatient follow-up appointment	Within seven (7) days after discharge from a hospitalization or per provider follow up instructions
Non-urgent, non-emergent medical problem (CHP+ ONLY)	Within thirty (30) calendar days (This thirty (30) calendar day standard does not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days)
Non-urgent, symptomatic care (including Behavioral Health Services)	Within seven (7) calendar days of the member's request for services
Non-symptomatic well care physical examinations	Within thirty (30) calendar days, unless an appointment is required sooner to ensure the recommended screenings in accordance with the American Academy of Pediatrics accepted Bright Futures schedule
Emergency behavioral health care	By phone within fifteen (15) minutes after initial contact, In person within one (1) hour of contact

MEDICARE ADVANTAGE CHOICE & SELECT ACCESS TO CARE STANDARDS	
APPOINTMENT TYPE	APPOINTMENT STANDARD TIMEFRAME
Emergency Care	24/7
Answering service (NurseLine)	24/7
Behavioral Health Non-Life-threatening emergency	24/7

Behavioral Health Life-threatening emergency	24/7
Behavioral Health Urgent visit	24 hours
Behavioral Health Urgent visit (MH/SUD)	24 hours
Behavioral Health Non - Urgent - Symptomatic	7 days
Behavioral Health EAP visit	N/A
Behavioral Health hospital discharge follow-up	7 days
Behavioral Health follow-up, non-urgent	7 days
Primary Care, Non Urgent - Symptomatic	7 days
Primary Care Urgent care visits	24 hours
Preventative/well care visits	30 days
Outpatient Follow-Up Appointments	7 days
Specialty Care routine care	60 days
Specialty Urgent care	24 hours

Expectation of Providers meeting timely stands: Quarterly open shopper calls are performed at random by the DHMP Health Plan Services staff to monitor provider compliance with these standards. Should a provider receive an open shopper call and not meet access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider's nonresponse to a requested CAP may result in network disenrollment/termination.

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 NurseLine 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 bona fide 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 VI: 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 VII: BENEFITS AND LIMITATIONS

Please refer to these websites for current benefits and limitations for all plans:

www.denverhealthmedicalplan.org

SECTION VIII: 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 nationally-accepted, evidenced-based clinical criteria to determine the medical necessity of requested services:

1. MCG Health™ Care guidelines Medicare Coverage Database
 - a. National Coverage Determination (NCD)
 - b. Local Coverage Determination (LCD)
3. HAYES, Inc. Knowledge Center
4. Wolters Kluwer's UpToDate
5. Medicaid Regulations (HCPF Code of Regulations)
6. Member Handbook

For copies of any of the specific criteria, or for questions about the UM program, please call 303-602-2100.

The following Provider Forms and Materials can be found on the website via the link below for reference:
denverhealthmedicalplan.org/provider-forms-and-materials

- Home Health Tips for Providers
- Services Requiring Prior Authorization
- UM Prior Authorization Request Form
- Medicare Provider Forms
- Oxygen Request Form
- Oral/Enteral Nutrition Form
- Adult Orthotics and Prosthetics

The following table provides a summary of the timeliness requirements for UM to provide notification of decisions to members and providers. Timeliness requirements can also be found on the website at the

following link: denverhealthmedicalplan.org/utilization-management-um

Summary of the Timeliness Requirements for All Lines of Business

TYPE OF REVIEW	COMM/EXCHANGE (ALL)	MEDICAID & CHP+	MEDICARE (ALL)
DECISIONS			
Urgent/Concurrent	24 hours	72 hours	72 hours
Expedited/Urgent Preservice	72 hours	72 hours	72 hours
Expedited Specialty Rx Part B Drugs	72 hours	72 hours	24 hours
Standard/Preservice	15 calendar days	10 calendar days	14 calendar days
Standard Specialty Rx Part B Drugs	15 calendar days	10 calendar days	72 hours
Retrospective/Postservice	30 calendar days	30 calendar days	30 calendar days
EXTENSIONS			
Urgent/Concurrent	48 hours	14 calendar days	14 calendar days
Expedited/Urgent Preservice	48 hours	14 calendar days	14 calendar days
Standard/Preservice	14 calendar days	14 calendar days	14 calendar days
Retrospective/Postservice	None	None	None

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 table may be used in those cases wherein the Provider needs additional time to provide sufficient information to make a determination.

The Company has posted Services Requiring Prior Authorization and the UM Prior Authorization Request Form on the website. See link below:
denverhealthmedicalplan.org/provider-forms-and-materials

ALL FIELDS MUST BE COMPLETED ON THE FORM AND THE REQUEST NEEDS TO INCLUDE CLINICAL RECORDS SUPPORTING MEDICAL NECESSITY IN ORDER TO PROCESS THE REQUEST.

Prior Authorizations should be faxed to the following numbers:

- Inpatient Admissions: 303-602-2127
- Outpatient Services and Elective Admissions: 303-602-2128
- Urgent/Expedited Services: 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.
- c. Seriously jeopardizes the enrollee's ability to attain, maintain or regain maximum function.

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 standard request and will be completed within the standard timeframe. See the above Summary of the Timeliness Requirements for All Lines of Business Table or on the website with link below denverhealthmedicalplan.org/utilization-management-um.

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 Health Plan Services at 303-602-2100.

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 Prior Authorization 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 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 IX: 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

- formulary change 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 brand is requested for a drug that has a generic available, 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:
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:
 - 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;
 - Serious impairment to bodily functions; or
 - 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 X: CARE COORDINATION 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 Care Managers have 52 expertise in case management and care coordination and focus solely on managing the more challenging and complex situations.

This department includes three care 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 care 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 Care Coordination Department includes the following:

1. Care Support Services: A team of non-clinical, bilingual staff (Health Plan Care Coordinators) 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. Transitions of Care (TOC): Provides short-term, 30day, intensive management and support for Members identified as high-risk during an acute inpatient admission setting
4. Care Coordination (CC): 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 care 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 CC Department can be made either through Denver Health Medical Plan's website referral form or by emailing a referral form to DHMPCC@dhha.org. Providers can also obtain more information by calling 303-602-2184 or visiting denverhealthmedicalplan.org.

SECTION XI: WELL-BEING SERVICES

ONLINE WELL-BEING PROGRAM

The online well-being program offers self-management support and information to individuals as they address health care needs and make health behavior changes. The services offered through the program are voluntary and are provided at no cost to the Company's Members.

Online workshops are available to Commercial and Medicare Members for 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

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 healthy 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 XII: 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

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, initiatives, and policies related to this purpose.

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
- 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
- Preventive health promotion
- Patient safety
- Complex health needs
- Adequacy and availability of services
- Clinical practice and preventive 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
- Management of asthma in adults and children
- Diabetes management
- ADHD in children and adolescents

All of the guidelines can be found at denverhealthmedicalplan.org at the bottom of the home page under the link titled “Quality Improvement”.

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

For more information on EPSDT services, please reference the Medicaid Preventive Health Services section.

SECTION XIII: HEALTH PLAN SERVICES DEPARTMENT

Providers should be aware that Health Plan Service Representatives are available for program Members and Providers to help solve problems, answer questions and provide information about benefits, services, eligibility and other available resources. For Providers, Health Plan Services is available Monday through Friday from 8 a.m. to 5 p.m. for Commercial, Medicaid, CHP+ and Medicare plans. For program Members, Health Plan Services is available Monday through Friday from 8 a.m. to 5 p.m. for Commercial, Medicaid and CHP+ members, and from 8 a.m. to 8 p.m. for Medicare members. They can be reached at 303-602-2100 or 1-800-700-8140 for Commercial & CHP+ plans; 303-602-2116 or 1-855-281-2418 for Medicaid Choice; 303-602-2111 or 1-877-956-2111 for Medicare Select/Choice plans; 303-602-2090 or 1-855-823-8872 for Elevate Exchange plans. For the hearing impaired, use TTY line 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 DHMP. Members of DHMP have a right to obtain all information provided within the Member Handbook at any time upon request. The health plan also makes available, upon request, additional information about the plan such as the structure and operation of DHMP and information about Physician Incentive Plans.

Members are mailed a Member newsletter on a quarterly basis. This newsletter contains important information and updates about the plan. Additionally, each Member is provided written notice of any

significant change to the following information, and will be provided 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 DHMP
- Benefits available to Member that are not through DHMP
- 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

TERMINATION OF PCP/PATIENT RELATIONSHIP

PCPs may request a Member's discharge from their practice by contacting the Health Plan Services Department at numbers listed by applicable line of business in this section. 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 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 Health Plan Services Department at numbers listed by applicable line of business in this section to verify that a Patient is eligible to receive services. For information on Real Time Eligibility (RTE), visit 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:

- 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 Medicaid case and a State ID can be generated for the newborn.
- If the mother is a Medicaid Member when newborn is born, then the newborn is guaranteed coverage for the first year under "Eligible Needy Newborn". If the newborn has been discharged and the Mother is a DHMC member, newborn should be too.
- 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.

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 numbers listed by applicable line of business in this section . 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 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 XIV: 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. QOCCs include all Serious Reportable Adverse Events (SRAEs), Never Events (NEs) and Hospital Acquired Conditions (HACs).

Members have the right to file grievances. Members, or their designated representative, must file their grievance within a certain amount of time from the incident. This time frame varies by line of business. Please refer before for the time in which grievance must be filed to be valid:

- Medicare Part C and D: 60 calendar days from the incident
- Commercial: 180 calendar days from the incident
- Medicaid/CHP+: Grievances may be filed at any time. Medicaid and CHP+ Members/DPRs may file a grievance at any time; there is no time limit for Medicaid/CHP+ members/DPRs. They may call the Grievances and Appeals department at 303-602-2261 (toll-free at 1-800-700-8140) or they may contact the Grievances 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 the form can be found on our website denverhealthmedicalplan.org. 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 Grievances and Appeals Department
777 Bannock St., MC 6000
Denver, CO 80204

AFTER FILING A GRIEVANCE

After receiving a grievance, the Company sends the member, or the member's DPR a written acknowledgment letter to confirm the grievance was received. Letters are sent following the guidelines below:

- Medicare: within 5 business days of receipt
- Commercial: within 5 business days of receipt
- Medicaid/CHP+: within 2 business days of receipt

The outcome of the grievance investigation and the date it was completed is sent to the member or the member's DPR. Members are notified (either orally or in writing) about grievance outcomes as expeditiously as the member's health condition requires but not to exceed the timeframes below:

- Medicare: Standard grievance 30 calendar days from receipt of the grievance. Expedited grievances – 24 hours
- Commercial: Standard grievances - 30 calendar days from receipt of the grievance. Expedited grievances – 72 hours
- Medicaid/CHP+: 15 business days from the receipt of the grievance

The member or their DPR may request an extension of the timeframe for the Company to complete its investigation. The Company may also request an extension if more information is needed and if the extension is in the member's best interest. The Company sends a letter informing the member or their DPR of the extension and the reason for the extension. If extended, the timeframe before a resolution letter is sent will be extended by the guidelines below:

- Medicare: 14 calendar days
- Commercial: 15 calendar days
- Medicaid/CHP+: 14 calendar days

IF MEMBER NEEDS HELP FILING A GRIEVANCE

The Company gives 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.

MEMBER 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 made by the Company is not right, the Member/DPR has the right to call or write the Company to Appeal the Adverse Benefit Determination.

HOW TO FILE A MEMBER APPEAL

Members, or their designated representative, must file their appeal within a certain amount of time from the date of the Notice of Adverse Benefit Determination. This time frame varies by line of business. Please refer below for the time in which appeals must be filed to be valid:

- Medicare Part C and D: 60 calendar days from the date of the Notice of Adverse Benefit Determination
- Commercial: 180 calendar days from the date of the Notice of Adverse Benefit Determination
- Medicaid/CHP+: 60 calendar days from the date of the Notice of Adverse Benefit Determination

First level appeals may be received verbally or in writing.

To Appeal an Adverse Benefit Determination, the Member/DPR may call the Grievance and Appeal Department or they may fill out the Appeal form in the back of the Company's Member Handbook (form is located on our website denverhealthmedicalplan.org), and fax to 303-602-2078, or mail to:

Denver Health Medical Plan, Inc.
Attn: Grievances and Appeals Department
777 Bannock St., MC 6000
Denver, CO 80204

FILING AN EXPEDITED MEMBER 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 request an expedited appeal by notifying the Grievance and Appeal Department at 303-602-2261 or toll-free at 1-800-700-8140. If an expedited Appeal is approved, the Company makes a decision on the Appeal and provides notification of the decision as expeditiously as the Member's health condition requires, but not to exceed 72 hours after the Company receives the Appeal.

If the Company denies a request for an expedited Appeal, the Company gives the Member/DPR prompt oral notice of the denial and send the Member/DPR a written notification within 2 business days. The Company processes 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 A MEMBER APPEAL

After receiving an appeal, The Company will send the member or the member's representative a written acknowledgment letter to confirm the appeal was received. Letters will be sent following the guidelines below:

- Medicare Part C: Acknowledgment letters will be sent within 5 business days of receipt
- Medicare Part D: No acknowledgment letter will be sent
- Commercial: Acknowledgment letters will be sent within 5 business days of receipt
- Medicaid/CHP+: Acknowledgment letters will be sent within 2 business days of receipt

MEMBER 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:

Standard Appeal Timeframes

- Medicare Part C Pre-service: 30 calendar days from receipt of the appeal
- Medicare Part C Post-service: 60 calendar days from receipt of the appeal
- Medicare Part D or Part B Drug: 7 calendar days from the receipt of the appeal
- Elevate Pre-service (written appeal review)/Commercial Large Group Pre-service: 30 calendar days from receipt of the appeal
- Elevate Post-service (written appeal review)/Commercial Post-service: 60 calendar days from receipt of the appeal
- Elevate (appeal committee review for pre and post-service review): committee meeting will be held within 60 calendar days from the receipt of the appeal request with notification of the decision sent within seven (7) calendar days
- Medicaid/CHP+: 10 business days from the receipt of the appeal

Expedited Appeal Timeframes

- *Medicare Part C: 72 hours from receipt of the appeal
- *Medicare Part D or Part B Drug: 72 hours from receipt of the appeal
- *Elevate/Commercial Large Group: 72 hours from receipt of the appeal
- *Medicaid/CHP+: 72 hours from receipt of the appeal

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 further appeal rights and how to pursue them. Oral notification is also provided for expedited appeals.

MEMBER APPEAL TIMEFRAME EXTENSIONS

The member or their DPR may be able to request an extension of the timeframe for the Company to complete its investigation. The Company may be able to also request an extension 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 of their DPR of the extension and the reason for the extension. If extended, the timeframe before a resolution letter is sent will be extended by the guidelines below:

Standard Appeal Extensions:

- Medicare Part C: 14 calendar days
- Medicare Part D or Part B Drug: No extension is allowed
- Commercial: No extensions are allowed
- Medicaid/CHP+: 14 calendar days

Expedited Appeal Extensions:

- Medicare Part C: 14 calendar days
- Medicare Part D or Part B Drug: No extension is allowed
- Commercial: No extensions are allowed
- Medicaid/CHP+: 14 calendar day

GETTING HELP FILING A MEMBER 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 MEMBER APPEAL

The Company has an internal second-level appeal process which applies to Commercial large group members 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 must file a second-level Appeal in writing within 60 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

SECOND-LEVEL APPEALS COMMITTEE***For Commercial Large Group member members:***

A committee will conduct this review. All committee members will not have been involved in any prior decision of or off the first level appeal, nor will they be subordinates of previous decision makers. The member has the right to participate in the review in person or by telephone conference, but is not required to. The member is notified in writing in advance as to when the committee meeting will occur, and if the member/DPR wishes to participate they can present their position to the committee.

For Elevate Exchange members:

Elevate members only have one level of internal appeal. If a Member/DPR is not satisfied with the Company's first level review decision, they may request an external review upon receipt of DHMP's decision.

For Medicare Choice>Select members:

Instead of a second-level Appeal with the Company, the next steps for appeals for Medicare Members include:

- The Independent Review Entity (IRE) appeal review
- All Part C partially favorable or adverse appeals decisions are forwarded by the Company to the IRE for

review. The Member/DPR does not have to make a request for an IRE appeal review

- For all Part D IRE requests, Members/DPRs or the member's prescribing physician or other prescriber acting on behalf of the member (in accordance with §423.600(a)) must file a request with the IRE within 60 calendar days from the date of the notice of the appeal decision
- IRE processing timeframes:
- Part C Standard pre-service request: 30 days
- Part C Post service request: 60 days
- Part B Drug request: 7 days
- Part D Standard Pre-service request: 7 days
- Part D Payment request: 14 days
- Part C Expedited request: 72 hours
- Part D Expedited request: 72 hours
- Post service and Part B drug requests cannot be expedited

Following an IRE decision, a Member may be eligible for additional levels of appeal review. There are no statutory or regulatory decision-making timeframes for Part C appeals at the third level of review and beyond.

- Administrative Law Judge (ALJ) review
- A request must be filed within 60 calendar days of receipt of the IRE decision
- Part D ALJ processing timeframes:
- Standard requests: Generally within 90 calendar days
- Expedited requests: Generally within 10 calendar days
- Appeals Council review
- A request must be filed within 60 calendar days of receipt of the ALJ decision.
- Part D Appeals Council processing timeframes:
- Standard requests: Generally within 90 calendar days
- Expedited requests: Generally within 10 calendar days
- Judicial Review
- A request must be filed within 60 calendar days of receipt of the Appeals Council review

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

For Medicaid and CHP+ members:

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's appeal process. The Member has 120 days from the date of notice of adverse action to request a hearing

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 Grievances and Appeals Department at 303-602-2261.

REQUEST FOR EXTERNAL REVIEW

If a Member/DPR is not satisfied with the Company's first level review decision (for Elevate members) or second level review decision (for Commercial large group members), they may request an external review upon receipt of DHMP's decision. The Member/DPR must file the request for an external review with the Company within four (4) months after the dated receipt of DHMP's adverse determination following the completion or exhaustion of the internal appeals process. The Member/DPR is eligible for a simultaneous external review of their first level appeal only if their appeal qualifies as urgent. 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 calendar 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 the Grievances and Appeals Department at 303-602-2261 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.

For Medicaid and CHP+ members, the Company will provide continuation of benefits during an appeal if all of the following are met:

- The appeal and request for continuation of benefits during an appeal must be requested on or before the later of:
 - » 10 days after the Notice of Adverse Benefit Determination is mailed or;
 - » The intended effective date of the proposed Adverse Benefit Determination
- The appeal applies to services previously approved and then denied or reduced
- The services were ordered by an authorized provider
- The authorization period has not expired
- Continuation of services must be requested by the member (not the provider)

If the Company continues or reinstate the member's benefits while the appeal is pending, the benefits are continued until one of the following occurs:

- The member withdraws the appeal or request for a State Fair Hearing
- The member does not request a State Fair Hearing with continuation of benefits within 10 days after the notice of an adverse appeal decision is mailed
- A State Fair Hearing decision adverse to the member is made
- The service authorization expires or the authorization limits are met

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.

SECTION XV: PROVIDER INQUIRIES, RECONSIDERATIONS AND DISPUTES

QUESTIONS ABOUT YOUR CLAIM PAYMENT OR HOW TO GET YOUR ISSUE RESOLVED?

The Company has three mechanisms in which you can inquire about a claims payment or denial. We offer a provider services help line, a written reconsideration process and finally a dispute process. Please note that your inquiry must follow the provider reconsideration process before the Company will accept your provider dispute.

Medicare claims denials for non-contracted providers follow a separate process than the steps outlined below. Please skip to the section below titled “Medicare Non-Contract Provider Disputes” for instructions.

1. *Inquiry:*

Please first contact our Health Plan Provider services line to discuss your issue and for assistance with routine questions or inquiries.

2. *Provider Reconsideration:*

If you disagree with your claims payment amount or denial from DHMP, you may submit a request for a claims reconsideration. Requests for reconsiderations must be submitted in writing on our reconsideration form (form is located on our website www.denverhealthmedicalplan.org). Submit the reconsideration form to the address found on the form.

DHMP allows 60 business days from date on your claim remittance advice (RA) to submit reconsideration requests. DHMP will review and reconsider your request within 30 business days of receipt of your request and our review determinations will be communicated via the provider RA. Following an adverse reconsideration determination, providers can submit a provider-carrier dispute to DHMP.

3. *Provider-Carrier Dispute:*

After you have requested a reconsideration of your claim determination from the Company, you may file a provider-carrier dispute if you disagree with our reconsideration decision. Requests for a provider-carrier dispute must be submitted in writing on our Provider Dispute form (form is located on our website at denverhealthmedicalplan.org). Submit the dispute form to the address found on the form. 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 dispute. Provider-carrier disputes must be received by DHMP within 30 calendar days of receiving your reconsideration determination. Only one provider-carrier dispute may be filed per claim.

- For participating providers, DHMP will review your dispute and provide our response to you within 45 calendar days (participating providers).
- For non-participating provider-carrier disputes, DHMP will review your dispute and provide our response to you within 90 calendar days.

This process does not apply to Utilization Review. If you have received a decision on a claim and have an issue with what was approved in an authorization, DHMP will uphold its original claim decision. No clinical review is performed on claims after the original pre-service UM decision Member appeal process has passed.

A provider has the right to designate a provider representative in the dispute resolution process. The representative has the right to present the dispute rationale in person, or if this is not practical through telecommunication or videoconference.

MEDICARE NON-CONTRACT PROVIDER DISPUTES

For Non-Contract providers who disagree with a claims payment amount:

1. Inquiry:

Please first contact our Health Plan Provider services line to discuss your issue and for assistance with routine questions or inquiries.

2. Medicare Non-Contract Provider Dispute:

If you disagree with your claims payment amount or denial from DHMP, you may submit a request for a claims dispute. Requests for disputes must be submitted in writing on our Provider Dispute form (form is located on our website at denverhealthmedicalplan.org). Submit the dispute form to the address found on the form. This form must have all required fields completed. Incomplete forms will be returned to the Provider. You must also submit a Waiver of Liability form (form is located on our website www.denverhealthmedicalplan.org) with your dispute request. Include all supporting documentation and evidence to support the dispute. Provider-carrier disputes must be received by DHMP within 60 calendar days of receiving your RA. Only one provider-carrier dispute may be filed per claim. Upon receipt of all required documentation, the Company will provide a written response to your dispute within 60 calendar days.

SECTION XVI: 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

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. 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.

- A. 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.
- B. 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.
- C. 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.
- D. 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 themselves 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 Respiratory 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.
- Directive Relating to CPR, C.R.S. 15-18.6-101, 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 XVII: 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 XVIII: 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 numbers listed by applicable line of business on page xxx 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 denverhealthmedicalplan.org/rte-transactions.

SECTION XIX: 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.

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.

SECTION XX: 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 MEDICAID CHOICE AND 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, Medicaid Choice, CHP+, other health care staff, and you – our member. Medicaid Choice and CHP+ are committed to partnering with you and your Provider. As a Medicaid Choice or 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 Forum.
- 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 MEDICAID CHOICE AND CHP+ HAVE THE FOLLOWING RESPONSIBILITIES:

Medicaid Choice and 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 Medicaid Choice or 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 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 including 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. The Company can also give the Member information in Braille, in large print, or other alternate formats at no cost if the Member needs it. The Company is 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.

- The Company must treat the Member with fairness and respect at all times.***

Our plan must obey laws that protect Members from discrimination or unfair treatment. The Company does 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 Annual Notice of Change (ANOC) / Evidence of Coverage (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 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 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 are 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.
- Inform Providers or a representative from DHMP when not pleased with care or service.

SECTION XXI: 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 (- Recombivax HB ®) or 10 gig of SmithKline Beecham (SB) vaccine (Fmgerix-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)
- The DHMP Care Management Team is available to help Providers connect to Care Management services by calling 303-602-2184. Care Management can also support families of Medicaid children (ages zero through 20) by assisting families with Medicaid and CHP+ resources; guiding families to appropriately use of Medicaid benefits; assisting with finding a Medicaid dentist; and assisting with coordination of transportation through the non-emergent medical transportation vendor, Intelliride at 303-398-2155

For more information please reference the DHMP Provider page, which can be found at:
denverhealthmedicalplan.org/early-and-periodic-screening-diagnostic-and-treatment-epsdt.

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 EPDST 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.

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 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 XXII: MEDICAID CHOICE 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.

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)

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.

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 Hospital excluded services include:

- Psychiatric/psychological care included and covered through the RAE Capitated Behavioral Health Benefit
- 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

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.

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.

Nurse Home Visitor Program: Home visiting program for first time mothers by Registered Nurses, with sites approved by and contracted with CDHS.

Portable and Liquid Oxygen: For specific procedure codes and descriptions of oxygen and oxygen equipment that are 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.

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

Prenatal Plus: Enhanced program for high risk pregnant women that provides a care coordinator, dietitian and mental health professional. The program is offered through four packages with approved services as listed in 10 C.C.R. 2505 – 10 §8.748.

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 Denver Health Medicaid Choice. 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
- Cavity Free at Three dental services
- 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
- 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 treatment for individuals aged 20 and under, DRG 772, as set forth in 10 CCR 2505-10, Section 8.300.4.5
- 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
- Pediatric Behavioral Therapies
- 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

ADDITIONAL INFORMATION:

No pre-existing condition limitations.

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

SECTION XXIII: DENVER HEALTH MEDICARE ADVANTAGE PROGRAM

DHMP HAS TWO MEDICARE ADVANTAGE PLANS FOR DENVER, ADAMS AND JEFFERSON 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 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 denverhealthmedicalplan.org/medicare-pharmacy.