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Section I Welcome!

Dear Provider,

Welcome! Thank you for becoming a participating provider with the Denver Health Medical Plan, Inc. We are glad you have chosen to participate.

The 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 healthcare services and related functions through, among other activities, the establishment and operation of a managed care organization to deliver quality, accessible, and affordable healthcare services in and around the City and County of Denver, Colorado. The Plan is a wholly owned subsidiary of the Denver Health and Hospital Authority, an academic, community-based, integrated healthcare system that serves as Colorado’s primary “safety net” system.

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

This manual explains your rights and responsibilities as a member of the Denver Health Medical Plan provider network in an easy to access, “user-friendly” format. Providers can contact DHMP for general information, policy clarification, or any other information related to this program. We can be reached at the numbers listed on the following page.
# DENVER HEALTH MEDICAL PLAN CONTACT LIST

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>Medical Director</td>
<td>303-602-2193</td>
<td>303-602-2081</td>
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<tr>
<td>Sarah Spillane, RN, BSN, MBA</td>
<td>303-602-2170</td>
<td>303-602-2126</td>
</tr>
<tr>
<td>Director of Utilization/Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachael Meir, PsyD</td>
<td>303-602-2184</td>
<td>303-602-2194</td>
</tr>
<tr>
<td>Director of Behavioral Health and Wellness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen Valentine, LCSW, CCM</td>
<td>303-602-2172</td>
<td>303-602-2139</td>
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<tr>
<td>Director of Intensive Case Management</td>
<td></td>
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<tr>
<td>Rosanne Day, RN</td>
<td>303-602-2147</td>
<td>303-602-2126</td>
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<tr>
<td>Manager of CM/UM</td>
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<tr>
<td>Michelle Beozzo, PharmD</td>
<td>303-602-2073</td>
<td>303-602-2081</td>
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<td>Director of Pharmacy Services</td>
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<tr>
<td>LeAnn Donovan</td>
<td>303-602-2002</td>
<td>303-602-2094</td>
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<tr>
<td>CEO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of QI/Accreditation</td>
<td>303-602-2051</td>
<td>303-602-2064</td>
</tr>
<tr>
<td>Laurie Goss</td>
<td>303-602-2065</td>
<td>303-602-2064</td>
</tr>
<tr>
<td>Director of Marketing and Commercial Products</td>
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<tr>
<td>Michael Robinson</td>
<td>303-602-2041</td>
<td>303-602-2096</td>
</tr>
<tr>
<td>Director of Contracting and Provider Relations</td>
<td></td>
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<tr>
<td>Jennifer Taylor</td>
<td>303-602-2124</td>
<td>303-602-2096</td>
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<tr>
<td>Credentialing Specialist</td>
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<tr>
<td>Provider Services Representatives</td>
<td>303-602-2046</td>
<td>303-602-2096</td>
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<tr>
<td>Patricia Williams</td>
<td>303-602-2014</td>
<td>303-602-2095</td>
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<td>Claims Manager</td>
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<th>MEMBER SERVICES</th>
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<tr>
<td>Richard French</td>
<td>303-602-2110</td>
<td>303-602-2138</td>
</tr>
<tr>
<td>Director of Member Services</td>
<td></td>
<td></td>
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<tr>
<td>Theresa Sager Foster</td>
<td>303-602-2112</td>
<td>303-602-2138</td>
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<tr>
<td>Customer Service Manager</td>
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<tr>
<td>Member Services</td>
<td>303-602-2116</td>
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<tr>
<th>COMPLIANCE</th>
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<tr>
<td>Lorna Pate, JD, MBA</td>
<td>303-602-2004</td>
<td>303-602-2074</td>
</tr>
<tr>
<td>Director of Compliance</td>
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Please visit us at [www.denverhealthmedicalplan.org](http://www.denverhealthmedicalplan.org)
Section II  Provider Responsibilities

Overview

Members of DENVER HEALTH MEDICAL PLAN will choose a specific provider who will be the member’s Primary Care Provider (PCP). The PCP is the manager of the member’s total health care needs. The PCP provides all routine and preventive medical services, as well as referrals for medically necessary diagnostic, specialist and hospital services. A formal referral process is typically required, with the exception of some limited specialty services that can be obtained without a referral. **HighPoint network members do not require referrals for specialty care.**

The primary care concept emphasizes keeping the member well. The goal of the Denver Health Medical Plan and the PCP is to educate the 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.

PCP Responsibilities

As a PCP, you have the responsibility to provide all routine and preventive primary care services to members of DHMP health programs who have you as a PCP. The PCP, as the manager of a patient’s care, initiates referrals for specialty care, if applicable. In addition, you will be actively involved in coordinating medically necessary care with other providers. Additional responsibilities include: having timely appointments available, participating in quality assurance utilization management programs, cooperating with quality improvement activities, complying with credentialing requirements, maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies, maintaining a separate medical record for each member, maintaining legible and comprehensive medical records for each encounter, allowing DHMP use of clinical and access performance data, and participating in the referral and prior authorization processes, as applicable.

Specialty Care Providers (SCP)

SCP’s are responsible for verifying member eligibility on the date of service before rendering the service, providing specialty consultation care as approved by the member’s PCP or the health program, providing additional services after discussing care with the PCP, and obtaining prior authorization from the health program for such services, as applicable. The SCP is also responsible for coordinating the member’s care with the PCP (including providing feedback to the PCP on services rendered and diagnoses identified within five business days of providing the service) and not making secondary referrals to other specialists for procedures or admissions without prior authorization, where applicable. The SCP is also responsible for communicating in writing their findings and recommendations to the patient’s nursing home. Record keeping requirements include maintaining confidentiality of medical information in compliance with all state and federal regulatory bodies, maintaining a separate medical record for each member, maintaining legible and comprehensive medical records for each encounter, participating in documenting the referral and prior authorization processes, as applicable, cooperating with quality improvement activities, and allowing DHMP use of clinical and access performance data.

Providers are explicitly prohibited from collecting payment, or attempting to collect payment through recipient for the cost or the cost remaining after payment for covered items or services rendered.

Reference: 8.012.2 A [www.sos.state.co.us](http://www.sos.state.co.us)
Moral or Religious Objections
As a DH Medical Plan provider you must notify us if you object to providing a service on moral or religious grounds. Please call Provider Relations at 303-602-2046.

As a Denver Health Medical Plan provider you should know that DHMP will not prohibit, or otherwise restrict any health care professionals from acting within the lawful scope of their practice, from advising or advocating on the behalf of a DHMP member who is the provider’s patient for the following:

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

Insurance
At all times providers must have insurance in the following kinds and amounts:
Worker’s Compensation Insurance as required by state statute, and Employer’s Liability Insurance covering all of contractor’s employees acting within the course and scope of their employment. Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operation, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:

- $1,000,000 each occurrence;
- $1,000,000 general aggregate;
- $1,000,000 products and completed operations aggregate; and
- $50,000 any one fire

If any aggregate limit’s is reduced below $1,000,000 because of claims made or paid, the Contractor shall immediately obtain additional insurance to restore the full aggregate limit and furnish to the State a certificate or other document satisfactory to the State showing compliance with this provision.

Automobile Liability Insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit as follows: $1,000,000 each accident combined single limit.
The Provider Relations Department is responsible for assisting in the full range of provider relations and service interactions within Denver Health Medical Plan, including working from beginning to end with provider contracting and pricing plus assisting with claim submission and proper payment.

The Provider Relations Department is responsible for building and maintaining positive relationships with providers. Provider Relations will work with providers to resolve issues and prevent issues from arising by serving as a liaison between DHMP and providers to facilitate positive communication and provide excellence in service; conducting routine and follow up visits to all priority providers as directed; and ensuring they are up to date with the most current information available.

The Provider Relations team is looking forward to a long successful relationship with each new provider. We are committed to providing excellent service in any issue that new or existing providers may have. We are dedicated to providing health care providers with the necessary tools, resources and information needed to understand the DHMP program and bill claims correctly.

Provider Relations has a dedicated web site to insure that providers are informed of all changes related to Denver Health Medical Plan:

www.denverhealthmedicalplan.org/providers

Provider Portal

As a contracted Provider you may want to consider accessing our web-based provider portal to verify eligibility for our members and check on claims status. If you would like more information, please contact Provider Relations at 303-602-2046/2047 or contact us via e-mail at: Managedcare.Providerrelations@DHHA.org
**Section IV  Credentialing and Re-credentialing of Practitioners**

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

DHMP’s provider selection policies and procedures include provisions that DHMP does not:

- Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her 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.

DHMP 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 his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

**Practitioner Rights**

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

DHMP credentials the following practitioners:

**Physical Health**
- Allopathic Physician (MD)
- Osteopathic Physician (DO)
- Doctor of Dental Sciences (DDS)*
- Doctor of Dental Medicine (DMD)*
- Podiatrist (DPM)
- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Physician Assistance (PA)
- Chiropractor (DC)

Non-physician practitioners who are licensed or certified by the state, have an independent relationship with the organization, and provide care under the organization’s medical benefits.

*Dentists who provide care under the medical benefit program only (i.e., Oral Surgeons)*
Certain practitioners that are exempt from the credentialing process are listed below. However, Denver Health Medical Plan does credential and re-credential hospital-based practitioners who provide care in an outpatient setting (i.e., anesthesiologist offering pain management services and University faculty who are hospital based and who also have private practices).

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

DHMP may delegate any or all elements of credentialing and re-credentialing responsibilities to a contracted entity but will perform oversight and is ultimately responsible to see that credentialing activities are performed according to DHMP standards. If these activities are delegated, there will be a mutually agreed upon document attached to the contract that describes the delegated activities and the responsibility for these activities. DHMP will perform a documented annual evaluation of each delegated entity’s credentialing activities.

### Council for Affordable Quality Healthcare (CAQH ProView)

DHMP 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 your professional and practice information. It helps reduce inquiries for administrative information and you can save even more time by keeping CAQH ProView profile complete and up-to-date. If you utilize CAQH, please ensure DHMP is authorized to have instant access to your information. If you are currently not utilizing CAQH ProView and are interested in participating and would like additional information, please contact your credentialing representative at 303-602-2124.

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

- Accurate completion and attestation to correctness of the most current Colorado Health Care Professional Credentials Application which contains questions regarding reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license, license sanctions, or felony convictions, history of loss or limitation of clinical privileges or disciplinary actions, and current malpractice insurance coverage amounts.
- Current, unrestricted license to practice medicine in the State of Colorado, and any other state in which the provider sees DHMP members.
- If board certified, current certification in field of practice; non-physicians must have a certificate, diploma or degree from an accredited program.
- Current DEA prescription number as applicable.
- Current Policy of professional liability insurance as stipulated in the Provider Agreement.
- Good standing with Medicare and Medicaid in any state in which the providers renders services to DHMP members.
Re-credentialing Requirement
The re-credentialing process takes place at least every three years. The elements listed under credentialing requirements are again reviewed and verified. The re-credentialing decision-making process may also incorporate information from the following sources:

- Member Grievances
- Provider Complaints
- Quality of Care Concerns
- Monthly monitoring activities
- Practitioner Office Site Quality issues
- Reports from Managed Care Provider Relations

Ongoing Monitoring of Practitioners
DHMP monitors for, identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

DHMP will review reports on a monthly basis regarding:

- Medicare/Medicaid Sanctions
- Sanctions or limitations on licensure
- Member complaints
- Practitioner adverse events
- Complaints related to office site quality
- When DHMP identifies such issues, it shall determine if there is evidence of poor quality that could affect the health and safety of its members and, depending on the nature of the event, implement appropriate interventions.

Practitioner Office Site Quality
Denver Health Medical Plan has a process to ensure that the practitioner offices meet the DHMP office site standards. DHMP will monitor member complaints regarding the following:

- Physical Accessibility: includes, but not limited to, ease of entry and accessibility of space within the building, including standards for physically disabled patients.
- Physical Appearance: includes but not limited to cleanliness, lighting, safety.
- Adequacy of waiting and examining room space: includes but not limited to adequate and appropriate size of seating for waiting rooms.
- Adequacy of Treatment Record Keeping: includes but not limited to file/record orderliness, security, confidentiality and documentation practices.

DHMP has set an acceptable threshold of 2 complaints received within 24 months regarding the elements listed above, and will perform a site visit once that threshold has been met.
Section V  Claims Submission

For claims submission information, please refer to our billing manuals on our website at http://www.denverhealthmedicalplan.org/provider-forms
Section VI Provider Inquiries

Provider Inquiries Regarding Claims Adjudication and Payment

Providers having questions about claims adjudication should review the DHMP Remittance Advice received with their payment. Questions regarding the remittance advice can be directed to DHMP Customer Service at (303) 602-2100, or faxed to (303) 602-2138.

RESUBMISSION OF A CLAIM

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

To re-submit a claim, re-date and re-sign a copy of the original claim and mark “RESUB” on the face of the claim. Include a copy of the remittance advice from Denver Health Medical Plan, Inc. (DHMP) with the original claim. Send re-submitted claims along with a letter of explanation as to why the claim is being resubmitted to:

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

Should a provider and DHMP not be able to resolve issues regarding claims adjudication, DHMP has established a Provider Carrier Dispute Resolution Process in accordance with Division of Insurance regulations. Providers who cannot resolve a disagreement in the normal course of business, as noted directly above, can use this process to request resolution. A Provider Carrier Dispute Resolution Form can be found in this Provider Manual (attachment 1) or contacting DHMP Provider Relations at (303) 602-2042. This form must have all required fields completed. Incomplete forms will be returned to the Provider. Include all supporting documentation and evidence that you have to support your request. You may fax the completed forms and documentation to (303) 602-2096 or mail to:

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

We will respond to your request within thirty (30) calendar days of receipt with the disposition of your request. This process does not apply to Utilization Review.
Section VII  Administrative Responsibilities

Appointment Standards
Member satisfaction is very important to Denver Health Medical Plan. Excessive waiting times for appointments are a major cause of member dissatisfaction with their health care provider and health program. Denver Health Medical Plan has established the following appointment standards for all contracted providers:

<table>
<thead>
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<th>Access to Services Standard</th>
<th>Timeframe</th>
<th>Compliance Goal</th>
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<tbody>
<tr>
<td>Emergency Care</td>
<td>24 hours a day, 7 days a week</td>
<td>100% of the time</td>
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<tr>
<td>Emergency Care—Behavioral Health Non-Life Threatening</td>
<td>Within 6 hours</td>
<td>100% of the time</td>
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<tr>
<td>Urgent Care—Medical and Behavioral Health</td>
<td>Within 24 hours</td>
<td>100% of the time</td>
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<tr>
<td>Primary Care—Routine Symptoms Non-Urgent</td>
<td>Within 7 calendar days</td>
<td>&gt;=90% of the time</td>
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<tr>
<td>Primary Care—Access to Afterhours Care</td>
<td>Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician</td>
<td>&gt;=90% of the time</td>
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<tr>
<td>Specialty Care—Non-Urgent</td>
<td>Within 60 calendar days</td>
<td>&gt;=90% of the time</td>
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<tr>
<td>Routine Behavioral Health Care</td>
<td>Within 10 business days</td>
<td>&gt;=90% of the time</td>
</tr>
<tr>
<td>Preventive/Well Visits</td>
<td>Within 30 calendar days</td>
<td>&gt;=90% of the time</td>
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<tr>
<td>Routine Behavioral Health Care — Follow-Up Care</td>
<td>Within 30 calendar days</td>
<td>&gt;=90% of the time</td>
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Wait Times
Wait times no longer than 30 minutes from the scheduled appointment time (except when provider is unavailable due to an emergency).

Denver Health Medical Plan 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 Denver Health Medical Plan providers for access issues.

The Denver Health Medical Plan 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 seven days a week, twenty-four (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 thirty minutes. The Denver Health Nurse Line is available at (303) 739-1211 twenty-four (24) hours a day, seven (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. Denver Health Medical Plan will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with DHMP.

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 means 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 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 Denver Health Medical Plan Utilization Management Department within 48 hours of the encounter. This can be accomplished by telephone or fax with the emergency room encounter note attached.

Denver Health Medical Plan 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.

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 Denver Health Medical Plan Utilization Management Department within 48 hours of the encounter. This can be accomplished by telephone or fax with the emergency room encounter note attached.

Denver Health Medical Plan 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 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. When transportation is provided in a true emergency, the member should notify Denver Health Medical Plan.
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. Denver Health Medical Plan is financially responsible for post-stabilization care services within or outside the network that are not pre-approved by DHMP, but are administered to maintain, improve, or resolve the member’s stabilized condition if:

- DHMP does not respond to the request of a facility providing post-stabilization care for pre-approval within one (1) hour of request;
- DHMP cannot be contacted; or
- DHMP and the attending provider at the requesting facility cannot reach an agreement concerning the member’s care.

In this situation, DHMP 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 DHMP physician or until the criteria below are met so that DHMP is no longer financially responsible for the post-stabilization care.

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

- A DHMP physician with privileges at the treating hospital assumes financial responsibility for the Member’s care;
- A DHMP physician assumes responsibility for the Member’s care through transfer;
- DHMP and the treating physician reach an agreement concerning the Member’s care; or
- The Member is discharged.

DHMP 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 DHMP.

**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.

**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 DHMP service area, or when the DHMP 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
- It was not reasonable given the circumstances to obtain the services through the DHMP provider network.
Prior approval or authorization is not required for Urgent Care Services. DH Medical Plan is responsible for payment for Urgent Care Services even if the facility is not contracted with DH Medical Plan 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 DHMP network.
Section VIII    Preventive Health Care

We encourage PCP’s 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 attachment 2 for the US Preventive Service Task Force (USPSTF) recommendations.

*Guidelines are subject to change so if you need clarification please call DH Medical Plan at 303-602-2046. New and revised guidelines will be sent periodically.*
Section IX Benefits and Limitations

Please refer to our website for current DHMP and Elevate benefit and limitations information.

Employer Group Plans for Denver Health, City and County of Denver, and Denver Police:

Elevate:
Section X  Utilization Management

The goal of the Utilization Management Department (UM) is to encourage the highest quality of care, in the most appropriate setting, from the most appropriate provider. Through the Utilization Management program, Denver Health Medical Plan seeks to avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines.

Denver Health Medical Plan uses both internally-approved guidelines and the following Interqual® Care Guidelines:
- Ambulatory Care (includes Durable Medical Equipment and Procedures)
- Inpatient Medical and Surgical Care (STAC and LTAC)
- General Recovery Guidelines (SNF, Acute Rehabilitation)
- Recovery Facility Care
- Home Care
- Behavioral Health Guidelines (Pediatric, Adult and Geriatric)
- Molecular Diagnostics

If you would like copies of any of the specific criteria, or if you have any questions about the Utilization Management program, please call (303) 602-2140.

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

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>COMM/Elevate (All)</th>
<th>MEDICAID &amp; CHP</th>
<th>MEDICARE (ALL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service/Prospective</td>
<td>15 Calendar Days</td>
<td>10 Calendar Days</td>
<td>14 Calendar Days</td>
</tr>
<tr>
<td>Expedited/Urgent Preservice</td>
<td>72 Hrs.</td>
<td>3 Working Days</td>
<td>72 Hrs.</td>
</tr>
<tr>
<td>Urgent Extension due to lack of info from member</td>
<td>Notify 24 hrs. /extend member time 48 hrs.</td>
<td>14 calendar days at enrollee requests</td>
<td>14 calendar days at enrollee requests</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 Hrs.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Urgent Concurrent Extension</td>
<td>72 Hrs.</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Retrospective/Post service</td>
<td>30 Calendar Days</td>
<td>10 Calendar Days</td>
<td>30 Calendar Days</td>
</tr>
<tr>
<td>Plans Extension for Standard or Retro</td>
<td>15 Calendar Days</td>
<td>14 calendar days</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Standard or Retro Extension due to lack of info from member</td>
<td>Notify 5 days, extend member time 45 days</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

* Decisions must be made within the stated days or hours of receipt of the request.

** By definition, there are no “urgent” posts-service/retrospective requests because the service has already been provided.

If the Utilization Management staff receives insufficient information to make a coverage determination, the staff will notify the provider of the specific information that is needed to make the determination. The extension timeframe in the above chart may be used in those cases in which the provider needs additional time to provide sufficient information to make a determination.

Please refer to our website for UM prior authorization forms:
http://www.denverhealthmedicalplan.org/utilization-management-um
Section XI Pharmacy Benefits - Denver Health Medical Plan

Denver Health Medical Plan (DHMP) - Large Group Pharmacy Webpage:  
http://www.denverhealthmedicalplan.org/pharmacy

Elevate Pharmacy Page:  http://www.elevatehealthplans.org/elevate-pharmacy

Pharmacy Department Contact Information:
• Phone: 303-602-2070
• Email: ManagedCarePAR@dhha.org
• Fax: 303-602-2081

Formulary
• DHMP and Elevate formularies:
  ○ Are located on the respective pharmacy webpages
  ○ The formulary updates document lists all updates
    ▪ On the DHMP pharmacy webpage this can be found under the Formulary/Drug List drop down
  ○ The formulary and formulary updates documents are updated quarterly
    ▪ The most current version can be found on the pharmacy webpages
    ▪ Copies are also available by request

• The formulary contains:
  ○ A list of covered drugs
  ○ Copayment information, including tiers
  ○ Drugs that require prior authorization
  ○ Limits on refills, doses or prescriptions

Generic Substitution
• Generic drugs are preferred on the formulary. Brand name drugs may be dispensed if the provider or member specifies the brand is required. When the brand is requested the member must pay their copay 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 Tier 3 copay.

Prior Authorization and Step Therapy Criteria
• The plan’s prior authorization and step therapy criteria can be found on the respective pharmacy webpages
• Criteria is updated quarterly
• The most current version can be found on the pharmacy webpages
• If a drug is non-formulary, all reasonable 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:
  - On the left side of the DHMP and Elevate pharmacy webpages
  - On the provider pharmacy webpage: [http://www.denverhealthmedicalplan.org/provider-pharmacy-information](http://www.denverhealthmedicalplan.org/provider-pharmacy-information)
  - On the provider forms webpage: [http://www.denverhealthmedicalplan.org/provider-forms](http://www.denverhealthmedicalplan.org/provider-forms)
  - Available by request

- Completed forms should include all pertinent medical necessity information
  - Incomplete requests may be pended while the Pharmacy Department outreaches to the provider to obtain the required information. If the required information cannot be obtained, the request may be denied.

- Prior authorization forms (see attachment 4) may be submitted by:
  - Fax
  - Email
  - Verbal by phone
  - Online upload from the provider forms webpage by clicking the “Click Here to Upload a Pharmacy Prior Authorization Form” link

- A request may be marked urgent to expedite the review 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.
  - Non-urgent requests received outside of business hours will be processed during the next business day.

- 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 Denver Health Medical Plan. Emergency and after-hours overrides are available 24 hours per day 365 days per year at 1-800-788-2949.
Section XII  Intensive Case Management

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

The Department includes three case management programs and a team dedicated to outreach and care coordination; each of which is an opt-out program available at no cost to any individual enrolled in any of the Denver Health Medical Plan (DHMP) insurances plans. Services and programs are designed to support the mission of DHMP by promoting members efforts to play an active and effective role in their care and addressing the social and behavioral determinants of health care outcomes. By providing case management services in an insurance (payer-based) setting, our focus is on the health and wellness of our members as well as being a liaison between providers of care.

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

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

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

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

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

Our case management staff works with members, families, and health care providers to make sure our 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 reassessment
- 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 Intensive Case Management Department can be made either through Denver Health’s internal Appointment Request List (ARL) referral system or email a referral form to caresupport@dhha.org. Providers can also obtain more information by contacting us directly at (303) 602-2080 or www.denverhealthmedicalplan.org.
Section XIII  Behavioral Health and Wellness Services

Health Coaching Program

Health Coaching offers self-management support, motivation, encouragement and compassion to individuals as they address chronic health care needs or make health behavior changes. The services offered through the program are voluntary and are provided at no cost to Denver Health Medical Plan members.

Health Coaches work with members who have a variety of health conditions or wellness goals including:

- Asthma
- Congestive Heart Failure
- Depression/Anxiety
- Diabetes
- Eating healthier
- High Blood Pressure
- Medication Adherence
- Pain Management
- Physical Activity
- Smoking Cessation
- Stress Management
- Weight Management

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

Health Coaching supports YOU and YOUR patients by helping them:

- Understand their diagnoses
- Become motivated to actively manage their health
- Make short and long-term goals to improve health
- Implement new lifestyle changes to reduce health risks
- Identify and address barriers to care
- Get connected to appropriate resources
- Learn self-care skills and strategies that follow your treatment plan
- Feel more prepared for clinic visits

For more information or to refer a member for Health Coaching, please contact Care Support Services at:

**Phone:** (303) 602-2080  
**Fax:** (303) 602-2194  
**Email:** caresupport@dhha.org  
**Web:** [www.denverhealthmedicalplan.org](http://www.denverhealthmedicalplan.org)
The National Diabetes Prevention Program (DPP) at Denver Health

Since 2013 over 2,000 patients have enrolled in our rolling, yearlong classes. Patients completing the program have lost 5% of their body weight on average. Individuals have lost up to 60 pounds! The DPP is an effective intervention for patients with prediabetes or other risk factors like overweight/obesity. We encourage 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. We now also offer 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. We will verify eligibility as needed:

- BMI of ≥ 24
- Prediabetes (e.g., A1c 5.7-6.4) in the past year OR History of Gestational Diabetes
- Sedentary lifestyle

How to refer your patients?

- Refer through 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 new diagnosis of diabetes and feel more confident about their health. By the end of the program they will learn:

- How to monitor blood sugar
- What their target blood sugar level should be
- 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 towards treating symptoms of depression and/or anxiety. Each of the modules will have up to 3 therapy calls. The module topics include: Managing Stress and Anxiety, Behavioral Activation, Coping with Illness, Managing Chronic Pain, Changing Negative Thoughts, Improving Sleep, Eating Healthy, Increasing Exercise, Improving Interpersonal Relationships, Grief and Loss, and Problem Solving.

For more information on the Telephonic Counseling for Depression and Anxiety program, please contact Christine Garcia at:

Phone: 303-602-2185
Email: Christine.Garcia@dhha.org
Learn and Burn Program
Behavioral Health and Wellness Services offers a monthly mixed health education and physical activity seminar series which is open to anyone with an interest in learning more about health and wellness. Topics vary but have included: Mind–Body Connection, Diabetes Care, Taking Care of Your Heart, How to Sleep Better at Night, Dealing with Stress, and Health Family Eating to name a few.

When: First Thursday of each month from 10:00 – 11:00 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 no cost education classes to Denver Health Medical Plan and Denver Health Medicaid Choice 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.

Cooking Matters at the Store
Patients can join us for a guided grocery store tour for tips on buying healthy, nutritious and affordable food to feed their family!

They will practice skills like:
• Buying fruits and vegetables on a budget
• Comparing unit prices to find bargains
• Reading and comparing food labels
• Identifying whole grains and sticking to your budget!

After the tour, they will receive:
• A workbook full of tasty recipes and simple tips on buying
• Healthy, low-cost foods
• Reusable grocery bag
• Calculator

Cooking Matters
This 6 week class is geared towards your patients who have little time to shop and cook and want to learn how to make a healthy meal for a family of four on a $10 budget.

We present:
• How to choose and make healthy snacks and meals
• Hands on food lessons
• What makes a good balanced diet
• Tips for chefs and nutritionists

What they will get:
• Opportunity to prepare and enjoy food as a class
• A tour of a local grocery store
• Information on how to get food stamps
Section XIV  Quality Improvement

The Quality Improvement Program (QI) is designed to support the mission of Denver Health Medical Plan (DHMP) by promoting the delivery of high-quality accessible healthcare services that will enhance or stabilize the health of DHMP 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. Performance metrics 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 (done annually)
- Member Services call data
- Medical record review
- Claims data
- Open Shopper studies
- Pharmacy data
- Case management data
- Utilization data
- Behavioral Health and Wellness data

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

DHMP uses a continuous improvement cycle where designated staff conducts a measurement of performance indicators, assesses and prioritizes the indicators on which we may improve, and then plans, implements, and evaluates interventions to improve the quality of care, quality of service, and patient safety of members. Data is collected on a prospective, concurrent, and/or retrospective basis dependent on which type best meets the measurement need. Quality Improvement data is 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. Quality Improvement works collaboratively with various DHMP departments to develop and implement initiatives targeted at improving clinical care, outcomes, safety and service.

DHMP network providers must agree to cooperate with QI activities and allow DHMP 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 DHMP members, and (2) to evaluate the manner in which care and services are delivered to these individuals. The Quality Improvement team is committed to maintaining a standard of excellence and enacts/monitors programs, initiatives, and policies related to this purpose. The subsequent section summarizes our member goals and strategies for meeting these aims.

The QI Program strives to achieve the following goals for all members:

- Measure, analyze, evaluate and improve the administrative services of the plan
- 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/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:
• Design and maintain the quality improvement structure and processes that support continuous quality improvement (CQI). The summarized approach to achieve this aim is as follows: (1) analysis of available data, (2) trending and barrier/root cause analysis of measures, (3) implementation of intervention(s), and (4) re-measurement of targets
• Assure compliance with all federal and Colorado state statutes and regulatory/contractual requirements.
• Objectively and systematically measure and analyze HEDIS, CAHPS 5.0 H, and other access/customer service data to promote improvement in member satisfaction
• Monitor member satisfaction and identify/address areas of dissatisfaction through an annual review of the following data: (1) CAHPS 5.0 H, (2) member feedback, (3) grievance and appeals data and (4) quality of care complaint(s)
• Monitor and maintain safety measures and address identified problems
• Design and maintain a chronic care improvement program that objectively and systematically measures and analyzes its health outcomes and enrollee satisfaction data
• Conduct an annual practitioner survey to evaluate satisfaction with the medical management process and services
• Monitor access reports and identify improvement opportunities for implementation
• Monitor and analyze targeted HEDIS® measures for health disparities and develop appropriate interventions
• Empower members to lead a healthy lifestyle through health promotion activities, community outreach efforts, and coordination with public and private community resources
• Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines
• Facilitate the participation of providers, the interdisciplinary care team and members in the QI Program.
• Communicate improvements in the QI Program to all stakeholders
• Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis
• Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
• Participate in the annual external independent review of quality outcomes. This 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 DHMP 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 Continuous Quality Improvement (CQI) of healthcare services. Areas targeted for CQI include:

- Cultural and Linguistic Member Needs
- Behavioral Health and Wellness Promotion
- Preventive Health Promotion
- Patient Safety
- Complex Health Needs
- Adequacy and Availability of Services
- Clinical and Practice Guidelines
- Continuity and Coordination of Care
- Quality of Care Complaints
- Member Satisfaction
- Practitioner Satisfaction
- Credentialing and Delegated Credentialing
- Delegation Activities and Oversight

Clinical Practice Guidelines

DHMP clinical and practice guidelines are developed, analyzed and posted annually. They are also distributed free of charge upon request. DHMP consults with practitioners to develop and apply evidence-based clinical practice guidelines and involves practitioners in the annual review and updating of established guidelines.

Preventive guidelines:
- Pediatric, Adolescent and Adult Immunizations
- Care of Well Newborn
- Prenatal Care
- Routine Cervical Cancer Screening
- Smoking Cessation
- Well Child Visit
- Adolescent Health
- Clinical Preventive Health Recommendations for Adults
- Fall Prevention for 65+ and Above

Clinical guidelines:
- Treatment of Depression in Adults in Primary Care
- Pharmacologic Management of Congestive Heart Failure
- Management of High Risk Newborns after discharge
- Management of Asthma in Adults and Children
- Diabetes Management
- ADHD in Children and Adolescents

All of the guidelines can be found at denverhealthmedicalplan.org under the About Us/Quality Improvement section.
Section XV  Member Rights and Responsibilities

Denver Health Medical Plan’s expectation is that health plan staff, 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. Denver Health Medical Plan informs Members of their specific rights and responsibilities through the Member Handbook. As a Denver Health Medical Plan provider, you are to understand and provide all care with respect to the rights and responsibilities of Members in the Denver Health Medical Plan.

Member’s Rights

Members have the right to:

- 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 primary care provider within the network of providers, to contact your primary care provider 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 Quality Improvement 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 primary care provider 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 Member 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 primary care provider 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.

Member’s 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 primary care provider.
• 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.)

Member’s 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 identification card available at the time of service and pay for any charges for non-covered benefits.
• To report your symptoms and problems to your primary care provider 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 primary care provider suggests.
• To get a referral from your primary care provider 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 Member Services representative with any questions.
• Inform providers or a representative from DHMP when not pleased with care or service.
Section XVI  Member Services Department

As a provider, you should be aware that Member Service Representatives are available for program members and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. to help solve problems, answer questions and provide information about benefits, services, eligibility, how a member can join the DHMP consumer advisory committee and other available resources. They can be reached at (303) 602-2100 or 1(800)-700-8140 (TTY/TDD line for the hearing impaired at 711).

Member services performs the following functions:

Member Information
Members are provided a Member Handbook at the time of enrollment (and at any time following enrollment, upon request), a resource that assists Members in understanding the rules and benefits of their DHMP Plan. Members of DHMP have a right to obtain all information provided within the Member Handbook at any time upon request. To request a Member Handbook, Members should call Member Services. DHMP 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 Denver Health Medical Plan Member newsletter on a quarterly basis. This newsletter contains important information and updates about the DHMP Plan. Additionally, DHMP will provide each Member written notice of any significant change to the following information, and will provide written notice at least 30 days before the intended effective date of change:

• Member disenrollment rights
• Provider information
• Member rights and protections
• Grievance, appeal, and State fair hearing processes
• Benefits available to Members through 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

Grievances and Appeals
The Member Services Department coordinates the intake and disposition or resolution of member Grievances and Appeals. Please refer to Section VII of this Provider Manual to learn more about member grievances and appeals.

Termination of PCP/Patient Relationship
Primary care providers may request a member’s discharge from their practice by contacting the Member Services Department at (303) 602-2100. Reasons for the discharge could include but are not limited to: abusive behavior by the member, noncompliance and failure to keep or cancel scheduled appointments.

When the request is made due to abusive behavior or noncompliance, 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 Denver Health Medical Plan Medical Director, the member will be advised of the situation and compliance will be formally requested by Denver Health Medical Plan.
If the member still refuses to accept or comply with medical advice, treatment or procedures, then the Denver Health Medical Plan, 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 thirty-one days written notice.

A member may be terminated if the member’s behavior is disruptive, unruly, abusive or uncooperative to the extent that the ability of the Denver Health Medical Plan and/or the PCP to supply services to the member or other members is impaired. The Denver Health Medical Plan 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 thirty-one days written notice.

**Eligibility Verification**
Providers are responsible for determining that a patient is eligible for services. Call the Denver Health Medical Plan Member Services Department at (303) 602-2100 to verify that a patient is eligible to receive services.

**Newborn Eligibility**
A member’s newborn children are eligible to receive services under the Denver Health Medical Plan for the first 31 days. For Elevate plans, newborns are covered for the first 60 days of life.

**Primary Care Provider Changes**
Denver Health Medical Plan members can change primary care providers at will or for cause by calling the Member 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 primary care provider (PCP).

**Medical Interpretation and Translation Services**
Denver Health Medical Plan Members and Providers can access Medical Interpretation and Translation Services by contacting Member Services at (303) 602-2100. All oral non-English language interpretation services are available at no charge to the member. Member Services can provide the proper contact number for our interpretation services hot line as well as help providers access a medical interpreter.

DHMP 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 Member Services.

**Hearing Impaired**
Advance scheduling of American Sign Language Interpreters is necessary to assure their availability when needed. Please contact Member Services at (303) 602-2100 so that they can contact the Care Support Services during regular business hours to schedule an American Sign Language Interpreter.

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

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

A TDD/TTY is also located in the Member Services area and that telephone number is 711.
Section XVII 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 you as their Designated Personal Representative (DPR) by filling out a Designation of Personal Representative Form (attachment 4). Once you are the Member’s DPR, you 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 action, including but not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member’s rights.

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

Members have the right to file grievances. Members/DPRs have one hundred eighty (180) calendar days from the date of the incident to inform DHMP of their grievance. They may call the Grievance and Appeals department at (303) 602-2261 (toll free 1-800-700-8140) or they may contact the grievance team in writing. A written grievance must include the Member’s name, health plan identification number, address, and phone number. Members/DPRs may also fill out the grievance form located in the back of the DHMP Member handbook or attachment 5 of this manual. Members/DPRs have the option to fax a copy of a written grievance to DHMP’s secure fax line at (303) 602-2078.

Address for Concerns and Grievances:

Denver Health Medical Plan, Inc.
Attn: Member’s Grievance and Appeal Department
938 Bannock Street, Mail Code 6000
Denver, CO 80204-4507

After Filing a Grievance

DHMP will send the Member/DPR a written acknowledgment letter within five (5) business days to confirm that the grievance was received. As expeditiously as the Member’s health condition requires, but not to exceed thirty (30) calendar days, DHMP will send the Member/DPR a letter with the results of the outcome of the grievance and the date it was completed. The Member/DPR may request an extension of fifteen (15) calendar days for DHMP to dispose of the grievance. DHMP may also extend the grievance disposal time frame by up to fifteen (15) calendar days if more information is needed, and if the extension is in the Member’s best interest. DHMP will send a letter informing the Member/DPR of the extension and the reason for the extension.

If Member Needs Help Filing a Grievance

DHMP will give Members/DPRs reasonable assistance in completing forms and taking other procedural steps necessary for the Member to fully exercise his or her 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 Denver Health Medical Plan Grievance and Appeals department at 303-602-2261, toll free at 1-800-700-8140, or TTY/ TDD at 711.
Notice of Action Letter

A Notice of Action letter is a letter that DHMP sends the Member/DPR if DHMP is making any change (action) to any part of the Member’s DHMP current or requested services.

An Action could be considered any of the following:
- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner; and/or
- The failure to act within the timeframes for resolution of grievances and appeals as provided in 10 C.C.R. 2505-10, Section 8.209.

A Notice of Action Letter Must Include:
- The action that DHMP plans to take;
- The reason for the action;
- The Member’s/DPR’s right to appeal this action;
- The date when they need to appeal by;
- When they may ask to speed up the appeal process;
- How to keep getting services while the appeal is being decided; and,
- When the Member might have to pay for those services they obtained while a final ruling was pending.

Advance Notice of Action

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

Appeals

An appeal is a request that the Member/DPR makes to review an action that DHMP takes. If the Member/DPR thinks an action taken by DHMP is not right, the Member/DPR has the right to call or write DHMP to appeal the action.

How to File an Appeal

The Member/DPR has one hundred eighty (180) calendar days from the date of the notice of action letter to file an appeal. All appeals must be received in writing. If a Member/DPR verbally requests to file an appeal, the appeal process will not begin until the date of receipt of the written appeal and receipt of related personal representative documents, if applicable.
To appeal an action the Member/DPR may:

- Fill out the appeal form in the back of the DHMP Member handbook (and attachment 5 of this manual) and fax to (303) 602-2078 or mail to:

Denver Health Medical Plan, Inc.
Attn: Grievance and Appeal Department
938 Bannock Street, Mail Code 6000
Denver, CO 80204-4507

Filing an Expedited Appeal

DHMP maintains an expedited review process for appeals, used when DHMP 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. DHMP ensures that punitive action may not be taken against a provider who requests an expedited resolution of an appeal or supports a Member’s appeal.

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

If DHMP denies a request for an expedited appeal, DHMP will give the Member/DPR prompt oral notice of the denial and send the Member/DPR a written notification within five (5) business days. DHMP will process the request as a standard appeal rather than an expedited appeal. DHMP will give the Member/DPR a ruling on the appeal within fifteen (15) calendar days if it denies a request for an expedited appeal. The Member/DPR can call or write the Grievance and Appeals department to file a grievance if they feel DHMP shouldn’t have denied the expedited appeal request.

After Filing an Appeal

DHMP will send the Member/DPR a written notice that the appeal was received within five (5) business days of receipt, unless the Member/DPR has filed an expedited appeal.

Appeal Decisions

DHMP 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 Appeals 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 his or her DPR; or 2) the legal representative of a deceased Member’s estate.
DHMP must resolve each appeal and provide written notice of the disposition to affected parties as expeditiously at
the Member’s health condition requires, but not to exceed the following timeframes:

- For Standard appeal decisions, within fifteen (15) calendar days from the date DHMP receives the appeal.
- For Expedited appeal decisions, seventy-two (72) hours after DHMP receives the appeal (unless the
timeframe has been extended). For notice of expedited appeal resolution decisions, DHMP will also provide
oral notification to Members/DPRs.

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

**Appeal Timeframe Extensions**

DHMP may extend the timeframe for resolution of expedited and standard appeals by up to fifteen (15) calendar
days if the Member requests the extension or if DHMP shows there is a need for additional information, and that
the delay is in the Member’s best interest. If DHMP lengthens the time, it must have a legitimate reason and must
explain this reason to the Member/DPR in an extension letter. The extension letter must include information on the
Member’s/DPR’s right to file a grievance regarding the extension and how to file a grievance.

**Getting Help Filing an appeal**

DHMP will give Members/DPRs reasonable assistance in completing forms and taking other procedural steps
necessary for the Member to fully exercise his or her appeal 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 Denver Health Medical Plan Grievance and Appeals department at 303-602-2261, toll free
at 1-800-700-8140, or TTY/TDD at 711 to request assistance.

**Second Level Appeal**

If the Member/DPR is not satisfied with the first level appeal decision, they have the right to file a second level
appeal with DHMP. The Member/DPR may file a second level appeal within thirty (30) calendar days of the first
level appeal determination. Providers, acting on behalf of the Member and with the Member’s written consent, may
request a second level appeal and act as the Member’s authorized representative throughout the second level appeal
process and at the Appeals Committee review.

The Member/DPR may request a second level appeal when:

- Services the Member seeks are denied or the ruling to approve services is not acted upon in a timely manner;
- The Member/DPR believes the action taken is wrong.

To request a second level appeal, the Member/DPR must send a letter to the DHMP 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; and
- The reason for appealing the action, denial or failure to act quickly.

**Second Level Appeals Committee**

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

**Expedited Second Level Appeals**

For expedited second level appeal requests, at least two people will conduct the Appeals Committee review, a physician reviewer, and at least one non-clinician. The reviewers will take into consideration all comments, documents, records and other information regarding the request without regard to whether the information was submitted or considered in making the initial adverse determination. Additionally, all expedited pre-service appeal requests will be evaluated by a physician with the clinical expertise in the same or similar specialty and his or her input will be taken into consideration when rendering a determination by DHMP. Expedited second level appeals will be processed within seventy-two (72) hours of the receipt date.

**Second Level Appeal Timeframe Extensions**

Like first level appeals, DHMP may extend the timeframe for resolution of standard second level appeals by up to fifteen (15) calendar days if the Member requests the extension or if DHMP shows there is a need for additional information, and that the delay is in the Member’s best interest. Expedited second levels appeals may not be extended.

If you need help filing a second level appeal, DHMP will assist. Call the Grievance and Appeals department at (303) 602-2261.

**Request for External Review**

If the Member/DPR is not satisfied with the decision made at the second level appeal, he or she has the right to file a request, in writing, for an external review. The request for an external review must be made within four (4) months of the first level appeal decision and within sixty (60) days of the second level appeal decision. Members/DPRs must first exhaust the internal appeal process before requesting an external review. Once the request for external review is received, DHMP will notify the Colorado Commissioner of Insurance of the request and submit it to them within two (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 DHMP. Within five (5) business days of notification, DHMP will submit all related case information to the assigned independent external review entity to provide a ruling. The independent external review entity has forty-five (45) days to provide a ruling on the submitted appeal.

An external review decision is binding on DHMP and the Member/DPR except to the extent DHMP 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, DHMP will keep covering services while the Member waits for the ruling of an appeal. Members/DPRs must call Utilization Management at (303) 602-2140 to make known that they want DHMP to keep covering their services. If the final resolution of the appeal upholds the DHMP action (remains adverse to the Member), member may be held responsible for the cost of the services furnished to the Member while the appeal is pending.
Effectuation of Appeal Resolutions

For Services not furnished while the appeal is pending: If DHMP reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, DHMP 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 DHMP reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, DHMP must pay for those services in accordance with regulations.
Section XVIII  Advance Care Directives

I. PURPOSE
To Outline the policy and procedures to be utilized by Denver Health Medical Plan (DHMP) 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.).

II. POLICY
A. Competent adults (age 18 and over) have the right under state law to make decisions regarding health care, including the right to accept or refuse treatment, and the right to formulate Advance Directives.

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

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

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

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

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

III. DEFINITIONS: (All defined words in this document are capitalized)
A. Advance Directive: The general term used to describe written instructions from the Member concerning his/her 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 3 Advance Directives: Medical Durable Power of Attorney, Living Wills, and CPR Directives.

B. 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 either:

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., antiarrhythmics, 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.).

C. **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, his/her own values and goals; and communicate, verbally or nonverbally, his/her decisions.

D. **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 (2 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.

E. **Medical Durable Power of Attorney (MDPOA):** Medical Durable Powers of Attorney 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.

**IV. 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 DHMP 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. 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.
V. 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.
   1. 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 re-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 primary care provider. However, hospital staff will assist in the development of Advance Directives for Members who desire to do so. Assistance will be provided by:
   1. Having Advance Directive forms available for the Member to review or complete;
   2. 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;
   3. 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; and
   4. Encouraging the Member to direct questions to his/her primary care physician.

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

H. Medical Durable Powers of Attorney (MDPOA)
   1. 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.
2. In all cases, the Member retains the right under state law to consent to, or refuse, any proposed medical treatment as long as he or she possesses the capacity to make decisions. A MDPOA does not become effective until the Member has been deemed to lack decisional capacity.

3. 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).)

4. 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.

5. An MDPOA shall have the same rights of access to the Member’s medical records as the Member him/herself and may confer with the Member’s physician concerning the Member’s medical condition.

6. If a MDPOA is unable or unwilling to serve in that capacity, the appointment will be revoked. If a Member appointed a spouse as his or her 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

1. 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.

2. When a Member wishes to execute a living will during a hospital stay, the following individuals cannot serve as witnesses:
   a) The attending or any other physician;
   c) Any nurse or other employee of hospital;
   d) Any patient at hospital;
   e) Persons likely to inherit from the Member’s estate (such as family members or close friend) or anyone known to have a claim against the Member’s estate. (Hospital Volunteers are permitted to witness Living Wills).

6. 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:
   a) 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.
   b) 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.
   c) 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.
   d) The attending physician or designee has made a reasonable attempt to notify one of the following in the stated order: (a) the Member’s spouse; (b) any of the Member’s adult children; (c) a parent; (d) MDPOA.
e) No action to challenge the validity of the living will has been filed within 48 hours after certification by the two (2) physicians of the terminal condition.

4. 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.

5. 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.
   a) 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 conscience 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: Compliant Department Denver, Colorado 80246-1530, by phone: 303- 692- 2000 or 1-800-886-7689 (In-state), or by email: hfdintake@cdphe.statte.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.
   b) 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 must be reported under the Medical Practice Act, C.R.S. 12-36-117.
   c) 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.

6. Note: As long as a Member is competent and somehow able to communicate his/her treatment decisions, his/her Living Will is inapplicable even though he/she may in fact be in a terminal condition.

J. CPR Directives
1. 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 he/she lacks 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.

2. A CPR directive must contain the following information:
   a) The person’s name, date of birth and sex;
   b) The person’s eye and hair color and race or ethnic background;
   c) If applicable, the name of the hospice program in which the person is enrolled;
   d) The name, address, and telephone number of the person’s physician;
   e) 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;
   f) The person’s directive concerning the administration of CPR, which must be countersigned by the person’s physician; and
   g) If applicable, the person’s directive regarding tissue donation.
h) 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.

3. 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 his/her 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.

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

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

6. 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.

7. When a Member is admitted with Limited or No CPR status (or changes his or her status to Limited or No CPR), the Member’s physician shall also enter an Order into CPOE ordering Limited or No CPR, according to the Member’s wishes. If a Member later revokes a CPR directive, the CPOE Order must also be changed.

8. 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.

9. During any CPR, the physicians responsible for the Member’s medical care will make the final judgment as to what procedures are carried out.

10. 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.

11. 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 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.

12. If any disagreement exists between the Member, Member’s representative, or his/her family and a member of the medical care team about the CPR status, the attending physician or his/her 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 his/her designee may seek consultation with the Director of Service, 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. 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.

13. 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:
   a) 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.
   b) 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.
   c) 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.
   d) 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.

14. 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.

VI. REFERENCES
Section XIX  Coordination of Benefits and Subrogation

Coordination of Benefits (COB) occurs when DHMP 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, DHMP coordinates benefits under each plan according to rules issued by the State of Colorado Division of Insurance. For example, a DHMP member may also be covered as a dependent on his/her spouse’s health insurance plan. In addition, a DHMP 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. DHMP covers claims for services covered by the member’s benefit plan when claims are denied by the workers’ compensation insurer.

Subrogation

DHMP may pay medical bills for which another person (or his or her insurer) is legally responsible. DHMP 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, DHMP has the right to put a legal hold or “lien” on any court judgment or settlement. “Subrogation” occurs when DHMP assumes a member’s right to recover from a third party who caused the member’s injury or illness. In this case, DHMP pays our member’s claims and files legal documents to collect funds from the third party’s insurer. If providers are aware that a third party is liable for the cost of a DHMP member’s services, they should notify the DHMP Claim Department.
Section XX Member Eligibility and Identification

DHMP members are issued an identification card (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 Denver Health Medical Plan Member Services Department at (303) 602-2100 to verify that a patient is eligible to receive services. Refer to the member’s ID card to identify any member co-payment amounts for office visits, urgent/emergency care, prescriptions, etc.
Section XXI      HIPAA Privacy and Security

DHMP has established a comprehensive Privacy and Security policy to protect members from inappropriate use or disclosure of their protected health information (PHI). Under this policy, DHMP has implemented appropriate administrative, physical, and technical safeguards to ensure the security of electronic PHI. Our Notice of Privacy Practices is posted on our company website. A copy of the notice is also available upon request.

Confidentiality of and Access to Medical Records

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

DHMP 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, reinsurance, financial auditing, and member satisfaction processes.
- For quality management.
- For utilization management.
- For disease management activities.
- To furnish information to providers who are treating DHMP 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 DHMP 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 protected health information (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 quality improvement, 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)). DHMP’s utilization review activities and claims review practices are considered payment activity, and DHMP’s quality improvement, accreditation, case management and care coordination activities are considered health care operations activities. Therefore, the disclosure of health information by physicians to DHMP without an individual authorization from the patient for these purposes is permissible under the HIPAA Privacy Rule. DHMP recognizes that physicians are concerned with compliance to applicable privacy laws. We at DHMP share those same concerns and will proceed only in a manner that is consistent with applicable laws.
Section XXII Corporate Compliance Program (Including Fraud, Waste, and Abuse Prevention Program)

A. Compliance Statement and Code of Conduct

Compliance Statement and Code of Conduct
It is DHMP’s policy to conduct its business in compliance with the laws and regulations of the United States and the State of Colorado and to assure that DHMP operates in a manner consistent with the letter and the spirit of the law. DHMP is committed to compliance with such laws and regulations and intends to assure that DHMP’s activities and operations, as carried out by the employees and other agents of DHMP, are conducted in compliance with such laws and regulations. In recognition of this commitment, DHMP has developed a Corporate Compliance Program and a Code of Conduct that has been adopted and endorsed by the DHMP Board of Directors. We expect that every employee, subcontractor, agent, and provider of DHMP respect and adhere to our Corporate Compliance Program and Code of Conduct. Failure to follow our Corporate Compliance Program or Code of Conduct may lead to formal disciplinary action, including termination of a contract and relationship with DHMP.

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

Scope
The scope of the Corporate Compliance Program covers all employees, temporary employees, volunteers, and other work force members, subcontractors, vendors, and agents, including participating providers, including any related entities, of DHMP promoting compliance with applicable federal and state law and regulations while adhering to the highest ethical standards. The DHMP Corporate Compliance Program also includes the Privacy and Security Program, promoting the confidentiality, privacy and security of member protected health information, as well as the DHMP Fraud, Waste, and Abuse Prevention Program.

All employees, temporary employees, volunteers, and other work force members, subcontractors, vendors, and agents, including participating providers, including any related entities, of DHMP are advised as follows:
- No employee or agent of has any authority to act contrary to the provisions of the Code of Conduct, or to authorize, direct or condone violations by any other employee or agent of DHMP.
- Any employee or agent of DHMP who has knowledge of facts or incidents that he or she believes may violate the Code of Conduct or the Corporate Compliance Program has an obligation to promptly report the matter.
- Any employee or agent who violates the Code of Conduct or the Corporate Compliance Program, or who orders or who knowingly permits a subordinate to violate the Code of Conduct or the Corporate Compliance Program, shall be subject to appropriate disciplinary action which may include discharge or termination of his/her relationship with DHMP.
B. Reporting Concerns

Please tell us if you have a compliance concern. You can call our toll-free anonymous Compliance Hotline (Values Line), email us, or send us a letter via fax or mail.

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

<table>
<thead>
<tr>
<th>Compliance Hotline</th>
<th>1-800-273-8452 (available 24/7. Reports can be made anonymously</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:compliancedhmp@dhha.org">compliancedhmp@dhha.org</a></td>
</tr>
<tr>
<td>Fax</td>
<td>(303) 602-2074</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Denver Health Medical Plan, Inc.</td>
</tr>
<tr>
<td></td>
<td>ATTN: Compliance Officer</td>
</tr>
<tr>
<td></td>
<td>938 Bannock Street, Mail Code 6000</td>
</tr>
<tr>
<td></td>
<td>Denver, Colorado 80204</td>
</tr>
</tbody>
</table>

C. Confidentiality and Non-Retaliation for Good Faith Reporting

Reasonable efforts will be made to protect the confidentiality of those who are reporting. However, confidentiality cannot be guaranteed and will not be possible in some circumstances. Compliance issues will be discussed only with persons with an absolute “need to know.” DHMP does not discriminate or retaliate against any employee, agent, subcontractor, or provider for reporting a compliance concern or for cooperating in any government or law enforcement authority’s investigation or prosecution.

D. Prompt Response and Corrective Action

All reports of suspected or actual compliance violations and/or reports of suspected or actual suspected fraud, waste, or abuse are taken seriously and investigated by the DHMP Compliance Department. DHMP takes appropriate actions to mitigate any harmful effects and works to identify opportunities for improvement and corrective actions designed to correct any underlying problems.

E. Enforcement of Standards through Well-Publicized Disciplinary Guidelines

DHMP encourages its providers to report compliance concerns and resolve issues through discussion and cooperation between DHMP and the provider even prior to requiring the implementation of formal remedies. When DHMP becomes aware of information concerning a provider (or the office staff working on behalf of the provider) that warrants further review and possible corrective action, including both non-disciplinary and disciplinary action, DHMP will further investigate and render a formal determination into the matter.

F. Fraud, Waste, and Abuse Prevention Program

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

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

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

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

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

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

Non-Discrimination
Covered services are provided to members with the same degree of care and skill as customarily provided to provider’s patients who are not members, according to generally accepted standards of provider practice. Members and non-members should be treated equitably. No discrimination against Members on the basis of race, gender, creed, ancestry, age, religion, marital status, health status, sexual orientation, mental or physical disability, color, national origin, source of payment for sources, gender identity, or any other grounds prohibited by law.

Suspension and Termination
*Please note:* If DHMP determines that the health, safety, or welfare of members 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, DHMP may immediately terminate the provider from participation with DHMP. DHMP also may suspend such provider’s participation pending any appeal to which the provider is entitled to or by applicable agreement with DHMP.
Attachments

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

Date: _____________________________
Provider Name: _______________________________________________________________
Vendor Name: __________________________________________________________________
Vendor Tax Identification Number: _______________________________________________
DHMP (Denver Health Medical Plan) Claim Number: _________________________________
Date of Service(s): _____________________________________________________________
Subscriber or Member Name: _____________________________________________________
Subscriber or Member ID Number: _______________________________________________
Patient Name: __________________________________________________________________
Patient Date of Birth: ___________________________________________________________
Dollar Amount in dispute, if applicable: _____________________________________________
Provider position statement explaining the nature of the dispute (please attach copy of the DHMP remittance advice):
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Supporting Documentation: please attach
Proof of timely filing: please attach
Proof of authorization or authorization number, if the service in question requires authorization:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Contact Name: __________________________________________________________________
Address _________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
Telephone Number: ___________________________ Fax Number: _________________________
E-Mail Address if applicable: ____________________________________________________

Please mail back to:
Denver Health Medical Plan, Inc.
Provider Relations-Provider Dispute Resolutions
P.O. Box 24992
Seattle, WA 98124-0992
## U.S. Preventive Services Task Force (USPSTF) Recommendations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Grade</th>
<th>Release Date of Current Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm screening: men</td>
<td>The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.</td>
<td>B</td>
<td>June 2014</td>
</tr>
<tr>
<td>Alcohol misuse: screening and counseling</td>
<td>The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.</td>
<td>B</td>
<td>May 2013*</td>
</tr>
<tr>
<td>Anemia screening: pregnant women</td>
<td>The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>B</td>
<td>May 2006</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease: men</td>
<td>The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 2009</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease: women</td>
<td>The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 2009</td>
</tr>
<tr>
<td>Bacteriuria screening: newborns</td>
<td>The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later.</td>
<td>A</td>
<td>July 2008</td>
</tr>
<tr>
<td>Blood pressure screening in adults</td>
<td>The USPSTF recommends screening for high blood pressure in adults age 18 years and older.</td>
<td>A</td>
<td>December 2007</td>
</tr>
<tr>
<td>BRCA risk assessment and genetic counseling/testing</td>
<td>The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.</td>
<td>B</td>
<td>December 2013*</td>
</tr>
<tr>
<td>Breast cancer preventive medications</td>
<td>The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.</td>
<td>B</td>
<td>September 2013*</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.</td>
<td>B</td>
<td>September 2002†</td>
</tr>
<tr>
<td>Breastfeeding counseling</td>
<td>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td>B</td>
<td>October 2008</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>A</td>
<td>March 2012*</td>
</tr>
<tr>
<td>Chlamydia screening: women</td>
<td>The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.</td>
<td>B</td>
<td>September 2014*</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men 35 and older</td>
<td>The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.</td>
<td>A</td>
<td>June 2008</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men younger than 35</td>
<td>The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women 45 and older</td>
<td>The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>A</td>
<td>June 2008</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women younger than 45</td>
<td>The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>A</td>
<td>October 2008</td>
</tr>
<tr>
<td>Dental caries prevention: infants and children up to age 5 years</td>
<td>The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.</td>
<td>B</td>
<td>May 2014*</td>
</tr>
<tr>
<td>Depression screening: adolescents</td>
<td>The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</td>
<td>B</td>
<td>March 2009</td>
</tr>
<tr>
<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>B</td>
<td>December 2009</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Falls prevention in older adults: exercise or physical therapy</td>
<td>The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>B</td>
<td>May 2012*</td>
</tr>
<tr>
<td>Falls prevention in older adults: vitamin D</td>
<td>The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>B</td>
<td>May 2012*</td>
</tr>
<tr>
<td>Folic acid supplementation</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>A</td>
<td>May 2009</td>
</tr>
<tr>
<td>Gestational diabetes melitus screening</td>
<td>The USPSTF recommends screening for gestational diabetes melitus in asymptomatic pregnant women after 24 weeks of gestation.</td>
<td>B</td>
<td>January 2014</td>
</tr>
<tr>
<td>Gonorrhea prophylactic medication: newborns</td>
<td>The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.</td>
<td>A</td>
<td>July 2011*</td>
</tr>
<tr>
<td>Gonorrhea screening: women</td>
<td>The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.</td>
<td>B</td>
<td>September 2014*</td>
</tr>
<tr>
<td>Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors</td>
<td>The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.</td>
<td>B August 2014*</td>
<td></td>
</tr>
<tr>
<td>Hearing loss screening: newborns</td>
<td>The USPSTF recommends screening for hearing loss in all newborns.</td>
<td>B July 2008</td>
<td></td>
</tr>
<tr>
<td>Hemoglobinopathies screening: newborns</td>
<td>The USPSTF recommends screening for sickle cell disease in newborns.</td>
<td>A September 2007</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B screening: nonpregnant adolescents and adults</td>
<td>The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.</td>
<td>B May 2014</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B screening: pregnant women</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.</td>
<td>A June 2009</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C virus infection screening: adults</td>
<td>The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.</td>
<td>B June 2013</td>
<td></td>
</tr>
<tr>
<td>HIV screening: nonpregnant adolescents and adults</td>
<td>The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.</td>
<td>A April 2013*</td>
<td></td>
</tr>
<tr>
<td>HIV screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untreated and whose HIV status is unknown.</td>
<td>A April 2013*</td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism screening: newborns</td>
<td>The USPSTF recommends screening for congenital hypothyroidism in newborns.</td>
<td>A March 2008</td>
<td></td>
</tr>
<tr>
<td>Intimate partner violence screening: women of childbearing age</td>
<td>The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>B January 2013</td>
<td></td>
</tr>
<tr>
<td>Iron supplementation in children</td>
<td>The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.</td>
<td>B May 2006</td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening</td>
<td>The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</td>
<td>B December 2013</td>
<td></td>
</tr>
<tr>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</td>
<td>B June 2012*</td>
<td></td>
</tr>
<tr>
<td>Obesity screening and counseling: children</td>
<td>The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
<td>B January 2010</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis screening: women</td>
<td>The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.</td>
<td>B January 2012*</td>
<td></td>
</tr>
<tr>
<td>Phenylketonuria screening: newborns</td>
<td>The USPSTF recommends screening for phenylketonuria in newborns.</td>
<td>B March 2008</td>
<td></td>
</tr>
<tr>
<td>Preeclampsia prevention: aspirin</td>
<td>The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.</td>
<td>B September 2014</td>
<td></td>
</tr>
<tr>
<td>Rh incompatibility screening: first pregnancy visit</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A February 2004</td>
<td></td>
</tr>
<tr>
<td>Rh incompatibility screening: 24–28 weeks’ gestation</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>B February 2004</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infections counseling</td>
<td>The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.</td>
<td>B September 2014*</td>
<td></td>
</tr>
<tr>
<td>Skin cancer behavioral counseling</td>
<td>The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.</td>
<td>B May 2012</td>
<td></td>
</tr>
<tr>
<td>Tobacco use counseling and interventions: nonpregnant adults</td>
<td>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>A April 2009</td>
<td></td>
</tr>
<tr>
<td>Tobacco use counseling: pregnant women</td>
<td>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.</td>
<td>A April 2009</td>
<td></td>
</tr>
<tr>
<td>Tobacco use interventions: children and adolescents</td>
<td>The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.</td>
<td>B August 2013</td>
<td></td>
</tr>
<tr>
<td>Syphilis screening: nonpregnant persons</td>
<td>The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.</td>
<td>A July 2004</td>
<td></td>
</tr>
<tr>
<td>Syphilis screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</td>
<td>A May 2009</td>
<td></td>
</tr>
<tr>
<td>Visual acuity screening in children</td>
<td>The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.</td>
<td>B January 2011*</td>
<td></td>
</tr>
</tbody>
</table>

*The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening.

"Previous recommendation was an "A" or "B."
Please allow 72 hours for request to be completed. Call 303-602-2070 or 877-357-0963 with questions.
After all portions are complete, fax to: 303-602-2081 or submit via email to: ManagedCarePAR@dhha.org
All areas MUST BE COMPLETED in order to process this request form. Please print legibly.

**Prior Authorization Request (PAR)-DH Managed Care**

<table>
<thead>
<tr>
<th><strong>Patient Information</strong> (May be completed by pharmacy staff if applicable)</th>
<th><strong>Date Initiated:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last:</td>
<td>First:</td>
</tr>
<tr>
<td>DH Medical Record #:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td>Sex: □ M □ F Phone Number:</td>
</tr>
<tr>
<td>□ DHMP □ DHMP POS □ CHP+ □ DH Medicaid Choice □ DH Medicare Choice □ DH Medicare Select □ DERP/CSA □ Elevate</td>
<td></td>
</tr>
<tr>
<td>Insurance #:</td>
<td></td>
</tr>
<tr>
<td>Drug Requested:</td>
<td>Strength: Qty:</td>
</tr>
<tr>
<td>Rx Directions (sig):</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Prescriber: DH Staff Provider? □ Yes □ No Clinic Fax #:</td>
<td></td>
</tr>
<tr>
<td>To be filled at: □ DH Primary Care Pharmacy □ Central Fill (mail order) □ Eastside □ La Casa Pharmacy □ Westwood □ Montbello</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>To be filled at: □ Park Hill □ Lowry □ Westside Pharmacy □ ID/AIDS Clinic Pharmacy □ DH Discharge Pharmacy □ Other</td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

**Clinic Portion** (May be completed by Provider or other designated individual)

<table>
<thead>
<tr>
<th>□ New Request</th>
<th>□ Renewal Request</th>
<th>□ Urgent (Life Sustaining Only) **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending</td>
<td>Fellow</td>
<td>Resident</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>Pager:</td>
<td>Clinic Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Completed By (if different):</td>
<td>Email address (if non-DH):</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT DIAGNOSIS**:

How long will pt be on this med?

Will Drug Need to Be Titrated? □ Yes □ No If yes, what doses?

**Medical Rationale/ Necessity - May provide clinical documentation for medical necessity (i.e. encounters, lab, radiology, etc.):**

Is the patient currently receiving this drug? □ Yes □ No If yes, greater than 3 mos? □ Yes □ No

Please list all other medications the patient has tried for this diagnosis and duration of use.

**Behavioral Health Management – If Applicable** (May be completed by Provider or other designated individual)

<table>
<thead>
<tr>
<th>Case Manager:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication monitoring: □ Yes □ No</td>
<td>Prescription Coordinated through DH Pharmacies: □ Yes □ No</td>
</tr>
</tbody>
</table>

**For DHMP Medical Services Use Only **Please Do Not Write Below This Line**

<table>
<thead>
<tr>
<th>Approved □</th>
<th>Denied □</th>
<th>Withdrawn (fax back to Pharmacy and Provider) □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature: ______________________ Date: <em><strong>/</strong></em>/____ Rx Begin Date: <em><strong>/</strong></em>/____ End Date: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Authorization Signature</td>
</tr>
</tbody>
</table>

**For after-hours urgent requests, please call the MedImpact help desk at 800-788-2949**

Form No: GEN_PF_104-01
Revised: 03_2014
I, ____________________________________________________________

(PRINT full name of member)

name and appoint _____________________________________________

(PRINT full name of representative)

to serve as my Designated Personal Representative. I understand that my Designated Personal Representative will have access to information about me that is created by or on behalf of the Denver Health Medical Plan, Inc. and that this information can include Protected Health Information. My Designated Personal Representative is to be provided information about me, on my behalf, in order to assist me as I request of him/her. This designation of a personal representative is being made in order that the designated individual acts on my behalf in:

____ All actions required of me in my relationship with the Denver Health Medical Plan;

____ Actions required of me in relation to the following specific purpose (check one that applies):

❏ Grievance (also known as a Complaint) ❏ Appeal ____________________ ❏ Other (please specify) ________________

I understand that my Designated Personal Representative may disclose my information to a third party, and that the third party may re-disclose information after it is provided by my Designated Personal Representative. I understand that I may revoke this Designation at any time by writing to the address below, and that this Designation will not expire unless and until I actively revoke it. I understand that my health care treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating a Designated Personal Representative.

I understand this executed form does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions or treatment or psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

Member signature: ___________________________________________ Date: __________________________

Parent or Legal Guardian may sign on behalf of minor child. NOTE: Legal Guardian, Power of Attorney, or equivalent may sign on behalf of an adult – documentation showing legal authority is required.

Member Date of Birth: ________________ Member ID # No: __________________________

Used for identity verification purposes only

Designated Personal Representative Signature: ______________________________

Relationship to Member: ___________________________ Phone number: _______________________

Return Completed Form To: Denver Health Medical Plan Inc.
ATTN: Grievance & Appeal Department
938 Bannock Street, Mail Code 6000
Denver, CO 80204
Phone: 303-602-2261 • Fax: 303-602-2078
Completion of this form is voluntary. You or your designated representative must submit this request within 180 days of event occurrence for complaints or within 180 days of the date on the initial denial letter for appeals. Please attach copies of all documents which may support your request. If this is an urgent request please contact the Grievance & Appeals Department directly at 303-602-2261. This form and any accompanying documents may be mailed or faxed to:

Denver Health Medical Plan
Attn: Grievance and Appeal Department
938 Bannock St., Mail Code 6000
Denver, CO 80204-0606
Phone: 303-602-2261
Fax: 303-602-2078
http://www.denverhealthmedicalplan.com/

DHMP Plan Type (Please check one):

Denver Health and Hospital Authority Employee (DHHA)
Medical Care HMO □
HighPoint HMO □
HighPoint Point of Service (POS) □

Career Service Authority (CSA)/ Denver Employee Retirement Plan (DERP):
HighPoint HDHP □
HighPoint DHMO □

Denver Police Protective Association (DPPA):
HighPoint HDHP □
HighPoint DHMO □

Elevate Plans:
Bronze HSA □
Silver Value □
Silver Select □
Silver Standard □
Gold Select □
Gold Standard □

Please provide the following information for the person the complaint or appeal is being submitted:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City/State/Zip:</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Telephone #:</th>
<th>Member ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Medical Record #:</th>
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</tr>
</tbody>
</table>
If other than Member listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Designation of Personal Representative (DPR) Form with your request. Without this form, we will be unable to process your complaint or appeal. The DPR Form can be obtained by visiting our Web site or calling the telephone number provided above.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone #:</th>
</tr>
</thead>
</table>

Relationship to Member: Spouse ☐ Son/Daughter ☐ Parent/Legal Guardian ☐ Member’s Provider ☐ Other ☐ (please specify) __________________________

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>City/State/Zip:</th>
</tr>
</thead>
</table>

Section A: COMPLAINT: If this is in regards to a complaint, please describe the issue in the box below. If you are filing an appeal, please go to section B. Include dates of service and staff names if applicable. You may use additional pages if necessary and/or attach supporting documentation.
**Attachment 5  Member Grievance and Appeal Form (cont.)**

**Section B: APPEAL:** If you wish to file an appeal to a previously denied service or claim, please provide the information requested below.

<table>
<thead>
<tr>
<th>Is this in regards to a denied claim? Yes □ No □</th>
<th>Is this in regards to a denied medical service or treatment? Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes: Claim #: ______________________________</td>
<td>If Yes, Please provide the date of the denial letter: ____________________</td>
</tr>
<tr>
<td>Date(s) of Service: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Provider Name: ________________________________</td>
<td></td>
</tr>
</tbody>
</table>

Please describe in the space provided below the reason and a brief description of your appeal. You may use additional pages if necessary and/or attach supporting documentation.

<table>
<thead>
<tr>
<th>Member Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Designated Personal Representative Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

If you have any questions or need help completing this form, please contact the DHMP Grievance & Appeals Department at 303-602-2261, 8:00am – 5:00pm Monday through Friday. If we are unable to take your call, please leave a message and we will return your call within 24 to 48 hours.

**Internal Use Only – Please do not write below this line**

<table>
<thead>
<tr>
<th>Receipt Date:</th>
<th>Complaint □ (or) Appeal □ Received By: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Type: Clinical □ Potential QOCC □ Benefit □ Pharmacy □ Claim □ Other □ |
|---------------------------|--------------------------------------------------|