COLORADO
Department of Health Care Policy & Financing

Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limit Survey

October 2017

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Nonquantitative Treatment Limit (NQTL) Survey of Behavioral Health Organizations

Background

Under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), Colorado is required to conduct an analysis of the benefits offered to its Medicaid members and people enrolled in the state's Children's Health Insurance Program (CHIP). MHPAEA stipulates that the state and its contracted managed care plans must not limit behavioral health services in a manner that is more restrictive than that by which it limits physical health services. The analysis takes into account both quantitative limits on services, such as visit limits or co-pays, and nonquantitative treatment limits (NQTLs). NQTLs are "soft limits" applied to covered benefits, such as prior authorization requirements, as well as structural approaches to service delivery, such as the development of treatment provider networks.

This survey is designed to collect essential information about how Colorado's five behavioral health organizations (BHOs) apply NQTLs to the services they cover for Medicaid members. The Department has identified five NQTLs about which it requires additional information for the purposes of the mandatory parity analysis. These NQTLs may or may not be applied to services across five classifications of covered benefits: inpatient, outpatient, emergency, and pharmacy services. The questions contained in this survey have been developed to help the BHOs describe how they manage the full range of benefits they provide to Medicaid members throughout Colorado.

Format of the Survey

The response section of this survey consists of five worksheets, each one representing an NQTL identified by the Department. Each sheet contains a series of questions about how the NQTLs are applied across four benefit classifications--inpatient, outpatient, emergency, and pharmacy services. Questions about NQTL application in the four classifications are repeated in four sections throughout each sheet. There is also a space for each BHO to identify itself in each section.

Survey Responses	There are cells to the right of survey questions where BHOs can type in their responses. Responses to this survey should be very succinct and limited to the substance of the questions being asked. Many of the survey questions only require "yes" or "no" answers. Please limit the length and complexity of responses accordingly.
Pharmacy Benefits	The Department is aware that the state, not BHOs, set pharmacy benefit policy through its prescription drug formulary and provider guidance. Nonetheless, this survey includes the same questions about NQTL application to benefits in the pharmacy classification as it does for the inpatient, outpatient, and emergency classifications. Wherever possible, BHOs should provide relevant and succinct answers to questions about pharmacy benefits, particularly when they illuminate availability and access for Medicaid members.

MHPAEA or Survey-Related Terms	Definition
Nonquantitative Treatment Limit	Non-numerical limits on the scope of duration of benefits for treatment.
Inpatient Services	Services in which: a) the patient is admitted to an institution, hospital, or facility for greater than 24 hours, or b) the patient receives residential care through a facility for greater than 24 hours, or c) the patient receives the specific benefit in an institutional setting which is not their usual place of residence (such as a licensed hospice facility) for greater than 24 hours, and d) the service is not a respite service
Outpatient Services	Services in which the patient receives treatment a) without being admitted to an institution, per definition of 'Inpatient Services', **and** b) services are not emergent, per definition of 'Emergency Services'. This includes the provision of equipment and supplies, such as DMEPOS, and services delivered in the home, school, and any settings that meet home and community based services characteristics. This excludes services provided by a pharmacy.
Emergency Services	Services which are specifically designated to be rendered on an emergent basis. Examples includes: 'behavioral emergency crisis services', 'hospital emergency room services', and 'emergency transportation'.
Pharmacy Services	Services which can be provided by pharmacies.
Prior Authorization	Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.
Concurrent Review	Requirement that services be periodically reviewed as they are being provided in order to continue authorization.
Retrospective Review	Protocol for approving coverage for a service after it has been delivered.
Network Provider Admission	Process of accepting treatment providers into the health plan's network of care professionals.
Establishing Charges	Methods for determining usual, customary, and reasonable charges for services.

Benefit Classification: INPATIENT SERVICES	**ABCD/ABCNE**	**BHI**	**CHP/FBHP**	**PRIME**	**DHMC**	**FFS Medical/Surgical**
NQTL: Prior Authorization						
Process						
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.	Yes	Yes	Yes for Inpatient, ATU, RTC CSU - Crisis Stabilization Unit - H0018 ET No Authorization Required. Need notification of admission	No. A list of services by procedure code that are not subject to prior authorization would be voluminous and unduly burdensome to produce. Therefore, attached as "RMHP Clinical Preauthorization List," is a list of all services (with procedure codes) that are subject to prior authorization.	No -Some services require prior authorization. Some services are available without restriction.	No
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.	In cases of retro-eligibility no prior authorization penalty but medical necessity rules apply.	Yes, there are exceptions: - provider isn't aware that member has Medicaid - retroactive eligibility - non contracted facilities - residential services provided by the CMHC's in BHI's catchment area	Yes - Retro Eligibility for patients - patient admitted and then inpatient psych facility discovers that patient has Medicaid.	Yes. Providers who are at financial risk, have trained on health plan guidelines and have agreed to adhere to them are exempt from prior authorization requirements.	Yes services that require prior authorization are evaluated for medical necessity against clinical criteria that is created through a process involving the feedback of network providers as well as review of national standards and guidelines. Experimental and investigational services are not a covered benefit.	Yes
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?	Yes and we do not require a secondary assessment.	For all BHI contracted facilities EXCEPT Children's Hospital, University Hospital and Denver Health an assessment completed by the CMHC is preferred. If the CMHC is unable to respond to the request for assessment within 1 hour, then the secondary assessment request is waived and the direct treatment provider performs the assessment. For non-contracted and out of area facilities, the direct treatment provider completes the assessment.	For Inpatient, ATU and RTC: Community Mental Centers are to be notified and involved in the evaluation. Other CMHCs may do a courtesy evaluation and then review with the parent MHC. CMHC may also grant approval for the facility to provide the initial clinical assessment to the UM Department. This does not apply to CSU admissions - BHO is notified of the admission.	Direct treatment providers complete the prior authorization request and submit it to the health plan for those services subject to prior authorization. The health plan reviews the request and approves or denies it.	Secondary Assessment from Utilization Management/Medical Director or Designee	Direct treatment provider
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?	10 Days	Per our Contract we have 3 business days and extensions of up to 14 calendar days can be made if 1. the member or requesting provider requests an extension or 2. BHI needs additional clinical information in order to make a decision and can justify that the extension is in the member's best interest. Operationally, decisions are most often made within a few hours.	Inpatient and ATU admission - 24 hours if patient already admitted and 72 hours prior to admission (generally 24 hours). Exception - patient in ER being stabilized prior to admission to inpatient psych facility) RTC admission - 10 calendar days CSU admission - does not apply. No prior authorization required	Ten calendar days.	Standard is 10 calendar days, expedited is 3 working days, if timeframe is extended, up to 14 additional calendar days	Variable
Strategy						
What is the **rationale** for prior authorizing services in this classification?	Appropriate level of care, is diagnosis covered, covered benefit	Fiscal management of high cost services and to identify utilizers of this intensive service so that they can be connected with the resources they need including 7 day post discharge appointments and ongoing care management.	To assess/evaluate medical necessity for these higher levels of care so that the patient receives the right treatment at the right time in the least restrictive setting. And as allowed per Amendment #7 of the Contract: 2.2.1.0	Those services that are high cost, high risk or for which there is a potential for overutilization are subject to prior authorization.	Prior authorization ensures patients are using the most efficacious, cost effective and safe procedure or treatment for their diagnosis.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are prior authorization policies the same for both **in-network and out-of-network** providers?	Yes	No. Out of Network (non-contracted) providers are not required to seek prior-authorization.	Yes	No.	Typically out of network providers are not covered, at times however if members are admitted to out of network facilities for care that is not available within the Denver Health System then prior authorization policy is the same as in-network	**Yes**
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?	Yes, providers are notified. Routine updates are sent quarterly. Updates are put on website as they occur.	Yes the plan would update providers if changes were made. Updates to these requirements are extremely rare and have not been made in at least the last 3 years.	Yes When there is a change in benefit or development of a different level of care (i.e. CSU) that can be utilized in providing services - providers are alerted to the changes. (And as new policies or procedures develop or change.)	Yes. The health plan provides updates annually.	Yes, annually	Providers notified via website
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?	Yes, Interqual	No	No	Yes	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?	No	Yes, annually	Yes Annually	No	Yes Yes, annually	Yes

Benefit Classification: OUTPATIENT SERVICES						
NQTL: Prior Authorization						
Process						
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.	No 00104 90785 90791 90792 90832 90833 90834 90836 90837 90838 90839 90840 90846 90847 90849 90853 90870 90875 90876 90887 96116 96372 97535 97537 98966 98967 98968 99221 99222 99223 99231 99232 99233 99238 99239 99251 99252 99253 99254 99366 99367 99368 99441 99442 99443 G0176 G0177 *H0001 H0002 H0004 *H0005 *H0006 H0020 H0023 H0025 H0031 H0032 H0033 H0034 H0035 H0036 H0037 H0038 H0039 H0040 H0043 H0044 H0045 H1011 H2000 H2001 H2011 H2014 H2015 H2016 H2017 H2018 H2021 H2023 H2024 H2025 H2026 H2027 H2030 H2031 H2032 H2033 M0064 *S3005 S5150 S5151 *S9445 S9453 S9454 S9485 T1005 *T1007 T1016 T1017 *T1019 *T1023 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99217 99218 99219 99220 99224 99225 99226 99234 99235 99236 99241 99242 99243 99244 99245 99255 99304 99305 99306 99307 99308 99309 99310 99315 99316 99318 99324 99325 99326 99327 99328 99334 99335 99336 99337 99341 99342 99343 99344 99345 99347 99348 99349 99350	No. The services that REQUIRE prior authorization are: H2015, H2016, H0037, H2033, H2022, H2012, H0045, S5151, S9480, H0005, H0035, 96101, 96118. All other outpatient services covered under the Medicaid contract do NOT require prior authorization.	No - 90791, 90792, H0002, H0031, H2000, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90875, 90876, 90853, 96372, H0032, H0033, H0034, E/M codes. H0001, H0031, S9485, T1017, H0004, H0006, H0045, H2017, H2027, H2011, S5150, S5151, S3005, T1007, T1019, T1023, H0020	No. A list of services by procedure code that are not subject to prior authorization would be voluminous and unduly burdensome to produce. Therefore, attached are two lists of all services (with procedure codes) that are subject to prior authorization. These are referred to as "RMHP Clinical Preauthorization List" and "RMHP DME Preauthorization Schedule."	No -Some services require prior authorization. Some services are available without restriction, some with quantity limits.	No
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.	No	Yes there are exceptions: - provider isn't aware that member has Medicaid - retroactive eligibility - services provided by the CMHC's in BHI's catchment area	Yes - Related to Crisis Services, certain codes do not need pre-authorization if the ET modifier is used Retro Medicaid eligibility - permit retro authorizations up to 30 days after date of service.	Yes. Providers who are at financial risk, have trained on health plan guidelines and agreed to adhere to them are exempt from prior authorization requirements.	Yes services that require prior authorization are evaluated for medical necessity against clinical criteria that is created through a process involving the feedback of network providers as well as review of national standards and guidelines. Experimental and investigational services are not a covered benefit.	Yes
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?	Yes, and we do not require a secondary assessment.	Secondary assessment is requested, but not required, for H2012, H2015 and H2016.	Majority of the time - Direct treatment provider. CMHC evaluators are involved in the pre-authorization process for intensive, community based services and day treatment	Direct treatment providers complete the prior authorization request and submit it to the health plan for those services subject to prior authorization. The health plan reviews the request and approves or denies it. One exception to this process is that labs (direct treatment provider) do not complete prior authorization request. In that instance, the provider ordering the labs completes the prior authorization request.	Secondary Assessment from Utilization Management/Medical Director or Designee	Direct treatment provider
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?	10 days	Per our contract with the State, determinations are made within 10 calendar days. Extensions of up to 14 calendar days can be made if 1. the member or requesting provider requests an extension or 2. BHI needs additional clinical information in order to make a decision and can justify that the extension is in the member's best interest.	10 calendar days	10 calendar days	Standard is 10 calendar days, expedited is 3 working days, if timeframe is extended, up to 14 additional calendar days	Variable
Strategy						
What is the **rationale** for prior authorizing services in this classification?	Appropriate level of care, is diagnosis covered, covered benefit	Fiscal management of high cost services and to identify utilizers of these intensive service so that they can be connected with the resources they need	Due to complexity and intensity of certain cases and services being requested. (i.e. intensive wrap-around services, Psych testing, etc.)	Those services that are high cost, high risk or for which there is a potential for overutilization are subject to prior authorization.	Prior authorization ensures patients are using the most efficacious, cost effective and safe procedure or treatment for their diagnosis.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are prior authorization policies the same for both **in-network and out-of-network** providers?	Everything requires a prior-authorization for out-of-network providers.	Yes	Yes	No	Typically out of network providers are not covered, at times however if members are referred to out of network facilities for care that is not available within the Denver Health System then prior authorization policy is the same as in-network	Yes
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?	Yes, providers are notified. Routine updates sent quarterly. Updates are put on website as the occur.	Yes providers are notified when updates occur. Updates are not made at planned intervals.	Yes When there is a change in benefit or changes made in the State's Medicaid contract (via amendments) - providers are alerted to the changes.	Yes, the health plan provides updates annually.	Yes, annually	Providers notified via website
Evidentiary Standards						

Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?	Yes, Interqual	No	No	Yes		Yes
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?	No	Yes, annually	Yes Annually	No	Yes Yes, annually	Yes, variable frequency of updates
Benefit Classification: EMERGENCY SERVICES						
NQTL: Prior Authorization						
Process						
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.	No services require prior auth.	No. Emergency services do not require prior authorization.	No Emergency Room visits, Crisis Services (i.e. outpatient codes where provider uses the ET modifier)	No. No emergency services are subject to prior authorization.	Prior authorization does not apply	No
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.	N/A	N/A	Does not apply	No	N/A	N/A
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?	N/A	N/A	Does not apply	Not applicable. No emergency services are subject to prior authorization.	N/A	N/A
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?	N/A	N/A	Does not apply	Not applicable. No emergency services are subject to prior authorization.	N/A	N/A
Strategy						
What is the **rationale** for prior authorizing services in this classification?	N/A	N/A	Does not apply - per State Contract, Emergency Room Services do not need pre-authorization whether it is through a contracted or non-contracted provider/facility	Not applicable. No emergency services are subject to prior authorization.	DHMP covers any emergency medical conditions or urgently needed services to evaluate and stabilize members.	N/A
Are prior authorization policies the same for both **in-network and out-of-network** providers?	N/A	N/A	Emergency Room services can be provided by contracted and non contracted facilities/providers	Yes	Yes	N/A
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?	N/A	Yes, providers would be updated should changes occur. However, no changes have occurred to these requirements thus far.	Yes When there is a change in benefit or changes made in the State's Medicaid contract (via amendments) - providers are alerted to the changes.	Not applicable. No emergency services are subject to prior authorization.	 Yes, annually	N/A
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?	N/A	N/A	No - Does not apply	Not applicable. No emergency services are subject to prior authorization.		N/A
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A	No - Does not apply	Not applicable. No emergency services are subject to prior authorization.	N/A N/A	N/A
Benefit Classification: PHARMACY SERVICES						
NQTL: Prior Authorization						
Process						
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs per the Medicaid contract. BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	No, attached as "RMHP Formulary Extract," is a list of all drugs covered. Those that are subject to prior authorization are indicated on the list.	Some medications require prior authorization. Some medications are available without restriction, some with quantity limits, some with step therapies.	**No**

Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs per the Medicaid contract. BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	Certain prescribers are exempt from prior authorization requirements because they have agreed by contract to follow certain protocols with respect to prescribing that the health plan has established, thereby obviating the need for prior authorization.	Drugs that require prior authorization are evaluated for medical necessity against clinical criteria that is created through a process involving the feedback of network providers as well as review of national standards and guidelines. Experimental and investigational medications are not a covered benefit.	Yes
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs per the Medicaid contract. BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	The prescribing practitioner completes and submits the prior authorization request to the health plan. The health plan (or its contracted PBM) reviews the request and approves or denies it..	The direct treatment provider is able to complete the authorization. The health plan Pharmacy Department reviews all authorization requests.	Direct treatment provider
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs per the Medicaid contract. BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	Almost all determinations are issued within 24 hours. The maximum time allowed for a determination is 5 days. RMHP will dispense a 72 hour emergency supply while we await additional information necessary to make a determination.	A decision will be provided no later than 24 hours after receipt of the request. If the request is incomplete or additional information is needed, an inquiry to the requesting party may be initiated within one working day from the day of the request. If no response is received from the party within 24 hours the request shall be denied. Services that require authorization are approved for up to a year.	Variable
Strategy						
What is the **rationale** for prior authorizing services in this classification?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Ensuring appropriate clinical use, dosing, step therapy (e.g., first line therapies are tried before others that have greater clinical risk). Ensures medications with high risk of adverse effect and very expensive medications are prescribed according to FDA and compendia supported use, and are prescribed by appropriate specialists, as applicable.	Many mental health medications are prescribed off label or with little to no supporting evidence. Prior authorization ensures patients are using the most efficacious, cost effective and safe product for their diagnosis.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are prior authorization policies the same for both **in-network and out-of-network** providers?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes	The policies are the same for both in and out of network prescribers. Prescriptions at out of network pharmacies are not covered. Non-registered pharmacies may be granted a 72 hour emergency supply.	Yes
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes. Updates occur whenever a change occurs (.e.g., new FDA approved indication).	Providers are notified of any changes annually per the provider handbook. The website lists quarterly changes to the formulary.	Providers notified via website
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes	Pharmacy staff review clinical criteria on an annual basis to evaluate data from government agencies (FDA approved package inserts), medical associations, national commissions, peer-reviewed clinical studies and medical journals, and authoritative compendia. After changes or updates are made the criteria is sent to network providers including board certified specialists for review and input which is taken into consideration before the finalization of the criteria.	Yes
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes. They are updated as often as changes occur (.e.g., new FDA approved indication).	Yes, annually	Yes

Benefit Classification: INPATIENT SERVICES	**ABC**	**BHI**	**CHP/FBHP**	**PRIME**	**DHMC**	**FFS Medical/Surgical**
NQTL: Retrospective Review						
Process						
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?	We adhere to the timely filing standards in the provider contract and we review on a case by case basis.	Yes. Providers have 60 days to file a claim from the date the service was provided or from the date they learned that a member was Medicaid eligible, whichever comes later.	Yes - 30 calendar days after date of service	No	No	2 years
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.	Yes	Yes	Yes	Yes	Yes	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.	Members with retro-eligibility.	Extensions can be granted if not all of the clinical information is available for review.	Extensions can be granted if not all the clinical information is available for review.	No	No	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?	30 days	60 days, unless an exception is made.	30 calendar days from date of receipt of the request for a retro review (All clinical document is sent and available for review)	30 days	Decisions - no later than 30 calendar days Extensions - 15 calendar days at member or health plan request/if in member's best interest	None
Strategy						
What is the **rationale** for retrospectively reviewing services in this classification?	Medical necessity, appropriate level of care, covered diagnosis	It gives the provider the opportunity to obtain authorizations for these services in situations in which prior authorization was not obtained.	Provides an opportunity to the facility to obtain authorizations for these services when a discovery occurs that the member was retro eligible with Medicaid.	To ensure that appropriate level of care and quality services are provided.	When a request is received for a reimbursement where the service(s) has been paid for by the member before the plan approved an authorization and payment.	Medical necessity
Are retrospective review policies the same for both **in-network and out-of-network** providers?	Yes	yes	Yes	No	In and out of network providers are treated the same. Out of network claims are not covered and would not be retrospectively reimbursed.	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?	Yes, updates on website.	yes	Yes - on as needed basis	Yes	Yes, annually	Yes, updates via website
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?	Yes, Interqual.	no	No	Yes	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?	No.	Yes, annually	Yes Annually	No	Yes, annually	Yes

Benefit Classification: OUTPATIENT SERVICES						
NQTL: Retrospective Review						
Process						
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?	Case by case basis.	Yes. Providers have 60 days to file a claim from the date the service was provided or from the date they learned that a member was Medicaid eligible, whichever comes later.	Yes - 30 calendar days after date of service	No	N/A	2 years

Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.	No 00104 90785 90791 90792 90832 90833	Yes	Yes	Yes	Yes	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.	Case by case basis.	Extensions can be granted if not all of the clinical information is available for review.	Retro Medicaid eligibility - permit retro authorizations up to 30 days after date of service. If not all clinical information is available and request sent to facility/provider to supply the rest of the clinical data	No	No	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?	30 days	60 days, unless an exception is made.	30 calendar days from date of receipt of the request for a retro review (All clinical document is sent and available for review)	30 calendar days	Decisions - no later than 30 calendar days Extensions - 15 calendar days at member or health plan request/if in member's best interest	None
Strategy						
What is the **rationale** for retrospectively reviewing services in this classification?	Medical necessity, appropriate level of care, covered diagnosis	It gives the provider the opportunity to obtain authorizations for these services in situations in which prior authorization was not obtained.	Provides an opportunity to the facility to obtain authorizations for these services when a discovery occurs that the member was retro eligible with Medicaid.	To ensure that appropriate level of care and quality services are provided.	When a request is received for a reimbursement where the service(s) has been paid for by the member before the plan approved an authorization and payment.	Medical necessity
Are retrospective review policies the same for both **in-network and out-of-network** providers?	Everything requires a prior-authorization for out-of-network providers.	yes	Yes	No	In and out of network providers are treated the same. Out of network claims are not covered and would not be retrospectively reimbursed.	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?	Yes, updates on website.	yes	Yes - as needed	Yes	Yes, annually	Yes, via website
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?	Yes, Interqual.	No	No	Yes		Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?	No	Yes, at least annually	Yes Annually	No	Yes Yes, annually	Yes

Benefit Classification: EMERGENCY SERVICES						
NQTL: Retrospective Review						
Process						
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?	N/A	No - does not apply. Authorization is not required for Emergency Services.	No - does not apply. No authorizations needed for ER Room Services or Crisis Services. Claims need to be submitted timely after date of service. If such a request comes in, time limit is 30 calendar days after date of service.	Not applicable. Emergency services are not subject to retrospective review.	N/A	N/A
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.	N/A	N/A	Yes	Not applicable. Emergency services are not subject to retrospective review.	Yes	N/A
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.	N/A	N/A	Extensions can be granted if not all the clinical information is available for review.	No	No	N/A

What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?	N/A	N/A	30 calendar days from date of receipt of the request for a retro review (All clinical document is sent and available for review)	Not applicable. Emergency services are not subject to retrospective review.	Decisions - no later than 30 calendar days Extensions - 15 calendar days at member or health plan request/if in member's best interest	N/A
Strategy						
What is the **rationale** for retrospectively reviewing services in this classification?	N/A	N/A	Extensions can be granted if not all the clinical information is available for review. Retro eligibility	Not applicable. Emergency services are not subject to retrospective review.	When a request is received for a reimbursement where the service(s) has been paid for by the member before the plan approved an authorization and payment.	N/A
Are retrospective review policies the same for both **in-network and out-of-network** providers?	N/A	N/A	Yes	Yes	In and out of network providers are treated the same. Out of network claims are not covered and would not be retrospectively reimbursed.	N/A
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?	N/A	N/A	Yes - on as needed basis	If RMHP changed its policy about retrospective review for emergency services, it would update providers.	Yes, annually	N/A
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?	N/A	N/A	No	Not applicable. Emergency services are not subject to retrospective review.	Yes	N/A
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A	Yes Annually	Not applicable. Emergency services are not subject to retrospective review.	Yes, annually	N/A
Benefit Classification: PHARMACY SERVICES						
NQTL: Retrospective Review						
Process						
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	No	120 days	2 years
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	Yes	Yes	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	No	No	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	There is no maximum amount of time because no retroactive disapprovals are issued.	A decision will be provided no later than 24 hours after receipt of the request. If the request is incomplete or additional information is needed, an inquiry to the requesting party may be initiated within one working day from the day of the request. If no response is received from the party within 24 hours the request shall be denied. Services that require authorization are approved for up to a year.	None

Strategy						
What is the **rationale** for retrospectively reviewing services in this classification?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	To identify patterns of fraud, abuse, gross overuse, underutilization or medically unnecessary care and implement corrective action when needed.	When a request is received for a reimbursement where the drug(s) has been paid for by the member before the plan approved an authorization and payment.	Medical necessity
Are retrospective review policies the same for both **in-network and out-of-network** providers?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes	In and out of network prescribers are treated the same. Out of network pharmacy claims are not covered and would not be retrospectively reimbursed.	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	No, providers are not updated about changes in retrospective review policies or procedures because they are not affected by them.	Providers are notified of changes and updates annually via the provider handbook.	Yes, via website
Evidentiary Standards						
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes	Pharmacy staff review clinical criteria on an annual basis to evaluate data from government agencies (FDA approved package inserts), medical associations, national commissions, peer-reviewed clinical studies and medical journals, and authoritative compendia. After changes or updates are made the criteria is sent to network providers including board certified specialists for review and input which is taken into consideration before the finalization of the criteria.	Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes. They are updated as often changes, such as new FDA-approved indications, occur.	Yes, annually	Yes

Benefit Classification: INPATIENT SERVICES	**ABC**	**BHI**	**CHP/FBHP**	**PRIME**	**DHMC**	**FFS Medical/Surgical**
NQTL: Network Provider Admission						
Process						
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?	Yes	Yes	Yes	Yes	Yes	No
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?	No	BHI does not have any documented exceptions.	No For inpatient services - only cover MH diagnoses allowed per state plan	No	No	No
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?	No	Yes	Yes	Yes	Yes, if a provider feels they offer services above and beyond what is typically provided for the applicable specialty that would result in a significant benefit to membership, they are able to submit supporting documentation for review	No
Strategy						
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?	Yes	Yes. Annually.	Yes	Yes		No
					Yes	
Evidentiary Standards						
Does the plan use **National Committee for Quality Assurance (NCQA)** guidelines for admitting providers into the network?	Yes	Yes	Yes	Yes		Yes
					Yes	
Does the plan use **URAC accreditation** criteria for admitting providers into the network?	No	No	Yes	No		No
					No	
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?	Yes	Yes	Yes	Yes		Yes
					Yes	
Benefit Classification: OUTPATIENT SERVICES						
NQTL: Network Provider Admission						
Process						
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?	Yes	Yes	Yes	Yes	Yes	No
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?	No	BHI does not have any documented exceptions.	Yes - Prescribers and PhD level psychologists are the exceptions and do not have to go through the internal credential committee	No	No	No
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?	No	Yes	Yes	Yes	Yes, if a provider feels they offer services above and beyond what is typically provided for the applicable specialty that would result in a significant benefit to membership, they are able to submit supporting documentation for review	No
Strategy						
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?	Yes	Yes. Annually.	Yes	Yes	Yes	No
Evidentiary Standards						
Does the plan use **National Committee for Quality Assurance (NCQA)** guidelines for admitting providers into the network?	Yes	Yes	Yes	Yes	Yes	Yes
Does the plan use **URAC accreditation** criteria for admitting providers into the network?	No	No	Yes	No	No, ER Physicians do not have to be a part of the network to have ER services reimbursed by the plan	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?	Yes	Yes	Yes	Yes	Yes, if a provider feels they offer services above and beyond what is typically provided for the applicable specialty that would result in a significant benefit to membership, they are able to submit supporting documentation for review	Yes
Benefit Classification: EMERGENCY SERVICES						

NQTL: Network Provider Admission						
Process						
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?	N/A	BHI does not credential emergency departments. Providers are not required to be credentialed/contracted with BHO. BHI pays for all covered emergency services in the emergency department regardless if a hospital is credentialed/contracted with BHI.	Facilities that provider emergency services do not have to be contracted in order to provide these services.	Yes	Yes	No
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?	N/A	N/A	N/A	No	ER Physicians do not have to be a part of the network to have ER services reimbursed by the plan	No
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?	N/A	N/A	N/A	Yes	Yes, if a provider feels they offer services above and beyond what is typically provided for the applicable specialty that would result in a significant benefit to membership, they are able to submit supporting documentation for review	No
Strategy						
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?	N/A	N/A	N/A	Yes		No
					Yes	
Evidentiary Standards						
Does the plan use **National Committee for Quality Assurance (NCQA)** guidelines for admitting providers into the network?	N/A	N/A	N/A	Yes	Yes	Yes
Does the plan use **URAC accreditation** criteria for admitting providers into the network?	N/A	N/A	N/A	No	No	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?	N/A	N/A	N/A	Yes	Yes	Yes

Benefit Classification: PHARMACY SERVICES						
NQTL: Network Provider Admission						
Process						
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	No; however RMHP's contracted PBM maintains an internal credentialing committee.		No
					Yes	
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	Yes. There are a small number of specialty and home infusion providers who were contracted with RMHP prior to the PBM taking over the provider admission process. RMHP continues to maintain direct contracts with these providers.		No
					Pharmacies must be credentialed by our PBM	
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	Yes		No
					Yes	
Strategy						
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	Yes		No
					Network access is reviewed regularly to make sure that members have appropriate access. However access needs are not used to comprise credentialing standards.	
Evidentiary Standards						
Does the plan use **National Committee for Quality Assurance (NCQA)** guidelines for admitting providers into the network?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	No	No	No
Does the plan use **URAC accreditation** criteria for admitting providers into the network?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	No	No	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?	N/A	N/A	Pharmacy benefits are not managed by the BHOs - nor do the BHOs contract for these services	Yes	Yes, all licenses are primary source verified.	Yes

Benefit Classification: INPATIENT SERVICES	**ABC**	**BHI**	**CHP/FBHP**	**PRIME**	**DHMC**	**FFS Medical/Surgical**
NQTL: Establishing Charges						
Process						
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?	Yes	Internal	Yes	Yes	Internal Process	Yes
How **frequently** does the plan update its charges for services in this classification?	DRGs are updated by CMS and per diems are updated on ad hoc basis.	When necessary. Rates are reviewed annually.	Reviewed on annual basis	RMHP makes updates whenever the Department makes updates.	Annually	DRGs are updated by CMS and per diems are updated on ad hoc basis.
Strategy						
What is the **rationale** for the plan's approach to establishing charges.	Market tolerance	BHI takes into consideration direct costs as well as current market values and cost.	Since this is a Medicaid contract, we keep that in perspective when negotiating rates with providers. Also stay informed of Medicare fee schedules and consideration of rate changes by CO Medicaid FFS	RMHP relies on the Department's rates and thus the Department's approach for establishing charges.	Based off of State's charges or strategic needs	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?	Yes	When necessary.	Yes	Yes	Yes	No
Evidentiary Standards						
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?	Yes	It is considered and reviewed when rates are reviewed.	Yes	Yes	Yes - inpatient APR-DRG	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?	No	RVU's are also used and considered when setting rates	Not applicable	Yes	Yes - inpatient units and values	No

Benefit Classification: OUTPATIENT SERVICES						
NQTL: Establishing Charges						
Process						
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?	Yes	Internal	Yes	Yes	Internal Process	Yes
How **frequently** does the plan update its charges for services in this classification?	Industry recognized self updating fee schedules, i.e. RBRVS	When necessary. Rates are reviewed annually.	Reviewed on annual basis	RMHP makes updates whenever the Department makes updates.	Annually	Annual review
Strategy						
What is the **rationale** for the plan's approach to establishing charges.	Industry standard	BHI takes into consideration direct costs as well as current market values and cost.	Since this is a Medicaid contract, we keep that in perspective when negotiating rates with providers. Also stay informed of Medicare fee schedules and consideration of rate changes by CO Medicaid FFS	RMHP relies on the Department's rates and thus the Department's approach for establishing charges.	Based off of State's charges or strategic needs	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?	Yes	When necessary.	Yes	Yes	Yes	Yes
Evidentiary Standards						
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?	Yes	It is considered and reviewed when rates are reviewed.	Yes	Yes	Yes	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?	Yes	RVU's are also used and considered when setting rates	Yes	Yes	Yes	Yes

Benefit Classification: EMERGENCY SERVICES						
NQTL: Establishing Charges						
Process						
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?	Yes	Internal	Yes	Yes		Yes
How **frequently** does the plan update its charges for services in this classification?	Case rates are updated on an basis	When necessary. Rates are reviewed annually.	Reviewed on annual basis	RMHP makes updates whenever the Department makes updates.	Internal Process Annually	Rates review annually
Strategy						
What is the **rationale** for the plan's approach to establishing charges.	Market tolerance	BHI takes into consideration direct costs as well as current market values and cost.	This is based on what services are provider who are presenting with a MH emergency. Per contract, covered SUD diagnoses billed on a UB04 are billed to FFS ER Practitioners who submit claims on CMS 1500 for covered MH and SUD diagnoses are responsibility of the BHOs	RMHP relies on the Department's rates and thus the Department's approach for establishing charges.	Based off of State's charges or strategic needs	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?	Yes	When necessary.	Not applicable	Yes	Yes	Yes
Evidentiary Standards						

Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?	No	Yes	No	Yes	Yes	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?	No	Yes	Not applicable	Yes	Yes	Yes

Benefit Classification: PHARMACY SERVICES

NQTL: Establishing Charges

Process						
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?	N/A	N/A	No - BHOs do not contract for Pharmacy Services	Delegated to vendor (PBM).	The plan negotiates contract rates with the PBM for brand, generic and specialty drugs.	Yes
How **frequently** does the plan update its charges for services in this classification?	N/A	N/A	N/A - BHOs do not contract for Pharmacy Services	At least every 3 days.	The contract rates can change when the contract is renegotiated.	Variable
Strategy						
What is the **rationale** for the plan's approach to establishing charges.	N/A	N/A	N/A - BHOs do not contract for Pharmacy Services	Achieve the lowest cost within available parameters to provide the best care and access for members.	The plan would like to negotiate the lowest drug costs it is able to.	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?	N/A	N/A	N/A - BHOs do not contract for Pharmacy Services	Yes	Yes	No
Evidentiary Standards						
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?	N/A	N/A	N/A - BHOs do not contract for Pharmacy Services	No	No	No
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?	N/A	N/A	N/A - BHOs do not contract for Pharmacy Services	No	No	No

Benefit Classification: INPATIENT SERVICES	**ABC**	**BHI**	**CHP/FBHP**	**PRIME**	**DHMC**	**FFS Medical/Surgical**
NQTL: Concurrent Review						Concurrent review equivalent to prior authorization for medical surgical. Renewing treatment services is renewing a PAR, or submitting a new PAR to continue treatment.
Process						
Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.	Yes	Yes	Yes	No	All Services in this category may be concurrently reviewed.	No
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.	Exception is one facility where a DRG contract is in place. We review when outlier days are incurred.	yes there are exceptions: - provider isn't aware that member has Medicaid - retroactive eligibility - non contracted facilities - residential services provided by the CMHC's in BHI's catchment area	No	No	The authorization review criteria are the same for all types of circumstances.	Yes
How **frequently** is concurrent review required for services in this classification?	Every 3 days.	Frequency varies based on the clinical presentation of the member. Typically no more frequently than every 3 days.	Every 3-5 days	Not applicable. RMHP does not conduct concurrent review for inpatient services.	Services are re-authorized for a change in the level of care or for each new occurrence. Daily UR reviews performed for concurrent days of hospital admission.	Variable

Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?	Yes and no secondary assessment is required.	For prior-authorization of concurrent inpatient requests: the direct service provider performs the request - no secondary assessment is required	Ideally to have direct treatment provider perform the concurrent review. Generally for higher levels of care, facilities have UM staff do the concurrent reviews with the Clinical Department. Opportunities exist for the direct treatment provider to discuss case with a BHO psychiatrist or appropriate	Not applicable. RMHP does not conduct concurrent review for inpatient services.	Secondary Assessment from Utilization Management/Medical Director or Designee	Both
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?	1 business day after the information is received.	Per our Contract we have 24 hours. Operationally, decisions are made within a few hours of receipt of request.	10 calendar days	Not applicable. RMHP does not conduct concurrent review for inpatient services.	Decisions - Urgent: 3 working days, Standard: 10 calendar days Extensions - Urgent/Standard: 14 working days at member or health plan request/if in member's best interest	Variable
Strategy						
What is the **rationale** for applying concurrent review to services in this classification?	Level of care, discharge planning, medical necessity	Fiscal management of high cost services and to identify utilizers of this intensive service so that they can be connected with the resources they need including 7 day post discharge appointments and ongoing care management.	To determine if the patient is still requiring this level of care or can be transitioned to a lower level of care that would be more appropriate.	Not applicable. RMHP does not conduct concurrent review for inpatient services.	To assist in the promotion and maintenance of optimally achievable quality of care. To provide a system to monitor the delivery of medical and related services in a timely, effective and efficient manner consistent with the delivery of quality care.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are concurrent review policies the same for both **in-network and out-of-network** providers?	Yes	No. Out of Network (non-contracted) providers are not required to seek prior-authorization.	Yes	Yes	Typically out of network providers are not covered, at times however if members are admitted to out of network facilities for care that is not available within the Denver Health System then concurrent review policy is the same as in network	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?	Yes, on the website	Yes	Yes	If RMHP changed its policy about concurrent review, it would update providers.	Yes, annually	Yes, via website
Evidentiary Standards						
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?	Yes, Interqual	No	No	Not applicable. RMHP does not conduct concurrent review for inpatient services.	Yes	No
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?	No	Yes, at least annually	Yes Annually	Not applicable. RMHP does not conduct concurrent review for inpatient services.	Yes, annually	Yes

Benefit Classification: OUTPATIENT SERVICES

NQTL: Concurrent Review

Process

Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.	No 00104 90785 90791 90792 90832 90833 90834 90836 90837 90838 90839 90840 90846 90847 90849 90853 90870 90875 90876 90887 96116 9637297535 97537 98966 98967 98968 99221 99222 99223 99231 99232 99233 99238 99239 99251 99252 99253 99254 99366 99367 99368 99441 99442 99443 G0176 G0177 *H0001 H0002 H0004 *H0005 *H0006 H0020 H0023 H0025 H0031 H0032 H0033 H0034 H0035 H0036 H0037 H0038 H0039 H0040 H0043 H0044 H0045 H1011 H2000 H2001 H2011 H2014 H2015 H2016 H2017 H2018 H2021 H2023 H2024 H2025 H2026 H2027 H2030 H2031 H2032 H2033 M0064 *S3005 S5150 S5151 *S9445 S9453 S9454 S9485 T1005 *T1007 T1016 T1017 *T1019 *T1023 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99217 99218 99219 99220 99224 99225 99226 99234 99235 99236 99241 99242 99243 99244 99245 99255 99304 99305 99306 99307 99308 99309 99310 99315 99316 99318 99324 99325 99326 99327 99328 99334 99335 99336 99337 99341 99342 99343 99344 99345 99347 99348 99349 99350	No. The services that REQUIRE prior authorization are:H2015, H2016, H0037, H2033, H2022, H2012, H0045, S5151, S9480, H0005, H0035, 96101, 96118. All other outpatient services covered under the Medicaid contract do NOT require prior authorization.	No - 90791, 90792, H0002, H0031, H2000, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90875, 90876, 90853, 96372, H0032, H0033, H0034, E/M codes. H0001, H0031, S9485, T1017, H0004, H0006, H0045, H2017, H2027, H2011, S5150, S5151, S3005, T1007, T1019, T1023, H0020	No	All Services in this category may be concurrently reviewed.	No
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.	No	Yes there are exceptions: - provider isn't aware that member has Medicaid - retroactive eligibility - services provided by the CMHC's in BHI's catchment area	Yes - Related to Crisis Services, certain codes do not need pre-authorization if the ET modifier is used	No	**The authorization review criteria are the same for all types of circumstances.**	No
How **frequently** is concurrent review required for services in this classification?	Weekly	Frequency varies based on the clinical presentation of the member.	Varies by intensity of outpatient services. (For example: Wrap around services - every 4 weeks, other outpatient services such as SUD - yearlv)	Not applicable. RMHP does not conduct concurrent review for outpatient services.	Re-authorization time frames dependent on type of outpatient service.	Variable
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?	Yes, no secondary assessment is required.	concurrent reviews are performed by the direct treatment provider	Concurrent reviews are performed by the direct treatment provider	Not applicable. RMHP does not conduct concurrent review for outpatient services	Secondary Assessment from Utilization Management/Medical Director or Designee	Direct treatment provider
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?	1 business day after the information is received.	Per our contract with the State, determinations are made within 10 calendar days. Extensions of up to 14 calendar days can be made if 1. the member or requesting provider requests an extension or 2. BHI needs additional clinical information in order to make a decision and can justify that the extension is in the member's best interest.	10 business days	Not applicable. RMHP does not conduct concurrent review for outpatient services	Decisions - Urgent: 3 working days, Standard: 10 calendar days Extensions - Urgent/Standard: 14 working days at member or health plan request/if in member's best interest	Variable
Strategy						
What is the **rationale** for applying concurrent review to services in this classification?	Level of care, discharge planning, medical necessity	Fiscal management of high cost services and to identify utilizers of these intensive service so that they can be connected with the resources they need	To continue to evaluate medical necessity	Not applicable. RMHP does not conduct concurrent review for outpatient services	To assist in the promotion and maintenance of optimally achievable quality of care. To provide a system to monitor the delivery of medical and related services in a timely, effective and efficient manner consistent with the delivery of quality care.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are concurrent review policies the same for both **in-network and out-of-network** providers?	**Yes**	yes	Yes	Yes	Typically out of network providers are not covered, at times however if members are referred to out of network facilities for care that is not available within the Denver Health System then concurrent review policy is the same as in network	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?	Yes, website is updated with any changes.	yes	Yes	If RMHP changed its policy about concurrent review, it would update providers.	Yes, annually	Providers updated via website
Evidentiary Standards						

Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?	Yes, Interqual.	No	No	Not applicable. RMHP does not conduct concurrent review for outpatient services	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?	No	Yes, at least annually	Yes Annually	Not applicable. RMHP does not conduct concurrent review for outpatient services	Yes, annually	Yes
Benefit Classification: EMERGENCY SERVICES						
NQTL: Concurrent Review						
Concurrent Review: Requirement that services be periodically reviewed as they are being provided in order to						
Process						
Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.	N/A	No. Emergency services do not require prior authorization.	Does not apply	No	Concurrent Review does not apply	N/A
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.	N/A	N/A	Does not apply	No	N/A	N/A
How **frequently** is concurrent review required for services in this classification?	**N/A**	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?	**N/A**	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?	**N/A**	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A
Strategy						
What is the **rationale** for applying concurrent review to services in this classification?	N/A	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A
Are concurrent review policies the same for both **in-network and out-of-network** providers?	**N/A**	N/A	Does not apply	Yes	N/A	N/A
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?	N/A	Yes, providers would be updated should changes occur.	Does not apply	If RMHP changed its policy about concurrent review, it would update providers.	Yes, annually	N/A
Evidentiary Standards						
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?	**N/A**	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	Yes	N/A
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A	Does not apply	Not applicable. RMHP does not conduct concurrent review for emergency services.	Yes, annually	N/A
Benefit Classification: PHARMACY SERVICES						
NQTL: Concurrent Review						
Process						

Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	No	Requests may be received for concurrent, post-service, or pre-service review.	No
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	No	Timeframes for authorization review are the same for concurrent, post-service, or pre-service review. The prior authorization review criteria are the same for all types of review.	Yes
How **frequently** is concurrent review required for services in this classification?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting	Not applicable. RMHP does not conduct concurrent review for pharmacy services.	The majority of requests are for pre-service review.	Variable
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?	N/A	N/A - The State sets Pharmacy policies	Pharmacy benefits are not managed by the BHOs BHOs are aware of the State's Formulary and procedures to follow if requesting an exception	Not applicable. RMHP does not conduct concurrent review for pharmacy services.	The health plan Pharmacy Department reviews concurrent authorization requests submitted by the treatment provider or a secondary.	Direct treatment provider
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?	N/A	N/A - The State sets Pharmacy policies		Not applicable. RMHP does not conduct concurrent review for pharmacy services.	A decision will be provided no later than 24 hours after receipt of the request. If the request is incomplete or additional information is needed, an inquiry to the requesting party may be initiated within one working day from the day of the request. If no response is received from the party within 24 hours the request shall be denied. Services that require authorization are approved for up to a year.	Variable
Strategy						
What is the **rationale** for applying concurrent review to services in this classification?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Not applicable. RMHP does not conduct concurrent review for pharmacy services.	Concurrent reviews take place when an authorization request is received and there is an active authorization on file that will expire within the next 24 hours.	To contain costs, provide only medically necessary care, and ensure criteria are met
Are concurrent review policies the same for both **in-network and out-of-network** providers?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Yes	Yes	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	If RMHP changed its policy about concurrent review, it would update providers.	Providers are notified of changes and updates annually via the provider handbook.	Providers updated via website
Evidentiary Standards						
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Not applicable. RMHP does not conduct concurrent review for pharmacy services.	Pharmacy staff review clinical criteria on an annual basis to evaluate data from government agencies (FDA approved package inserts), medical associations, national commissions, peer-reviewed clinical studies and medical journals, and authoritative compendia. After changes or updates are made the criteria is sent to network providers including board certified specialists for review and input which is taken into consideration before the finalization of the criteria.	Yes
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?	N/A	N/A - The State sets Pharmacy policies	Per State's Pharmacy Plan	Not applicable. RMHP does not conduct concurrent review for pharmacy services.	Yes, annually	Yes