



Message from the CEO

Thank you to everyone who shared candid feedback in our recent member engagement survey. Your input is essential—and it plays a critical role in how we continue to strengthen our partnerships and support the providers and communities we serve.

We're encouraged by our Net Promoter Score of 81%, reflecting strong member loyalty, with 44% "very likely to recommend" and 36% "likely to recommend." This reinforces the value of our collaboration and the impact we are making together.

Two areas stood out clearly: the need for more consistent communication and follow-through, and a stronger, more proactive approach. While many of you value our work together, only about half feel we are anticipating needs as effectively as we should.

Based on your feedback, we are focused on improving your experience by ensuring:

- You receive timely, consistent communication, with clear ownership and reliable follow-through
- You have greater visibility and clarity, so you always understand the status of requests and key initiatives
- You are supported proactively, with earlier insights on payer changes, contract updates, and operational considerations
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Guided by our mission to empower providers, elevate care, and strengthen communities, we are focused on enhancing how we partner with you. Thank you for your partnership as we continue to get better—together.

Warm Regards,

Darik Croft, MBA
President/CEO
Rocky Mountain Health Network

NETWORK UPDATE: Known Payer Issues & Progress

As part of our ongoing commitment to transparency and support, we want to share updates on several payer-related issues that may be impacting claims processing, provider loading, and payments. Our team is actively working with each payer to resolve these concerns and minimize disruption to your practice.

Cigna

We continue to monitor and address the following issues:

- **Improper claim denials that do not align with contract terms.**
- **Incorrect processing of bilateral procedures, resulting in underpayment or denial.**

Our team is escalating these trends through Allegiance and working to ensure affected claims are reviewed and reprocessed appropriately.

TRICARE West Region

Providers may experience:

- **Delays in provider loading and demographic updates.**
- **Incorrect billing address updates, where TRICARE is automatically changing billing addresses based on information in NPES rather than contracted details.**

We are addressing these discrepancies directly with TRICARE to prevent future disruptions and correct impacted records.

United Behavioral Health (Optum Behavioral Health)

We are actively collaborating with UBH around several operational challenges:

- **Group NPI Requirement:** UBH now requires all independent providers previously credentialed without a group NPI to obtain one in order to remain under RMHN's agreement.
- **Provider & Practice Loading Delays:** There have been delays with new tax ID enrollments. We are working with UBH to reprocess and pay any outstanding claims appropriately.
- **New Fee Schedule (Effective 12/01/2025):** The updated fee schedule led to widespread claim issues for many providers and practices. Corrections and reprocessing efforts are underway.

We appreciate your patience as these matters are resolved.

UnitedHealthcare (UHC)

Several changes occurred toward the end of 2025 and early 2026:

- **Provider Updates via CAQH:** UHC transitioned RMHN provider adds, terminations, and updates to a CAQH-based process. While CAQH participation is not required for RMHN providers, the new workflow—managed entirely by RMHN—has resulted in some provider loading delays on UHC's end.
- **Network Misalignment:** UHC mistakenly moved many medical providers into the behavioral health network, removing them from the medical network and causing claim processing issues. While most corrections have been completed, a small number of providers remain pending.

We are continuing follow-up efforts until all records are fully corrected.

We're Here to Help

If you are experiencing ongoing issues related to any of the items above, please reach out to Mollie Brandal at mbrandal@rmhn.org. We are committed to advocating on your behalf and appreciate your partnership as we work through these payer challenges together.

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|---|--|
| ✓ Process Primary, Secondary, Tertiary Insurance Claims | ✓ Fee Schedule Analysis |
| ✓ Claims Resolution/Denial Management | ✓ Medical Coding |
| ✓ Financial Arrangement Setup | ✓ Daily/Monthly Close |
| ✓ Statement Generation | ✓ Deposit Reconciliation |
| ✓ Monthly Reporting | ✓ Insurance Follow-up |
| | ✓ Payment Posting to Insurance and Patient Account |

Learn more about RMHN Business Services by contacting **Christy O'Connor** at (406) 237-5849 or visiting www.RMHN.org.

QUICK TIP

Reviewing EOB's and Reimbursement

We strongly encourage all providers and practices to regularly review Explanation of Benefits (EOBs) and monitor reimbursement amounts to ensure claims are being paid in accordance with your contracted rates. Identifying discrepancies early helps prevent ongoing payment issues and delays.

Best Practices for Reviewing EOBs:

- Compare allowed amounts on EOBs to your contracted fee schedule, not just billed charges.
- Watch for underpayments, especially on high-volume services or bilateral/multiple-procedure claims.
- Check denial and adjustment codes carefully to confirm they align with payer policies and contract terms.
- Monitor trends, not just individual claims—recurring issues often signal a systemic payer problem.
- Retain EOBs and remittance advice for documentation when submitting reconsiderations or appeals.

If you are unsure of your current reimbursement schedule or have questions about whether payments align with your contract, please reach out for assistance: Mollie Brandal mbrandal@rmhn.org

Our team is happy to help review concerns and support resolution efforts with the payer.

RMHN offers **optional assistance** with Medicaid and Medicare enrollment, revalidation, and updates. This is an **add-on service** designed to support providers who prefer help navigating government payer requirements. Participation is **not required**—providers may choose to complete Medicaid and/or Medicare enrollment on their own.

Enrollment Timeline & Frequency

- **Initial Enrollment:** Required before billing Medicaid or Medicare
- **Revalidation:** Required every 5 years
- **Updates:** Required when changes occur (e.g., ownership, address, taxonomy)

Providers may **opt in or out** of RMHN assistance for **Medicaid, Medicare, or both** at any time.

Service Fees

Medicaid Enrollment Fees

Provider Applications

- Sole Owner / Sole Proprietor: **\$250 per application**
- Initial Provider Application: **\$100 per application**
- Provider Revalidation: **\$100 per application**
- Other Provider Updates: **\$50–\$100 per application**

Facility Applications

- Initial Enrollment: **\$250 per application**
 - Revalidation: **\$250 per application**
 - Other Facility Updates: **\$50–\$100 per application**
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Medicare Enrollment Fees

Provider Applications

- Sole Owner / Sole Proprietor: **\$250 per application**
- Provider Reassignment (CMS-855R): **\$100 per application**
- Initial Provider Application (CMS-855I): **\$150 per application**
- Provider Revalidation: **\$150 per application**
- Railroad Retirement Provider Application: **\$100 per application**

Facility Applications

- Initial Enrollment
 - o Part A: **\$250 per application**
 - o Part B: **\$250 per application**
- Revalidation
 - o Part A: **\$250 per application**
 - o Part B: **\$250 per application**

Additional Service

- Provider Enrollment Verification: **\$25 per provider**
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Questions or Need Assistance?

If you are unsure whether enrollment or revalidation is required—or would like support with the process—please contact: Mollie Brandal mbrandal@rmhn.org.

PRACTICE RESOURCES

VA Recovery Audit Information

EDUCATION

TRAIN Learning Network

TRAIN is a national learning network that provides quality training opportunities for professionals who protect and improve the public's health

<https://www.train.org>

UHC Virtual Provider Educational Series - Direct Connect

Direct Connect is a free online tool on our portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, phone calls and spreadsheets.

It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution timeframes
- Run real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using our UnitedHealthcare Provider Portal. Email directconnectsupport@optum.com to get started with Direct Connect. Direct Connect is a self-service platform allowing providers to communicate effectively with United Healthcare on overpayment requests.

Register - Tuesday 5/19, 12-1pm

Register - Tuesday 5/26, 12-1pm

UHC Virtual Provider Educational Series-Coding

Coding Corner

Health care professionals can decrease the potential for claim denials with UnitedHealthcare by utilizing our coding corner training courses.

To help decrease the potential for claim denials, we encourage you to utilize these valuable coding resources. We created this information with the Optum® Payment Integrity provider education team of certified coders, nurses, physicians and qualified health care practitioners. of certified coders, nurses, physicians and qualified health care practitioners.

Register - Thursday, 6/18, 1-2pm

Humana Risk Adjustment 2026 monthly Learning Series CME and CEU Sessions for May

(If you would like the full list of classes for the year, please send us an email using the email button below.)

Class Registration Links:

Obesity - 5/7, 1pm

Medicare Risk Adjustment Overview - 5/13, 10am

Cerebrovascular Accident - 5/27, 10am

Optum 2026 National Documentation and Coding Education Calendar for May

(If you would like the full list of classes for the year, please send us an email using the email button below.)

Class Registration Links:

Quality Reporting - 5/19, 9-10am

Risk adjustment model updates and mid-year ICD-10 code updates -
5/19, 1-2pm

Risk adjustment model updates and mid-year ICD-10 code updates -
5/20, 10-11am

Document and coding: Rheumatoid and other arthritis - 5/20, 12-
12:30pm

Document and coding: Rheumatoid and other arthritis - 5/21, 8-8:30am

Risk adjustment model updates and mid-year ICD-10 code updates -
5/21, 9-10am



Contact Us by
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Our Website

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