



**DENVER HEALTH**  
**MEDICAL PLAN** INC.™

# PROVIDER MANUAL

Last Updated: March 1, 2026



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## FORMS

Visit our website at **[DenverHealthMedicalPlan.org/For-Providers](https://denverhealthmedicalplan.org/for-providers)** to access the forms below:

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

Denver Health Medical Plan will reimburse non-participating qualified ambulance claims in accordance with Colorado regulation 4-2-66 & HB 19-1174. The appropriate form is available on the DHMP website at **[DenverHealthMedicalPlan.org/Form/Colorado-Out-Network-Ambulance-Claim-Attestation](https://denverhealthmedicalplan.org/Form/Colorado-Out-Network-Ambulance-Claim-Attestation)**. It is the provider's responsibility to attach the form to the paper medical claim to ensure expedient accurate reimbursement. DHMP policy is to reimburse qualified non-publicly funded ambulance service providers at 325% of the applicable Medicare fee schedule for the same geographic area including mileage. Other non-participating providers will be reimbursed at 100% of the applicable Medicare rates for the date of service.

## SECTION I: WELCOME!

Dear Provider,

Welcome! Thank you for becoming a participating Provider with Denver Health Medical Plan, Inc. (DHMP).

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

DHMP offers many different plans and networks, including Elevate Child Health Plan Plus (CHP+) and Elevate Medicaid Choice. Among the commercial products are Denver Health Medical Plan (Employer Group) and Elevate Health Plans (Exchange/CO Option or Individual market products). Additionally, DHMP offers two Elevate Medicare Advantage Plans (HMO/ HMO D-SNP). Unless otherwise noted herein, DHMP will refer broadly to all products falling under the DHMP umbrella.

### ***Background Information of Elevate Medicaid Choice***

DHMP is contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to operate a Medicaid Managed Care Program. Elevate Medicaid Choice provides or arranges for covered health care benefits and related services to Medicaid-eligible residents of the City and County of Denver, Colorado and surrounding counties.

This manual explains DHMP network Provider rights and responsibilities and is an extension of the Contract. Providers can contact DHMP for general information, policy clarification, or any other information related to this program at the numbers listed below.

### **DHMP CONTACT LIST:**

| CONTACT INFO                           | PHONE                                                                                                                                                                                                         | FAX          | PREFERRED METHOD           |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|----------------------------|
| DHHA Enterprise Compliance Services    | 303-602-3255                                                                                                                                                                                                  | 303-602-7024 |                            |
| Credentialing Department               |                                                                                                                                                                                                               |              | DHMPCredentialing@dhha.org |
| Health Plan Services (Member/Provider) | DHHA Employer Group Plans & Elevate CHP+:<br>303-602-2100<br>Elevate Exchange/CO Option Health Plans:<br>303-602-2090<br>Elevate Medicaid Choice:<br>303-602-2116<br>Elevate Medicare Advantage: 303-602-2111 | 303-602-2138 |                            |
| Pharmacy Services                      | 303-602-2070                                                                                                                                                                                                  | 303-602-2081 |                            |
| Provider Relations                     | 303-602-2003                                                                                                                                                                                                  | 303-602-2516 |                            |
| Quality Improvement                    |                                                                                                                                                                                                               |              | DL_DHMP_QI@dhha.org        |

|                        |              |                                                                                                                                                                                                    |  |
|------------------------|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Utilization Management | 303-602-2140 | Urgent/Expedited Fax:<br>303-602-2160<br>Outpatient Fax:<br>303-602-2128<br>Inpatient Admit and<br>Discharge Notifications<br>Fax: 303-602-2127<br>Inpatient Clinical Records<br>Fax: 303-602-2004 |  |
| Care Management        | 303-602-2184 | 303-602-2146                                                                                                                                                                                       |  |

## SECTION II: PROVIDER RESPONSIBILITIES

### OVERVIEW

Members choose specific Physicians to be their Primary Care Provider (PCP). A Primary Care Provider’s responsibility is to manage the total health care needs of the member. This includes routine and preventive medical services, medically necessary diagnostic referrals, and specialist and hospital services. A formal referral process is typically required for those services, with the exception of limited specialty services that can be obtained without a referral. The Prior Authorization List can be found on our website to determine if a service requires Prior Authorization at [DenverHealthMedicalPlan.org/Provider-Forms-And-Materials](http://DenverHealthMedicalPlan.org/Provider-Forms-And-Materials). See the Utilization Management Section for the Prior Authorization Lists and instructions.

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

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

### PCP RESPONSIBILITIES

The PCP is responsible for verifying Member eligibility on the date of service before rendering services. They are also responsible for providing routine and preventive primary care services per Members benefit program as the designated PCP. The PCP manages the Patient’s care initiates referrals for specialty services, as applicable and coordinates medically necessary care with other Providers. PCPs are required to:

- Have timely appointments available
  - » Urgently needed services or emergency – immediately;
  - » Services that are not emergency or urgently needed, but the member requires medical attention – within 7 business days; and
  - » Routine and preventive care – within 30 days
- Participate in Quality Assurance Utilization Management programs
- Comply with Quality Improvement activities
- Meet Credentialing Requirements
- Maintain confidentiality of medical information in compliance with all state and federal regulatory entities,
- Maintain a separate medical record for each Member,
- Ensure legible and comprehensive medical records for each encounter are maintained,
- Authorize the use of clinical data and access to performance data

- Follow the Referral and Prior Authorization Guidelines Process
- Provider offices must make accommodations for people with disabilities to include offices/ exam rooms and equipment
- Follow the policies and procedures of the Billing Guide

## **SPECIALTY CARE PROVIDERS (SCP)**

Specialty Care Providers are responsible for:

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

## **DHMP PROVIDER PORTAL:**

The provider portal is your go-to resource for managing patient care anytime, anywhere. You can access important information, send secure messages, check claims status, request and view authorizations with a single sign-on and check member eligibility.

To access the portal, your local administrator must register and submit the Provider Attestation Form. A local administrator is the single primary point of contact for the provider office and is responsible for maintaining provider accounts for office staff and conducting an annual review of staff access within the portal.

NOTE: Registration to the Provider Portal may be denied if the registrant's email does not match the name of the company (e.g. @gmail.com emails or 3rd party billers may be denied unless the contracted provider group sends in writing that access is allowed). If you have a denied registration, email [DHMP\\_Portal@dhha.org](mailto:DHMP_Portal@dhha.org) for account verification or additional attestation requirements.

The link below contains the tools needed to access the portal:

- Create a Provider Portal Account
- Reference the Provider Portal User Guide
- Complete the Provider Attestation Form

[DenverHealthMedicalPlan.org/DHMP-Your-Provider-Portal](https://DenverHealthMedicalPlan.org/DHMP-Your-Provider-Portal)



## VERIFYING ELIGIBILITY, BENEFITS, AND NETWORK PARTICIPATION STATUS

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

Network Participation status for Providers and Practitioners is identified by Line of Business tiering. Tier definitions are below:

- Tier 1: A contracted Provider considered in-network, listed in the Provider Directory and that does not require authorization unless service is on the Prior Authorization Requirement Grid for specific Lines of Business. Services must meet Medical Necessity and be a covered benefit.
- Tier 2: A contracted Provider considered out-of-network, not listed in the Provider Directory, and requires prior authorization for Lines of Business. Services must meet Medical Necessity and be a covered benefit.
- Tier 3: Non-Participating Provider (Out of Network Provider) is identified for all Lines of Business for services unavailable, untimely access, and requires Prior Authorization and a One Time Agreement. Services must meet Medical Necessity and be a covered benefit.

Medicaid/CHP+: Check the State of Colorado Provider Portal website or call the number on the back of the ID card.

Medicare: Call the number on the back of the ID card.

DHMP Commercial Plans: Call the number on the back of the ID card.

For information on Real Time Eligibility (RTE), visit:

[DenverHealthMedicalPlan.org/Real-Time-Eligibility-RTE-Transactions](https://denverhealthmedicalplan.org/Real-Time-Eligibility-RTE-Transactions)

## UNDERSTANDING NETWORK PARTICIPATION STATUS

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

## COMPLIANCE WITH FEDERAL AND STATE LAWS AND RULES AND REGULATIONS

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

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

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

### **Values Line:**

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

**DHHA Enterprise Compliance Services:**

- Phone: 303-602-3255
- Fax: 303-602-7024
- Mail: Denver Health, Enterprise Compliance Services, 601 Broadway St., MC 7776, Denver, CO 80204

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

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

**Non-Discrimination**

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

**HIPAA**

Providers are responsible for protecting the confidentiality, privacy and security of DHMP's Member information. Providers must follow the rules and standards laid out in the Health Insurance Portability and Accountability Act (HIPAA) Act.

**Collecting Payment**

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

Reference: 8.012.2.A. [www.sos.state.co.us](http://www.sos.state.co.us).

**Supervisory Billing Notice**

DHMP permits supervisory billing when services are provided in accordance with all applicable federal and state laws, payer policies, and credentialing requirements. Services rendered by unlicensed or provisionally licensed practitioners must be billed accurately to reflect the individual who performed the service and the level of supervision provided. Claims submitted for supervised services may be reimbursed at a lower rate than services rendered independently by fully licensed practitioners, consistent with benefit and fee schedule provisions. Failure to appropriately disclose supervised care or to follow required billing and documentation standards may result in claim denials, recoupments, or other penalties as enforced under state or federal law. It is the responsibility of the practice to ensure that all supervisory billing is submitted accurately and in full compliance with applicable requirements.

Bill Supervisory Services on a CMS-1500

Rendering vs. Billing Provider:

This is the most common compliance failure point. Providers are responsible for staying with up-to-date billing regulations. Suggested 1500 form billing:

- Box 24J (Rendering Provider):
  - » Enter the individual who actually performed the service

- » Use their individual NPI, even if they are supervised
- » This must reflect who touched the patient
- Box 33 (Billing Provider):
  - » Enter the supervising provider or group that is credentialed with the payer
  - » This is who is legally responsible and paid

#### Documentation Must Support Supervision:

Even if the claim is technically correct, claim audits will look for:

- Supervising provider name and NPI
- Type of supervision (direct vs indirect)
- Frequency of review/sign-off
- Supervisor attestation or co-signature (if required)

If documentation doesn't clearly support supervision, the claim can be recouped by DHMP upon audit review.

#### ***Prohibition of Payment to an Excluded Provider***

Federal law prohibits entities that participate in federal health care programs from entering into business or maintaining certain relationships with individuals or entities that have been excluded from participating in federal health care programs. No federal health care program payments may be made for any items or services furnished or prescribed by an excluded provider, supplier or entity. As such, DHMP, including its affiliated entities, shall not employ, contract with or make a payment to providers if such providers have been excluded, debarred or are otherwise ineligible to participate in federal health care programs, or if they have been convicted of federal offenses related to the provision of health care items or services.

DHMP conducts exclusion screening of providers prior to contracting, prior to payment and monthly thereafter to ensure that providers are not excluded from participation in federal programs.

Initial and monthly sanction screenings are conducted using the following databases:

1. GSA exclusion database – System for Award Management (SAM)
2. Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE)
3. Other state and federal exclusion lists
4. Centers for Medicare & Medicaid Services' (CMS) Preclusion List (monthly screening only)

If a provider is identified as an excluded provider, all claims with a date of service that falls into the exclusion period will be denied by DHMP. Additionally, if claim payments were made by DHMP to a provider during their exclusion period, DHMP will recoup those funds. This includes claims for all DHMP lines of business: Medicare, Medicaid, CHP+ and Commercial (both Employer Group and Individual Exchange/CO Option).

If your exclusion has been rescinded or terminated, please contact DHMP with evidentiary documentation so that your claims may be adjudicated.

#### **MORAL OR RELIGIOUS OBJECTIONS**

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

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

- Member's health status, medical care or treatment options, including alternative treatments that may be self-administered
- Information the Member needs to decide among all relevant treatment options

- Risks, benefits and consequences of treatment or non-treatment
- Member’s right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment options

## SECTION III: PROVIDER RELATIONS

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

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

Providers can access DHMP changes and updates that impact interaction with MCO by accessing the following link: [DenverHealthMedicalPlan.org/Providers](http://DenverHealthMedicalPlan.org/Providers).

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

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

DHMP has policies and procedures to select and evaluate its contracted Providers that complies the National Committee for Quality Assurance (NCQA) standards and Centers for Medicare and Medicaid Services (CMS) requirements regarding credentialing, re-credentialing and ongoing monitoring.

DHMP’s Provider selection policies and procedures include provisions: DHMP does not make credentialing and recredentialing decisions based on an applicant’s race, ethnic/national identity, gender, age or sexual orientation, or on type of procedure or patient (e.g., Medicaid) in which a practitioner specializes. This does not preclude DHMP from including practitioners in the network who meet certain demographic or specialty/cultural needs. The organization does not include gender, age or ethnicity of a practitioner when presenting credentialing or recredentialing files to the Credentialing Committee for review and/or approval. To ensure practitioners are not discriminated against, the QI Director conducts an annual audit of IDNPs (initially credentialed within the past 12 months) to review the following practitioner information: date of birth, gender and languages spoken. Any practitioner complaint is reviewed on a case by case basis for resolution.

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 their health care, including the right to refuse treatment and to express preferences about future treatment decisions

#### Revalidation

- HCPF revalidation site: [Colorado.gov/Pacific/HCPF/Revalidation](http://Colorado.gov/Pacific/HCPF/Revalidation)

## INSURANCE

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

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

## PRACTITIONER RIGHTS

1. Review information submitted to support credentialing applications. In the verification process, if any discrepancies are found in the information provided by a practitioner, the Credentialing Department personnel will contact the practitioner or provider representative by phone, email or in writing to validate the correct information. DHMP must notify the practitioner if there is a substantial variation in information regarding actions on license, malpractice claims history and board certification. The practitioner may not review references, recommendations or other information that is peer review protected. DHMP is not required to reveal the source of information if law prohibits disclosure.
2. Correct any erroneous information in their credentialing application in writing, prior to formal approval of the credentialing process and presentation at the Credentialing Committee meeting date. The practitioner or provider representative is also notified by email of the deadline for submitting the corrections. The notification includes the following:
  - a. Erroneous information must be corrected within 10 business days
  - b. Submission of corrections must be in the correct format (Colorado State Application via the CAQH website)
  - c. Corrections must be submitted to DHMP’s Credentialing Department personnel
  - d. Receipt of the corrections is documented
3. Receive the status of their credentialing or recredentialing application upon request by contacting DHMP Credentialing Department personnel via email at [DHMPCredentialing@dhha.org](mailto:DHMPCredentialing@dhha.org)

4. Receive notification of these rights:
  - a. Providers are informed of their rights through the Provider Newsletter, which is sent via email annually, and is also available on DHMP's website: [DenverHealthMedicalPlan.org/Provider-Newsletters](http://DenverHealthMedicalPlan.org/Provider-Newsletters)
  - b. Providers are informed of their rights through the Provider Manual which is available on DHMP's website: [DenverHealthMedicalPlan.org/Provider-Manual](http://DenverHealthMedicalPlan.org/Provider-Manual)
  - c. Providers may also contact the Provider Relations Department via email at [ManagedCare.ProviderRelations@dhha.org](mailto:ManagedCare.ProviderRelations@dhha.org) for their rights.

The Practitioner may not review references or recommendations or other information that is peer-review-protected, and DHMP is not required to reveal the source of information if law prohibits disclosure.

#### **Practitioners who need to be credentialed:**

##### ***Physical Health***

- Allopathic Physician (MD)
- Osteopathic Physician (DO)
- Doctor of Dental Surgery (DDS)\*
- Doctor of Medicine in Dentistry (DMD)\*
- Podiatrist (DPM)
- Certified Nurse Midwife (CNM)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Clinical Nurse Specialist (CNS)
- Physician Assistant (PA)
- Chiropractor (DC)
- Non-physician practitioners who are licensed or certified by the state, have an independent relationship with the organization and provide care under the organization's medical benefits

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

##### ***Behavioral Health***

- Psychiatrist (MD, DO)
- Psychologist (PsyD, PhD, EdD or Master's level degree)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage Family Therapist (LMFT)
- Applied Behavior Analyst (ABA)
- Certified Addiction Specialist, Counselor (ACC, ACB, ACA)

##### ***Allied Health***

- Acupuncturist (ACU)
- Audiologist (AUD)
- Genetic Counselors
- Optometry (OD)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Speech and Language Pathologist (SLP)
- Telemedicine Consultant

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

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

DHMP is authorized to have instant access to information. If interested in utilizing CAQH ProView, please send email to [DHMPCredentialing@dhha.org](mailto:DHMPCredentialing@dhha.org).

### ***Credentialing and Recredentialing Application Process***

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

All practitioners are required to be recredentialled at least every 36 months for continued participation. DHMP assures that the applicant is notified of the recredentialing process and required documentation is provided in a timely manner to meet the 36-month timeframe.

The practitioner credentialing and recredentialing processes begin with the completion of an application, signed and dated pages or attestation on the CAQH application, and submission of requested documentation. The applications include attested responses to the following questions regarding:

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

### ***Verification Process***

Primary source verification can be obtained verbally, in writing or electronically, as described below:

1. Verbal verification is documented on a contact form and includes the information obtained, the name of the person from the primary source supplying the information, the date the information was received and the signature of the Credentialing Department personnel who took the verbal information.
2. Written verification includes the date the information was supplied by the source, and the signature of the person on letterhead from the primary source supplying the information. The Credentialing Department personnel dates and signs the written documentation upon receipt.
3. Electronic verification (i.e., internet/online) can include WebCrawler verifications from approved sources and screen printouts. All electronic verification including, but not limited to, WebCrawler verification must include the primary source supplying the documentation and the date the information was generated.

The Credentialing Department personnel who obtains this online verification must electronically provide the date of the sourced information if it is not generated by the supplier and sign the document.

4. See Attachment B for a list of acceptable verification sources for practitioner credentialing.

5. Initial Credentialing Process

- a. Licensure: A current, valid Colorado state license or compact license/compact-issued practice privilege from another participating state must be verified and re-verified from primary sources. Verification must show the license was in effect at the time of the credentialing decision. If there are any adverse actions on the licensure, all the appropriate documentation is obtained. If the practitioner holds licensures in other states, only the licensures in Colorado must be verified.
- b. Drug Enforcement Agency: Certificates are verified for practitioners who indicate they have DEA prescriptive authority through primary source verifications directly through the DEA website, as well as the American Medical Associate (AMA) Physician Profile if held by the physician practitioner (not applicable to PsyD, PhD, EdD and Master's-level behavioral health providers.). If a practitioner has a pending DEA certificate, the practitioner may be eligible to be credentialed if the practitioner has in place a designated alternate practitioner to write all prescriptions on their behalf until the practitioner has a valid DEA certificate. The credentialing file must document the absence of the DEA or CDS certificate and the name of the designated practitioner. A practitioner may decide to not obtain a DEA certificate and the application must also reflect this situation. In both cases of pending DEA and the absence of DEA registrations, the Credentialing Department personnel present the applying practitioner with a form for completion to document their designated alternate prescribing practitioner. The Credentialing Department personnel must validate by primary source verification that this designee has a valid Colorado state license and current DEA registration.
- c. Hospital Affiliation: The practitioner should document on the Colorado state application which hospital(s) they are affiliated with and use as the primary admitting facility. Additionally, the practitioner should also document any coverage arrangements they may have through an affiliated practitioner or hospitalist.
- d. Education Verification: Medical education and training verification is not necessary for MDs and DOs who, through primary source verification, are confirmed to be board certified. If the practitioner is not board certified, only the highest level of education/training is verified (e.g., residency, graduation from medical school). Verification of fellowship is not required or accepted as verification of education and training by NCQA. The acceptable verification sources for physicians for medical school and residency training are AMA Physician Profile, American Osteopathic Association (AOA) and Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Verification of training or graduation from a graduate school for non-physician practitioner and allied health practitioner if they are not board certified is obtained through verification of licensure with the applicable State board. Other acceptable source of verification may include written verification from the institution awarding the degree. Additional verification sources that are recognized by NCQA include: Federation of State Medical Boards (FCVS) closed residency programs, the recognized residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

- e. Board Certification: Active board certification is required three years after the physician's highest level of education to be included in DHMP network. Information regarding any/all board certifications or appropriate professional specialty certificates must be provided on the application. Certifications are primary source verified. Expiration dates or board certifications are documented. If a practitioner has a certification that does not expire, DHMP will verify that the board certification is current and document the date of the certification. Board certification is primary source verified during credentialing and recredentialing. The verification sources for physicians are American Board of Medical Specialties

(ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided or on current AMA Physician Profiles. The ABMS Certified Doctor Verification Program, accessible through the ABMS Web site, is intended for consumer reference only and is not an acceptable source for verifying board certification. Boards in the United States that are not members of the ABMS or AOA are not verified if the organization documents within its policies and procedures which specialty boards it accepts. For other health care/allied professionals, the verification sources are primary source appropriate specialty board sites.

- f. Work History: Work history does not need to be primary source verified. The practitioner is required to either submit a curriculum vitae or resume, or document a minimum of five years of work history following completion of their education on the credentialing application. The practitioner must provide the beginning and ending month and year for each position. The Credentialing Department personnel review explanations of work gaps provided by providers on the Colorado state application. If clarification is needed, it may be provided verbally or in writing. Explanation of work history gaps greater than six months or greater than 1 year must be clarified in writing by the practitioner.
  - g. Malpractice Insurance Coverage: DHMP requires all practitioners to carry minimum malpractice coverage amount of \$1 million per incident and \$3 million aggregate. Malpractice coverage is documented on the application to include the liability insurance carrier, policy number, liability limits and effective policy period dates. A corresponding copy of their current insurance certificate must be provided that includes the practitioner's name and matches the liability entry on the application. Practitioners who have coverage through the Federal Tort Claims Act (FTCA) or Self-Insurance Trust or have governmental immunity are exempt from carrying the minimum amounts of malpractice insurance of \$1/\$3 million.
  - h. Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions: All practitioners complete the attestation questions on the credentialing application regarding their claim's history. The Credentialing Department personnel collect and verifies all sanctions and claims. Written narratives/testimonials are provided by the practitioner to outline the circumstances surrounding any incident(s) identified and any disciplinary action taken. The NPDB is primary source verified during credentialing and recredentialing. The NPDB documents all claims, settlements, adverse actions, restrictions and sanctions for a specific practitioner. The Credentialing Department personnel reviews the NPDB report and if there are adverse actions that require review by the Credentialing Committee, the Credentialing Department personnel obtains all the necessary information for presentation to the Credentialing Committee for direct approval.
  - i. National Provider Identifier (NPI): The Credentialing Department personnel verifies the practitioner's NPI number in NPDES.
  - j. Office of Inspector General (OIG) and System for Award Management (SAM): The OIG is queried for each practitioner going through credentialing and recredentialing for information on Medicare/Medicaid sanctions. The SAM is queried for each practitioner going through credentialing for records of debarments, suspension and other exclusionary actions which would make them ineligible for receiving Federal contracts, subcontracts and Federal assistance and benefits.
6. Recredentialing Process
- a. Licensure: A current, valid Colorado state license or compact license/compact-issued practice privilege from another participating state must be verified and re-verified from primary sources. Verification must show the license was in effect at the time of the credentialing decision. If there are any adverse actions on the licensure, all of the appropriate documentation is obtained. If the practitioner holds licensures in other states, only the licensures in Colorado must be verified.
  - b. Drug Enforcement Agency (DEA): Certificates are verified for practitioners who indicate they have DEA prescriptive authority through primary source verifications directly through the DEA website, or the AMA Physician Profile if held by the physician (not applicable to PsyD, PhD, EdD and Master's-level behavioral health providers). If a practitioner has a pending DEA certificate, the practitioner may be

eligible to be credentialed if the practitioner has in place a designated alternate practitioner to write all prescriptions on their behalf until the practitioner has a valid DEA certificate. The credentialing file must document the absence of the DEA or CDS certificate and the name of the designated practitioner. A practitioner may decide to not obtain a DEA certificate and the application must also reflect this situation. In both cases of pending DEA and the absence of DEA registrations, the Credentialing Department personnel present the applying practitioner with a form for completion to document their designated alternate prescribing practitioner. The Credentialing Department personnel must validate by primary source verification that this designee has a valid Colorado state license and current DEA registration.

- c. **Clinical Privileges Hospital Affiliation:** The practitioner should document on the Colorado state application any hospital(s) they are affiliated with and use as the primary admitting facility. Additionally, the practitioner should also document any coverage arrangements they may have through an affiliated practitioner or hospitalist.
- d. **Board Certification:** Active board certification is required three years after the physician's highest level of education to be included in DHMP's network. Information regarding any/all board certifications or appropriate professional specialty certificates must be provided on the application. Certifications are primary source verified, and board certifications are documented. If a practitioner has a certification that does not expire, DHMP will verify that the board certification is current and document the date of the certification. Board certification is primary source verified during credentialing and recredentialing. The verification sources for physicians are ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. The ABMS Certified Doctor Verification Program, accessible through the ABMS Web site, is intended for consumer reference only and is not an acceptable source for verifying board certification. Boards in the United States that are not members of the ABMS or AOA are not verified if the organization documents within its policies and procedures which specialty boards it accepts. For other/allied health care professionals, the verification sources are primary source appropriate specialty board sites.
- e. **Malpractice Insurance Coverage:** DHMP requires all practitioners to carry minimum malpractice coverage amount of \$1 million per incident and \$3 million aggregate. Malpractice coverage is documented on the application to include the liability insurance carrier, policy number, liability limits and effective policy period dates. A corresponding copy of their current insurance certificate must be provided that includes the practitioner's name and matches the liability entry on the application. Practitioners who have coverage through the FTCA or Self-Insurance Trust or have governmental immunity are exempt from carrying the minimum amounts of malpractice insurance of \$1/\$3 million.
- f. **Malpractice History, Medicare/Medicaid Sanctions and Licensure Sanctions:** All practitioners complete the attestation questions on the recredentialing application regarding their claim's history. The Credentialing Department personnel collect and verifies all sanctions and claims. Written narratives/ testimonials are provided by the practitioner to explain the circumstances surrounding any incident(s) identified and/or any disciplinary action taken. The NPDB is primary source verified during credentialing and recredentialing. The NPDB documents all claims, settlements, adverse actions, restrictions and sanctions for a specific practitioner. The Credentialing Department personnel review the NPDB report and if there are adverse actions that require review by the Credentialing Committee, the Credentialing Department personnel obtain all the necessary information for presentation to the Credentialing Committee for direct approval.
- g. **National Provider Identifier (NPI):** The Credentialing Department personnel verifies the practitioner's NPI number in NPPES.
- h. **Office of Inspector General (OIG) and System for Award Management (SAM):** The OIG is queried for each practitioner going through recredentialing for information on Medicare/Medicaid sanctions. The SAM is queried for each practitioner going through recredentialing for records of debarments, suspension, and other exclusionary actions which would make them ineligible for receiving Federal

contracts, subcontracts, and Federal assistance and benefits.

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

### ***File Completion and Pre-Credentialing Review***

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

### ***Notification of Credentialing and Recredentialing Decision***

Practitioners going through credentialing and recredentialing are notified within 60 calendar days of the Medical Director or the Credentialing Committee's decision (Attachment C). A practitioner is considered to be credentialed as of the date of the Medical Director's decision for a clean file or the Credentialing Committee's decision for a file that is not clean.

### ***Practitioner Appeal Rights***

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

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

### ***Listings in Provider Directory and Member Materials***

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

### ***Termination and Reinstatement***

If DHMP terminates a practitioner for administrative reasons such as the practitioner failed to provide complete credentialing information and not for quality reasons, DHMP may reinstate the practitioner within 30 calendar days of termination per NCQA timelines (120 days) and is not required to complete an initial credentialing. The practitioner must complete an application for initial credentialing if DHMP reinstates the practitioner more than 30 days after the termination.

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

### ***Initial Sanction Information***

DHMP collects and reviews all sanction information including limitations on licensure that it receives before making a credentialing decision. Queries are conducted within 120 days prior to the decision date.

1. The NPDB is queried for each provider for verification of malpractice suits, adverse acts, sanctions, exclusions or restrictions against the practice privileges of a practitioner.

2. The LEIE (OIG) is queried for each provider for information on Medicare/Medicaid sanctions.
3. The SAM is queried for each practitioner for records of debarments, suspension and other exclusionary actions which would make them ineligible for receiving Federal contracts, subcontracts and Federal assistance and benefits.
4. All active Colorado state licenses held by a practitioner are queried via the State's web page for verification and sanction information.

### ***Ongoing Monitoring***

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

1. Collecting and reviewing Medicare/Medicaid sanction – LEIE (OIG) is queried monthly.
2. Collecting and reviewing sanctions or limitation on licensure – Appropriate State Boards are queried for all licensed health care professionals monthly.
3. Collecting and reviewing complaints – Member complaints are under the charge of the Appeals and Grievances Department's Grievance Coordinators. All provider complaints are forwarded to the Credentialing Department personnel, who in turn provide the information to the appropriate credentialing office to be considered at the time of the provider's recredentialing. The Credentialing Department personnel include provider complaints in the monitoring log presented to the Credentialing Committee and the QMC at least every six months.
4. Collecting and reviewing practitioner adverse events - Provider adverse events are under the charge of the Medical Director and the QI RN.
5. Any practitioner identified through the processes of 1-4 is brought to the attention of the Medical Director, Chief Compliance and Audit Officer (or designee), Privacy Officer and Contracting/Provider Relations Department for determination of necessary actions. When DHMP identifies such issues, it determines if there is evidence of poor quality that could affect the health and safety of its members, and depending on the nature of the event, implement appropriate interventions. Practitioner rights related to possible actions for quality issues for directly credentialed practitioners are described in the policy "Practitioner Appeal Rights and Notification to Authorities Based on Issues of Quality of Care".
6. DHMP reviews information released from the appropriate regulatory bodies as referenced above in 1-4 within 30 calendar days of its release.
7. Monitoring of complaints related to office site quality is addressed in DHMP's "Practitioner Office Site Quality policy".

### **PRACTITIONER OFFICE SITE QUALITY**

DHMP has a process to ensure that Practitioner offices meet DHMP office site standards. DHMP will monitor Member complaints regarding the following:

- Physical accessibility: includes, but is not limited to, ease of entry and accessibility of space within the building, including standards for physically disabled Patients
- Physical appearance: includes, but is not limited to, cleanliness, lighting and safety
- Adequacy of waiting and examining room space: includes, but is not limited to, adequate and appropriate size of seating for waiting rooms
- Adequacy of treatment record keeping: includes, but is not limited to, file/record orderliness, security, confidentiality and documentation practices

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

## NOTIFICATION OF CHANGES MUST BE PROACTIVE

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

## CREDENTIALING: ADDITIONS, CHANGES & TERMINATIONS (ACT)

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

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

## SECTION V: ADMINISTRATIVE RESPONSIBILITIES

### APPOINTMENT STANDARDS

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

| ACCESS TO SERVICES STANDARD                                  | TIMEFRAME                     | COMPLIANCE GOAL  |
|--------------------------------------------------------------|-------------------------------|------------------|
| Emergency Care – Medical, Behavioral, Substance Use Disorder | 24 hours a day, 7 days a week | 100% of the time |

|                                                                                                  |                                                                                                                     |                   |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------|
| Urgent Care – Medical, Behavioral, Substance Use Disorder                                        | Within 24 hours                                                                                                     | 100% of the time  |
| Primary Care — Routine, Non-urgent Symptoms                                                      | Within 7 calendar days                                                                                              | ≥ 90% of the time |
| Behavioral Health, Mental Health and Substance Use Disorder – Routine, Non-urgent, Non-emergency | Within 7 calendar days                                                                                              | ≥ 90% of the time |
| Prenatal Care                                                                                    | Within 7 calendar days                                                                                              | ≥ 90% of the time |
| Primary Care — Access to After-hours Care                                                        | Office number answered 24 hrs a day, 7 days a week by answering service or instructions on how to reach a physician | ≥ 90% of the time |
| Preventive/Well Visits                                                                           | Within 30 calendar days                                                                                             | ≥ 90% of the time |
| Specialty Care — Non-urgent                                                                      | Within 30 calendar days                                                                                             | ≥ 90% of the time |

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

|                                  |                                                                                                      |
|----------------------------------|------------------------------------------------------------------------------------------------------|
| Emergency behavioral health care | By phone within fifteen (15) minutes after initial contact, In person within one (1) hour of contact |
|----------------------------------|------------------------------------------------------------------------------------------------------|

| MEDICARE ADVANTAGE ACCESS TO CARE STANDARDS |                                |
|---------------------------------------------|--------------------------------|
| APPOINTMENT TYPE                            | APPOINTMENT STANDARD TIMEFRAME |
| Emergency Care (Medical/BH                  | 24/7 (immediately)             |
| NurseLine / Answering Service               | 24/7                           |
| Urgent Care (PCP, BH, Specialty)            | Within 24 hours                |
| Non-Urgent, Symptomatic Care                | Within 7 business days         |
| • PCP – Symptomatic                         | Within 7 business days         |
| • BH – Non-urgent, follow-up                | Within 7 business days         |
| • BH – Hospital discharge follow-up         | Within 7 business days         |
| • Outpatient follow-up                      | Within 7 business days         |
| Routine / Preventive Care                   | Within 30 calendar days        |
| • PCP – Well visits                         | Within 30 calendar days        |
| • Specialty – Routine                       | Within 30 calendar days        |

## WAIT TIMES

Wait times should be no longer than 30 minutes from the scheduled appointment time (except when Provider is unavailable due to an emergency).

DHMP will monitor Providers and assess compliance to these standards in the following manner:

- Periodic office visits
- Provider open access (shopper) surveys
- Review grievances and complaints related to DHMP's Providers for access issues

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

## AFTER-HOURS CALLS AND COVERAGE STANDARD

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

## EMERGENCY SERVICES

If a Member seeks treatment in a hospital emergency department for a medical emergency, the emergency department should provide screening or treatment without PCP authorization. Prior approval or authorization is not required for emergency services. The Member has the right to use any hospital or other setting for emergency care. DHMP 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 is defined herein as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under 42 C.F.R. §438.114
- Needed to evaluate or stabilize an emergency medical condition

If a Member contacts their PCP with an emergency, the PCP may instruct the Member to seek immediate medical services through the 911 system or go to the nearest emergency room. Hospital staff should try to contact DHMP’s UM Department within 48 hours of the encounter. This can be accomplished by telephone or fax, with the emergency room encounter note attached.

DHMP is financially responsible for any care given, in-network or out-of-network, which is necessary to stabilize the Member’s emergency medical condition. Prior Authorization or referral is not required for stabilization care services.

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

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

**POST-STABILIZATION CARE SERVICES**

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member’s condition. DHMP 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 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
- 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.

## **NON-EMERGENT AIR AMBULANCE**

While it is expected that these actions will rarely be necessary, please remember that there is protocol and this does need to be reviewed. There are no contracted providers for this care. Please submit a prior authorization for all air ambulance care before proceeding with any further plans.

## **URGENTLY NEEDED SERVICES**

Urgently Needed Services, as defined in 42 C.F.R. § 422.113(b)(1)(iii), means covered services that are not emergency services as defined above, provided when a Member is temporarily out of DHMP's service area, or when DHMP's Provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required:

- As a result of an unforeseen illness, injury or condition; and
- Given the circumstances, it was not reasonable to obtain the services through DHMP's Provider network.

Prior approval or authorization is not required for urgent care services. DHMP is responsible for payment for urgent care services even if the facility is not contracted with DHMP 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; 3) contact DispatchHealth at 720-487-9530 to utilize in-home urgent care services; or 4) go to the nearest urgent care center, whether or not the urgent care center is within DHMP's network.

## **SECTION VI: PREVENTIVE HEALTH CARE**

We encourage PCPs to coordinate and request preventive health care services for their Patients. These include annual check-ups, regular screening procedures and appropriate immunizations. See Attachment 2 for the U.S. Preventive Service Task Force (USPSTF) recommendations.

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

## SECTION VII: BENEFITS AND LIMITATIONS

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

***DenverHealthMedicalPlan.org***

## SECTION VIII: UTILIZATION MANAGEMENT (UM)

The goal of the UM Department is to encourage the highest quality of care, in the most appropriate setting, from the most appropriate Provider. Through the UM program, DHMP seeks to avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. The organization distributes a statement to all Members and to all Practitioners, Providers and employees who make UM decisions, affirming the following: 1) UM decision-making is based only on appropriateness of care and service and existence of coverage; 2) the organization does not specifically reward practitioners or other individuals for issuing denials of coverage; and 3) there are no financial incentives for UM decision makers.

DHMP uses both internally-approved guidelines and the following nationally-accepted, evidenced-based clinical criteria to determine the medical necessity of requested services:

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

For copies of any of the specific criteria used in making a decision for a member care or for questions about the UM program, please call Health Plan Services at 303-602-2100.

The following Provider Forms and Materials can be found on the website via the link below for reference:  
[DenverHealthMedicalPlan.org/For-Providers](http://DenverHealthMedicalPlan.org/For-Providers)

- Servicing Requiring Prior Authorization
- Provider Tips - Applied Behavior Analysis (ABA)
- Provider Tips - Behavioral Health
- Provider Tips - Breast Pumps
- Provider Tips - Cochlear Implant Tip Sheet
- Provider Tips - Early Intervention Services (EIS)
- Provider Tips - Home Health Care
- Provider Tips - Infertility
- Provider Tips - Neuropsychology Testing
- Provider Tips - Newborn Enrollment
- Provider Tips - Outpatient Therapy
- Authorization Submissions
- UM Prior Authorization Request Form
- Medicaid Provider Forms

- Transition of Care/Continuation of Care Form
- Clinical Coverage Determination Criteria
  - » Dental-Related General Anesthesia and Facility Charges
  - » Hair Prosthesis
  - » Oral/Enteral Feedings
  - » Sleep Apnea

## WHEN TO SUBMIT ADVANCE NOTIFICATION OR PRIOR AUTHORIZATION

Physicians, health care professionals and ancillary care Providers are responsible for Advance Notification for planned services on the Prior Authorization list.

**Additionally, Prior Authorization is required for all out-of-network services.**

Advance Notification with supporting clinical documentation should be submitted as far in advance as possible, but at least two (2) weeks before the planned service date is recommended to allow enough time for coverage review.

Prioritization of case review is based on the specifics of the case, the completeness of the information received, CMS requirements and/or other state or federal requirements.

The following table provides a summary of the timeliness requirements for UM to provide notification of decisions to members and providers. Timeliness requirements can also be found on the website at the following link: [DenverHealthMedicalPlan.org/Utilization-Management-UM](http://DenverHealthMedicalPlan.org/Utilization-Management-UM).

If the UM staff receives insufficient information to make a coverage determination, the staff will notify the Provider of the specific information that is needed to make the determination. The extension timeframe in the table below may be used in those cases wherein the Provider needs additional time to provide sufficient information for UM to make a decision.

### *Summary of the Timeliness Requirements for All Lines of Business*

| TYPE OF REVIEW                      | EXCHANGE/<br>CO OPTION | DHHA<br>EMPLOYER GROUP | MEDICAID & CHP+  | MEDICARE (ALL)   |
|-------------------------------------|------------------------|------------------------|------------------|------------------|
| <b>DECISIONS</b>                    |                        |                        |                  |                  |
| Urgent/Concurrent                   | 72 hours               | 72 hours               | 72 hours         | 72 hours         |
| Expedited/Urgent Preservice         | 72 hours               | 72 hours               | 72 hours         | 72 hours         |
| Expedited Specialty Rx Part B Drugs | 72 hours               | 72 hours               | 72 hours         | 24 hours         |
| Standard/Preservice                 | 15 calendar days       | 15 calendar days       | 10 calendar days | 7 calendar days  |
| Standard Specialty Rx Part B Drugs  | 15 calendar days       | 15 calendar days       | 10 calendar days | 72 hours         |
| Retrospective/Postservic            | 30 calendar days       | 30 calendar days       | 30 calendar days | 30 calendar days |
| <b>EXTENSIONS</b>                   |                        |                        |                  |                  |
| Urgent/Concurrent                   | None                   | 48 hours               | 14 calendar days | 14 calendar days |
| Expedited/Urgent Preservice         | 48 hours               | 48 hours               | 14 calendar days | 14 calendar days |

|                          |                  |                  |                  |                  |
|--------------------------|------------------|------------------|------------------|------------------|
| Standard/Preservice      | 15 calendar days | 15 calendar days | 14 calendar days | 14 calendar days |
| Retrospective/Postservic | 15 calendar days | 15 calendar days | None             | None             |
| Part B Drugs             | None             | None             | None             | None             |

DHMP has posted Services Requiring Prior Authorization and the UM Prior Authorization Request Form on the website at [DenverHealthMedicalPlan.org/For-Providers](http://DenverHealthMedicalPlan.org/For-Providers).

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

Prior Authorizations should be faxed to the following numbers:

- Inpatient Admissions: 303-602-2127
- Outpatient Services and Elective Admissions: 303-602-2128
- Urgent/Expedited Services: 303-602-2160
- Inpatient Clinicals: 303-602-2004

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

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or, for a person with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently; or
- In the opinion of a Physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
- Seriously jeopardizes the enrollee's ability to attain, maintain or regain maximum function.

If submitting an urgent request, supporting documentation must be provided to show why the request meets the above definition of urgent. Urgent requests that do not meet the above definition may be downgraded to a standard request and will be completed within the standard timeframe. See the above Summary of the Timeliness Requirements for All Lines of Business Table or on the website with link below [DenverHealthMedicalPlan.org/Utilization-Management-UM](http://DenverHealthMedicalPlan.org/Utilization-Management-UM).

Please do not send duplicate requests for services that are within the appropriate determination timeframe. This causes duplicate work and slows down the authorization process. For questions about an authorization request or submitted request with no response within the above timeframes, please call Health Plan Services at 303-602-2100.

**ADVANCE NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS/CLAIMS PAYMENT**

If Advance Notification or Prior Authorization requirements are not followed, claims may be denied in whole or in part and, as required under the Provider's agreement with DHMP.

Advance Notification or Prior Authorization is valid only for the date of service or date range stated on the notification or Prior Authorization. If the specified date of service or date range has passed and the service(s) has not been delivered, a new Advance Notification or Prior Authorization request must be submitted. No changes can be made to a completed/decisioned authorization request including extending dates of service or changing codes or units.

Subject to state and federal regulations, including regulations pertaining to a care Provider's inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain the Ownership System (PECOS)\* list, the provision of Advance Notification or receipt of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon:

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

## **FACILITIES: STANDARD NOTIFICATION REQUIREMENTS**

### ***Confirming Coverage Approvals***

Prior to rendering any service please refer to the Prior Authorization List. The purpose is to enable the facility and the Member to have an informed pre-service conversation. In cases where the service is not covered, the Member can then decide whether to receive and pay for the service out-of-pocket.

Please see the Prior Authorization Grid at [DenverHealthMedicalPlan.org/For-Providers/Prior-Authorizations](https://denverhealthmedicalplan.org/For-Providers/Prior-Authorizations).

## **DURABLE MEDICAL EQUIPMENT (DME) AUTHORIZATION AND BILLING REQUIREMENTS**

### ***Durable Medical Equipment Gap Filling Process for Participating Providers:***

If new or miscellaneous Durable Medical Equipment (DME) is submitted with no pricing available, an invoice will be required to determine claim pricing. If an invoice is unavailable, DHMP will refer to contractual terms or may apply gap fill methods, which will require a review of medical necessity. Participating providers must follow authorization requirements for new or used DME/prosthetics with a purchase price of \$1,000 or greater, as well as for all rental DME regardless of dollar amount.

### ***Durable Medical Equipment Gap Filling Process for Nonparticipating Providers:***

Authorization must be requested for all Durable Medical Equipment (DME) due to the provider's nonparticipation status. Payment will be made using the fee schedule deemed appropriate by DHMP based on the contract line. If new or miscellaneous DME is submitted with no pricing available, an invoice will be required to determine claim pricing. If an invoice is unavailable, DHMP may apply gap fill methods, which will require a review of medical necessity.

Please note: Gap fill rates are non-negotiable, and medical necessity documentation review is not considered part of the authorization process.

## **SECTION IX: PHARMACY BENEFITS FOR DHMP**

Pharmacy website content can be found at [DenverHealthMedicalPlan.org/Provider-Pharmacy-Information](https://denverhealthmedicalplan.org/Provider-Pharmacy-Information). Copies of all information available on the website are available by request at no charge.

### **PHARMACY DEPARTMENT CONTACT INFORMATION:**

Phone: 303-602-2070

Fax: 303-602-2081

Email: [ManagedCarePAR@dhha.org](mailto:ManagedCarePAR@dhha.org)

## FORMULARY

The formularies contain:

- A list of covered drugs, including restrictions and preferences
- Tiers
- Drugs that require Prior Authorization
- Limits on refills, doses or prescriptions

## FORMULARY UPDATES

- The Medicare formularies are updated monthly and updated documents are posted when updates occur
- For all other plans (Commercial Employer Group, Commercial Exchange/CO Option, Medicaid and CHP+), formularies and formulary change documents are updated quarterly
- The most current version can be found on the pharmacy webpages

## GENERIC SUBSTITUTION

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

## PRIOR AUTHORIZATION AND STEP THERAPY CRITERIA

- DHMP Prior Authorization and step therapy criteria can be found on the respective pharmacy webpages
  - » Medicare criteria are updated monthly
  - » For all other plans (Commercial Employer Group, Commercial Exchange/CO Option, Medicaid and CHP+), criteria are updated quarterly
- The most current version can be found on the pharmacy webpages

## PROCESS FOR SUBMITTING A PRIOR AUTHORIZATION (ALSO KNOWN AS AN EXCEPTION REQUEST)

- Prior Authorization forms are located at [DenverHealthMedicalPlan.org/Provider-Forms-And-Materials](https://denverhealthmedicalplan.org/Provider-Forms-And-Materials)
- Completed forms should include all pertinent medical necessity information, including chart notes.
  - » Incomplete requests may be pended while the Pharmacy Department attempts to reach the Provider to obtain the required information. If the required information cannot be obtained, the request may be denied.
- Prior Authorization forms may be submitted by:
  - » Fax
  - » Mail
  - » Phone
  - » Online at [DenverHealthMedicalPlan.org/For-Providers/Prior-Authorizations](https://denverhealthmedicalplan.org/For-Providers/Prior-Authorizations)
- A request may be marked urgent to expedite the review:
  - » Medicare: When the standard timeframe may jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function
  - » Commercial: In situations where a delay: could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; would subject the Member to severe pain without the treatment that is the subject of the request; or could create substantial limitation to the Member's ability to live independently
  - » Medicaid/CHP+: A Member has acute symptoms of sufficient severity (including severe pain) such that

a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman and/or her unborn child;
  2. Serious impairment to bodily functions; or
  3. Serious dysfunction of any bodily organ or part
- Members and Providers are notified of the decision at minimum via written communication

### **THIRD-PARTY PHARMACY ADMINISTRATOR FOR OUTPATIENT PRESCRIPTIONS**

MedImpact is the pharmacy benefit manager for DHMP. Emergency and after-hours overrides are available 24 hours a day, 365 days a year at 1-800-788-2949.

## **SECTION X: CARE COORDINATION MANAGEMENT**

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

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

More specifically, the Care Coordination Department includes the following:

1. Care Support Services: A team of non-clinical, bilingual staff (Health Plan Care Coordinators) dedicated to providing basic care coordination services (i.e., help with arranging appointments and transportation, Patient education, community referrals), performing scripted assessments, providing outreach interventions to address gaps in care, and assisting case managers in file reviews and implementation of appropriate interventions
2. Complex Case Management (CCM): Provides comprehensive case management services to high-risk Members with multiple and complex needs
3. Transitions of Care (TOC): Provides short-term, 30day, intensive management and support for Members identified as high-risk during an acute inpatient admission setting
4. Care Coordination (CC): Provides intensive, personalized support, monitoring, outreach, and engagement for individuals with medical and behavioral care needs and who are also high-cost/high utilizers of the health care system
5. Disease Management: Controlling Blood Pressure (CBP), Diabetes Management (DM), Special Health Care Needs (SHCN), and Chronic Conditions (Complex)
6. Maternal Care: Program for our High-Risk Pregnant members and up to 1 year after birth and/or loss

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

- A comprehensive needs assessment and periodic re-assessment

- Coordination of primary and specialty care
- Support in following treatment plans
- Promote self-awareness and self-management through development and maintenance of care plans
- Resource connection and coordination
- Improve understanding and management of benefits
- Member education

Referrals to the CM Department can be made either through DHMP’s website referral form or by emailing a referral to [DHMPCC@dhha.org](mailto:DHMPCC@dhha.org). Providers can also obtain more information by calling 303-602-2184 or visiting [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org).

## SECTION XI: WELL-BEING SERVICES

### MYSTRENGTH ONLINE WELL-BEING PROGRAM

The online well-being program, myStrength, offers self-management support and information to individuals as they address health care needs and make health behavior changes. The services offered through the program are voluntary and are provided at no cost to DHMP’s Members. Visit [DenverHealthMedicalPlan.org/Members/Mytrenchth](http://DenverHealthMedicalPlan.org/Members/Mytrenchth) for more information.

Online workshops are available to Commercial and Medicare Members for a variety of health conditions or wellness goals including:

- Asthma
- Congestive heart failure
- Depression/anxiety
- Diabetes
- Eating healthier
- High blood pressure
- Medication adherence
- Pain management
- Physical activity
- Smoking cessation
- Stress management
- Weight management

### TELEPHONIC COUNSELING FOR DEPRESSION AND ANXIETY

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

### LEARN AND BURN PROGRAM

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

When: First Thursday of each month from 10 a.m. to 11 a.m.  
Where: Glenarm Recreation Center, 2800 Glenarm Place, Denver, CO 80205 (across from the Denver Health Eastside Clinic)

**EDUCATION CLASSES**

Behavioral Health and Wellness Services offers free education classes to DHMP’s members. Topics vary, but have included weight management, family nutrition, chronic pain, diabetes, mood/emotional health, heart health and smoking cessation, to name a few.

**SECTION XII: QUALITY IMPROVEMENT (QI)**

The Quality Improvement (QI) Program is designed to support the mission to provide affordable, high quality healthcare coverage for all in partnership with Denver Health. The QI Program provides a formal structure and process designed to monitor and evaluate the quality and safety of care and service through defined performance metrics, which are derived from a variety of data sources, including:

- Availability and accessibility of network adequacy
- Care management, claims, health plan services, pharmacy, population health, and utilization data
- Clinical and preventative guidelines
- Credentialing and delegated credentialing
- Continuity and coordination of care
- Complex health needs
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Cultural and linguistic member needs
- Healthcare Effectiveness Data and Information Set (HEDIS), including medical record review
- Health Outcomes Survey (HOS)
- Member and provider satisfaction
- Patient safety
- Preventive health promotion
- Provider access surveys
- Quality of clinical care

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 and effectively providing care and managing health outcomes.

DHMP uses a continuous improvement cycle where designated staff conduct a measurement of performance indicators, assess and prioritize the indicators, and then plan, implement, and evaluate interventions to improve the quality of care, quality of service, and Patient safety. Data is collected on a prospective, concurrent, and/or retrospective basis, dependent on which type best meets the measurement need. 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. QI works collaboratively with various departments within DHMP to develop and implement initiatives targeted at improving clinical care, outcomes, safety and service.

DHMP’s network Providers must agree to cooperate with QI activities and allow DHMP to leverage 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's Members, and 2) to evaluate the way care and services are delivered. The QI team is committed to maintaining a standard of excellence and enacts/monitors programs, initiatives, and policies related to this purpose.

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

- Ensure quality of care and services that meet CMS, State of Colorado and NCQA requirements utilizing established, best practice goals and benchmarks to drive performance improvement
- 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 community resources
- Encourage safe and effective clinical practice through established care guidelines
- Educate Members about Patient safety through health promotion activities, member newsletters and community outreach efforts

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

- Design and maintain the QI structure and processes that support continuous quality improvement (CQI) 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, HOS and other access/customer service data to promote improvement in Member satisfaction
- Monitor Member satisfaction and identify/address areas of dissatisfaction through an annual analysis of the following data: 1) CAHPS, 2) Member feedback, 3) Grievance and Appeals data and 4) quality of care complaint(s)
- Monitor and maintain safety measures and address identified problems
- Design and maintain a chronic care improvement program that objectively and systematically measures and analyzes its health outcomes
- Conduct an annual Practitioner survey to evaluate satisfaction
- 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 community resources
- Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines
- Facilitate the participation of Providers, the interdisciplinary care team and Members in the QI Program
- Communicate improvements in the QI Program to all stakeholders
- Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis
- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
- Participate in the annual external independent review of quality outcomes, which includes, but is not limited to, any or all of the following: 1) medical record review, 2) performance improvement projects and studies, 3) surveys, 4) calculation and audit of quality and utilization indicators, 5) administrative data

analyses, and 6) review of individual cases.

- For external review of activities involving medical record review, 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 develop projects, DHMP's QI Department uses clinical and service performance benchmarks established by the State of Colorado, CMS, NCQA 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
- Health Plan Utilization Management (UM) and Care Management (CM)
- Preventive health promotion
- Pharmacy management
- Patient safety
- Complex health needs
- Adequacy and availability of services
- Clinical practice and preventive guidelines
- Continuity and coordination of Medical and Behavioral Health (BH)
- Quality of care complaints
- Member satisfaction
- Provider satisfaction
- Credentialing and delegated credentialing
- Delegation activities oversight

## **CLINICAL PRACTICE GUIDELINES**

DHMP is to disseminate all clinical practice and preventive care guidelines to practitioners, members, potential members, and the public at no cost. DHMP shares clinical practice and preventive care guidelines for all members, including members with special health care needs or disabilities, through QI and QMC activities.

## **CULTURAL AND LINGUISTIC OBJECTIVES (CLAS)**

The QI Program incorporates ongoing monitoring of the cultural and linguistic needs of membership, including but not limited to the following:

- Identify language needs and cultural background of members, including prevalent languages and cultural groups using enrollment data
- Identify languages and cultural background of practitioners in provider network to assess whether or not they meet members' language needs and cultural preferences in alignment with NCQA network adequacy requirements
- Develop, implement and evaluate the culturally- and linguistically-appropriate services in collaboration with DHMP staff and other departments and staff, as needed
- Ensure interpreter and translation services and auxiliary communication devices will be available to the member at no cost
- Document and forward member needs identified during member contacts or upon receipt of the member questionnaire to the Health Plan Care Management Department, as needed
- Evaluate CAHPS questions that relate to interpretation and health literacy satisfaction to identify areas for improvement, and implement action plans, as needed
- Monitor HEDIS measures health disparities and conduct a yearly analysis of the data is to assist in the development of targeted health prevention and education programs that address, identify and reduce

health disparities based on available data

- Identify annually, using aggregated member Race/Ethnicity/Language (R/E/L) data, languages that must be used in patient materials for quality improvement and marketing activities
- Assess annually aggregated provider R/E/L data to ensure all materials, including translated materials meet the reading comprehension for the population
- All member written materials for prevalent populations (five percent of total membership or >1,000 members, whichever is less, in a line of business) are translated and made available to members in the respective languages
- These materials appear at a 6th-grade reading level and are available, upon request in Braille, large print, audio tape format, or other applicable formats to meet member needs
- Maintain a library of culturally-sensitive health prevention and education materials to be used in member mailings
- Participate in network and State/Federal initiatives for reducing health disparities for Plan membership and community, as required

Clinical and Preventive guidelines:

- Adult depression
- Asthma care
- Diabetes management for non-pregnant adults in the outpatient setting
- Antenatal and postpartum care
- Management of hypertension in adult outpatients
- Pediatric and adolescent preventive healthcare
- Pediatrics early intervention, child find or developmental delay

All the guidelines can be found at [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org) at the bottom of the home page under the link titled “Quality Improvement” ([DenverHealthMedicalPlan.org/For-Providers/Quality-Improvement-Program](http://DenverHealthMedicalPlan.org/For-Providers/Quality-Improvement-Program)).

## **EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)**

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children age 20 and under and pregnant people who are enrolled in Medicaid. EPSDT is the key to ensuring that children and adolescents receive appropriate preventive screenings for vision, medical and dental care, as well as immunizations and lead testing. Any care needed to correct or ameliorate a discovered condition is also eligible. Any care not within the EPSDT services may be a wrap benefit with the State. If care is denied after secondary medical necessity review, a referral is made to Care Management for alternative resources.

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

EPSDT training is available on the DHMP website at [DenverHealthMedicalPlan.org/For-Providers/Provider-Forms-And-Materials](http://DenverHealthMedicalPlan.org/For-Providers/Provider-Forms-And-Materials), and on the HCPF Website at [HCPF.colorado.gov/epsdt](http://HCPF.colorado.gov/epsdt). For Denver Health providers, EPSDT trainings are also available in Workday Learning.

## **POPULATION HEALTH MANAGEMENT**

DHMP’s Population Health Management (PHM) Program aims to identify population health needs through



segmentation and risk stratification of members and identify targeted opportunities for intervention. DHMP’s Population Health team provides support to the Care Management team to support care coordination efforts, evaluate program outcomes, and identify individuals for Care Management outreach. The Population Health Management team evaluates the success of its population health programs in each of its targeted areas annually.

**SECTION XIII: HEALTH PLAN SERVICES DEPARTMENT**

Health Plan Service Representatives are available for program Members and Providers to help solve problems, answer questions and provide information about benefits, services, eligibility and other available resources. For Providers, Health Plan Services is available Monday through Friday from 8 a.m. to 5 p.m. for Commercial, Medicaid, CHP+ and Medicare plans. For program Members, Health Plan Services is available Monday through Friday from 8 a.m. to 5 p.m. for Commercial, Medicaid and CHP+ members, and from 8 a.m. to 8 p.m. seven days a week for Medicare members. They can be reached at 303-602-2100 or 1-800-700-8140 for Commercial Employer Group & CHP+ plans; 303-602-2116 or 1-855-281-2418 for Medicaid Choice; 303-602-2111 or 1-877-956-2111 for Medicare Advantage plans; 303-602-2090 or 1-855-823-8872 for Commercial Exchange/CO Option. For the hearing impaired, use TTY line at 711.

**MEMBER INFORMATION**

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

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

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

**TERMINATION OF PCP/PATIENT RELATIONSHIP**

PCPs may request a Member’s discharge from their practice by contacting the Health Plan Services Department at numbers listed by applicable line of business in this section. Reasons for the discharge could include, but are not limited to, abusive behavior by the Member, non-compliance of treatment plan, failure to keep scheduled appointments or frequent cancellation of scheduled appointments.

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

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

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

## **ELIGIBILITY VERIFICATION**

Providers are responsible for determining that a Patient is eligible for services. Call the Health Plan Services Department at numbers listed by applicable line of business in this section to verify that a Patient is eligible to receive services. For information on Real Time Eligibility (RTE), visit [DenverHealthMedicalPlan.org/RTE-Transactions](http://DenverHealthMedicalPlan.org/RTE-Transactions).

## **NEWBORN ELIGIBILITY**

### ***Commercial Plans: Pre-enrollment***

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

### ***Commercial Plans: Enrollment***

- The family deductible and family out-of-pocket maximum will continue to apply to the newborn (and all other Members) after the first 31 days, if the newborn is actively enrolled in the plan.
  - » The Member must actively enroll the newborn in the plan within the first 60 days for Exchange/CO Option and pay the required premiums for coverage to continue beyond the first 31 days.
  - » The Member must complete and submit an enrollment change form to their employer within the first 30 days for Employer Group Plans.

### ***Medicaid Newborn Eligibility:***

- When a baby is born, the mother or the Provider must notify the State regarding the delivery so the newborn can be added to the mother's Medicaid case and a State ID can be generated for the newborn.
- If the mother is a Medicaid Member when newborn is born, then the newborn is guaranteed coverage for the first year under "Eligible Needy Newborn". If the newborn has been discharged and the mother is a Elevate Medicaid Choice member, newborn will be too. Newborn will follow mother's attribution.

**Medicaid Newborn Billing:**

- All claims for the newborn should be billed under the newborn's own State ID.
- Prior Authorization requirements will be relaxed for non-contracted providers for 90 days after the newborn is assigned to DHMP to allow for the transitions of care process. After 90 days, the newborn will either need to transition to a Medicaid Choice network provider or would need to contact Health First Colorado to disenroll from Medicaid Choice.

**CHP+ Newborn Eligibility:**

- When a baby is born, the mother or the Provider must notify the State regarding the delivery so the newborn can be added to the mother's CHP+ case and a State ID can be generated for the newborn.
- If the mother is a CHP+ Member when newborn is born, then the newborn is guaranteed coverage for the first 30 days until their presumptive eligibility is approved. Once eligibility is approved then newborn will have coverage the first year (12 months). If the newborn has been discharged and the mother is a DHMP member, newborn should be too. Newborn will follow mother's attribution.

**CHP+ Newborn Billing:**

- All claims for the newborn should be billed under the newborn's own State ID.

**PRIMARY CARE PROVIDER CHANGES**

DHMP's Members can change their PCP at will or for cause. The change takes effect the first day of the following month. Any reissued specialist referrals must be by the new PCP.

**MEDICAL INTERPRETATION AND TRANSLATION SERVICES**

DHMP's Members and Providers can access medical interpretation and translation services by contacting Health Plan Services at numbers listed by applicable line of business in this section. All oral non-English language interpretation services are available at no charge to the Member. Health Plan Services can provide the proper contact number for the interpretation services hot-line as well as help Providers access a medical interpreter.

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 Health Plan Services.

**HEARING IMPAIRED**

Advance scheduling of American Sign Language Interpreters is necessary to assure their availability when needed. Please contact Health Plan Services during regular business hours to schedule an American Sign Language Interpreter. They can be reached at 303-602-2100 or 1-800-700-8140 for Commercial Employer Group & CHP+ plans; 303-602-2116 or 1-855-281-2418 for Medicaid Choice; 303-602-2111 or 1-877-956-2111 for Medicare Advantage plans; 303-602-2090 or 1-855-823-8872 for Commercial Exchange/CO Option. For the hearing impaired, use TTY line at 711.

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

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

A TTY telephone number is also available by calling 711.

# SECTION XIV: MEMBER GRIEVANCES AND APPEALS

## ACTING ON BEHALF OF A MEMBER

Any person with a Member’s written consent may file an Appeal or Grievance and act as the Member’s authorized representative:

- Providers for our Medicare Members do not need a signed Appointment of Representative (AOR) or Designated Personal Representative (DPR) form to start an appeal or grievance.
- All non-Medicare Plans must have a signed AOR or DPR form to submit an appeal or grievance on the member’s behalf.

## GRIEVANCES (COMPLAINTS)

A Grievance is an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination (prior authorization denial), 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, network adequacy, benefits, wait times.

A quality-of-care grievance (QOC-G) is a complaint submitted by a member in regard 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.

A quality-of-care concern (QOC-C) is submitted by a provider or facility regarding 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, or their designated representative, must file their grievance within a certain amount of time from the incident. This time frame varies by line of business and is listed below (note: any grievance filed after the timeframe will be dismissed):

- Medicare Part C and D: 60 calendar days from the incident
- Commercial: 180 calendar days from the incident
- Medicaid/CHP+: Grievances may be filed at any time

### How to file:

Members or their designated DPR may call the Grievances and Appeals Department at 303-602-2261 or they may contact the Grievances Team in writing or through the online portal. A written Grievance must include the Member’s name, health plan ID number, address, and phone number and the complaint details. Members/ DPRs may also fill out the Grievance Form located in the back of DHMP’s Member Handbook or the form can be found on our website [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org). 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  
Attn: Grievances and Appeals Department  
777 Bannock St., MC 6000  
Denver, CO 80204

## AFTER FILING A GRIEVANCE

After receiving a grievance, DHMP sends the member, or the member’s DPR a written acknowledgment letter to confirm the grievance was received. Acknowledgement letters are sent following the guidelines below:

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

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

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

|           | EXCHANGE CO<br>OPTION AND PEAK | DHHA EMPLOYEES   | MEDICAID & CHP+  | MEDICARE (ALL)   |
|-----------|--------------------------------|------------------|------------------|------------------|
| GRIEVANCE |                                |                  |                  |                  |
| Expedited | 72 hours                       | 72 hours         | None             | 24 hours         |
| Standard  | 15 calendar days               | 15 Calendar days | 14 calendar days | 30 calendar days |
| Extension | 15 calendar days               | 15 Calendar days | 14 calendar days | 14 calendar days |

## IF MEMBER NEEDS HELP FILING A GRIEVANCE

DHMP gives Members/DPRs reasonable assistance in completing forms and taking other procedural steps necessary for the Member to fully exercise their Grievance filing rights. This assistance includes, but is not limited to, providing interpreter services and a toll-free number that has adequate TTY/TDD and interpreter capability. Members/DPRs can the Grievances and Appeals Department at 303-602-2261.

## MEMBER APPEALS

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

## HOW TO FILE A MEMBER APPEAL

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

- Medicare Part C and D: 65 calendar days from the Integrated Denial Notice (IDN)
- Commercial: 180 calendar days from the date of the Notice of Adverse Benefit Determination
- Medicaid/CHP+: 60 calendar days from the date of the Notice of Adverse Benefit Determination

First level appeals may be received be verbally or in writing.

To Appeal an Adverse Benefit Determination, the Member/DPR may call the Grievances and Appeals Department at 303-602-2261 or they may fill out the Appeal Form in the back of DHMP's Member Handbook (located on our website at [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org)), and fax to 303-602-2078, or mail to:

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

## **FILING AN EXPEDITED MEMBER 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 request an expedited appeal by notifying Health Plan Services at 303-602-2261. If an expedited Appeal is approved, DHMP makes a decision on the Appeal and provides notification of the decision as expeditiously as the Member's health condition requires, but not to exceed 72 hours after DHMP receives the Appeal.

If DHMP denies a request for an expedited Appeal, DHMP gives the Member/DPR prompt oral notice of the downgrade and sends the Member/DPR a written notification within two (2) business days. DHMP processes the request as a standard Appeal rather than an expedited Appeal. The Member/DPR can call or write the Grievances and Appeals department to file a Grievance if they feel DHMP should not have downgraded the expedited Appeal request.

## **AFTER FILING A MEMBER APPEAL**

After receiving an appeal, DHMP will send the member or the member's representative a written acknowledgment letter to confirm the appeal was received. There are no acknowledgement letters for expedited appeals due to the short turnaround timeframe. Letters will be sent for standard appeals following the guidelines below:

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

## **MEMBER APPEAL DECISIONS**

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.

During the decision/resolution process of the appeal, the Member/DPR may present evidence about the Appeal in writing (in the case of expedited Appeal decisions, Members/DPRs have less time to do so). The Member/DPR may request copies of any documents free of charge that are used in their Appeal case file by calling Health Plan Services at 303-602-2261. The Appeal case file includes medical records and any other records used during the Appeal process that are not considered private under state and federal law. Included as parties to the Appeal are 1) the Member and their DPR; or 2) the legal representative of a deceased Member's estate.

DHMP must resolve each appeal and provide written notice of the disposition to affected parties as expeditiously as the Member's health condition requires, but not to exceed the following timeframes:

|                                | EXCHANGE CO<br>OPTION AND PEAK | DHHA EMPLOYEES   | MEDICAID & CHP+  | MEDICARE (ALL)                                                                      |
|--------------------------------|--------------------------------|------------------|------------------|-------------------------------------------------------------------------------------|
| APPEALS PROCESSING             |                                |                  |                  |                                                                                     |
| Expedited                      | 72 hours                       | 72 hours         | 72 hours         | 72 hours for Part C and Part D                                                      |
| Extension                      | None                           | 15 calendar days | 14 calendar days | 14 calendar days; No extension for Part B drugs                                     |
| Standard Pre Service           | 30 calendar days               | 30 calendar days | 10 calendar days | 7 calendar days for Part B; 30 calendar days for Part C; 7 calendar days for Part D |
| Extension                      | None                           | None             | 14 calendar days | 14 calendar days for Part C only                                                    |
| Standard Post Service (Claims) | 60 calendar days               | 60 calendar days | 10 calendar days | 60 calendar days; 7 days for Part D                                                 |

The written notice of the Appeal resolution will contain the results of the resolution process and the date it was completed. If the outcome is not wholly in the Member's favor, the letter will also provide information on the further appeal rights and how to pursue them. Oral notification is also provided for expedited appeals.

## MEMBER APPEAL TIMEFRAME EXTENSIONS

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

## GETTING HELP FILING A MEMBER APPEAL

DHMP will give a Member/DPR reasonable assistance in completing forms and taking other procedural steps necessary for the Member to fully exercise their Appeal filing rights. This assistance includes, but is not limited to, providing interpreter services and a toll-free number that has adequate TTY and interpreter capability. Members/DPRs can call Health Plan Services at 303-602-2261.

## SECOND-LEVEL MEMBER APPEAL

DHMP has an internal second-level appeal process which applies to Commercial Employer Group members only. If the Member/DPR is not satisfied with the first-level Appeal decision, they have the right to file a second-level Appeal with DHMP. The Member/DPR must file a second-level Appeal in writing within 60 calendar days of the first-level Appeal determination. Providers, acting on behalf of the Member with the signed DPR form, may request a second-level Appeal. They may participate 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 first-level appeal denial is wrong

To request a second-level Appeal, the Member/DPR must submit a written request to DHMP's Grievances and Appeals Department. The writing should contain:

- Member name, address and Member identification number
- The action, denial or failure to act quickly on which the request Appeal is based
- The reason for appealing the action, denial or failure to act quickly

## **SECOND-LEVEL APPEALS COMMITTEE**

### ***For Commercial Employer Group members:***

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

### ***For Commercial Exchange/CO Option members:***

Elevate Health Plans (Exchange/CO Option) members only have one level of internal appeal. If a Member/DPR is not satisfied with DHMP's first level review decision, they may request an external review upon receipt of DHMP's decision. The external review will be performed by the Department of Insurance (DOI). The Member/DPR must file the request with the DOI within four (4) months after the receipt of DHMP's adverse determination. The Member/DPR is eligible for a simultaneous external review of their first level appeal only if their appeal qualifies as urgent.

### ***For Medicare Advantage members:***

Instead of a second-level Appeal with DHMP, the next appeal step includes:

- The Independent Review Entity (IRE) appeal review
- All Part C partially favorable or adverse appeals decisions are automatically forwarded by DHMP to the IRE for review. The Member/DPR does not have to make a request for an IRE appeal review.
- For all Part D (medication) second-level appeal requests, Members or DPRs must file a request directly with C2C Innovative Solutions within 60 calendar days from the date of denial.
- IRE processing timeframes:
  - » Part C Expedited request: 72 hours
  - » Part C Standard pre-service request: 30 days
  - » Part C Post service request: 60 days
  - » Part D Expedited request: 72 hours
  - » Part D Drug Standard request: 7 days
  - » Part D Claims Payment request: 14 days
  - » Post service requests cannot be expedited

Following a Medicare IRE decision, a Member may be eligible for additional levels of appeal review.

- There are no statutory or regulatory decision-making timeframes for Part C appeals at the third level of review and beyond.
- All third, fourth and fifth level appeals must be submitted within 60 days of the previous level denial decision.
- The member must submit the appeals directly to the upper levels for review.
- The Medicare Member is informed of their appeal rights at the end of each stage of the appeal process.

### ***For Medicaid and CHP+ members:***

If the Member disagrees with the decision DHMP makes in the Appeal, they can request a State Fair Hearing once they have exhausted DHMP's appeal process. The Member has 120 days from the date of notice of

adverse action to request a hearing

## CONTINUATION OF BENEFITS DURING AN APPEAL

In some cases, DHMP will keep covering services while the Member waits for the ruling of an Appeal. A Member/DPR must call Health Plan Services at 303-602-2261 to make known that they want DHMP to keep covering their services. They must contact HPS within 24 hours before the care ends or within 10 days of a denial notification. If the final resolution of the Appeal upholds DHMP's Adverse Benefit Determination, the Member may be held responsible for the cost of the services furnished to the Member while the Appeal was pending.

For Elevate Medicaid Choice members, DHMP will provide continuation of benefits during an appeal if all of the following are met:

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

## EFFECTUATION OF APPEAL RESOLUTIONS

If DHMP overturns a service that was 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 overturns the previous denial, DHMP must pay for those services in accordance with regulations.

## SECTION XV: PROVIDER INQUIRIES, RECONSIDERATIONS AND DISPUTES

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

DHMP has a pathway to challenge a claims payment or denial. We offer a provider claim services help line, a written reconsideration process and finally a dispute process. Please note that your inquiry must follow the provider reconsideration process before DHMP will accept your provider dispute.

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

#### 1. *Inquiry:*

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

#### 2. *Provider Reconsideration:*

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

DHMP allows 60 business days from date on your claim remittance advice (RA) to submit reconsideration requests. DHMP will review and reconsider your request within 30 business days of receipt of your

request and our review determinations will be communicated via the provider RA. Following an adverse reconsideration determination, providers can submit a provider dispute to DHMP.

### **3. *Provider Dispute:***

After you have requested a reconsideration of your claim determination from DHMP, you may file a provider dispute if you disagree with our reconsideration decision. Requests for a provider dispute must be submitted in writing on our Provider Dispute form (form is located on our website at [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org)). Submit the dispute form to the address found on the form. This form must have all required fields completed. Incomplete forms will be returned to the Provider. Include all supporting documentation and evidence to support the dispute. Provider disputes must be received by DHMP within 30 calendar days of receiving your reconsideration determination. Only one provider dispute may be filed per claim.

- For participating providers, DHMP will review your dispute and provide our response to you within 45 calendar days (participating providers).
- For non-participating provider disputes, DHMP will review your dispute and provide our response to you within 90 calendar days for Commercial Employer Group, Commercial Exchange, Medicaid and CHP+, and 60 calendar days for Medicare.
- A provider has the right to designate a provider representative (Billing Service Agent) in the dispute resolution process.

## **MEDICARE NON-CONTRACT PROVIDER DISPUTES**

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

### **1. *Inquiry:***

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

### **2. *Medicare Non-Contract Provider Dispute:***

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

## **SECTION XVI: ADVANCE CARE DIRECTIVES**

### **PURPOSE**

This section is meant to outline the Policy and Procedures to be utilized by 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.).

### **POLICY**

Competent adults (age 18 and over) have the right under state law to make decisions regarding health care, including the right to accept or refuse treatment and the right to formulate Advance Directives. Pursuant to the Patient and Self-Determination Act, DHMP will provide all competent adult Members with written information about Advance Directives. This information will be available for Members on 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.

- A. Network Providers will comply with Members' valid, apparent, and available Medical Durable Power of Attorney (MDPOA) and Living Will directives, as described in this Policy.
- B. In the event that a Member suffers a cardio/pulmonary arrest, network Providers will honor Members' CPR Directives if they are valid, apparent, and immediately available to the care Providers. In all other circumstances, appropriate resuscitation efforts will be initiated. For Members undergoing anesthesia or invasive ambulatory procedures who have No CPR or Limited CPR status, a decision should be reached with the Member prior to the procedure as to whether the designated CPR status will be temporarily suspended during the procedure. If no clear consensus as to CPR status is reached prior to the procedure, the Limited or No CPR status will be suspended during anesthesia/the procedure and during immediate recovery, but typically not longer than 24 hours following the procedure.
- C. Members are not required to have an Advance Directive and the existence or lack of an Advance Directive does not determine a Member's access to care, treatment, and services. A Member will not be discriminated against based on whether or not they have executed an Advance Directive.
- D. In the event the Member's attending Physician cannot comply with the terms of an Advance Directive valid on its face on the basis of conscience, the attending Physician shall transfer the care of the Member to another Physician who is willing to comply with the terms of the directive. In this situation, the Member's attending Physician shall provide a clear and concise statement of limitation to the Member/Member's decision-maker

## DEFINITIONS:

### ***Advance Directive:***

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

### ***Cardiopulmonary Resuscitation (CPR) Directive:***

CPR Directives are authorized under the Colorado Medical Treatment Decision Act, C.R.S. 15-18.6-101, et seq. A CPR Directive is a legal document, executed by a competent adult/legal representative over 18 years of age and countersigned by a Physician, providing direction concerning the administration of CPR. CPR refers to measures taken to restore cardiac function or to support breathing in the event of cardiac or respiratory arrest or malfunction. CPR includes, but is not limited to, chest compressions, delivering electric shock to the chest, and/or placing tubes in the airway to assist breathing. Denver Health classifies CPR status as one of the following:

- 1. Complete CPR: all medically appropriate efforts to maintain or restore cardiopulmonary function will be made. In the event of a cardiopulmonary arrest, the CPR team will be notified.
- 2. No CPR: no cardiopulmonary resuscitation will be performed. Therapeutic efforts and drugs which provide or maintain Member comfort and support human dignity (e.g., suctioning, oxygen, narcotics, anxiolytic agents, IV fluids, and medications) may be used. This category does not mean no care.
- 3. Limited CPR: CPR efforts will be made, limited by pre-event written orders, including but not limited to:
  - i. Airway and breathing: withhold artificial ventilation, or withhold endotracheal intubation
  - ii. Circulation: withhold defibrillation, withhold administration of acute CPR drugs (e.g., antiarrhythmic, vasopressors), withhold chest compressions, or withhold blood or blood products – may set limits, e.g., four (4) units

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

**Decisional Capacity:**

A person who has the functional ability to:

1. Comprehend information relevant to the particular decision to be made
2. Consider the available choices, their own values and goals; and communicate, verbally or nonverbally, their decisions

**Living Will:**

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

**Medical Durable Power of Attorney (MDPOA):**

MDPOAs are authorized by the Colorado Patient Autonomy Act, C.R.S. 15-14-506. A MDPOA is a signed and dated document that allows a competent adult to specify an agent to make health care decisions on their behalf in the event the Member lacks decision-making capacity. The Member can also provide instructions to the agent about their wishes.

**Responsibility:**

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

**Procedures:**

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

- D. In all cases, the medical and nursing staff is responsible for documenting the existence of an Advance Directive in the Member's medical record.
- E. An Advance Directive is a permanent part of the medical record. All properly executed Advance Directives, including CPR Directives, are valid from admission to admission, and remain valid until they are specifically revoked by the Member (or by the guardian, if originally executed by the guardian). Therefore, to ensure that the Member's Advance Directive(s) continues to reflect that Member's wishes, staff should review a competent Member's Advance Directives with the Member at each admission, upon Member request, or if a significant change in the Member's condition warrants discussion. However, unless the Member makes a change to their Advance Directive(s), the existing directive remains valid and a new document should not be created on each admission.
- F. A detailed discussion about Advance Directives is primarily the responsibility of the Member's outpatient PCP. However, hospital staff will assist in the development of Advance Directives for Members who desire to do so. Assistance will be provided by:
- Having Advance Directive forms available for the Member to review or complete
  - Providing for availability of nursing staff, clinical social work staff, and chaplains to assist the Member in accessing the Advance Directives process, counseling, and assistance in executing Advance Directives, if desired
  - Providing the Nursing administrator with a list of the on-duty clinical social worker and/or chaplain for nights or weekends from which appropriate referral can be made, if necessary
  - Encouraging the Member to direct questions to their PCP
- G. An Advance Directive may be revoked at any time by the person making the directive.
- H. MDPOAs
- A MDPOA authorizes another person (an "agent") to make decisions on behalf of a Member specifically with regard to the administration of health care when and if the Member lacks decisional capacity. An agent has the authority to consent to, or refuse, medical treatment, including artificial nourishment and hydration, on behalf of a Member who lacks decisional capacity.
  - In all cases, the Member retains the right under state law to consent to, or refuse, any proposed medical treatment as long as they possess the capacity to make decisions. A MDPOA does not become effective until the Member has been deemed to lack decisional capacity.
  - The MDPOA shall act in accordance with the terms, directives, conditions or limitations stated in the MDPOA, and in conformance with the Member's wishes that are known to the agent. If the MDPOA contains no directives, conditions or limitations relating to the Member's medical condition, or if the Member's wishes are not otherwise known to the MDPOA, the MDPOA shall act in accordance with the best interests of the Member as determined by the MDPOA (C.R.S. 1514-506(2).)
  - A MDPOA may NOT consent to or refuse treatment over the Member's objection (even if the Member has been deemed incompetent). In the event that an MDPOA wishes to make major health decisions over the objections of a Member that lacks capacity, the MDPOA should consider pursuing a court-appointed guardianship.
  - An MDPOA shall have the same rights of access to the Member's medical records as the Member themselves and may confer with the Member's Physician concerning the Member's medical condition.
  - If a MDPOA is unable or unwilling to serve in that capacity, the appointment will be revoked. If a Member appointed a spouse as their MDPOA, a subsequent divorce, legal separation, or annulment automatically revokes the agent's appointment, unless otherwise expressly provided for in the MDPOA document.
- I. Living Wills
- Under Colorado law, any competent adult may execute a Living Will directing that life-sustaining procedures be withheld or withdrawn if, at some future time, the Member is in a terminal condition and either unconscious or incompetent to decide whether a medical intervention should be accepted or rejected.

- When a Member wishes to execute a Living Will during a hospital stay, the following individuals cannot serve as witnesses:
  - » The attending or any other physician
  - » Any nurse or other employee of hospital
  - » Any Patient at hospital
  - » Persons likely to inherit from the Member's estate (such as family members or close friends) or anyone known to have a claim against the Member's estate (hospital volunteers are permitted to witness Living Wills)
- Pursuant to C.R.S. 15-18-107, a Physician is legally required to withhold or withdraw all life-sustaining medical procedures (or transfer care of the Member to another Physician who is willing to comply with the declaration) if a signed and witnessed Living Will is presented and all of the following conditions are met:
  - » The Member is unconscious or incompetent. The duration of incapacity may or may not be specified in the Living Will, and Colorado law does not require any specified length of time.
  - » The Member is diagnosed as being in a terminal condition, which is defined as an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death.
  - » The attending Physician has obtained a confirming consultation from another Physician certifying that the Member is in a terminal condition, and both Physicians have certified in the medical record that the Member has a terminal condition, and the notation is dated and timed.
  - » The attending Physician or designee has made a reasonable attempt to notify one of the following in the stated order: 1) the Member's spouse; 2) any of the Member's adult children; 3) a parent; 4) MDPOA.
- No action to challenge the validity of the Living Will has been filed within 48 hours after certification by the two physicians of the terminal condition.
- In the case of a terminally ill Member who is pregnant, a medical evaluation must be made as to whether the fetus is viable and could, with a reasonable degree of medical certainty, develop to live birth with continued application of life-sustaining procedures. If such is the case, the Living Will must be disregarded.
- If the Physician objects to, or cannot abide by the declarations of the Living Will, they must immediately withdraw from the case and transfer care of the Member to another Physician who is willing to comply with the Living Will.
  - » In this situation, the Member's attending physician shall provide a clear and concise Statement of Limitation to the Member's decision-maker. Such statements should:
    - i. Clarify any differences between institution-wide conscience objections and those that may be raised by individual Physicians
    - ii. Identify the state legal authority permitting such objection
    - iii. Describe the range of medical conditions or procedures affected by the conscious objection
    - iv. Inform the Member of their right to file a complaint with the Colorado Department of Public Health and Environment by mail: 4300 Cherry Creek Drive South HFEMSC-A2, Attn: Complaint Department Denver, Colorado 80246-1530, by phone: 303-692-2000 or 1-800-886-7689 (in-state), or by email: [hfdintake@cdphe.state.co.us](mailto:hfdintake@cdphe.state.co.us) with concerns regarding non-compliance with the Member's Advance Medical Directives; and identify the attending Physician to whom the Member's care will be transferred
  - » Refusal of the Physician to comply with the terms of a valid Living Will and failure to transfer the care of the Member to another Physician that will comply constitutes unprofessional conduct and must be reported under the Medical Practice Act, C.R.S. 12-36-117.
  - » If any other health care Provider objects to, or cannot abide by, the conditions of the Living Will, they should notify their immediate supervisor for resolution.

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

#### J. CPR Directives

- Any adult over the age of 18 who has decisional capacity to consent to or refuse medical treatment may execute a CPR Directive. An adult Member's legal guardian, MDPOA, or proxy decision-maker may execute a CPR Directive for that adult if they lack decisional capacity. The following persons may execute a CPR Directive for a minor: the parents of a minor, if married and living together; the custodial parent or parent with decision-making responsibility for such a decision; or the legal guardian of a minor. CPR Directives must be countersigned by the Member's Physician to be valid.
- A CPR Directive must contain the following information:
  - » The person's name, date of birth and sex
  - » The person's eye and hair color and race or ethnic background
  - » If applicable, the name of the hospice program in which the person is enrolled
  - » The name, address, and telephone number of the person's Physician
  - » The person's signature or mark or that of a person authorized to sign the CPR Directive on behalf of the person, and the date the CPR Directive form was signed
  - » The person's directive concerning the administration of CPR, which must be countersigned by the person's Physician
  - » If applicable, the person's directive regarding tissue donation
- Provider can provide a form that meets these requirements to the Member upon request. In addition, the Member shall be encouraged to obtain a State of Colorado-issued CPR Directive identification necklace or bracelet for the Member's permanent use.
- Every Member admitted to the hospital shall have a designated CPR status. The CPR status of each Member shall be considered to be in the complete CPR status category unless the Member/guardian has executed a CPR Directive or as otherwise ordered by the attending Physician or their Physician designee. No or Limited CPR status is to be documented in the Member's medical record and a copy of the CPR Directive must be kept immediately accessible within the Member's medical record. No order limited CPR status may be written unless the Member/Member's decision-maker consents to having that order written.
- In the absence of a valid, apparent, and immediately available CPR Directive, a person's consent to CPR shall be presumed.
- When a Member's CPR status is classified in the Limited CPR or No CPR category, the attending Physician or their designee should write an explanatory note outlining the reasons for this decision. The note should state the Member's wishes, when known. It is also appropriate to mention any consultative opinions (e.g., neurology, neurosurgery, etc.), discussions with Nursing and/or Reparatory Therapy, and discussions with family members or other interested parties, if applicable. The attending Physician should countersign the note and the order declaring the No CPR or Limited CPR status within 24 hours.
- A valid CPR Directive for any person who is admitted shall be implemented as a Physician's order concerning resuscitation as directed by the person in the CPR Directive, pending further Physician's orders.
- When a Member is admitted with Limited or No CPR status (or changes their status to Limited or No CPR), the Member's Physician shall also enter an order Limited or No CPR in CPOE, according to the Member's wishes. If a Member later revokes a CPR Directive, the CPOE order must also be changed.
- CPR status shall be reviewed by the treating team on a regular basis for Members in intensive care units, and as appropriate for other hospital Members.
- During any CPR, the Physicians responsible for the Member's medical care will make the final judgment as to what procedures are carried out.
- A CPR Directive may be revoked at any time by a person who is the subject of the directive. Only those CPR Directives originally executed by a guardian, agent, or proxy decision-maker may be revoked by a

guardian, agent, or proxy decision-maker.

- Colorado law requires health care Providers to comply with a person's CPR Directive that is apparent and immediately available. Colorado law also provides that any health care Provider, facility, and/or any other person who, in good faith, complies with a CPR directive shall not be subject to civil or criminal liability or regulatory sanction for such compliance.
- If any disagreement exists between the Member, Member's representative, or their family and a member of the medical care team about the CPR status, the attending Physician or their designee may convene, as soon as possible, a group meeting of all interested parties and medical team members. The main purpose of this meeting shall be to resolve the CPR status disagreement. If, after such a meeting, major disagreement of the CPR status still exists, the attending Physician or their designee may seek consultation with the Director of Service (DOS), Legal Services, or with the hospital Ethics Committee. Under Colorado law, a competent adult Member has a right to direct their CPR status, and Physicians have a duty to comply with a Member's wishes as expressed in a valid CPR Directive that has not been revoked. Providers are immune from liability if they so comply. However, if there is a reasonable question about the validity of a CPR Directive or the identity of the Member, resuscitation shall be initiated (see 6-CCR- 10152(4.4)(f)(3)). Whether a reasonable question as to the validity of a CPR Directive exists depends upon the circumstances and shall be determined by the attending Physician in consultation with the medical care team, the DOS, Legal, and/or the Ethics Committee.
- Surgical Procedures and Invasive Ambulatory Procedures for Members with CPR Directives: Members with No CPR or Limited CPR orders may present a dilemma regarding appropriate therapy when undergoing anesthesia care or invasive ambulatory procedures. Anesthesia care inherently involves depression of, and/or potential loss of, central nervous system, cardiovascular and respiratory functions. Therefore, this type of care frequently implies a form of resuscitation. The following procedures are intended to provide guidance in the care of these Members during the preoperative period and prior to, during and following invasive ambulatory procedures:
  - » The anesthesiologist, attending Physician, or designee should discuss with the Member and medical care team which specific resuscitation modalities are appropriate to maintain adequate cardiopulmonary function during the administration of, and recovery from, the anesthetic and/or the procedure.
  - » A decision should then be reached pre-operatively as to whether or not the designated CPR status will be temporarily changed or suspended. This should be documented in the medical record.
  - » If the above is not feasible (e.g., emergency surgery), care of the Member should be carried out with reasonable adherence to the Member's directives, being mindful of the Member's goals and values.
  - » In the event that no clear consensus as to CPR status is reached with the Member prior to anesthesia, the Limited or No CPR status will be suspended during anesthesia and while the Member recovers from anesthesia, but typically not longer than 24 hours following surgery. For example, a Member's status may be returned to No CPR status upon discharge from PACU.
- Tissue Donation: The CPR Directive form includes a section for the Member to provide a directive regarding tissue donation. This section allows a competent Member to make their wishes known in advance, should the Member be unable to do so at a later time. While a Physician may explain to the Member what tissue donation may involve, the Physician may not approach the Member regarding tissue donation.

### **References:**

- Patient and Self-Determination Act, P.L. 101-508, 42 USC §§ 4206, 4751.
- Colorado Medical Treatment Decision Act, C.R.S. 15-18-101, et seq.
- Department of Public Health and Environment Rules Pertaining to Implementation and Application of Advance Medical Directives for CPR, 6 CCR 1015-2.

- Colorado Patient Autonomy Act, C.R.S. 15-14-503, et seq.
- Directive Relating to CPR, C.R.S. 15-18.6-101, et seq.
- Department of Health and Human Services, Centers for Medicare and Medicaid Services, Advance Directives, 42 C.F.R. § 489.102.
- The Joint Commission, Comprehensive Accreditation Manual for Hospitals, Standards R.I.2.20 and R.I.2.80.

## SECTION XVII: COORDINATION OF BENEFITS AND SUBROGATION

Coordination of Benefits (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 or more different health 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 their spouse or domestic partner’s health insurance plan. In addition, a Member’s auto insurance may provide personal injury protection (PIP) or medical payment benefits which cover medical expenses incurred as a result of injuries sustained in an automobile accident. Workers’ Compensation insurance provides coverage for medical care received as a result of a work-related injury or condition. There is no primary or secondary insurer for Workers’ Compensation claims; Workers’ Compensation insurance pays if the claim results from a work-related condition. 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 their insurer) is actually legally responsible for paying instead. 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 its Member’s claims and files legal documents to collect funds from the third party’s insurer. If a Provider is aware that a third party is liable for the cost of a Member’s services, they should email the Provider Relations Department at [ManagedCare.ProviderRelations@dhha.org](mailto:ManagedCare.ProviderRelations@dhha.org).

## SECTION XVIII: MEMBER ELIGIBILITY AND IDENTIFICATION

DHMP’s Members are issued an ID card upon enrollment into a benefit plan. Members are instructed to present their ID card when seeking medical services. The ID card alone does not guarantee eligibility. Providers are responsible for determining that a Patient is eligible for services. Call DHMP Health Plan Services Department at numbers listed by applicable line of business on page 3 to verify that a Patient is eligible to receive services. Refer to the Member’s ID card to identify any Member copayment amounts for office visits, urgent/emergency care, prescriptions, etc. For information on Real Time Eligibility (RTE), visit [DenverHealthMedicalPlan.org/RTE-Transactions](http://DenverHealthMedicalPlan.org/RTE-Transactions).

## SECTION XIX: HIPAA PRIVACY AND SECURITY

DHMP has established a comprehensive Privacy and Security policy to protect Members from inappropriate use or disclosure of their PHI. Under this policy, DHMP has implemented appropriate administrative, physical, and technical safeguards to ensure the security of electronic PHI. Its Notice of Privacy Practices is posted on DHMP's 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. DHMP requires that medical records be stored securely, so that access is granted to only those individuals who are authorized to do so in the performance of their duties, that they are organized and stored that allows for easy retrieval and that the practice periodically conducts training centered on member confidentiality requirements.

DHMP leverages Member information for many different purposes, including:

- For general plan administration purposes, including processing and paying claims, verification of enrollment and eligibility, Coordination of Benefits with other benefit plans, subrogation, re-insurance, financial auditing and Member satisfaction processes
- For quality management
- For UM
- For disease management activities
- To furnish information to Providers who are treating 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 PHI without an individual authorization from the Patient for treatment, payment and some health care operations purposes and for certain other specific purposes outlined by the HIPAA Privacy Rule (45 C.F.R. §§ 164.502, 164.506). The definition of health care operations includes QI, accreditation and licensing activities (45 C.F.R. § 164.501). Covered entities may disclose PHI to other covered entities for the other covered entity's treatment, payment and limited health care operations purposes, as defined by the Privacy Rule, as long as the request relates to current or former Patients or Members (45 C.F.R. § 164.506(c)(4)). DHMP's utilization review activities and claims review practices are considered payment activity, and DHMP's QI, 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. DHMP shares those same concerns and will proceed only in a manner that is consistent with applicable laws.

### SUSPENSION AND TERMINATION

Please note: If DHMP determines that Member health, safety, or welfare is endangered by the conduct of any participating Provider, or if the participating Provider's license, admitting privileges, or both are limited, suspended, or revoked, 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 or by applicable agreement with DHMP.

## SECTION XX: MEMBER RIGHTS AND RESPONSIBILITIES

As a new or existing practitioner, you should be aware of certain rights and responsibilities that Denver Health Medical Plan, Inc. (DHMP) members are entitled to and responsible for.

### 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.
- Obtain available and accessible services covered by the contract.
- Receive medical/behavioral health care that is based on objective scientific evidence and human relationships.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Have a partnership based on trust, respect and cooperation among the provider, staff and member that will result in better health care.
- Be treated with courtesy, respect and recognition of their 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 and in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
- Choose or change their Primary Care Provider (PCP) within the network of providers, to contact their PCP whenever a health problem is of concern to them and arrange for a second opinion at no cost, if desired.
  - » Note: Members may change their PCP at any time. The change will be effective immediately when the member makes an appointment with a new provider. Members do not need to notify DHMP.
- Expect that their medical records and anything they say to their provider will be treated confidentially and will not be released without their consent, except as required or allowed by law.
- Get copies of their medical records or limit access to these records, according to state and federal law.
- Know the names and titles of the doctors, nurses and other persons who provide care or services to them.
- Have a candid discussion with their provider about appropriate or medically-necessary treatment options for their condition, regardless of cost or benefit coverage.
- Participate with their providers in making decisions about their 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 (QI) Program.
- Receive information about DHMP, its services, its practitioners and providers and members' rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions and limits on covered services.
- Learn more about their PCP and their qualifications, such as medical school attended or residency. Visit [DenverHealthMedicalPlan.org/Find-Doctor](http://DenverHealthMedicalPlan.org/Find-Doctor) for our web-based directories, or call Health Plan Services at 303-602-2100.
- Express their 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 them to sign; refuse to sign these forms until they 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 they do not want applied to their care; or to change their mind before undergoing a procedure for which they have already given consent.

- Instruct their providers about their wishes related to advance directives, such 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 they need them when getting their health care services.
  - Change enrollment during the times when rules and regulations allow them to do so.
  - 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 DHMP cannot be changed after prior authorization or retrospectively denied except for fraud, abuse or change in eligibility status at the time of service.
  - Make recommendations regarding DHMP's Member Rights and Responsibilities policies.
- Voice a complaint or appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the complaint/appeal process.

## **MEMBERS HAVE THE RESPONSIBILITY TO:**

- Treat providers and their staff with courtesy, dignity and respect.
- Pay all premiums and applicable cost sharing (i.e., deductible, coinsurance, copays).
- Make and keep appointments, be on time or call if they will be late or must cancel an appointment and have their DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- Report their symptoms and problems to their PCP, ask questions and take part in their health care.
- Learn about any procedure or treatment and think about it before it is done.
- Think about the outcomes of refusing treatment that their PCP suggests.
- Follow plans and instructions for care that they have agreed upon with their provider.
- Provide, to the extent possible, correct and necessary information and records that DHMP and its providers need in order to provide care.
- Understand their health problems and participate in developing mutually-agreed upon treatment goals to the degree possible.
- State their complaints and concerns in a civil and appropriate way.
- Learn and know about plan benefits (i.e., which services are covered and non-covered) and to contact a DHMP Health Plan Services representative with any questions.
- Inform providers or a representative from DHMP when not pleased with care or service.
- To notify DHMP of any third party insurance, including Medicare.

## **MEMBERS OF ELEVATE MEDICAID CHOICE AND CHP+ HAVE THE FOLLOWING RIGHTS:**

### ***Balance Billing Prohibition Now Applies to CHP+ | Medicaid Policy Reminder***

#### **New Balance Billing Prohibition, CHP+**

Under federal regulation (42 CFR 457.1233), CHP+ members are protected from balance billing. This applies to all covered services, including those rendered by contracted or out-of-network providers.

#### **What this means for providers:**

If you provide services to a CHP+ member, whether you are contracted with the plan or providing care under an authorized service, you may not bill the member for any remaining balance after the health plan has paid for the covered service.

#### ***Billing Prohibition for Covered Services, Medicaid***

#### **Reminder: Medicaid Members Cannot Be Billed for Covered Services**

As a reminder, Health First Colorado (Colorado's Medicaid Program) prohibits billing members for any covered

services. This applies even if a provider is out-of-network, so long as the service is a Medicaid covered benefit.

### **What this means for providers:**

If a Medicaid member receives a covered service, you may not charge or balance bill the member under any circumstance.

For any billing or reimbursement questions, please reach out directly to the health plan for assistance.

## **SECTION XXI: MEDICAID PREVENTIVE HEALTH CARE**

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

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

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

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

### **PEDIATRIC IMMUNIZATION RECOMMENDATIONS NOTES:**

1. This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturer’s package inserts for detailed recommendations.
2. Infants born to HBsAg-negative mothers should receive 2.5 gig of Merck vaccine (- Recombivax HB<sup>®</sup>) or 10 gig of SmithKline Beecham (SB) vaccine (Fmgerix-B<sup>®</sup>). The second dose should be administered > one month after the first dose. The third dose should be given at least two months after the second, but not before six months of age.
3. Infants born to HBsAg-positive mothers should receive 0.5mL hepatitis B immune globulin (HBIG) within 12 hours of birth, and either 5 lag of Merck vaccine (Recombivax HB<sup>®</sup>) or 10 gig of SB vaccine CEngerix-B<sup>®</sup>) at a separate site. The second dose is recommended at one to two months of age and the third dose at six months of age.
4. Infants born to mothers whose HBsAg status is unknown should receive either 5 gig of Merck vaccine (Recombivax HB<sup>®</sup>) or 10 lag of SB vaccine (Engerix-B<sup>®</sup>) within 12 hours of birth. The second dose of vaccine is recommended at one month of age and the third dose at six months of age. Blood should be drawn at the time of delivery to determine the mother’s HBsAg status; if it is positive, the infant should

receive HBIG as soon as possible (no later than one week of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.

5. Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series during the 11 to 12 year-old visit, and unvaccinated older adolescents should be vaccinated whenever possible. The second dose should be administered at least one month after the first dose, and the third dose should be administered at least four months after the first dose, and at least two months after the second dose.
6. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received > one dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The fourth dose (DTP or DTaP) may be administered as early as 12 months of age, provided six months have elapsed since the third dose, and if the child is unlikely to return at 15 to 18 months of age. Td (tetanus and diphtheria toxoids) is recommended at 11 to 12 years of age if at least five years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every ten years.
7. Three H. Influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB®[Merck]) is administered at two and four months of age, a dose at six months is not required.
8. The American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) both recommend a total of four doses of inactivated poliovirus vaccine (IPV) given at approximately 2 months of age, 4 months, 6-18 months and a final dose at 4-6 yrs of age.
9. The second dose of MMR is recommended routinely at 4 to 6 years of age, but may be administered during any visit, provided at least one month has elapsed since receipt of the first dose, and that both doses are administered at or after 12 months of age. Those who have not previously received the second dose should complete the schedule no later than the 11 to 12 year visit.
10. Susceptible children may receive Varicella vaccine (Var) during any visit after the first birthday, and those who lack a reliable history of chickenpox should be vaccinated during the 11 to 12 year-old visit. Susceptible children > 13 years of age should receive two doses, at least one month apart.

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

## **EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)**

The EPSDT benefit provides comprehensive and preventive health care services for members aged 20 and under, as well as pregnant persons who are enrolled in Medicaid. EPSDT is a required Medicaid benefit that ensures eligible members under age 21 receive all medically necessary services, even if the service is not covered for adults under the State Plan. EPSDT is the key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

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

### ***EPSDT Services***

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

### ***Screening Services***

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

### ***Diagnostic Services***

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

### ***Treatment***

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

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

- For benefits covered by Elevate Medicaid Choice, place a referral in EPIC to the appropriate practitioner or facility to be reviewed for authorization by DHMP's UM Department. Phone: 303-602-2140 (see UM policy MCD\_CHP\_UM01, Utilization Review Determinations Including Approvals and Actions, for more information)
- For Wrap Around Benefits not covered by Elevate Medicaid Choice, place a referral through ColoradoPAR (see Pediatric and Adolescent Preventive Healthcare Guidelines, PolicyStat ID 2212803, for more information)
- The DHMP Care Management Team is available to help Providers connect to Care Management services by calling 303-602-2184. Care Management can also support families of Elevate Medicaid Choice children (ages zero through 20) by assisting families with Medicaid resources; guiding families to appropriately use of Medicaid benefits; assisting with finding a Medicaid dentist; and assisting with coordination of transportation through the non-emergent medical transportation vendor, Intelliride at 303-398-2155

For more information, please reference the DHMP Provider page, which can be found at: [DenverHealthMedicalPlan.org/Early-And-Periodic-Screening-Diagnostic-And-Treatment-EPSDT](http://DenverHealthMedicalPlan.org/Early-And-Periodic-Screening-Diagnostic-And-Treatment-EPSDT).

### ***Periodicity Schedule***

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

### ***Medical Necessity***

"Medical necessity for EPSDT services" is defined as:

- A service that is found to be equally effective treatment among other less conservative or more costly treatment options
- Meets one of the following criteria:
  - » The service is expected to prevent or diagnose the onset of an illness, condition, or disability
  - » The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental

- effects of an illness, injury, or disability
- » The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability
- » The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living
- May be a course of treatment that includes observation or no treatment at all
- The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements:
  - » The service is medically necessary
  - » The service is in accordance with generally accepted standards of medical practice
  - » The service is clinically appropriate in terms of type, frequency, extent, and duration
  - » The service provides a safe environment or situation for the child
  - » The service is not for the convenience of the caregiver
  - » The service is not experimental and is generally accepted by the medical community for the purpose stated

***Members may self-refer for the following EPDST services:***

- Well-child checks
- Immunizations
- Vision screening/eyeglasses
- Hearing screening

***EPDST services that require a PCP referral and/or Prior Authorization:***

- Speech (PCP referral)
- Physical therapy/occupational therapy (PCP referral)
- Home Health (PCP referral and Prior Authorization)
- Substance use disorders treatment (PCP referral and Prior Authorization), these services are coordinated and provided through the Medicaid Choice Behavioral Health vendor, Colorado Access. A Tip Sheet for BH services is available in the DHMP provider website.

***Wrap Around Benefits***

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

***Wrap Around Benefits associated with EPDST:***

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

***EPDST Provider Responsibility***

- Provide health screening services, including immunizations, according to EPDST guidelines and Bright Futures Periodicity Schedule

- Promptly diagnose, treat or provide a referral for problems identified during the screening process
  - » If a Provider is not licensed or equipped to render necessary treatment, the Provider is responsible to make a referral to another Provider or make a referral to the UM Case Managers to assist with a referral
- Utilize the ColoradoPAR Provider Portal for Wrap Around services available through Colorado Health First for delivery of medically necessary services to EPSDT-eligible Members
- Providers must document screening components delivered, any risks identified, referrals made, and follow-up steps in the member's health record.
- Providers must ensure EPSDT information and services are accessible to members with limited English proficiency or disabilities, including offering interpreter services where appropriate.

#### ***Tracking of EPSDT-required services***

Follow-up and treatment should begin as soon as possible and no later than six months after the screening identifies a need. Initiation of treatment, if required, must occur within an outer limit of six months after a referral has been placed. To ensure the delivery of EPSDT-required services, the following tools should be utilized as needed:

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

## **SECTION XXII: ELEVATE MEDICAID CHOICE PROGRAM OVERVIEW – MEDICAL SERVICES, BENEFITS & EXCLUSION SUMMARY**

### **OVERVIEW**

Elevate Medicaid Choice is a health care program offered by DHMP. Providers of Elevate Medicaid Choice are limited to DHHA unless they have been specifically contracted. NOTE: Elevate Medicaid Choice Members ***shall not be held liable*** for any of the following:

- Elevate Medicaid Choice's debts in the event of Elevate Medicaid Choice's insolvency
- Covered services provided to the Member for which the State does not pay Elevate Medicaid Choice
- Covered services provided to the Member for which the State or Elevate Medicaid Choice does not pay the health care Provider that furnishes the services under a contract, referral, or other arrangement
- Payments for Covered Services furnished under a contractual, referral, or other arrangement to the extent those payments are in excess of the amount that the Member would owe if Elevate Medicaid Choice provided the services directly

### **ADMISSIONS:**

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

### **CONCURRENT REVIEW:**

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

## COVERED SERVICES:

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

## ABORTION:

Abortions are a covered benefit only in the following circumstances:

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

NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

- Ectopic pregnancies (pregnancy occurring in other than a normal position or place)
- Miscarriage (spontaneous abortion)

## FAMILY PLANNING SERVICES:

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

## EXCLUSIONS:

The following services are excluded from coverage:

### ***Acupuncture***

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

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

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

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

### ***Autopsy Charges***

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

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

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

**Counseling** for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders; or chronic situational reactions.

**Dental services:**

- Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.
- For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related cost resulting from the services when determined by the Contractor to relate to a dental condition.

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

**EPSDT Services** not provided under this contract are:

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

**Experimental** or investigational services or pharmaceuticals.

**Government-Sponsored Care:**

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

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

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

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

**Hearing Aids** with the exception of EPSDT covered services, diagnostic procedures performed for the purposes

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

### ***High colonics***

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

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

***Home Health Services:*** Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.

- Long-term Home Health as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.
- Home Health Services provided by a person who ordinarily resides in the Client's home, or is an immediate family member, are not covered.

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

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

### ***Hypnosis***

***Immunizations*** related to foreign travel.

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

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

***Inpatient Hospital*** excluded services include:

- Psychiatric/psychological care included and covered through the RAE Capitated Behavioral Health Benefit
- Discharge medications and experimental drugs
- Inpatient hospital services defined as experimental by the Medicare program
- For Medicaid-approved benefits, Medicare Patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities

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

## ***Isometric Exercise***

***Expenses for Medical Reports***, including presentation and preparation.

***Laboratory Services*** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

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

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

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

***Portable and Liquid Oxygen***: For specific procedure codes and descriptions of oxygen and oxygen equipment that are covered by Elevate Medicaid Choice and that are covered by State Medicaid, please contact Elevate Medicaid Choice Provider Relations at 303-602-2050.

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

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

***Physical Examinations*** of the following nature are excluded:

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

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

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

***Psychiatric/Psychological Care*** as follows:

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

**Reversal** of surgically performed sterilization or subsequent re-sterilization. Procedures, services and supplies relating to sex change or transformation.

**SNF Services** are a Wrap Around Benefit.

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

**Transportation, Non-Emergent**, to medical appointments.

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

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

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

- Auditory services for children. HMO-covered services include screening and medically necessary ear exams and audiological testing. Wrap around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation
- Cavity Free at Three dental services
- Comprehensive dental assessment, care and treatment for children
- Dental services for adults. These are limited to emergency services and minimal medically necessary dental services for adults with concurrent medical conditions
- Drug/alcohol treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only
- HCBS Services including case management (for Model 200 children), home modification, electronic monitoring, personal care and non-medical transportation
- Hospice services, however, Client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested
- Hospital backup level of care as defined by 10 CCR 2505-10, Section 8.470
- Inpatient substance abuse rehabilitation treatment for individuals aged 20 and under, DRG 772, as set forth in 10 CCR 2505-10, Section 8.300.4.5.
- Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department and HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai
- Non-emergency transportation to medical appointments for covered services only, through the Client's county of residence
- Pediatric Behavioral Therapies
- Private-Duty Nursing (PDN), nursing services only
- SNF services (skilled nursing and rehabilitation services) if Client meets level of care certification. Wrap Around SNF services include those services set forth at 10 CCR 2505-10, Section 8.440.1., notwithstanding the list of covered services set forth above. Wrap Around SNF services also include any Medicare cross-over benefits

## ADDITIONAL INFORMATION:

No pre-existing condition limitations.

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

## SECTION XXIII: ELEVATE MEDICARE ADVANTAGE PROGRAM

### DHMP HAS TWO MEDICARE ADVANTAGE PLANS FOR ARAPAHOE, ADAMS, DENVER AND JEFFERSON COUNTY RESIDENTS:

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

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

#### ***Covered Benefits***

Like all Medicare health plans, Elevate Medicare Advantage offers all of the benefits covered by Original Medicare. DHMP members also get more than what is covered by Original Medicare.

For a full listing of covered benefits of each plan, Providers should consult the Explanation of Coverage (EOC) on DHMP's website at [DenverHealthMedicalPlan.org/Medicare-Existing-Members](https://denverhealthmedicalplan.org/Medicare-Existing-Members).

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

## SECTION XXIV: PALLIATIVE/HOSPICE CARE

### COMMERCIAL PLANS (EMPLOYER GROUP AND EXCHANGE):

#### ***Eligibility & Oversight***

- Coverage required for terminal illness ( $\leq$  6 months life expectancy).
- Must be coordinated by a certified hospice provider.
- Coverage may extend beyond 6 months with medical review.
- Requires physician certification and may include prior authorization.

### ***Core Benefits***

- Routine home care: Minimum \$150/day, for at least 90 days per benefit period.
- Crisis/inpatient care: Covered separately from routine cap.
- Subject to plan's standard cost-sharing (deductible, coinsurance).

### ***Additional Services (outside daily limit)***

- Bereavement counseling: At least \$1,400 over 12 months.
- Supplies, medications, therapies, equipment, transportation, and physician services must be included.

### ***Notification & Protections***

- Insurers must notify providers within 2 business days if services are excluded.
- All limitations must comply with this regulation.

## **ELEVATE MEDICAID CHOICE PLAN:**

Hospice care services are wrap-around service, which is a benefit that is authorized and reimbursed by the State of Colorado Medicaid on a fee for service basis upon determination of Medical Necessity.

Palliative care services must be determined on a case by case basis. Palliative services for end of life care are considered hospice service; therefore, is a wrap-around service. Palliative care for a chronic condition is authorized and reimbursed by DHMP. If the services are provided as home health and are expected to extend beyond 60 days, DHMP is responsible for the initial 60 days and after that timeframe the services become a wrap-around service. The provider should be submitting authorization requests to the State of Colorado at least 30 days in advance of extending beyond the 60 days.

## **ELEVATE CHILD HEALTH PLAN *PLUS* (CHP+) PLAN:**

Hospice care services are authorized and reimbursed by DHMP.

Home health care services are authorized and reimbursed by DHMP. Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Division of Insurance Regulation 4-2-8 as amended.

## **ELEVATE MEDICARE ADVANTAGE PLAN:**

Once CMS identifies a member as hospice eligible, it will be added to the DHMP enrollment system, and a flag will be added for Hospice to prevent payment for Original Medicare covered services.

Medicare Advantage plan members may receive care from any Medicare certified hospice program (in network or out of network). Original Medicare (rather than DHMP) will pay the hospice provider for the services they receive.

The claim must first go to original Medicare and then must be submitted to DHMP as secondary with evidence showing what Medicare paid.

Services covered by Elevate Medicare Advantage that are not hospice covered (e.g., dental, vision, etc.) should still be billed to DHMP as primary coverage.

A hospice restriction does not get removed until the plan receives communication from CMS.