AdvancedHealth
Bridging the Future of Healthcare

2024 - 2025 Provider Manual

Advanced Health, LLC
An Oregon Coordinated Care Organization
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WELCOME TO THE ADVANCED HEALTH NETWORK

Chief Executive Officer

It is with absolute pleasure that I welcome you to Advanced Health! Working together and collaboratively, Advanced Health has established its reputation for delivering high-quality health care services in a manner that is characterized by friendliness and cooperation. I am humbled and privileged to serve as the organization's Chief Executive Officer and welcome every opportunity to interface with our panel of distinguished providers. Following the Table of Contents, you will find information about key contact personnel within Advanced Health. I expect my staff to be accessible and responsive to your concerns, but should that not occur, please contact me directly. I look forward to working with you and building our shared legacy of community service.

Ben Messner

Chief Medical Officer

Welcome to a strong cohesive group of providers who have been delivering specialty and primary care in Coos and Curry counties for more than several decades. A large part of the mission at Advanced Health is to support providers and patients in access to and delivery of health-related services within the structured evidence-based and utilization guidance of the Oregon Health Authority. I and the staff at Advanced Health are available to introduce you to and/or facilitate the delivery of services and support you in the care you give to your patients.

Wendy Haack, DO

Director of Behavioral Health

Wholistic care has always been a passion of mine even before I realized how intricately the mind and body were woven together. It was clear, in my early days as an oncology nurse, that the care of the mind and the soul was equally, if not more important, than the medications and therapies we used to treat physical ailments. Providing evidence based and compassionate care while empowering patients to partner with their healthcare team yielded amazing results. Today, more than ever, it is imperative that all healthcare professionals see and treat every individual in their entirety; Advanced Health is committed to that mission. As we look to the future, our goal is to assure excellent and seamless physical and mental health care, creating an environment that allows individuals to thrive.

Kera Hood, RN, BS

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CONTACT INFORMATION

Coos Bay Office Hours are 8:00 AM – 5:00 PM, Weekdays 289 LaClair Street Coos Bay, OR 97420 Phone: 541.269.7400 TTY for Hearing Impaired: 711 or 800.735.1232	**Fax Numbers** Administrative Office: 541.269.7789 Claims Department: 541.269.0141 Credentialing: 541.266.0141 Contracting: 541.269.7789 Member Services: 541.269.2052 Authorizations: 541.269.7147
PROVIDER SERVICES Lisa Frischkorn Director of Member Services	**CLAIMS** Chris Wilson Director of Health Information Systems Jacki Bohannon Claims Manager
MEDICAL SERVICES Jaime Simmons, RN Director of Medical Services	**MEMBER (CUSTOMER) SERVICES** Lisa Frischkorn Director of Member Services
PHARMACY Brandie Feger, RPh Pharmacy Manager (licensed in OR)	**CONTRACTING** Chris Hogan Chief Financial Officer
COMPLIANCE Michael Hale, JD, BSN, CHC Chief Compliance Officer	**INTENSIVE CARE COORDINATION** Ross Acker, MS, LPC Director of Care Coordination
QUALITY and METRICS Anna Warner, BS, CPHQ Executive Program Director	**PRIMARY CARE CASE MANAGEMENT** Lisa Frischkorn Director of Member Services
OPERATIONS Samantha Vendrathi Chief Operating Officer	**CREDENTIALING** Cristina Oregel Credentialing Manager

RESOURCES

Resources Sponsored by Advanced Health

Nurse Advice Line: The contractually arranged telephone services of a registered nurse are made available 24 hours per day, seven days per week, by calling our main line at 541-269-7400 and choosing Option #4 or directly at 207-228-6527. If you are interested in having a direct access line for your office, please contact your Advanced Health Provider Services Representative. This service is available to Members to assist in clarifying whether the Members' needs are emergent or urgent or can be addressed by the primary care provider the following business day.

Provider Portal: Advanced Health's provider portal is available at https://visibiledi.com/advancedhealth/Home/Login. To register for access to the provider portal, please visit Advanced Health's website at https://advancedhealth.com. Click on the link *for providers*, then on the link *policies and forms,* and finally on the link *online user registration.* Follow the directions located on the form and submit it for approval. Please visit the Message Center for important Updates. You can find User Information, a VisibiIEDI User Guide, a Quick start guide, Resources, Release notes, Line finder, Provider Resources, Provider Trainings, and Careers on the Portal.

Advanced Health's Website, https://advancedhealth.com, offers easily accessible information for both Members and providers including pharmacy information; policies and procedures; forms; calendar of events; link to the Oregon Health Authority's (OHA's) *prioritized list,* contract information, and information regarding the Oregon Health Plan (which is Oregon's Medicaid benefit).

Community Resources: Advanced Health works closely with a variety of community partners to provide health-related educational opportunities and activities. Please visit the website for a full list of available programs.

Interpretation Services: Advanced Health provides medical interpreter services for over 240 languages. We can provide Spanish interpretation through directly employed qualified personnel who can be deployed to provider offices for face-to-face interpretation services. In addition, Advanced Health contracts for medical interpretation services for a wide array of foreign languages; these services are available telephonically and by Video with facilitation by Advanced Health THW's. Please contact Member (Customer) Services to arrange for interpreter services. Ideally, make arrangements with Member Services at least 48 hours prior to the scheduled appointment date. For urgent needs of less than 48 hours, please contact Member Services. Providers may choose to coordinate interpretation services; however, the cost will not be reimbursed unless arrangements have been made through Member Services.

Traditional Health Workers: Every Medicaid Member assigned to Advanced Health is entitled, upon request, to receive the services of a Traditional Health Worker (i.e., community health worker; peer support specialist; peer wellness specialist; patient navigator; birth doula; tribal THW). At Advanced Health, most Traditional Health Workers are embedded in case management or care coordination teams. Providers are encouraged to recommend traditional health worker services to Members as needed. For assistance in linking any Member with a Traditional Health Worker, please contact Advanced Health Customer Services.

Advance Directive Education: Information for Members and the public about Advance Directives and how to complete one is available on Advanced Health's website at: http://advancedhealth.com/members/forms/

Resources Sponsored by the Oregon Health Authority

Oregon Health Evidence Review Commission (HERC): The HERC reviews medical evidence to prioritize health spending for the Oregon Health Plan (OHP) and to promote evidence-based medical practice on a statewide basis through comparative effectiveness reports, including coverage guidance and multisector interventions, health technology assessments, and evidence-based practice guidelines. The Commission uses a transparent public process to ensure its decisions are made in the best interest of patients and taxpayers, while considering input from providers, beneficiaries, and the public, including those affected by the conditions discussed. http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/index.aspx

Prioritized List of Health Services: The HERC ranks health care conditions and treatment pairs in order of clinical effectiveness and cost-effectiveness. The *Prioritized List of Health Services* emphasizes prevention and patient education. In general: treatments that help prevent illness are ranked higher than services that treat an illness after it occurs; and the Oregon Health Plan covers treatments that are ranked above a covered *Prioritized List* line for the patient's reported medical condition. To learn more about the *Prioritized List:*http://www.oregon.gov/OHA/HPA/CSI-HERC/Pages/Searchable-List/aspx

Oregon Health Plan Dental Services: The Oregon Health Plan has a list of covered and non-covered dental services, similar to the *Prioritized List of Health Services*. To learn more about dental services, view OHP's Dental Services Program at http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx

Reporting Non-Compliance and Fraud, Waste, and Abuse: Advanced Health takes its fraud, waste, and abuse monitoring and reporting responsibilities very seriously, and a discussion of these issues appears later in the Manual. In the event that a provider believes Advanced Health has engaged in fraud, waste, or abuse, and the provider elects not to report these concerns directly to Advanced Health through its established communication channels, the provider is obligated to report such concerns to both the Medicaid Fraud Control Unit of the Oregon Department of Justice and to the Oregon Health Authority's Fraud Investigation Unit. http:www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

Oregon Health Plan Policies, Rules, and Guidelines may be accessed at
http://www.oregon.gov/DHS/POLICIES/Pages/dhs-oha-policies-guidelines.aspx

The Oregon Health Plan Fee Schedule may be accessed at
http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx

The State of Oregon Advance Directive Form may be accessed at
https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.aspx

INTRODUCTIONS

To Advanced Health

Advanced Health is an Oregon certified Coordinated Care Organization (CCO) that partners with professional physical, behavioral, and oral health care organizations to administer the Medicaid benefit to Oregon Health Plan (OHP) beneficiaries (or "Members") in Coos and Curry Counties of southwest Oregon. In addition, Advanced Health partners with a number of community-based social service agencies that address the social determinants of health and equity, with a special emphasis on those agencies that serve families with children aged zero to five.

Advanced Health is locally owned by nine longstanding health providing organizations: Southwest Oregon Independent Practice Association; Bay Area Hospital; Coquille Valley Hospital District; North Bend Medical Center; Bay Clinic; South Coast Orthopedics; Coos County; ADAPT; and Advantage Dental. While *equity Members* are represented on Advanced Health's governing board, they are joined by *community Members*, at least two of whom must also be Community Advisory Council Members, thereby assuring that Advanced Health is community governed. The entire board is responsible for the management of Advanced Health, while the role of *equity Members* is delimited to the adoption of the annual work plan and budget.

During its first seven years as a CCO, Advanced Health achieved acclaim for its consistent attainment of rigorous clinical quality metrics and for bending the Medicaid cost curve. Advanced Health remains accountable and steadfast in its commitment to improving the health of our community by working toward mutually shared goals of better care, reduced health disparities, and lower costs. Advanced Health does this through a focus on individual patients, whole health, and local community involvement. Advanced Health's commitment is to its Members: to provide them with high-quality health care services; to treat them with kindness, dignity, and respect; and to empower qualitatively sound health decision-making.

To The Provider Network

Advanced Health utilizes two similar, but distinct, contractual pathways for creating its *Provider Network*. The first, and most common, is through Privileged Provider Agreements. These agreements are typically between Advanced Health-and-larger health services organizations that either contract directly with or employ direct-service providers. These differ from the second contract type, Network Provider Agreements, in that Advanced Health, or its staff, minimally engages in, or assists with, the administrative or management functions of the health services organizations. To become a Privileged Provider, Advanced Health conducts rigorous screening of the health service organization and subcontracts administrative and management "*Privileges"* to the extent the organization is able to demonstrate capability, capacity, skill, and efficiency at a level equivalent or greater than Advanced Health, and in a manner which meets state and federal criteria.

Both privileged providers and network providers are referred to as "in-network," and their contractual agreements may be characterized as risk-sharing and/or value-based. Advanced Health may additionally contract with "out-of-area" providers – particularly those who practice in specialty areas not immediately available in the local community. These providers are also "in-network," albeit they are "out-of-area," and the resultant contracts may or may not be value-based or risk-sharing in nature. Finally, Advanced Health may contract on a delimited case-by-case basis with "out-of-area" providers. These providers may be "out-of-network" and "out-of-area," and it is unlikely that their contracts will include risk-sharing or value-based elements.

To this Manual

This Provider Manual has been developed as a resource for important operational information concerning the role of the provider and his or her staff in the delivery of health care to Advanced Health's Members. It is Advanced Health's responsibility to its network providers to ensure that essential and helpful information is readily available. Though this Manual is provided as an informational resource for Advanced Health's providers, it is not all-inclusive and is not a policy document. This Manual is intended to supplement the Provider Contract and Advanced Health's policies and procedures. In the event that conflicting information is identified among multiple documents, the information contained in the Provider Contract shall have

precedence and is binding, followed by written policies and procedures, and then lastly, this Provider Manual.

WORKING WITH ADVANCED HEALTH

Provider Participation Requirements

Advanced Health encourages the participation of providers who are located in Coos and Curry Counties of southwest Oregon, and requires providers to meet the following basic criteria before serving Members of the Oregon Health Plan who are enrolled with Advanced Health:

- Hold a current license to practice in the State of Oregon;
- Meet Advanced Health's credentialing requirements; and,
- Execute a provider agreement with Advanced Health or one of Advanced Health's privileged provider organizations.

Credentialing

Advanced Health's provider selection policy is straight forward: Advanced Health contracts with any worthy provider who meets the organization's provider participation requirements, as specified in its adopted credentialing policies and procedures. Advanced Health has established comprehensive policies, procedures, and formats that guide and inform the provider selection and credentialing process. Physical health providers and outpatient and integrated behavioral health providers shall submit credentialing applications through Southwest Oregon Independent Practice Association (SWOIPA). Dental professionals affiliated with Advantage Dental shall submit credentialing applications through Advantage Dental. All other behavioral health providers shall submit credentialing applications to Advanced Health. Contact the Advanced Health Credentialing department with any questions.

Provider Training Plan, In-Service and Continuing Education

Advanced Health believes that the availability of its services is enhanced when provider practices are well qualified to inclusively meet the needs of diverse individuals. Advanced Health's credentialing policies and procedures set forth the organization's requirements for continuing medical education that, in large part, mirror the requirements of state licensing and regulatory boards. Advanced Health's current provider training plan focuses on in-service education, not only for providers, but for their employed staff Members as well, in four distinct areas: health literacy, adverse childhood experiences, cultural and linguistic competency, and trauma-informed practices. In-service educational requirements are summarized in the credentialing policies and procedures.

Site Evaluations

Advanced Health requires a site visit for each new provider address or office to assess accessibility and identify any office site deficiencies and makes additional site visits if there have been multiple complaints filed. Site evaluations follow a standardized assessment tool and include physical accessibility, physical appearance, and adequacy of waiting and examining room space. Below is a sampling of items that may be reviewed:

- Wheelchair access meeting Americans with Disabilities Act (ADA) standards/requirements;
- Adequate waiting room space for patient volume;
- Confidentiality in the reception area;
- After hours emergency coverage to respond immediately;
- After hours urgent coverage to respond within 30 minutes; and
- Patient waiting time does not exceed 45 minutes of appointment time.

Leaves of Absence

A Leave of Absence may be requested when an Advanced Health provider temporarily ceases to practice in Coos or Curry County for a period of three to twenty-four (24) months. Absences of less than ninety days are not considered leaves of absence, and the procedures described below are not necessary. A voluntary leave of absence may be obtained by submitting a written notice to the Chief Medical Officer. The notice must state the approximate first and last date of the leave of absence and may not exceed twenty-four (24) months. Leaves of absence for military duty may be extended beyond two years on a case-by-case basis. Absences of more than twenty-four (24) months, which are not for military duty, will require termination of provider status. During the leave of absence, the provider is moved to inactive status in Advanced Health's database system. The provider's responsibilities are suspended. Once the leave has commenced, providers may continue to receive payments for medical care rendered prior to the leave date. However, providers are not eligible to provide or be compensated for medical services rendered after the effective date of the leave of absence.

Reinstatement

Prior to resuming the delivery of services to Members, providers returning from a leave of absence must notify Advanced Health of their return. If the provider's credentials with Advanced Health have lapsed during the period of the leave, re-credentialing must occur.

Terms for Locum Tenens Providers

From time to time, participating providers may require assistance from locum tenens providers and/or temporary associates. In all cases, a locum tenens associate must be working for and bill under a participating provider. The term length for locum tenens will not exceed sixty (60) days per CMS rule. CMS and OHA billing guidelines apply. If a locum tenens provider's term will be greater than 60 days, then they must go through the initial credentialing process prior to rendering services.

Change of Information

Please notify Advanced Health within seven business days in advance of any intended changes which may restrict or impact the ability to contact or interact with an office or clinic. This may include changes regarding telephone number, physical or billing address, tax identification number, Membership status, closing practice, and billing identification. If prior notice is infeasible, the practitioner must notify Advanced Health immediately, but no more than one (1) business day, of any such changes.

Termination of Provider's Panel Participation

When a participating provider leaves the service of Advanced Health or one of its privileged providers, Advanced Health is required to demonstrate a good-faith effort by notifying all Advanced Health Members who were seen by the departing provider within 15 days of his/her termination notice. Advanced Health requests that participating providers furnish as much notice of termination as possible as set forth in contractual language. If a participating provider elects to terminate his/her contract with Advanced Health or SWOIPA without cause, not less than 30 days prior written notice is required.

PROVIDER RESPONSIBILITIES

Responsibilities of Primary Care Providers

The Primary Care Provider (PCP) facilitates authorizations to specialists to provide for the complete health care needs of the Member. Providers are reimbursed a monthly primary care case management fee (also known as "capitation"). PCPs receive a monthly report of all Members currently assigned to them. Members may choose their PCP or are assigned a PCP from a mutually agreed upon rotation list of available PCPs within the local vicinity of the patient's home. The PCP's responsibilities as the manager of the Member's care are as follows:

- The PCP provides all primary preventative healthcare services. In addition, female members may directly access a women's health specialist to provide routine and preventive health care services if the PCP is not a women's health specialist;
- When specialized care is medically necessary, the PCP will facilitate an authorization to a specialist or specialty facility;
- The PCP must contact the Plan to obtain authorization to specialty providers, except in cases when an Advanced Health Member has original Medicare as their primary insurance;
- The PCP will coordinate care and share appropriate medical information with the plan as well as with specialty providers to whom they refer their patients;
- The PCP will refer Members for a second opinion at the Member's request. Referrals to non-contracted providers require prior authorization from Advanced Health;
- The PCP will document in their patient's medical record whether or not an individual has executed an advance directive;
- The rendering provider will forward copies of the sterilization and hysterectomy form to the Advanced Health's Claims Department; and
- The PCP will adhere to the medical record standards that were developed and approved by the Ambulatory Record Certification Program of the Oregon Medical Association.
- Provide or arrange for health care for the Member, 24 hours per day, seven days per week;
- Arrange sufficient call-share coverage to assure that Members may access the PCP or his or her knowledgeable call-share system, at any time, during or after regular office hours;
- Instruct Members to contact the PCP before obtaining anything other than absolute emergency care;

- Review information from specialists and incorporate the same into the medical record;
- Identify all Members who qualify as *special populations* or as *persons with special health care needs*, and refer such Members for case management services, or intensive care coordination, as appropriate;
- Develop and/or countersign plans of care for all assigned Members receiving case management services or intensive care coordination;
- Agree to accept, as his or her patients, in equal proportion to all other PCPs, those eligible Members as assigned by Advanced Health, in order to assure that all Members have access to primary care services;
- Perform all medical laboratory and radiologic services, either in-office or at the office of a participating practitioner in accordance with Advanced Health's policies;
- Arrange for prior authorization, as appropriate, for elective hospital inpatient, residential treatment, home health, and other services, in advance (noting that specialists may also request prior authorizations); and,
- Assume responsibility for the training and education of individuals working within the medical practice to assure that the procedures for coordinated care delivery are followed correctly.

Responsibilities of Dental Providers

Responsibilities of Specialists and Behavioral Health Providers

When a Member requires treatment that the PCP determines would best be provided by a specialist or behavioral health practitioner, the PCP will provide a referral to a participating specialist or behavioral health provider. It is specifically noted, however, that Members may directly access the services of behavioral health providers in the absence of a referral from the PCP, or prior authorization from Advanced Health.

Under most circumstances, Members may be seen for up to three visits, regardless of diagnosis, without prior authorization. There are circumstances where no authorization may be required or which Members with special healthcare needs, including those who meet intensive care coordination criteria, may never require prior authorization to be seen by a specialist for specific medical services or types of services. More information on criteria and current policies related to prior authorizations can be found on Advanced Health's website, or by contacting Advanced Health's case management team. For the majority of Members and cases which do not meet a special circumstance, a prior authorization request must be submitted through Advanced Health's provider portal, or by facsimile request.

Prior authorizations are not required for Members wanting to access in-network behavioral health services. Members may be referred or can self-refer to see a behavioral health provider of their choosing at any time and for any or no stated reason. When making referrals, Members and healthcare practitioners are encouraged to utilize Advanced Health's directory of in-network behavioral health providers, which can be found on Advanced Health's website.
Specific specialist and behavioral health practitioner responsibilities include:

- Understanding that it is not the Member's responsibility to obtain a referral, prior authorization, or authorization number before receiving services from a specialist or behavioral health provider;
- Working with primary care providers to ensure that the referral or prior authorization process is completed correctly and documented in the Member's medical record;

- Advising the primary care provider of the status of the patient, including recommendations for follow-up or continuing care;
- Obtaining proper prior authorization if the Member needs a service for which prior authorization is required;
- Notifying the Member when the requested service has been approved;
- Ensuring that treatment and services provided are documented and incorporated into the Member's primary care medical record, as medically necessary; and,
- Educating and training of all individuals working within their medical practice to ensure that Advanced Health's coordinated care policies and procedures are followed correctly.

Accepting New Enrollees

Participating providers who are subject to the agreement between Advanced Health, either directly or through a sub-contractual mechanism with a privileged provider, agree to be open to accept new enrollees for as long as their assigned caseloads are less than the average caseload carried by any other provider of the same type (i.e., primary care provider; behavioral health practitioner). If a participating provider is open to accepting new patients who are commercially insured, then the provider is also open to accepting new Members who receive Medicaid benefits. A provider must provide Advanced Health with a minimum of sixty (60) days advanced written notice of their intent to close their practice to all new patients.

Serving Enrollees

Advanced Health's providers are contractually obligated to provide covered services outlined in the provider services agreement (contract) that are no less than the amount, duration, and scope of the same services to beneficiaries of fee-for-service Medicaid programs. Providers may not arbitrarily deny or reduce the amount, duration, frequency, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. Advanced Health maintains policies and procedures that promote and ensure parity in the delivery of physical health and behavioral health services.

Advanced Health's policies require, and cause its providers to require, that Members receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language, and ability to understand.

Non-Discrimination

Providers are cautioned that all contractual agreements with Advanced Health include comprehensive prohibitions regarding discrimination in the assignment of patients and services provided to those patients in accord with federal and state statutes. Providers may not discriminate on the basis of race, color, creed, nationality, language(s) spoken, educational attainment level, gender, religious affiliation or lack thereof, sexual orientation, gender identification, disability status, marital status, veteran status, housing status, or any other unlawful categorization. Similarly, Advanced Health may not discriminate against any provider, or applicant seeking to become a provider, on any unlawful basis, or on the basis that the services furnished by the provider are high cost in nature.

Dismissing or Transferring Assigned Members

An Advanced Health Member may be released from medical or dental care by a participating provider when, in the practitioner's professional judgment, it is in the best interest of the patient to do so. Prior to discharging or dismissing a Member from a primary care provider or primary care dentist, we encourage the use of Advanced Health's case management and Intensive Care Coordination team, either by calling Customer Services, sending in a referral, or sending a "Blue Card" to Customer Service. If the primary care provider or dentist does decide to dismiss a Member, they fax or mail a copy of the Dismissal Letter to Advanced Health Customer Service. The provider must also agree to be responsible for Member care for 30 days post-dismissal for coordination of care and urgent needs. All patient dismissals will be documented in the provider and Member's record.

An Advanced Health Member may not be released from medical, dental, or behavioral health care solely because:

- The Member has a physical or mental disability;
- There is an adverse change in the Member's health;
- The Member's utilization of services (either under- or over-utilization);
- The Member's mental illness;
- The Member has filed a grievance or requested a hearing;
- The Member has been diagnosed with end-stage renal disease or placed in hospice after the date of enrollment;
- The Member has exercised his or her option to make decisions regarding his or her care.; or,
- The Member displays uncooperative or disruptive behavior that results from a special need (except when continued assignment seriously impairs the provider's ability to furnish services to other Members).

An Advanced Health Member may be released from medical or dental care for:

- Multiple missed appointments, at least three or more, that are documented in the Member's medical record; such documentation must include steps taken by the provider to determine the reasons for the missed appointments and the assistance that has been provided to the Member to minimize missed appointments; this may include sending a notification ("Blue Cards" to Advanced Health Customer Service);
- Disruptive, unruly, or abusive behavior to the point that it seriously impairs the practitioner's ability to furnish services, either to the Member or to other patients or Members;
- The threat of, or commission of, an act of physical violence directed at a practitioner, the practitioner's staff Members, or other patients in the office or at the site;
- Fraudulent or illegal acts, including permitting the use of the Member's identification card by another person, theft of prescription pads, alteration of written prescriptions, theft, or other criminal acts committed on the provider's premises, or,
- The violation of a mutually agreed-upon treatment contract for opiate or other controlled substance use.

All Members who are being released by their attending provider will be contacted by Customer Service for reassignment and screening for Intensive Care Coordination needs. Advanced Health Members have the right to file a complaint with Advanced Health when a practitioner releases a Member from care.

In the case of a threat or act of physical violence made by, or to, a Member, the practitioner, or its administrative agent, must inform Advanced Health's Chief Compliance Officer, whom additionally serves as it's Risk Officer, immediately, but not more than forty-eight (48) hours from when practitioner became aware of the incident. Advanced Health's Chief Compliance Officer must also be made immediately aware of any fraudulent or illegal act by, or too, any Member, as Advanced Health may have additional obligations to investigate and report to state and federal authorities. All such notifications must be submitted to Advanced Health in writing and must provide a detailed account of the incident, and any actions sought and implemented by the practitioner or administrative agent. For continuity of care, Advanced Health must be informed of all such incidents before a Member is released from medical care by the practitioner.

If there is a decision to withdraw a Member from a practitioner's panel, for any reason, the Member must be notified in writing. Such notification must occur at least thirty (30) calendar days in advance of the effective date of the termination. The letter must specify the reasons for the dismissal, and a copy of the letter must be provided to Customer Service. During the thirty calendar days between notification and release, the practitioner shall remain responsible for the acute, urgent, or emergent care of the Member. [If a Member's disruptive behavior creates direct risks for other patients or staff Members, the thirty days may be reduced to as little as a single day.] The practitioner will make medical records available to another practitioner upon receiving a signed release from the Member. Advanced Health will assign the Member to another provider effective on the first of the following month.

Providers should make every effort to resolve problems with Members. Practitioners may inform Members that their behavior may result in termination. Advanced Health will assist practitioners in resolving issues with Members, and it is anticipated that a Case Manager or Care Coordinator will work with the Member, the Member's family, and other relevant agencies and authorities, as needed, to assure that essential health care services are provided in a manner that is safe for all concerned.

Accessibility of Practitioners

All providers must have provisions for Members with visual and/or hearing impairments (e.g., access to an American Sign Language interpreter). Similarly, all providers must have procedures for obtaining interpretation and translation services for Members who need them. Finally, providers must meet ADA standards for accessibility, including easy wheelchair access; elevators operable from wheelchairs (if elevators are at the site); easy wheelchair access to exam rooms; easy wheelchair access and handrails in restrooms; and comfortable seating and bariatric exam tables or dental chairs for patients who are obese.

To ensure that Advanced Health's Medicaid beneficiaries have timely access to medically appropriate health care services and that the standards of the Oregon Health Authority and the Center for Medicaid and Medicare Services (CMS) are met, practitioners shall provide timely care in the manner specified in Table 1.

Table 1
Availability Expectations

Type of Care	Type of Need	Expected Timeframe
Physical Health	Well-Care	Within 4 weeks from the date of patient's request
Physical Health	Urgent Care	Within 72 hours or as indicated in the initial screening
Physical Health	Emergency Care	Seen and treated immediately or referred immediately to an emergency department depending on patient's condition
Behavioral Health	Crisis, with Need to Assess Risk to Self or Others	Mobile, 24-hours per day, 365 days per year, STAT
Behavioral Health	Urgent Care	Within 24 hours
Behavioral Health	Routine Care	Seen for an intake assessment within 7 days of the request, with a second appointment occurring as clinically appropriate.
Substance Use Disorder	Pregnant women Interim services IV drug use Opioid use disorders Medicated Assisted Treatment (MAT) Veterans and their families	-immediate access -within 72 hours of being waitlisted -assessment/intake immediately -assessment/intake within 72 hours -as soon as possible and no more than 72 hours for assessment and induction, no less than 2 follow up appointments in one-week post-induction and assessment -assessment/intake immediately
Dental Care	Dental Emergency	Within twenty-four (24) hours. Treatment of a Dental Emergency Condition or Dental Urgent Care service should be provided in an ambulatory dental office setting or an ASC. Emergency Dental Services may be provided in a Hospital setting when appropriate.
Dental Care	Dental Urgent Care	For pregnant individuals: Within one week or as indicated in the initial screening in accordance with OAR 410-123- 1060. For non-pregnant individuals: Within 2 weeks or as indicated in the initial screening. Treatment of a Dental Emergency Condition or
Dental Care	Routine or Follow-Up Appointment	For pregnant individuals: Within 4 weeks, unless there is a documented special clinical reason that makes a period of longer than 4 weeks appropriate. For non-pregnant individuals: Within 8 weeks, unless there is a documented special clinical reason that makes a period of longer than 8 weeks appropriate.

Availability of Practitioners

Advanced Health's providers are required to demonstrate that 24-hour coverage is available to their patients. Patients, emergency departments, and other providers must have the ability to reach the provider or the provider's covering call-share practitioner. Participating providers agree to provide 7-day-per-week, 24-hour-per-day coverage for all Members. The practitioner or call-share practitioner will be available on a 24-hour basis to provide care or to direct Members to the most appropriate treatment setting. A recorded message directing the Member to contact the local emergency department is not sufficient to meet this requirement. Providers must have an adequate telephone answering system or service to ensure Member access to the practitioner or call- share practitioner during periods when the clinical office is not open, and phones are not answered by available staff Members.

Participating providers shall agree to make arrangements for covering practitioners when they are unavailable. Advanced Health must be notified of the practitioners who regularly participate in group call-share arrangements, and these practitioners must be credentialed by Advanced Health or one of its privileged providers. To ensure continuity of care, the call-share practitioner shall document and transmit information to the Member's primary care medical record.

Practices on Emergency and Urgent Care Services

Emergency Care Services: Emergency services are defined as *health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and out-patient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.* Advanced Health does not require prior authorization for emergency or urgent care services. A Member may access these services 24-hours per day, seven days per week. The attending emergency physician, or the provider, actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

Members are instructed in the Advanced Health Member Handbook to call their primary care provider whenever they need health care services. Primary care providers are expected to reinforce these instructions at regular intervals, as appropriate, with their assigned Members. If a Member calls and information is adequate to determine that the Member's condition may be emergent in nature, the provider must respond immediately by telephone. If a Member believes that he or she has an emergency medical condition, they are instructed to call 911 or go to the nearest emergency department. The CCO defines "emergency medical condition" as a 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:

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

Out-of-Area Emergency Services: Advanced Health's Members who require services that cannot wait until they return home are instructed in the Member Handbook to go to the nearest emergency department, or to call 911. No prior authorization is required for any emergency service, although continuing care may require prior authorization after the emergency is abated. Members are also advised to contact their primary care provider for follow-up and/or transfer of care.

When the primary care provider is notified of an out-of-area emergency which requires follow-up or has resulted in inpatient admission, the primary care provider is expected to monitor the Member's condition,

arrange for appropriate care, and determine whether the Member can be safely transferred to a participating hospital in coordination with Advanced Health's Transitions of Care Team, part of the Case Management department.

Urgent Care Services: Members are instructed to contact their primary care provider for all medical care, including urgent care, or alternately to contact their behavioral health specialist or dentist for urgent care needs involving oral or behavioral health. Calls from Members that are truly urgent in nature must receive responses within thirty (30) minutes; if the information is insufficient to determine the nature of the call, the call shall be treated as if it is truly urgent. If the Member's need is found to be urgent, the primary care provider, attending dentist, or attending behavioral health specialist shall provide or arrange for appropriate care.

Inappropriate Utilization of Emergency Services: Some Advanced Health Members may use the emergency department to obtain routine care that could have been provided in another office or in a lower cost outpatient setting. Advanced Health will work with primary care providers and attending behavioral health specialists to provide counseling to Members who inappropriately use emergency department services. Please call such matters to the attention of the Intensive Care Coordination Team, who will work with the Member's case manager, primary care and attending providers, family Members, and other agencies as necessary and appropriate.

Post-Stabilization Services

Advanced Health defines post-stabilization services as covered services, related to an emergency medical condition that is provided after a Member is stabilized to maintain the stabilized condition, or to improve or resolve the Member's condition when Advanced Health does not respond to a request for pre-approval within one hour, or Advanced Health cannot be contacted, or Advanced Health's representative and the treating physician cannot reach an agreement concerning the Member's care, and an Advanced Health physician is not available for consultation. Advanced Health is financially responsible for post-stabilization care services obtained within or outside of its network that are pre-approved by an Advanced Health provider or another representative.

Additional Standards

Participating providers are responsible for assuring access to services 7 days a week, 24 hours a day, 365 days a year, other than in an emergency room for non-emergent conditions. This includes arrangements to assure patient awareness after hours to another participating provider. Coverage shall be provided in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care personally or to direct Members to the setting most appropriate for treatment.

The average wait times should be no more than 45 minutes for patients who arrive on time for a scheduled appointment.

If a provider must cancel an appointment, the provider must make a good-faith effort to contact the Member and reschedule for a later time.

Applicability of Federal Laws: As a federal subcontractor, Advanced Health receives federal funds to provide services to our Members. Participating providers furnishing services to Advanced Health Members are subject to laws applicable to individuals and entities receiving federal funds. Participating providers

who treat Members are required to comply with all applicable state and federal laws and regulations regarding Medicare and Medicaid.

Submitting Encounter Data: Participating providers are required to submit to Advanced Health all data, including medical records, necessary to comply with CMS and MAP Encounter Data requirements. CMS also requires that Advanced Health and its contracted providers certify the completeness and truthfulness of their encounter data. State and federal regulations require the submission of encounter data for no- and low-cost claims.

Regulatory Access to Books and Records: Participating providers are also required under law to allow State and/or Federal regulatory agencies to audit, evaluate and inspect books, contracts, medical records, patient care documentation and other records for ten (10) years, or until completion of the regulatory audit, whichever is later, for purposes of evaluating the timeliness, quality and appropriateness of care or to evaluate any aspect of services performed.

Quality Review and Compliance with Advanced Health's Practice Standards: All participating providers must cooperate with the requests and requirements of quality review organizations when such activities pertain to services for Advanced Health Members. Participating providers must also comply with Advanced Health practice guidelines, medical policies, Quality Assurance (QA) programs, and medical management programs. Advanced Health's policies also require that providers exchange appropriate information for coordinating the care of Members who are identified as included in a *priority population* or as having *special health care needs.*

ADVANCED HEALTH OHP MEMBERSHIP and BENEFITS

Identification Cards

Advanced Health sends Member identification cards to the Member when they are enrolled in the health plan. It is the responsibility of the treating provider to verify a Member's eligibility on the date of service and that the service is covered under the OHP Benefit Package prior to rendering services. The provider is also required to verify that the patient is enrolled in Advanced Health and seek any necessary authorization required.

Enrollment and Disenrollment

Only the Oregon Health Authority is empowered to enroll or disenroll an individual in the Oregon Health Plan. Neither Advanced Health nor any of its providers or contractors hold the authority to enroll or disenroll an individual in the Oregon Health Plan. Advanced Health's policies governing enrollment and dis-enrollment are set forth in Exhibit 3. For persons who may require assistance in applying or qualifying for the Oregon Health Plan, certified "assisters" are available. For help in identifying an approved "assister," please contact the Oregon Department of Human Services, a federally qualified health center, or Coos Health and Wellness. Also, a search tool is available on the OHA website to help find community partner "assisters" at https://healthcare.oregon.gov/Pages/find-help.aspx.

Eligibility Verification

The Health Services Division (HSD), formerly known as Medical Assistance Programs (MAP), is responsible

for determining patient eligibility for the Oregon Health Plan (OHP). Participating providers who are registered to use Advanced Health's provider portal may access patient eligibility, authorization, and PCP information online at www.docshp.com. To register for access to the provider portal, please visit our website at www.advancedhealth.com, click on For Providers →Policies and Forms →Online User Registration. Follow the instructions located on the form for submission.

Advanced Health must receive a signed "Agreement to Access Confidential Client Data" for each clinic. Clinic administrators, office managers, or facilitators are required to sign this document on behalf of the clinic/facility they represent. Only one agreement needs to be on file for each clinic/facility. Once there is an agreement on file, clinics and facilities may begin registering users. An "Online User Registration Request" must be completed and submitted to Advanced Health for each user accessing the provider portal. Forms can be faxed to Advanced Health at 541-266-0141.

Basic Benefit Packages

Benefits provided to Advanced Health Members are based on the *Prioritized List of Health Services*, OAR 410-0520. To obtain a current version of the Prioritized list, visit http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized -List.aspx. Covered condition/treatment pairs for medical services are defined by specific ICD-10-CM procedure codes and CPT procedure codes. Table 2 provides a quick reference chart that illustrates the medical, dental, or behavioral health services OHP covers for each benefit package.

Table 2
Guide to Member Benefits

Covered Services	OHP Plus Children/Individuals (Ages 0-20)	OHP with Limited Drug* OHP Plus Non-Pregnant Adults (Ages 21 and Older)
Acupuncture	Covered	Covered
Chiropractic	Covered	Covered
Substance Use Disorder	Covered	Covered
Dental (Basic services, including cleaning, fillings, and extractions. Urgent, immediate treatment. Other services are limited*	Covered	Covered
Diagnostic studies	Covered	Covered
Durable Medical Equipment and Supplies (DME)	Covered	Covered
Emergency Services	Covered	Covered
Hearing Aids & Exams	Covered	Covered
Home Health	Covered	Covered
Hospice Care	Covered	Covered
Hospital Care (Inpatient/Outpatient)	Covered	Covered
Immunizations	Covered	Covered

Labor & Delivery	Covered	Covered
Laboratory & X-Ray	Covered	Covered
Medical Transportation	Covered	Covered
Mental Health Services	Covered	Covered

Covered Services	OHP Plus Children/Individuals (Ages 0-20)	OHP with Limited Drug* OHP Plus Non-Pregnant Adults (Ages 21 and Older)
Naturopathy	Covered	Covered
Pain Management	Covered	Covered
Physical, Occupational & Speech Therapy	Covered	Covered
Physician Services	Covered	Covered
Podiatry	Covered	Covered
Prescription Drugs	Covered	Limited*
Private Duty Nursing	Covered	Covered
Skilled nursing facility (SNF)	Covered	Covered
Vision Care	Covered	Limited*

Non-Covered Services

It is important to understand the nature of the treatment/condition pairs that fall below the funded line on the *Prioritized List of Health Services*. Please keep these principles in mind:

- Treatment/condition pairs are defined by specific CPT procedure codes and ICD-10-CM diagnoses codes. Claims, referrals, and prior authorization requests must have accurate CPT and ICD-10-CM codes in order to determine coverage eligibility. ICD-10-CM codes must be used to the greatest degree of specificity.
- The presence or absence of a comorbid condition may affect coverage. Providing information about comorbid conditions with requests for referrals or prior authorizations may decrease the likelihood of denial of these requests.
- Diagnostic services are covered until a diagnosis is reached.
- Services for non-funded treatment/condition pairs may be provided at the Member's expense; however, Members may be required to sign waivers or consents prior to the provision of treatment.
- In the case of non-covered treatment that may exist for the patient's condition, providers must assure that the patient is informed of: clinically appropriate treatment for the patient's condition, whether covered or not; community resources that may be willing to provide non-covered services; and, future health indicators that may warrant a repeat diagnostic visit.

The Oregon Health Authority requires providers to use the 3165-waiver form before treating and charging

a Member for a service not covered by Advanced Health or the Oregon Health Plan. The waiver, which will be completed/signed by the provider and signed by the Member, gives the Member information about the service they will be receiving and for which they will be financially responsible, including the condition being treated; the expected date of the service; the estimated charges; and other types of potential charges, such as lab, radiation, and hospital charges.

A copy of the waiver is available on the Advanced Health website. The form is also available in large print and in Spanish. https://advancedhealth.com/providers/resources/ .

Providers may not bill Members for non-covered services without a completed waiver in place prior to rendering the service. Members may not be billed for services that would otherwise be covered but are not supported by a diagnosis of established coding guidelines, or services that require authorization or are submitted untimely.

Excluded Services and Limitations

Certain services or items are not covered under any program or for any group of eligible Members. It is the responsibility of the provider to inform Members if certain services are not covered by the Oregon Health Plan or Advanced Health. If a Member chooses to proceed with a non-funded or excluded service, it is the responsibility of the provider to specify the total cost of the service to the Member and to have the Member sign an *OHP Client Agreement* formally accepting full financial responsibility for the service. This form is available at https://aix-xweb1p.state.or.us/es xweb/DHSforms/Served/he3165.pdf

Additional Benefit Information

Mental Health Services: Mental Health services are a covered benefit through Advanced Health. No prior authorization is required for Members who wish to access outpatient mental health services.

Prescriptions for medications used to treat mental health diagnoses are billed by pharmacies directly to OHA's Health Services Division (HSD). Prescriptions written by Advanced Health's contracted providers for medications that are used in conjunction with mental health medications (e.g., medications that treat side effects for mental health drug therapy) are covered by Advanced Health but are subject to patient eligibility, plan benefits, limitations, and exclusions.

Substance Use Disorder Services: Advanced Health has contracted with ADAPT for the provision of outpatient, residential, and inpatient addiction treatment in Coos and Curry Counties. Members may self-refer to these services. No prior authorization from Advanced Health is required. Medication-Assisted Treatment (MAT) services are present in Coos County and Curry County.

Pharmacy Benefits: Oregon Health Plan Members currently have drug benefits as part of their benefits package. The coverage of medications is dependent upon whether the drug is included on Advanced Health's Drug Formulary. The diagnosis must be covered and is subject to exclusions and limitations. It is mandatory that generic medications be substituted whenever possible. Some medications on the formulary require prior authorization. Any medications not listed on the formulary must be authorized in advance. Please use the Medication Authorization Form and/or consult Advanced Health's most recent Drug Formulary at www.advancedhealth.com.

Dental Services: Dental Services are a covered benefit for Advanced Health Members. This includes anesthesia, hospital, or ambulatory surgical services for patients with severe medical needs.

Authorization is required for some services prior to services being rendered.

Preventive Care Services: Advanced Health practitioners are expected to implement the "A" recommendations of the Guide to Clinical Preventive Services.

Member Medical and Dental Care Access

Advanced Health's participating practitioners must ensure that health care services are accessible to people with disabilities or who have other special needs, such as visual or hearing impairments.

Members with Limited English Proficiency (LEP): Advanced Health can arrange for a qualified or certified health care interpreter to be present for most appointments, with 48 hours advance notice. Advanced Health is able to arrange telephone-based interpretation, provide in person Spanish interpretation, and facilitate InSight Video Interpretation in over 240 languages, including American Sign Language on site. Please contact Member Services. Advanced Health also provides translation services for written materials as needed, at no cost to the Member. Contact Member Services with questions or arrange interpretation or translation services.

Members with Visual or Hearing Impairments: Providers and practitioners should be prepared to meet the needs of the visually and/or hearing impaired. To arrange for a sign language interpreter to be present at an appointment, please contact Member Services at least 48 hours prior to the scheduled appointment. For urgently needed sign language interpreter services, local options might include Southwestern Oregon Community College, or the Emergency Department or the Social Services office at Bay Area Hospital. The Oregon Telecommunication Relay Service is available at 800.735.1232 to facilitate phone communication with Members utilizing special telecommunication devices.

There is no charge to Members for interpreter services or the use of special telecommunication devices.

Family Planning Services

Members are not required to seek prior authorization or referral from their assigned primary care provider prior to seeking women's health care or family planning services. Advanced Health respects the right of every Member to choose their family planning provider and family planning methods. Family planning services include family planning visits (i.e., physical exam and birth control education), birth control supplies, pregnancy testing, counseling to address reproductive health issues, laboratory tests, radiology services, medical and surgical procedures including tubal ligations and vasectomies and pharmaceutical supplies and devices. Please see OAR 410-130-0585 for additional information.

Reproductive Specialty Services

Hysterectomy and Sterilization policies are found in Oregon Administrative Rule 410-130-0580. Providers are encouraged to review the rules and regulations that apply to hysterectomies and sterilization and to be conversant with them. Consents must be informed to protect the professional liability of the provider, and forms populated precisely to avoid the denial of a claim. The required forms vary depending upon the procedure and the age of the person seeking the procedure. Each form must be completed and dated in a particular order and within a particular time frame in relation to the procedure.

The DMAP Hysterectomy and Sterilization Procedures Manual will direct providers in the process of garnering consent properly and completing forms correctly. This Manual can be downloaded at http://www.oregon.gov/oha/HealthPlan/Policies/130rb100114.pdf This is a federally funded program that offers no leeway for claims and forms that are incomplete, incorrect, improperly sequenced, or

illegible. Hysterectomy and Sterilization Consent Forms (DMAP Forms 741, 742A, and 742B) may be obtained from http://www.oregon.gov/oha/HealthPlan/Pages/forms.aspx Please note that separate and distinct forms are used for persons aged 21 years and older, persons aged 15 to 20, women who are capable of childbearing, and women who are sterile prior to hysterectomy. Forms are available in English and Spanish.

The practitioner performing the procedure must attach a copy of the correctly completed consent form to the claim. If a correctly completed informed consent form is not attached, the claim, and all associated claims (hospital, anesthesiology, etc.), will be denied.

If the patient is facing a life-threatening emergency in which prior acknowledgment is not possible, the physician performing the hysterectomy must clarify in writing their determination that prior acknowledgment was not possible, and that the hysterectomy was performed under a life-threatening and emergent situation.

Non-Emergency Medical Transportation (NEMT):

NEMT is among the benefits available to Oregon Health Plan Members, and includes transportation assistance for regularly scheduled medical, pharmacy, dental, and behavioral health appointments. Members may contact Bay Cities Transportation Brokerage directly at 1.877.324.8109 to schedule transportation. Please try to schedule transportation at least 48 hours prior to the assigned appointment time when possible. Same day NEMT transportation may be available if circumstances prevent the ability to schedule at an earlier time. Contact Member Services, or Bay Cities Brokerage, for any issues or questions that might arise regarding the transportation benefit.

MEMBER RIGHTS AND RESPONSIBILITIES

The following information about member rights and responsibilities is excerpted from Advanced Health's Member Rights, Protections and Responsibilities Policies and Procedures. As a provider, having knowledge of Member Rights and Responsibilities is an expectation, and is important in communications with members.

Members have the right to:

- Be treated with dignity and respect and consideration for your privacy;
- Be treated by providers the same as other people seeking health care.
- Have a stable relationship with a care team that is responsible for managing your overall care.
- Not to be held down or kept away from people because it would be easier to care for you, to punish you, or to get you to do something you don't want to do.
    - Materials explained in a way and in a language you can understand.
    - Materials that tell you about CCOs and how to use the health care system. (Member Handbook is one good source for this)
    - Written materials that tell you your rights, responsibilities, benefits, how to get services, and what to do in an emergency. (Member Handbook is one good source for this)
    - Information about your condition, treatments and alternatives, what is covered, and what is not covered. This information will help you make good decisions about your treatment. Get this information in a language and a format that works for you.
    - A health record that keeps track of your conditions, the services you get, and referrals.
        - Have access to your health records.
        - Share your health records with a provider.

- Written notice mailed to you of a denial or change in a benefit before it happens. You might not get a notice if it isn't required by federal or state rules.
- Written notice mailed to you about providers who are no longer in-network. In network means providers or specialist that work with Advanced Health.
- Be told in a timely manner if an appointment is cancelled.

They have the right to get this care:

- Care and services that put you at the center. Get care that gives you choice, independence, and dignity. This care will be based on your health needs and meet standards of practice.
- Services that consider your cultural and language needs and are close to where you live. If available, you can get services in non-traditional settings such as online.
- Care coordination, community-based care, and help with care transitions in a way that works with your culture and language. This will help keep you out of a hospital or facility.
- Services that are needed to know what health condition you have.
- Help to use the health care system. Get the cultural and language support you need. This could be:
    - Certified or qualified health care interpreters.
    - Certified traditional health workers.
    - Community health workers.
    - Peer wellness specialists.
    - Peer support specialists.
    - Doulas.
    - Personal health navigators.
- Help from CCO staff who are fully trained in CCO policies and procedures.
- Covered preventive services.
- Urgent and emergency services 24 hours a day, 7 days a week without approval or permission.
- Referrals to specialty providers for covered coordinated services that are needed based on your health.
- Extra support from an OHP Ombudsperson.

They have the right to do these things:

- Choose your providers and change those choices.
- Get a second opinion.
- Have a friend, family member, or helper come to your appointments.
- Be actively involved in making your treatment plan.
- Agree to or refuse services. Know what might happen based on your decision. A court-ordered service cannot be refused.
- Refer yourself to behavioral health or family planning services without permission from a provider.
- Make a statement of wishes for treatment. This means your wishes to accept or refuse medical, surgical, or behavioral health treatment. It also means the right to make directives and give powers of attorney for health care, listed in ORS 127.
- Make a complaint or ask for an appeal. Get a response from Advanced Health when you do this.
    - Ask the state to review if you don't agree with Advanced Health's decision. This is called Hearing.

Get free certified or qualified health care interpreters for all non-English languages and sign language.

Member's responsibilities as an OHP member

They must treat others this way:

- Treat Advanced Health staff, providers, and others with respect.
- Be honest with your providers so they can give you the best care.

They must tell OHP this information:

Call OHP/ONE Customer Service Line at 1- 800-699-9075 (TTY 711) when you:

- Move or change your mailing address.
- If any family moves in or out of your home.
- Change your phone number.
- Become pregnant and when you give birth.
- Have other insurance.

They must help with their care in these ways:

- Choose or help choose your primary care provider or clinic.
- Get yearly checkups, wellness visits, and preventive care to keep you healthy.
- Be on time for appointments. If you will be late, call ahead or cancel your appointment if you can't make it.
- Bring your medical ID cards to appointments. Tell the office that you have OHP and any other health insurance. Let them know if you were hurt in an accident.
- Help your provider make your treatment plan. Follow the treatment plan and actively take part in your care.
- Follow directions from your providers' or ask for another option.
- If you don't understand, ask questions about conditions, treatments, and other issues related to care.
- Use information you get from providers and care teams to help you make informed decisions about your treatment.
- Use your primary care provider for tests and other care needs unless it's an emergency.
- Use in-network specialists or work with your provider for approval if you want or need to see someone who does not work with Advanced Health.
- Use urgent or emergent services appropriately. Tell your primary care provider within 72 hours if you do use these services.
- Help providers get your health record. You may have to sign a form for this.
- Tell Advanced Health if you have any issues, complaints, or need help.
- Pay for services that are not covered by OHP.
- If you get money because of an injury, help Advanced Health get paid for services we gave you because of that injury.

MEDICAL RECORD DOCUMENTATION PRACTICES

Participating providers are required to safeguard patient-identifying information and to maintain records in a manner consistent with State and Federal laws. If evidence of substandard medical record keeping is identified by a random chart audit, the provider will be educated regarding the policy and further monitoring done as deemed necessary. In addition, payments for claims may be withheld until the

deficient practices are corrected. Participating Providers are required to submit corrective action plans for non-compliant processes.

Participating Providers agree to adhere to the medical record standards as outlined below:

- All pages contain patient name;
- Address is contained in biographical/personal data;
- Telephone numbers are contained in biographical/personal data;
- Work telephone number is contained in biographical/personal data;
- Employer is contained in biographical/personal data;
- Marital status is contained in biographical/personal data;
- All entries contain author identification and are appropriately authenticated by the author;
- All entries are dated. Every entry must contain complete date (mm/dd/yy);
- The record is legible;
- There is a complete medical condition list, which states significant illnesses, etc., single sheet prominently displayed;
- Medication allergies and adverse reactions to medications, or the lack of them (NKDA/NKA) is prominently displayed;
- There is an appropriate past medical history in the chart, which includes serious illness, surgeries, accidents, family history, and mental health history. This applies to patients seen three times or more and must be easily found within the record;
- If OB patient, there is an Oregon uniform prenatal record or its equivalent in the record.

  The form must be complete to current date;
- There is documentation of smoking habits and history of alcohol use and substance abuse. This applies to records of patients aged 14 and older who have been seen three or more times, or who have been seen before the third visit for an annual health exam;
- There is pertinent history with subjective and objective reasons for presenting problem;
- There is a pertinent physical exam for presenting problem;
- Lab and other studies are ordered as appropriate;
- Working diagnosis is consistent with findings. Diagnosis is specific and clearly identified;
- Plans of action/treatment are consistent with the diagnosis. Includes tests, medications, patient education, and ancillary services;
- The encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. (Includes hospital discharge planning when a patients hospitalized.);
- Unresolved problems from previous visits are addressed;
- There is evidence of the appropriate use of consultants;
- If a consultation is requested, there is a note from the consultant in the record.
- All consultation, lab, and imaging reports filed in the chart or initialed by the primary care physician. (Includes hospital and ER records.);

- Consultation and abnormal lab and imaging study results have an explicit notation in the chart regarding follow up plans when appropriate;
- There is no evidence that the patient is placed at an inappropriate risk by a diagnostic or therapeutic problem. Includes tests, medications, and authorizations to consultants, treatments, preventive care, and follow-up;
- An immunization record has been initiated for children (10) ten years old and under, or any appropriate history has been made in the medical record for adults;
- Preventive services are appropriately used;
- Medical records are organized, permitting effective patient care and quality review;
- All documents in the medical record are securely attached in the chart;
- There is no more than one patient in each chart;
- There is documentation of patient education;
- If medications are prescribed, they are recorded on a medication sheet that is easily found and is current in the record or all current medications are listed in each chart note;
- All entries must be dated and legible, and must include author identification;
- All signatures must be full and legible and must include the title of the writer. The use of a rubber stamp to identify the signature of the practitioner is acceptable if the provider has signed a statement saying they are the only one person who will use the stamp to sign a document. The statement must be kept on file in the provider's administrative office;
- A clinical entry must be made for every patient-provider contact;
- Should it be necessary to correct an entry in the medical record, the error should be crossed through one time with ink. The cross-through must be initialed and dated by the corrector. Do not write "error";
- A medical record shall not be permanently filed until it is reviewed and completed by a responsible practitioner; and
- Records may be removed from the care provider's jurisdiction and safety only in accordance with a court order, subpoena, or statute. All records are the property of the participating provider and shall not be taken away without the permission of the clinical site. Unauthorized removal of records by providers or the provider's staff is prohibited.

These standards are used in conjunction with the medical record-keeping requirements stated in OAR 410-141-0180 to which Participating Providers are subject.

Advanced Health maintains the right to review Member medical records for quality improvement, utilization review, payment, and medical management purposes. HIPAA privacy regulations allow these activities as part of Advanced Health healthcare operations.

Records Retention: All medical records pertaining to Advanced Health Members must be retained for ten (10) years after the date of services for which claims are made. If an audit, litigation, research, evaluation, or other action involving the records is started before the end of the ten (10) year period, the clinical records must be retained until all issues arising out of the action are resolved.

ADVANCE DIRECTIVES POLICY

Advanced Health follows federal and state regulations that require Members to be informed of their right to make health care decisions and execute Advance Directives. An Advance Directive is a formal document that allows a patient to express their desires and control their health care needs at times when they are unable to communicate those desires or make decisions.

Advanced Health's members are encouraged to complete a Power of Attorney for Health Care, which is a type of Advance Directive. To comply with the federal Patient Self-Determination Act (Section 4751 of OBRA 1991, 42 CFR Part 489, Subpart I) and Oregon regulations (ORS 127.649), it is required that all practitioners document prominently in the patient's medical record the existence of an Advance Directive.

At Advanced Health, primary care providers are charged with the responsibility of discussing the importance of Advance Directives for all patients over the age of majority. Even if the patient elects not to execute an Advance Directive, the medical record must indicate that the offer of an Advance Directive was made, and that related counseling was provided. Dentists are also required to discuss and recommend Advance Directives with patients prior to any oral surgical procedure.

If the Member is also a Medicare beneficiary, CMS rules require that documentation must be prominently displayed in the medical record stating either that an Advance Directive has been signed and is included in the chart, or that an Advance Directive has not been signed. The lack of an entry stating an Advance Directive has been signed is inadequate; if an Advance Directive has not been executed it must be explicitly stated so in a prominent location in the patient's medical record.

Proof of compliance with the above Advance Directive requirements is part of the routine medical record review, which is necessary for the re-certification for participation on Advanced Health's provider panel.

Information for Members and the public about Advance Directives and how to complete one is available on Advanced Health's website at: http://advancedhealth.com/members/forms/

Providers of Behavioral Health services shall furnish information to Members on a Declaration for Mental Health Treatment and Advance Directives in accordance with ORS 127.736 *Form of Declaration* and ORS 127.531 *Form of Advance Directive*. A Declaration for Mental Health Treatment is a written statement of an individual's preferences concerning their mental health treatment. The declaration is made when the individual can understand and legally make decisions related to the treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make treatment decisions. Advanced Health makes a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment.

AUTHORIZATION REQUESTS AND UTILIZATION REVIEW

Overview

Advanced Health maintains a specialized provider network that includes primary care, medical, dental, behavioral health specialists, and Durable Medical Equipment (DMS) vendors.

Some services, medications, or items that you order may need a prior authorization (PA). A prior authorization request allows a clinical review of requested services to ensure medical necessity. Clinical review requirements have been defined with procedures for the review of requested treatments, surgeries and other health-related items, which follow Oregon Health Authority (OHA) rules and guidelines, the Prioritized List of Health Services and any applicable state and federal laws, as part of the Oregon Health Plan (OHP) Member's benefit package. Please refer to the most current Prioritized List at http://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

An authorization may be required if Advanced Health is secondary to primary health coverage. Advanced Health is a payer of last resort unless the Member also has Indian Health coverage. If a Member has Indian Health, Advanced Health will become primary coverage. If a Member has Medicare or a Medicare HMO primary and services are covered by Medicare, no PA is required. Only covered benefits will be paid for.

Please refer to Advanced Health's Medical Authorization Grid to know what services require prior authorization. The grid is updated annually and is located within **Provider Forms and Resources on our website**, www.advancedhealth.com. Hover over the word Provider and then choose Provider Forms and Resources.

If an authorization is required but was not obtained prior to services being rendered, the service may be denied.

Submitting a Prior Authorization (PA) Request

- Forms are located on our Advanced Health website, www.advancedhealth.com: Hover over the word **Provider** and then choose **Provider Forms and Resources** to find the prior authorization request forms. The forms can be downloaded and populated electronically, printed and submitted to Advanced Health by fax or secure email using the email address Authorizations@Advancedhealth.com or the number listed on the top right-hand corner of the form (541-269-7174). The form can also be mailed to Advanced Health, Attn: Medical Management, 289 La Clair Street, Coos Bay, OR 97420.
- Provider and staff can use the **DOCS Portal** (www.docshp.com) to confirm requests are received and an authorization number has been created, or they can call **Customer Service at 541-269-7400**. Please apply to gain access to the DOCS Portal by completing the Online User Registration form within the Provider Forms and Resources, **Online User Registration** listed under Administrative. Once approved, you can go to www.docshp.com to use the portal to look up Member eligibility and authorization status.

Required Information for Authorization: The following information is required for authorizations:

- Patient Name, Date of Birth, Member ID#
- Name of Primary Care Physician
- Name of Referred Provider
- Primary Diagnosis Code(s)
- Date(s) of Service
- Procedure Code(s)
- Chart Notes Attached
- Hospital Notification of Admit or Observation with patient Demographic Sheet (for Inpatient Authorization Request)

Other PA Requirements:

- The Primary Care Provider (PCP) is accountable to submit prior authorizations, with the exception of Behavioral Health. Advanced Health will accept clinical data from any source.

- An out of network specialist provider with a valid authorization, requested by PCP or created by Advanced Health, may request additional follow-up services from Advanced Health with proper documentation showing the need for follow-up.

- Upon completion of the authorization, approved services will be given an authorization number. This number must be included on the claim when submitted.

- When a prior authorization is requested by PCP, the PCP is responsible for relaying the outcome of the authorization and the authorization number to the requested provider or facility.

Authorization numbers can be located on the Provider Portal at www.docshp.com.

Utilization Review

The mission of Medical Management/Utilization Review (UR) is to enhance Member health and deliver quality, cost-effective health care services through collaboration with Members, providers, and the community. The program's scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities, home health care services, outpatient care, and office visits.

The UR team reviews the benefits available to the Member under the appropriate rules. The focus is on determining whether a service constitutes a covered benefit, whether criteria for coverage have been satisfied, and whether the service is the most cost-effective option among those available. Clinical specialists with appropriate licenses or certifications perform this function under the direct supervision of the Chief Medical Officer or Behavioral Health Director.

Utilization review for planned and/or scheduled service requests is accomplished using relevant Oregon Administrative Rules, the Prioritized List, CMS' NCD or LCD criteria guidelines, and published national evidence-based guidelines such as those from OHRQ, NCCN, the Milliman Clinical Guidelines (MCG) and the American College of Radiology's Appropriateness Criteria. Commercial evidence-based resources, such as *Hayes Review* and *Up to Date,* are also utilized.

In some cases, a direct review of recently published medical literature is performed in order to identify best practices in areas of medicine and behavioral health that are rapidly changing. Advanced Health's goal is to identify current standards of care and criteria for establishing medical necessity in order to ensure that all Members receive the best possible high-quality care.

At a minimum, Members will be provided those Covered Services that are medically appropriate and described as a funded condition with treatment that pairs on the Prioritized List of Health Services, including Ancillary Services. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by a MD who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs.

If the PA is approved, Advanced Health will fax a notification to the requesting provider. If the PA is denied, Advanced Health will provide a written notice to the requesting provider and the enrollee informing both of any decision denying a service authorization request, or when a requested service is reduced in an amount, duration, or scope that is less than requested.

Authorizations are typically valid for 90 days from the date of authorization unless an extension to the standard authorization period has been requested.

Authorization is not a guarantee of payment. Payment depends upon Member eligibility on the date of service, contract terms, and compliance with rules, regulations, and policies of Advanced Health and Department of Human Services Department (DHS) as applicable.

Time Frames for Authorization Decisions

Pharmacy authorization requests are reviewed within 24 hours of receipt. If additional information is needed to make a decision, the timeframe may be extended an additional 48 hours.

All other non-pharmacy authorization requests will be determined valid or non-valid within 24 hours of receipt on business days or within 24 hours immediately following a non-business day.

Advanced Health shall process Standard authorization requests, for services not previously authorized, and provide notice as expeditiously as the Member's condition requires and no later than 14 days following receipt of the request for service. If additional information is necessary to make a decision that is in the Member's best interest, or at the request of the Member or provider, the time frame may be extended up to 14 additional days.

For cases in which a provider indicates, or Advanced Health determines, that following the Standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Advanced Health must make an Expedited decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for service. Advanced Health may extend the 72-hour time period by up to 14 calendar days if an extension is determined necessary and is in the Member's best interest or is requested by the Member.

If additional information is necessary to provide a complete review and to reach an authorization decision, a fax will be sent to the requesting provider seeking the additional information. The reviewer may also consult with the requesting provider, when appropriate, to allow for a complete and

thorough review. If the information requested is not received, the PA may be denied for insufficient information.

If it is necessary to extend the timeframe to allow for a complete and accurate review, Advanced Health will notify the Member in writing and telephonic communication to explain the reason for the extension.

Specialty Services Not Requiring Authorization

Direct access to specialists:
For Members with **Special Health Care Needs (SHCN)**, determined through a comprehensive assessment and noted to have ongoing special conditions requiring a course of treatment or regular care monitoring, Advanced Health will allow direct access to a specialist, at no cost to the Member. The specialist should be appropriate for the Member's condition and identified needs. The PCP can simply refer the Member to the specialist without an authorization. The referring provider should also notify Advanced Health of the referral by submitting the **Physician Authorization Form**, found on our website, marking the **SHCN Box** at the top of the form, and providing the name and contact information of the specialist. This will allow the creation of an authorization number to be provided to the specialist for billing purposes. This authorization will include pre-approved visits (i.e., 6 visits in 6 months), allowing the Member to establish with a specialist to receive care. This notification would also provide Advanced Health Intensive Care Coordination (ICC), and Care Management (CM) Teams notification of SHCN Members.

No Prior-Authorizations are required for services related to OB care, family planning, immunizations, women's health exams, or HIV/AIDS testing and prevention services. In addition, no authorization is required for physician services or surgical services provided by a participating provider in Oregon if the primary diagnosis is HIV/AIDS.

Please refer to Advanced Health's **Medical Authorization Grid** to know what services require prior authorization. The grid is updated annually and is located within **Provider Forms and Resources** on our website, www.advancedhealth.com. Hover over the word **Provider** and then choose **Provider Forms and Resources**.

A Second Opinion may be requested by a provider with no PA required. If a qualified Participating Provider cannot be arranged by the referring provider then the Manager of Medical Services, or the Director of Behavioral Health, within Advanced Health can create an authorization with pre-approved visits (i.e.6 visits in 6 months) allowing the Member to establish with specialist and receive care, at no cost to the Member.

Pharmacy Authorizations

When requesting authorization for medications, please use the medication authorization form or infusion authorization form, which can be found on our website at www.advancedhealth.com. The form can be faxed to our Pharmacy Department at 541-269-7147. Please ensure that the form is completely filled out as this will help process the prior authorization in a timely manner.

Medications that are listed on Advanced Health's drug formulary and/or for which the Member has a covered diagnosis are covered. Some medications may have step therapy edits, age, or quantity restrictions that may apply. Some medications are on Advanced Health's formulary and may require prior authorization. Medications that require prior authorization are indicated by "PA" next to the medication

name. Medications over $500 also require a prior authorization, regardless of if they are on the formulary or not. Advanced Health updates the formulary on an annual basis at a minimum. The current formulary and pharmacy authorization form can be found on our website at www.advancedhealth.com.

Medications used primarily by mental health providers are paid by the State from the "7-11" fund and are not subject to payment by Advanced Health. Injectable and IV medications are covered with prior authorization. Compounded, experimental, investigational, cosmetic, and lifestyle medications are not a covered benefit.

Generic Medications: Advanced Health has a mandatory generic medication plan. Generic medications should always be substituted by the pharmacist if one is available for a name brand.

Non-Formulary Medications/ Medications Requiring a Prior Authorization: An authorization request is required for medications that are not listed on Advanced Health's formulary or are on the formulary but require prior authorization. If a prescription for a non-formulary medication is written after hours or on the weekend and requires prior authorization, pharmacies are instructed to provide a three-day supply and are to submit a prior authorization request. These requests will be reviewed by Advanced Health's on-call staff. Pharmacies are encouraged to call the MedImpact Help Desk at 1-800-788-2949 for assistance at any time.

Discharge Medications: Please refer to Advanced Health's formulary when prescribing discharge medications. An override for a five-day supply will be provided for hospital discharge medications if the medications are either not on the formulary or require prior authorization. Medications not listed on the formulary must be authorized. If authorization cannot be obtained, then a five-day supply should be provided so that prior authorization can be obtained from the physician. You can also contact the MedImpact Pharmacy Help Desk at 800-788-2949.

Specialty Medications: Specialty medications, such as injectable medications are dispensed through MedImpact Direct Specialty. You may contact MedImpact Direct Specialty at 1-877-391-1103.

Pharmacy Help Desk: MedImpact is Advanced Health's Pharmacy Benefits Management (PBM) company. They help us monitor our drug utilization and process pharmacy requests for medications. Please feel free to contact the Help Desk with any questions: 1-800-788-2949.

Retroactive Authorization Guidelines

In order to be considered for approval, the authorization must be determined to be medically necessary and appropriate. Retroactive requests will be reviewed for approval under the following conditions:

- The request must be received within 90 days of the date of service. Providers must describe the reason that the authorization was not requested in a timely manner;
- The Member was eligible on the date of service;
- The service and diagnosis are paired and considered above the line in accordance with the Prioritized List and are covered under the Member's OHP benefit package; (Please note that not meeting these conditions does not exclude a service from being approved, it may still be approved by MD review) and
- Retroactive authorizations will not be granted for pharmacy benefits without a justified reason.

Provider Appeals of Authorization Decisions

Advanced Health no longer reviews Provider initiated Appeals (Provider Reconsideration Request).

- A Provider may submit an appeal on the members behalf ONLY with the member's written consent
- Providers may submit a new authorization request with additional supporting documentation.
- Members are welcome to submit a written or verbal appeal, within 60 days of a denial notice.
- Peer to Peer reviews will be done on an informational basis only. A P2P will not overturn a prior authorization determination.

See the **Member Grievance and Appeal System** section of this Provider Manual for an overview of the process.

Authorizations for Behavioral Health Services

Authorizations are not needed for in-network outpatient Behavioral Health services with contracted providers. Timeframes for Members receiving outpatient services are 14 days. All other services, including urgent services, should be received within 72 hours of referral or request. Requests for out of network services, day treatment, psychiatric residential, and inpatient care are required to have prior authorizations and may be submitted to Advanced Health by completing the Behavioral Health Authorization Request form.

Please refer to Advanced Health's Authorization Grid to know what services require prior authorization. The grid is updated annually and is located within **Provider Forms and Resources on our website**, www.advancedhealth.com. Hover over the word Provider and then choose Provider Forms and Resources.

PRACTICE GUIDELINES

Advanced Health uses evidence-based practice guidelines to promote the highest quality clinical and health outcomes for Advanced Health Members. Practice guidelines are adopted in consultation with

network providers and the Clinical Advisory Panel. The guidelines are reviewed annually and updated as appropriate. Advanced Health's decisions for utilization management, Member education, coverage of services, or other areas to which the guidelines apply, must be consistent with the adopted practice guidelines.

Clinical practice guidelines may be recommended for the improvement of health outcomes for Advanced Health Members based on prevalent conditions in the community and other identified needs. Clinical practice guidelines may be recommended to the Advanced Health by

- the Advanced Health Clinical Advisory Panel;
- the Advanced Health Board of Directors;
- the Advanced Health Pharmacy and Therapeutics Committee;
- the Advanced Health Interagency Quality Committee;
- physical Health providers, oral health providers, substance use treatment providers, behavioral health providers, or any provider in the Advanced Health network;

Submit any recommendations to the Chief Medical Officer. The Advanced Health Clinical Advisory Panel reviews recommendations for clinical practice guidelines and determines which guidelines to adopt.

Information about current clinical practice guidelines is available on the Advanced Health website http://advancedhealth.com/providers/clinical-practice-guidelines/. From the home page, hover over **Providers** and choose **Clinical Practice Guidelines** from the menu. Hard copies of clinical practice guidelines are also available upon request. Providers, please contact Provider Services for information about practice guidelines and to request copies of the information. Members should contact Member Services to request copies of practice guidelines.

Advanced Health monitors data from the Member Grievance system, including Notices of Adverse Benefit Determination, Requests for Appeal, and Member Complaints to ensure coverage decisions and utilization management decisions are consistent with the adopted clinical practice guidelines.

CASE MANAGEMENT

Overview

A significant portion of the population served by Advanced Health will require a greater than average amount of available resources. It is anticipated that these needs will be addressed through a robust system of care coordination services. In times past, these case management services were centralized at Advanced Health; but effective in early 2020, case management services are now embedded in primary care practices. Advanced Health expects that the preponderance of case management services will be performed at the primary care practice level and carried out by traditional health workers and nurse case managers.

In the Advanced Health network, primary care providers, care coordinators, and case managers work collaboratively, utilizing health information systems to develop plans of care that have the effect of coordinating physical health, intellectual and developmental disability services, DHS-funded long-term care and supports, and ancillary services: between settings of care; with services Members receive from other managed care entities; with services the Member may receive from fee-for-service Medicaid; and with the services the Member receives from community and social support systems. Advanced Health's

case management and intensive care coordination services are the primary methods for achieving these ends.

Primary care providers should refer to their case management teams, Members who evidence complex medical and social needs. Early identification of these Members can significantly improve the quality of care, Member satisfaction, and health outcomes while controlling health care costs. Members who may benefit from case management include:

- Patients with a newly diagnosed chronic condition;
- Patients in an acute phase of illness requiring coordination of multiple services;
- Patients with unstable chronic illnesses;
- Patients whose social determinants of health render health care delivery challenges; and,
- Members who request the services of a traditional health worker.

Case managers are charged with the responsibilities of:

- Monitoring all aspects of care;
- Evaluating alternatives to care;
- Developing a problem list and plan of care;
- Managing and coordinating care;
- Documenting care information and actions taken;
- Coordinating care with multiple providers, community resources, and if consent has been granted, with the Member's family, parents, legal guardians, and/or advocates.

Member education may serve as one component of case management services. Member education is provided on a variety of topics and may include general information about disease processes, an analysis of medication usage, or plan-specific information on routine preventative health screenings as well as screening for disease-related complications. Member education may occur in a variety of settings using various resources, depending on the Member's individual needs. Whenever possible, case managers will apprise Members of disease-specific, community-based, educational resources. Disease prevention, disease-specific information, and wellness activities are included on Advanced Health's website, within the Member Handbook, and through mailings and other resources. A monthly calendar of educational offerings is available at Advanced Health's website.

Primary care dentists may refer to Advanced Health's case management and ICC teams for coordination and management of identified Members.

Initial and Annual Health Risk Assessment

When Members are newly enrolled with Advanced Health, Advanced Health's traditional health workers, who are Members of the Member/Customer Services team, will conduct a health and risk assessment within ninety days of enrollment. If health or other risk factors are identified, the primary care team will be notified of these occurrences at the time the Member is assigned to a primary care provider. The primary care team, in turn, will ensure that the Member receives case management services from the provider's case management team.

Primary care providers are required to reassess the health status and risk factors for all assigned Members at annual intervals. These assessments may be carried out by the provider's case management team and must be documented in the medical record.

Maternity Case Management

Providers may notify Advanced Health when a Member becomes pregnant and receive a ten-dollar incentive for this notification. A pregnancy notification form may be faxed to Advanced Health at 541.269.7147. The form must be submitted within two weeks of the pregnancy test or office visit. Upon receipt Advanced Health will mail out a pregnancy information packet to the member containing resources and pregnancy milestones.

Resources for Health-Related Services

Advanced Health budgets for *health-related services* annually. Typically, health-related services are those non-medical services that would prove beneficial to a Member in addressing the Member's current health status or intervening social determinants of health. To be eligible to receive a *health-related service*, the service must be *non-encounterable*, represent a one-time or time-limited expenditure, and be included in the patient's treatment plan with measured outcomes related to treatment plan objectives. Advanced Health's providers and Members of their case management teams may request *health-related services*. Please contact Advanced Health's case management team for information related to current processes governing *Health Related Services*.

INTENSIVE CARE COORDINATION

Overview

New regulations adopted by the Centers for Medicaid and Medicare Services, and the Oregon Health Plan, require Coordinated Care Organizations to provide Intensive Care Coordination (ICC) to all persons who are diagnosed with special health care needs, or who are among the Membership of a priority population if such individuals need or can benefit from such services. By rule, ICC must be centralized at Advanced Health and overseen by an individual who is licensed in Oregon by a mental health licensing board. This individual is assisted by a registered nurse and/or a specialized nurse with an advanced degree in the field of nursing and oversees ICC teams, largely comprised of certified traditional health workers, who are deployed throughout Advanced Health's communities.

At Advanced Health, primary care providers, care coordinators, and case managers work collaboratively, using health information systems. Providers are encouraged to increase their use of health information systems such as the Collective Platform and Activate Care. Each software platform has distinct uses. The Collective Platform details emergency room utilization of our Members and provides an opportunity for personnel to customize tailored case management and care coordination guidelines. Activate Care unifies health and social care providers around each Member's plan of care.

Within the Active Care cloud-based platform, Care Team Members collaboratively develop plans of care that have the effect of coordinating physical health, intellectual and developmental disability services, DHS-funded long-term care and supports, and ancillary services: between settings of care; with services

Members receive from other managed care entities; with services the Member may receive from fee-for-service Medicaid; and with the services the Member receives from community and social support systems. Advanced Health's case management, and intensive care coordination services, are the primary methods for achieving these ends.

Assertive Community Treatment (ACT) serves adults who are diagnosed with severe and persistent mental illness. Similarly, the System of Care (SOC) serves children and adolescents who are diagnosed with severe emotional disturbances. Because ACT and SOC provide intensive care coordination, if Members are enrolled in ACT or SOC, it is not required that they also are enrolled in ICC. Coordination between ACT, SOC, and ICC occurs at the Advanced Health level, between the ICC Director and the Behavioral Health Director.

All Members who are enrolled in ICC services are served by written plans of care. Primary care providers may be involved in the development of the plan of care. Primary care providers are required to notify ICC whenever they identify a Member who falls among the *priority population* or who has a special health care need if such Member cannot be adequately served by the primary care provider's case management team. Similarly, primary care providers must notify ICC whenever they become aware of a *triggering event.*

Advanced Health has adopted comprehensive policies and procedures governing ICC. These are presented in Exhibit 9.

Eligible Populations

Every Advanced Health Member who is identified as being a Member of a priority population, or who has *special health care need*s, is entitled to receive Intensive Care Coordination. Advanced Health conducts social health needs assessment within thirty (30) days after receipt of a referral for these services in addition to an initial Health Risk Screening that identifies Members with *special health care needs,* or those who are receiving Medicaid-funded long-term care or support services, or who are Members of a *priority population*. All such Members shall be offered these services if it is likely that the Member can benefit from the service. In the event that a Member is offered ICC services, and elects to forego these services, the information is documented in the Member's file by the care coordinator performing the outreach. A Member's refusal of ICC services will not affect their benefits or ability to enroll or reenroll in ICC services in the future.

Persons with Special Health Care Needs: Persons with *special health care needs* are defined as those individuals, with an emphasis on children and adolescents, *who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by other persons, in general.*

Priority Populations: The Oregon Health Plan identifies the following sub-populations for priority consideration in the delivery of coordinated care services (i.e., ICC):

Children

- Aged birth to five years and at risk of maltreatment;
- In need of early intervention services;
- Screen positive for adverse childhood experiences;

- In foster care
- At risk of losing foster care placement, current caregiver placement, or school or daycare placement;
- Children with serious emotional disturbances;
- Youth served by the Oregon Youth Authority;

Adults

- Pregnant women;
- Individuals with intellectual/developmental disabilities;
- Persons in need of targeted support services;
- Persons in need of behavioral health services;
- Persons receiving medication-assisted treatment;
- Individuals diagnosed with severe and persistent mental illness;
- Persons who are IV drug users;
- Individuals diagnosed with HIV/AIDS;
- Individuals diagnosed with tuberculosis;
- Veterans and Members of their families;
- Individuals at risk of first episode psychosis;
- Dually eligible Members receiving DHS long-term services and supports(LTSS);
- Dually eligible Members receiving DHS long-term care services (LTC);
- Members transitioning from the State Hospital; and,
- Members in the transition from one care level to another.

Triggering Events: Members who are not typically eligible for ICC services may receive those services upon the occasion of a triggering event. In addition, all Members receiving ICC services must be re- assessed, and plans of care updated, whenever a triggering event occurs. Triggering events include, but are not limited to:

- New emergency department visit or hospital admission;
- New pregnancy;
- New chronic disease diagnosis (including behavioral health);
- New behavioral health diagnosis;
- Opioid drug use;
- IV drug use;
- Suicide attempt, ideation, or planning;
- New I/DD diagnosis;
- New reports of abuse, neglect, or adverse childhood experience;

- Recent homelessness;
- Two or more billable primary Z code diagnoses within one month;
- Two or more caregiver placements within the past six months;
- Newly identified risks for involvement in the criminal justice system;
- Children aged zero to six who have been newly excluded from school or daycare (including suspension, expulsion, or seclusion in the school setting);
- Member's child has a new behavioral health need;
- Member newly discharged from LTC to community setting;
- Member newly discharged from a residential setting to a community setting;
- Severe high level of self-reported or detected alcohol or benzo usage while enrolled in a medication-assisted treatment program;
- Two or more admissions to an acute care psychiatric hospital in a six-month period;
- Two or more re-admissions to an emergency department for psychiatric reasons in a six-month period; and,
- Exit from a specialized program (MAT, SOC, ACT).

ICC for Members with SPMI or SED

Assertive Community Treatment: Assertive Community Treatment (ACT) is an evidence-based program that addresses the unique needs of adult Members with Severe and Persistent Mental Illness (SPMI). ACT is a form of ICC services for these Members. Advanced Health provides certified ACT services, as well as ACT-like, services as a behavioral health benefit. All adult Members who are diagnosed with SPMI shall be offered ACT or ACT-like services and shall be encouraged and assisted to accept these services. If a Member is eligible for ACT services and declines participation in the program: the Member's refusal to participate must be documented in the clinical record and, every continuing effort shall be made to enroll the Member in ACT services.

System of Care/Wraparound: System of Care (SOC) is a state-mandated program that addresses the unique needs of children and youth in the foster care system and those youth who are diagnosed with Serious Emotional Disturbances (SED). SOC is a form of ICC services for these Members and is a behavioral health benefit. All children and youth who are diagnosed with SED shall be offered SOC services and shall be encouraged and assisted to accept these services. If a Member is eligible for SOC services and the Member's parent or legal guardian declines participation in the program: the parent or guardian's refusal to participate must be documented in the clinical record; and every continuing effort shall be made by program staff to enroll the Member in SOC services. Referrals for SOC are staffed by the SOC Wraparound Review Committee. Referrals may be sent directly to the Wraparound provider at Kairos for Coos County residents and Curry Community Health for Curry residents.

FRAUD, WASTE, AND ABUSE

Advanced Health has fraud, waste and abuse policies and procedures in place that enable Advanced Health to help prevent and detect fraud, waste, and abuse activities. This includes operational policies

and controls in areas such as claims, authorization, utilization management, Member and provider grievances, credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities. Advanced Health has adopted rigorous policies and procedures governing fraud, waste, and abuse.

What is the False Claims Act & Why is it Important?

Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages, plus civil penalties of $5,500 to $11,000 per false claim.

Qui Tam Whistleblower Provisions: The False Claims Act contains qui tam, or whistleblower, provisions. Qui tam is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a qui tam case, the citizen whistleblower may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A qui tam suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action.

Definitions:

- *Abuse:* Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to health programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health plan.

- *Fraud:* An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some authorized benefit to him/her, or some other person. It includes any act that constitutes fraud under applicable State or Federal law.

- Waste: Over-utilization of services or practices that result in unnecessary costs, such as providing services that are not medically necessary.

- *Incident:* A situation of possible fraud, waste, and abuse which has the potential for liability to Advanced Health, State of Oregon, MAP, or MAP contractors.

Examples of Potential Fraud, Abuse or Suspicious Activity:

- Intentionally or recklessly reporting encounters or services that did not occur, or where products were not provided.

- **I**ntentionally or recklessly reporting overstated or up coded levels of service.

- Intentionally or recklessly billing Advanced Health or OHA more than the usual charge to non-Medicaid Recipients or other insurance programs.

- Altering, falsifying, or destroying clinical records for any purpose, including, without limitation, for the purpose of artificially inflating or obscuring such provider's own compliance rating or collecting Medicaid payments otherwise not due. This includes any intentional misrepresentation or omission of fact(s) that are material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or provider.

- Intentionally or recklessly making false statements about the credentials of persons rendering care to Members.

- **I**ntentionally or recklessly misrepresenting medical information to justify referrals to other networks or out-of-network providers when such parties are obligated to provide the care themselves.

- **I**ntentionally failing to render Medically Appropriate Covered Services that they are obligated to provide to Members under the CCO Contract, any subcontract with Advanced Health, or applicable law.

- **K**nowingly charging Members for services that are Covered Services or intentionally or recklessly balance-bill a Member the difference between the total fee-for-service charge and Advanced Health's payment to the provider, in violation of Applicable Law.

- Intentionally or recklessly submitting a claim for payment when such party knew the claim:

    - had already been paid by OHA or Advanced Health,
    - had already been paid by another source.

- Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

- Any practice that is inconsistent with sound fiscal, business, or medical practices, and which:

    - results in unnecessary costs;
    - results in reimbursement for services that are not medically necessary; or
    - fails to meet professionally recognized standards for health care.

- Evidence of corruption in the enrollment and disenrollment process to skew the risk of unhealthy Member or potential Members toward or away from Advanced Health or any other CCO.

- Attempts to solicit kickbacks or bribes.

Advanced Health will assist CMS, the Oregon Health Authority, and any other governmental agencies as needed in providing information and other resources during the course of an investigation of potential fraud and/or abuse incidents.

How Serious is Fraud & Abuse?

Fraud is a crime, and abuse violates other applicable laws and administrative rules. Both undermine the integrity of the program. Some of the applicable State and Federal laws include:

- 31 USC 3729-3733: Federal False Claims Act
- Deficit Reduction Act of 2005, Section 6032
- 31 USC Chapter 38: Administrative remedies for false claims and statements
- 42 USC 1320a-7b: Definition of fraud, waste, and abuse
- ORS 411.670 to 411.690: Submitting wrongful claim or payment prohibited
- ORS 646.505 to 646.656: Unlawful trade practices
- ORS 162: Crimes related to perjury, false swearing, and unsworn falsification
- ORS 164: Crimes related to theft
- ORS 165: Crimes involving fraud or deception
- ORS 165.69 through 165.698: False claims for health care payments
- ORS 166.715 to 166.735: Racketeering
- OAR 410-120-1395 to 410-120-1510: Program integrity, sanction, fraud & abuse; common law claims founded in fraud, including fraud, money paid by mistake, and money paid by false pretenses.

How to Report Potential Fraud, Abuse or Suspicious Activity: If you suspect insurance fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following ways:

Advanced Health Phone 541-269-7400
Advanced Health Fax 541-269-7789
DHS's Fraud & Abuse Hotline 1-800-372-8301

OHA Office of Program Integrity (OPI)
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Secure email: OPI.Referrals@oha.oregon.gov
Hotline: 1-888-FRAUD01 (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

Fraud or Abuse by a Member must be reported to:

DHS Fraud Investigation Unit
PO Box 14150
Salem, OR 97309

Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
https://www.oregon.gov/odhs/financial-recovery/Pages/fraud.aspx

Frequently Asked Questions

Q: Can an individual remain anonymous when reporting suspected fraud & abuse?

A: Yes, both the Compliance reporting hotline and the Compliance reporting website include options to remain anonymous.

Q: Is someone that is reporting suspected cases of fraud and/or abuse protected from retaliation?

A: Yes, State and Federal laws protect those who report against retaliation (discharge, demotion, suspension, threats, harassment, or another manner of discrimination) because of the lawful acts of the employee in reporting under the False Claims Act.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Advanced Health continues to ensure that it conducts business in a manner that safeguards Member information in accordance with the privacy act pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The enacted privacy regulations have been fully implemented throughout this organization, and Advanced Health is fully committed to the protection of Personal Health Information (PHI). Advanced Health has adopted policies, procedures, tools, and handbooks to aid in the practice, monitoring, and safekeeping of protected health information. While these documents are too extensive to include as Exhibits to this Manual, they are available for inspection and review by providers and Members.

Advanced Health recognizes that under HIPAA privacy regulations, only the minimum necessary Member information is to be requested. However, please note that the regulation allows the provision, transfer, and sharing of Member information that the plan may need in the normal course of business activities to make decisions about care. The requested information needed for payment or health operations would include the Member's medical record to make an authorization determination or to resolve a payment issue.

The requested information may be faxed to Advanced Health. Advanced Health's fax system is secure, and only authorized personnel have access to the information. An email should never be used to transfer Member information unless it is encrypted and secured.

The Privacy Notification Statement that is available to all Advanced Health Members is available upon request. If you have any questions, please contact Member/Customer Service at 541-269-7400.

Healthcare providers who transmit or receive health information in one of the HIPAA transactions must adhere to HIPAA privacy and security regulations.

All individually identifiable health information contained in the medical record, billing records, or any computer database is confidential, regardless of how and where it is stored. Examples of stored information include but are not limited to: clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disc, or optical media formats.

Health information contained in medical or financial records is to be disclosed only to the patient or legal guardian unless the patient or legal guardian authorized the disclosure to another individual or organization, or a court order has been sent to the provider. Health information may only be disclosed to those immediate family Members with the verbal or written permission of the patient or the patient's legal guardian. Health information may be disclosed to other providers involved in caring for the Member without the Member or Member's legal representative's written or verbal permission.

Patients must have access to and be able to obtain copies of their medical and financial records from the provider.

Information may be disclosed to insurance companies or their representatives for Quality and Utilization Review, payment, or medical management. Providers may release legally mandated health information to the State and County Health Divisions and to disaster relief agencies.
All health care personnel who generate, use, or otherwise deal with individually identifiable health information must uphold the patient's right to privacy.

Extra care shall be taken not to discuss patient information (financial and/or clinical) with anyone who is not directly involved in the care of the patient, or involved in payment, or determination of the financial arrangements for care.

Employees (including providers) shall not have unapproved access to their own records or records of anyone known to them who is not under their care.

Advanced Health staff strictly adheres to HIPAA mandated confidentiality standards as well.

Although not contractually required, Advanced Health strongly encourages its providers to ensure that all Members of the office staff are annually trained in the protection of confidential, individually identifiable health information.

SECLUSION AND RESTRAINT

Advanced Health's members must be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation in accordance with federal and state regulations. This requirement is included in Advanced Health Member Rights, Protections and Responsibilities Policies and Procedures and the Privileged Provider and Network Provider Agreements.

24-HOUR MOBILE AND IN-OFFICE BEHAVIORAL HEALTH CRISIS MANAGEMENT SERVICES

Crisis management services are immediate, initial, and of limited duration, and purposed at responding to behavioral health emergencies. To access Behavioral Health crisis services, call the Coos Health and Wellness Crisis Hotline at 888-543-5763, or Curry Community Health's 24-hour Crisis Line 877-519-9322. Responses consist of a brief crisis intervention and safety plan over the phone, or an in-person crisis team consisting of a licensed behavioral health clinician and peer support specialist that can assist with crisis

intervention and referral services. The crisis team may request law enforcement assistance if they feel that safety may be compromised. Services are at no cost to the Member and available 24/7. Providers can request a follow up from the crisis team. Services can also be performed in the provider's office.

MEMBER GRIEVANCE AND APPEAL SYSTEM

Advanced Health is responsible for providing a meaningful process for timely resolution of all Member grievances, including complaints, appeals for adverse benefit determinations, and requests for a fair hearing with an Oregon Administrative Law Judge. This includes setting a standard resolution and an expedited resolution timeframe. These grievances can be related to overall concerns about the quality of care, access to services, or extension of appeal or authorization timeframes. This process meets all guidelines established by the Centers for Medicare and Medicaid and the Health Services Division (HSD).

Advanced Health notifies Members about the Member grievance system through the Member Handbook, the Advanced Health website, various written notices, and verbally. Advanced Health notifies providers about the Member grievance system through similar means as well as this Provider Manual, contractual provisions, and copies of the Advanced Health Member Grievance System Policies and Procedures. A provider or an authorized representative may file a grievance at any time, either orally or in writing, on behalf of a member, with written consent from the Member.

Advanced Health does not, and requires all contractors, and network providers not to:

- Discourage a Member from using any aspect of the Member grievance system;
- Take any punitive action against a provider who requests an expedited resolution or supports a Member's grievance or appeal;
- Encourage the withdrawal of a complaint, appeal, or hearing request that has been filed, or;
- Use the filing or resolution of a complaint, appeal or hearing request as a reason to retaliate against a Member or to request Member dis-enrollment

Providers may contact the Grievance System Coordinator at 541-269-7400 with any concerns, questions, or complaints.

Information gathered through the grievance system is used for quality improvement and to ensure Members' access to clinically appropriate covered services and coordinated care that meets the Members' needs and respects their dignity. A quarterly report of complaint and appeal data is provided to the Oregon Health Authority as required by contract. The aggregated report data is reviewed by the Clinical Advisory Panel and the Interagency Quality Committee. A review of each provider's grievance and complaint records forms one component of the re-credentialing process and may form the basis for provider counseling or sanctions.

Complaints

If a Member is dissatisfied with Advanced Health, a health care service, or a provider, they may contact Advanced Health Member Services to make a complaint, either verbally or in writing. Members may also make a complaint directly to the OHA. Members can receive reasonable assistance from Advanced Health staff in filing their complaints. Complaint forms are posted on the Advanced Health website in both English and Spanish.

Advanced Health will respond to each complaint, in writing, within 5 business days. If a resolution can't be reached in 5 business days, the timeframe to resolve the complaint may be extended up to a total of 30 calendar days. In the course of investigating and resolving a Member complaint, the Advanced Health Grievance System Department may request information from a provider or clinic.

Complaints are categorized by type: access, provider/plan interaction, quality of care, consumer rights, billing issues, etc. Complaint data is monitored for opportunities to improve services, especially complaints raising issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors related to improving services for health equity.

Appeals

If Advanced Health makes a decision to deny, stop, or reduce a medical service, or deny provider claim/request for payment, the Member will receive a Notice of Adverse Benefit Determination. This notice will include information on why the decision was made and how a Member can request an appeal or a state fair hearing to review the decision. An appeal request must be filed within 60 days of the Notice of Adverse Benefit Determination. A Member, their representative, or their provider (with written permission) may file an appeal verbally or in writing either with Advanced Health or with OHA. Advanced Health offers reasonable assistance in filing an appeal.

To file an appeal, contact Member Services or complete the Request to review a health care decision, OHP form number 3302. It is available on the Advanced Health or OHA websites. All appeal requests are reviewed by different health care professionals than were involved in the original review decision. A Notice of Appeal Resolution is sent to the Member informing them of the outcome of the appeal request within 16 days. A copy of the Notice of Appeal Resolution will be faxed to the requesting provider. If more information is needed and it is in the Member's best interest, the timeframe for the appeal resolution may be extended an additional 14 days. If AH fails to adhere to required time frames for processing standard, expedited, or extended appeals, the member is deemed to have exhausted the CCO's appeal process and the member may initiate a contested case hearing.

Continuing Benefits: If a Member was already receiving a service before Advanced Health's decision to stop authorizing the service, the Member may request a continuation of the benefit while the appeal is under review. The appeal must be requested within 10 days of the Notice of Adverse Benefit Determination to be eligible for the continuation of benefits. If the appeal decision upholds the denial decision, then the Member may be required to pay the cost of the services that were received after the effective date of the Notice of Adverse Benefit Determination.

Expedited Appeals: Expedited appeals are available when a Member or provider indicates, or Advanced Health determines, that taking the standard time for resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Appeals meeting criteria to be expedited are reviewed within 72 hours of the request. Advanced Health ensures that punitive action is not taken against any provider who requests an expedited appeal resolution or supports a Member's appeal. Advanced Health makes reasonable efforts to provide oral notice of each expedited resolution in addition to the written notice. If Advanced Health's medical reviewers determine that a request to expedite an appeal does not meet criteria for an expedited decision, the resolution timeframe will be changed to the standard 16-day timeframe, and a notice will be sent to the Member informing them of the decision. If the member does not agree with the decision they have a right to file a grievance. A

provider or an authorized representative may file a grievance at any time, either orally or in writing, on behalf of a member, with written consent from the Member.

Contested Case Hearings

After an appeal, a Member, their representative, or their provider (with written permission) may request a state fair hearing with an Oregon Administrative Law Judge by filing the Administrative Hearing Request form, MSC 443, with OHA. The Administrative Hearing Request form is enclosed with the Notice of Appeal Resolution and is also available on the Advanced Health and OHA websites. Advanced Health or OHA can also help to fill out the Hearing Request form. A hearing request must be filed within 120 days of the date of the Notice of Appeal Resolution. Hearings often take more than 30 days to prepare.

OHP Hearings Unit
500 Summer Street NE, E49
Salem, OR 97301-1079
Fax: 503-945-6035

Continuing Benefits: If a Member was already receiving a service before Advanced Health's decision to stop authorizing the service and received continuing benefits during the appeal, the Member may request a continuation of the benefit while awaiting the hearing. The hearing must be requested within 10 days of the Notice of Appeal Resolution to be eligible for the continuation of benefits. If the hearing decision is adverse to the Member, then the Member may be required to pay the cost of the services that were received after the effective date of the original Notice of Adverse Benefit Determination.

Expedited Hearing: A Member or their provider may request an expedited hearing if the standard time for resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. You should receive a decision in 2 working days. The state will call to follow up within 2 working days after getting the request.

"**Grievance System**" means the overall system that includes:

(a) Grievances to Advanced Health on matters other than adverse benefit determinations;
(b) Appeals to Advanced Health on adverse benefit determinations; and
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute. (i.e. denial upheld on an appeal, or any required appeal timeframes not met by Advanced Health)

1. Advanced Health accepts Grievances, Appeals, and Hearing requests in written or verbal format.
2. Members can request reasonable assistance submitting a complaint, appeal or hearing.
3. Members can submit a complaint, appeal or hearing at any time without fear of retaliation by the CCO, their Provider, provider staff or CCO staff. Members shall not be discouraged from using any aspect of the grievance system. Members will not be encouraged to withdraw any complaint, appeal, or hearing request submitted.
4. Members can also submit complaints directly to the Department of Human Services Governor's Advocacy Office and OHA Ombuds Office.
5. Advanced Health shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.
6. Upon request, Advanced Health shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse

benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals;

Each Grievance and Appeal will be responded to in writing within 5 business days.

- Grievances will be resolved in five business days, or up to 30 days with a written extension for investigation and resolution
- Each Expedited Appeal will be responded to in writing within three days, and verbally within 24 hours.
- Each Standard Appeal will be resolved in 16 days with the possibility of up to 28 days with notification of a written extension.
- Verbal notification of extensions will be made for both Standard and Expedited Appeals

"**Adverse Benefit Determination**" means any of the following, consistent with 42 CFR § 438.400(b):

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(B) The reduction, suspension, or termination of a previously authorized service;

(C) A denial, in whole or in part, of a payment for a service. A payment denied solely because the claim does not meet the definition of a "clean claim" at CFR 447.45(b) is not an adverse benefit determination;

(D) The failure to provide services in a timely manner pursuant to OAR 410-141-3515;

(E) The MCE's failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;

(F) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

(G) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

"**Appeal**" means a review by an MCE, pursuant to OAR 410-141-3890 of an adverse benefit determination

"**Contested Case Hearing**" means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;

"**Continuing benefits**" means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910

"**Expedited Appeal**" Each MCE shall establish and maintain an expedited review process for all oral and written appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860. Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative.

"**Grievance**" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. A Grievance also includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision

"**Reasonable Assistance"** includes but is not limited to:

(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;

(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

CLAIMS SUBMISSION AND PAYMENT

For the latest news and updates, please visit: http://advancedhealth.com/providers/claims

Provider Portal

Advanced Health's provider portal can be accessed at https://www.visibiledi.com/advancedhealth

The provider portal is an intuitive, easy-to-use platform that allows provider and billing staff to resolve most inquiries quickly. Please consider using the provider portal for simple inquires prior to calling the claims phone line. The portal allows provider offices to perform the following functions:

- Verify member eligibility and PCP assignment.
- Check the status of a submitted authorization.
- Check the status of a submitted claim.
- Review adjudication details and dollar amounts for paid claims.
- Download ANSI X12 835 Remittance Advice files.
- Download PDF Explanation of Payment (EOP) reports on demand.
- Manually submit claims (direct data entry).
- Access to LineFinder – A proprietary tool that makes it easy to search the Prioritized List of Health Services and related code sets from data.oregon.gov.

Users can self-register for portal access at https://visibiledi.com/advancedhealth/Account/Register and must provide a valid email address, Tax ID, and provider NPI. Access will be granted within 24-48 hours pending verification. You will receive a confirmation email from support@visibiledi.com. Please check your spam filter if you do not receive a timely response.

For issues with portal registration or functionality, please email portal.support@advancedhealth.com.

Submissions

Advanced Health accepts electronic claims (837P & 837I) for professional and institutional billing for both primary and secondary claims. We work closely with TriZetto Payer Solutions and their many trading partners for electronic claims submission.

The payer ID for professional claims (CMS1500/837P) is DOCSO (all alpha characters) The payer ID for institutional claims (UBO4/8371) is UOCSO (all alpha characters).

For questions or issues regarding electronic claim submissions, please contact the Advanced Health account representative at TriZetto Payer Solutions:

Elisha Wooten Account Manager, TTPS
3300 Rider Trail South
Earth City, MO 63045
Office: (800) 969-3666 Ext. 3361
Fax: (314) 802-5039
Email: Elisha.York@Cognizant.com

Claims can be submitted via manual entry directly into the Advanced Health provider portal:
https://www.visibiledi.com/advancedhealth

Please be aware that claims submitted on paper have significantly longer processing times. If you are unable to bill electronically, or enter the claims manually into the provider portal you may send paper claims to the following address:

Advanced Health
Claims Department
P.O. Box 241866
Apple Valley, MN 55124

Please note that Advanced Health does not accept claims submitted via fax. Any unsolicited claims received via fax will be securely destroyed without response.

Electronic Data Interchange (EDI)

Advanced Health does not accept direct EDI submissions from providers. Most providers will use a clearinghouse that will submit their claims to numerous payers in a HIPAA 5010 compliant ANSI X12 837 file. Your clearinghouse will transmit claims for Advanced Health to our clearinghouse (TriZetto Payer Solutions). File acknowledgements (ANSI X12 999) and claim acknowledgements (ANSI X12 277) will be transmitted to TriZetto for your clearinghouse to obtain. Claim Remittances (ANSI X12 835) will be similarly distributed. Please confer with your clearinghouse to ensure that you are receiving these highly informative files.

Claims Rejections

Claims may be rejected for various reasons, such as invalid diagnosis code, invalid procedure code, unknown member, incorrect National Provider Identifier (NPI), etc. Rejected claims are claims that were NOT accepted into Advanced Health's claim system for processing. Your clearinghouse can obtain an electronic notification of these rejections in the form of an ANSI X12 277 file. Claim rejections are not denials and will not show up in an Explanation of Payment (EOP), or an 835 claim remittance file. They cannot be appealed. You must correct the issue and resubmit it until the claim is officially accepted.

Timely Filing Requirements

Per OAR 410-141-3565, providers must submit claims to Advanced Health within 120 days from the date of service to facilitate collection of encounter data and effective utilization management.

Initial claims may be submitted within 365 days of the date of service under the following circumstances only:

- **Pregnancy;**
- **Eligibility issues such as retroactive deletions or retroactive enrollments;**
- **Secondary/Tertiary claims (another insurance is the primary payer like Medicare, commercial insurance, etc.).**
- **Other cases that delay the initial claim to Advanced Health, not including failure of the provider to verify the member's eligibility. Please reach out to Advanced Health;**
- **Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL.**

Corrected claims (initial claims submitted timely that need correction) must be received within 365 days from the date of service or within 180 days from the prior adjudication date, whichever is the later date.

Claims received outside the timely guidelines outlined above will be systematically denied.

No payments will be issued for claims received more than 18 months from the date of service. Please note that this applies to both participating and non-participating providers.

Duplicate Claims

Roughly 10% of all claims received are duplicate claim submissions. This can be because the provider did not process their EOP or remittance in a timely manner, or because the initial claim was denied, and the provider is hoping for a different outcome. Duplicate claims create unnecessary waste in the claims billing and adjudication processes. As such, Advanced Health will not review these claims once they are identified. Duplicate claim submissions will be systematically denied unless submitted as a corrected claim using the appropriate frequency code.

Corrected Claims

Many claims are denied due to the lack of pertinent information, improper coding, or other administrative errors. Claims can be submitted for reconsideration within 365 days from the date of service or within 180 days from the prior adjudication date, whichever is the later date. The claim must be submitted with a

frequency code 7 to indicate that is a resubmission, otherwise it will be systematically denied as duplicate. Medical records may be required if the corrected billing involves changing existing or adding additional diagnosis codes or procedure codes.

If a claim was previously denied for lack of timely filing, sending a corrected claim will not supersede the timely filing denial.

Provider Claim Appeals

If a provider disagrees with an Advanced Health determination, they may file an appeal within 365 days from the date of service or within 180 days from the prior adjudication date, whichever is the later date. Appeals received outside of the timely filing timeframe will not be processed as the original denial will be upheld and the appeal will be considered untimely.

All appeal requests must include the following: 1) Member name and identification number; 2) Claim number assigned by Advanced Health to the claim at issue; 3) Provider/Contact name and phone number; 4) Service denied; 5) Issue or reason for the appeal; and 6) Any pertinent clinical information or related documentation that would be of assistance in reviewing the request to support the reasons for the reversal or the adverse organization determination.

Appeals are reviewed by the Advanced Health Compliance Department and Chief Medical Officer, who may uphold the decision, overturn the decision, or request additional information. If the final decision upholds the original denial and the provider does not agree with the decision, then the provider may contact the Oregon Health Authority to request an Administrative Review.

The appeal must be in writing with all supporting documentation and any additional information not previously considered or known by Advanced Health. Provider Appeal Request forms can be found on our website at www.advancedhealth.com.

Coordination of Benefits

Other health insurance coverage information is important in the Coordination of Benefits (COB) process. COB occurs when a member is covered by two or more insurance plans. Providers can assist in the COB process by asking the Advanced Health member if they have other coverage.

COB - Commercial Insurance Notification

Please securely notify Advanced Health at cob@advancedhealth.com if you discover that a member has an additional insurance policy that Advanced Health does not have on record, or if you believe a member's additional insurance on file with Advanced Health has changed or terminated.

COB/TPL State Reporting Requirements

Providers who provide services to individuals covered by Oregon Medical Assistance programs need to report to the Office of Payment and Recovery (OPAR) if they discover COB/TPL information that is different from the information the state currently has on record at:
https://apps.oregon.gov/dhs/opar

For additional details, please visit:
https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx

Secondary Claims

Advanced Health is always the payer of last resort, except for Indian Health Services (IHS) and Veterans Administration (VA) policies. If the member has other healthcare coverage, bill the primary carrier prior to billing Advanced Health.

When COB is involved, claims should be filed with the primary insurance carrier first. An EOP is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier's EOP. However, if an Advanced Health member has Indian Health Services (IHS) or VA, the claim should be filed with Advanced Health prior to submitting the claim to VA or IHS for secondary payment consideration.

In accordance with HSD rules for COB, Advanced Health will calculate benefit reimbursement by using the Advanced Health allowed amount or the primary carrier's allowed amount, or the billed amount (whichever is less) minus the primary carrier's payment. In some instances, the primary carrier's payment exceeds the allowed amount or the primary carrier's payment is 100% allowable. When this happens, the balance will appear on your Advanced Health remittance as a provider write-off. The patient cannot be billed for this amount.

Medicare Crossovers

To reduce the administrative burden on providers and health plans, most secondary claims for Medicare members will be automatically forwarded to Advanced Health by CMS. Please allow 45 days before submitting Medicare secondary claims directly to Advanced Health to avoid duplicate claims submissions.

Third Party Liability (TPL/TPR)

As described by the Oregon Health Authority, Third Party Resources (TPR) means any individual, entity, or program that is, or may be liable to pay all or part of the medical cost of any medical assistance furnished to a member. Third Party Resources include but are not limited to:

- Private Health Insurance
- Medical Support from Absent Parents
- Medicare
- Court Judgements or settlements from a liability insurer
- Employment Related Health Insurance
- Workers' Compensation
- Auto Insurance

Advanced Health is required by HSD to pursue recovery of Third-Party Resources when it is found that an Advanced Health member has other coverage. If Advanced Health has paid claims for a member, and then upon further investigation finds that the member has other healthcare coverage at the time of service, Advanced Health will recoup the monies paid to the provider that furnished the service.

NOTE: For Workers Compensation cases that have been paid by Advanced Health, regardless of if the WC carrier has paid for services or not, Advanced Health will recoup monies from all providers that have submitted claims and were paid. Providers may bill Advanced Health with an itemized claim with a copy of the "Medical Bill Analysis" from the workers compensation carrier, or after a final denial/determination from the WC carrier has been issued. The documentation date must match the date of service on the original claim submission.

Providers are required to comply with this policy per State and Federal requirements. In addition, providers are required to comply with Federal and State confidentiality requirements. HSD considers the disclosure of Advanced Health member claims information in connection with Advanced Health Third Party Resource recovery actions a purpose that is directly connected with the administration of the Medicaid program. Reference: OHP FCHP Contract, Section 27, subsections A-C.

Third-Party Liability - Injury/Illness Notification

Please securely notify Advanced Health at tpl@advancedhealth.com if you discover that a member has sustained injuries or illness for which a third party may be liable, such as a motor-vehicle accident (MVA), on-the-job injury, etc.

Member Requirements

Be advised that not all members have the same benefits through Advanced Health. The following explains what benefits are available to which members:

- CCOA - Medical, Mental Health, Dental, Non-Emergent Medical Transportation (NEMT).
- CCOB - Medical, Mental Health, NEMT
- CCOE - Mental Health, NEMT
- CCOG - Mental Health, Dental, NEMT
- CCOF – Dental, NEMT

Provider Requirements

The following billing standards allow for accurate processing and pricing of individual provider's services based on fee schedule and pricing structures within Advanced Health's claims system:

- The rendering provider's NPI, and name must be present and in the appropriate location.
- The billing provider's (vendor) NPI, name, address, and phone number must be present and in the appropriate location.
- All providers listed on the claim (billing, rendering, referring, ordering, supervising, attending, etc.) must have a valid Oregon Medicaid ID on the date of service for the claim to be payable.
- Specialist visits require a referring provider.
- Ancillary services such as lab, pathology, radiology and DME supplies require an ordering provider.
- Claims received with more than one rendering provider's services billed on the claim will be rejected.

Claim Processing

Claim Denial Information: When the determination is made to deny payment for a service, for which the member may be financially responsible, the member and the treating provider will receive a written notification (Notice of Action) within 14 calendar days of the decision to deny payment. Notice of Action letters sent to members are formatted in accordance with HSD regulations and include the following information: 1) Reason for denial; 2) Information regarding Advanced Health's formal patient complaint and appeal process; and 3) the notice of hearing rights (MAP 3030). The denial notification that is sent to the provider will include the reason for denial. The denial reason will be indicated on the provider's EOP from Advanced Health for the service denied.

Claim Review Guidelines: Advanced Health reserves the right to review any claim submitted. Claims are reviewed for but are not limited to the following reasons: 1) Medical necessity; 2) Proper coding; and 3) Medical appropriateness.

Claim Adjudication

Advanced Health shall process all claims in accordance with the current CCO contract, OHA and CMS guidelines, applicable OARs and CFRs, the National Correct Coding Initiative, as well as industry standards and best practices as appropriate.
The Prioritized List of Health Services is a key part of determining if a service is covered by OHP. More information can be found on OHA's website: https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx
Additionally, several code sets are available at https://data.oregon.gov which complement the Prioritized List when determining coverage:

- Generally not covered:
  - Informational Diagnosis Codes (Group 6033)
  - Undefined Diagnosis Codes (Group 6030)
  - Excluded Procedures (Procedure Code Group 1118)
  - Conditions Not Covered (Diagnosis Code Group 6031)
  - Oregon Medicaid Other Provider Preventable Conditions
  - Oregon Medicaid Healthcare Acquired Conditions
- Generally covered:
  - Diagnostic Procedure Codes (Group 1119)
  - Diagnostic Workup File (Code Group 6032)
- Generally covered when accompanying a covered service:
  - Ancillary Services (Procedure Code Group 6060)

Claim Documentation Requests

When additional documentation is required to process a claim, Advanced Health will reach out to the billing provider via phone, fax, or email to obtain all necessary information. Documentation not received within 14 days of request may result in a claim denial.
Common Documentation Requests include:

- Sterilization Consent forms
- Invoices for hearing aids, DME supplies or equipment repairs
- Documentation to review EPSDT Medical Necessity and Appropriateness
- Itemized bills for Inpatient hospital claims
- Documentation for modifiers that indicate a service has been increased, reduced, or discontinued
- Documentation for unlisted procedures
- Other documentation as requested

All records received from providers must be legible to a degree that a meaningful review may be completed. Records may be considered illegible due to poor handwriting or poor copy quality. If the records cannot be read, the documentation may be considered illegible. When illegible records are received, Advanced

Health may reach out to the provider for a legible copy. If a legible copy cannot be obtained, the services are considered not documented and are therefore non-billable and will not be reimbursed.

Reimbursement

Advanced Health reimburses participating providers based on allowable charges. The allowable charge is the lesser of the billed charge or the contracted rate for the service and provider in question.

835 vs EOP

835: This is a type of electronic transmission of healthcare payment and benefit information. It is also referred to as Electronic Remittance Advice (ERA). It is an electronic file summarizing the claim that was billed, listing the amount billed versus the amount paid, a payment summary and any messages defining the meaning of explanation codes used in the 835. This file can be electronically accepted into a clinic or facilities healthcare system and allows for the automatic posting of the payment information. These are encrypted and are provided to clearinghouses for electronic pickup or distribution**.**

EOP: Explanation of Payment (EOP) is a physical letter summarizing the claim that was billed, listing the amount billed versus the amount paid, a payment summary and any messages defining the meaning of explanation codes used in the EOP. These are posted in the Advanced Health Provider Portal and may be viewed in a PDF format by those with portal access to do so.

Paper Check vs EFT

Paper Check: For payees who choose to receive a paper check payment this is mailed to the payees verified address of their choosing.

EFT: Electronic Funds Transfer (EFT) are electronic payments conducted through Automated Clearing Houses (ACH). These payments are directly deposited to the payees verified bank account of their choosing. EFTs are generally preferable to paper checks. Please contact Advanced Health if you would like to begin receiving EFT payments directly instead of paper checks.

Refunds

Provider Refunds

If a payment error is identified, please refund the full amount promptly. Enclose a copy of the EOP highlighting or marking the claim. Please provide a brief explanation or reason for the refund with any additional information if required. If the claim requires reprocessing, Advanced Health will handle it promptly.

Advanced Health Requests Refund

Advanced Health may request provider refunds up to one year from the date of service if refund is due for an administrative reason. For refund requests generated due to the member having other medical coverage, Advanced Health may request a refund if the provider may bill the other coverage based on the primary carrier's timely filing limit. Refunds are due within 30 days from the date of the request letter. If payment is not received within that time frame, a "punch credit" may be taken from your next claims payment and will be reflected on the EOP provided by Advanced Health.

General Refund Information
If the refund is based on an Advanced Health processing error, the provider is not required to resubmit the claim. Advanced Health will review the refund and reprocess the claim.

Refunds may be mailed to:
Advanced Health
Attention: Claim Refund
289 LaClair St
Coos Bay, OR 97420
Please note that refund checks must be made out to Southwest Oregon IPA, or the check may be returned unprocessed.

Billing Guidelines

Advanced Health follows HSD and Medicare guidelines for all lines of business. Below are some common Medicare guidelines that are considered when processing claims:

- Multiple Procedure Reduction
- Assistant Surgeon Allowances
- Global Billing Period
- ASC List of Medicare-Approved Procedures
- NCCI Edits

Billing Modifiers

When using the following modifiers, providers are asked to attach a medical or operative report, or applicable medical records, and an explanation of why the modifier is being submitted. Without this information, the claim may be denied.

- 22 (Increased Procedural Services)
- 24 (unrelated evaluation and management service by the same physician during the post-operative sessions)
- 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)
- 52 (reduced service)
- 53 (Discontinued Procedure)
- 73 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia)
- 74 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia)

Billing Practices Subject to Reduction

Unbundling occurs when two or more CPT® or HCPCS codes are used to describe a procedure performed when a single, more comprehensive code exists that accurately describes the entire procedure. Claims identified as having unbundled procedures will be denied.

Reductions in payment for multiple surgical, bilateral and combined procedures are not collectable from the Advanced Health Member. These reductions are considered contractual write-offs.

Co-surgery is defined as two surgeons of different specialties operating together to perform a single surgery, expressed under one CPT® code. Advanced Health allows 125 percent of the allowable charge, which is divided equally. Additional surgical assistants are not covered.

Incidental coverage procedures, such as the removal of appendix at the same time of other intra-abdominal surgery with no pathology, are not reimbursed separately. The incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the more extensive procedure. The allowable charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

Mutually exclusive procedures are two or more procedures that usually are not performed at the same session, on the same patient and on the same date of service. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the physician should be submitting only one of the codes.

Evaluation and Management (E&M) rules apply to the E&M services included in CPT® code ranges 99201-99499 and Miscellaneous Services codes 99024-99025. The separate billing of and E&M service will not be allowed when a substantial diagnostic or therapeutic procedure has been performed on the same date of service by the same provider.

Specialty Guidelines

Ambulance Provider Guidelines

Medically appropriate ground or air ambulance services are covered when rendered in accordance with the most current HSD Medical Transportation Service Guide and HSD General Rules.

Emergency Medical Transportation

A service will qualify for Advanced Health reimbursement as an emergency ambulance transport when a sudden, unexpected occurrence creates a medical crisis requiring immediate transportation to a site, usually a hospital, where appropriate medical care is available. When transport occurs, the patient must be transported to the nearest appropriate facility able to meet their medical needs. (OAR 410-136-3160 (4)).

Base Rate

Advanced Health reimbursement for ambulance base rate includes any procedures/services performed, all medications, non-reusable supplies and/or oxygen used, all direct and indirect costs including general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance provider, use of reusable equipment and any other miscellaneous medical items and special handling that may be required during transport. Reimbursement of the first ten miles included in the payment of the base rate (OAR 410-136-3180(3aB).

Equipment, Devices and Supplies

Advanced Health will not reimburse non-hospital providers for equipment, devices or supplies used in conjunction with hospital inpatient or outpatient services. Reimbursement for these services is included in the hospital's payment.

Durable Medical Equipment (DME) Billing Guidelines

Durable Medical Equipment (DME) are items used to serve a specific therapeutic purpose in the treatment of an illness or injury, which can withstand repeated use, are generally not useful to a person in the absence of illness, injury or disease and appropriate for use in the patient's home.

DME and medical supplies may require prior authorization. Please see the current authorization grid for current coverage information.

DME benefits are not provided for repair or maintenance of rented equipment. The repair or maintenance of rented DME is the responsibility of the participating DME supplier at no additional charge to the member. For purchased equipment, when medically necessary repairs or maintenance are required, an authorization must be requested by the DME supplier. The DME supplier agrees to provide all DME services and supplies and orthotic and prosthetic devices, if applicable, according to the following standards: 1) Free delivery; 2) Free installation; 3) 24/7 emergency services; 4) Rental equipment repair and maintenance services; 5) Clinical professionals for patient education and home management, as well as written educational materials and instruction manuals; and 6) Availability of standard/economical models that meet the patient's medical needs and quality standards.

Benefits for DME are provided in accordance with the OHP benefit package. Benefits will be provided if the prescribed equipment meets Advanced Health's DME and medical necessity requirements. DME rental will not exceed the purchase allowance.

Rental vs. Purchase

Advanced Health has the option of approving either rental or purchase of DME. Based on medical necessity, rental may be approved for a specified number of months, rental may be approved up to the purchase allowance, or purchase may be approved.

Payment Allowance

Benefit payment for rental of DME is based on Advanced Health monthly rental allowance (not to exceed the purchase allowance). Benefit payment for the purchase of DME is based on the Advanced Health purchase allowance. Rental DME is considered purchased once the monthly rental allowance equals the purchase allowance. The patient then owns the DME and neither the member, nor Advanced Health can be billed for the additional rental or purchase of the equipment.

Therapy and Rehabilitation Services

Outpatient therapy (physical, occupational and speech) benefits are subject to member eligibility, OHP benefits and HSD guidelines. Providers are responsible for verifying eligibility and benefits prior to rendering service to Advanced Health members. See current authorization grid for current coverage information.

Benefit Limitations

Services must be covered by the member's OHP benefit package. Services must be performed by a licensed therapist or a therapy assistant under direct supervision of a therapist who must be in constant attendance while therapy treatments are being performed. Therapy treatments must not exceed one hour per day, per each type of therapy. Up to two modalities will be authorized per day of treatment and must be billed in conjunction with a therapeutic procedure code. Maintenance therapy is not a covered service.

Home Health Agency Billing Guidelines

Advanced Health recognizes the need to maintain consistency of billing requirements for Advanced Health and HSD whenever possible. Therefore, we require home health agencies to file claims using the UB-04 claim form in accordance with HSD guidelines.

Services must be prescribed by a physician and the signed order must be on file at the home health agency. The order must include the ICD-10 diagnosis code indicating the reason that home health services are being requested. The orders on the plan of care must specify the type of services to be provided to the member with respect to the professional who will provide them, the nature of the individual services, specify frequency and specific duration. The orders must clearly indicate how many times per day, each week or month they are to be provided.

Authorization is required for all home health care with the exception of initial nursing evaluation or therapy evaluations when provided by a local provider. The authorization will include the service, revenue codes, ICD-10 codes and the quantity/units of visits requested. Authorizations will be approved for the 60-day certification period upon medical review.

The following services or items are covered when administered in accordance with HSD's therapy guidelines and the member's benefit coverage, if the diagnoses are above the line on the prioritized list:

- Skilled nursing services
- Skilled nursing assessment (including OASIS assessment)
- Home health aide services
- Occupational therapy services
- Physical therapy services
- Physical therapy evaluation (including OASIS assessment)
- Speech and language pathology services
- Speech and language evaluation (including OASIS assessment)

Vision Services Guidelines

Vision exams, including routine visual diagnostic, and medical exams, do not require prior authorization when administered by an in-network provider, and in accordance with Advanced Health guidelines. Vision therapy, surgical procedures, eyeglasses and contacts for adults aged 21 and over, and any additional vision procedure or hardware may require prior authorization. Please see Advanced Health's authorization grid for current prior authorization requirements. Advanced Health uses MAP's visual services rules and will authorize payment for vision services for covered services that are subject to member eligibility and benefit package limitations and exclusions. Providers are responsible for verifying member eligibility and benefit package prior to administration of vision services.

Additional Information:

- Routine vision exams are defined as CPT codes 92002-92014 that are paired with the primary diagnosis code Z01.00.
- Routine vision exams and the determination of refractive state are limited to once every 24 months for adults aged 21 or older.
- Routine vision exams for children through the age of 20 are not limited in quantity when clinically appropriate.
- Diagnostic evaluations and medical examinations are not limited if documentation in the physician's or optometrist's clinical record justifies the medical need for diagnosis. Adult diagnostic and medical eye exams require that the medical provider who referred the member for vision services be included on the claim to prevent claim denials.

- Eyeglasses must be provided by Sweep in most instances. Prior authorization is not required for eyeglasses/fittings for children through the age of 20.

Hearing Services

Advanced Health utilizes HSD's speech-language, pathology, audiology and hearing aid service guidelines for the administration of hearing and audiology services. All benefits are subject to member eligibility and OHP benefit plan limitations and exclusion. Routine hearing exams do not require authorization when administered by a local provider. Hearing aids and repairs must be authorized. Services must be an OHP covered service and are subject to member eligibility and benefit limitations.

Services Not Requiring Authorization:

- One basic audiology assessment per calendar year
- One basic comprehensive audiometry per calendar year
- One hearing aid evaluation, tests, selection per calendar year
- One electroacoustic evaluation for hearing aid, monaural, per calendar year
- One electroacoustic evaluation for hearing aid, binaural, per calendar year
- Hearing aid batteries (limited to 60/year)

Services Requiring Authorization:

- Hearing aids
- Repair of hearing aids - including ear mold replacement.
- Assistive listening devices
- Cochlear implant batteries (except disposable zinc air batteries)

Additional Information:

- All hearing services must be performed by a licensed audiologist or hearing aid dealer
- Reimbursement is limited to binaural hearing aids no more frequently than every 5 years for adults who meet the following criteria: 1) Loss of 435 decibel (dB) hearing level or greater in two or more of the following frequencies 1000, 2000 and 3000 and 4000 Hertz (Hz).
- Binaural hearing aids will be reimbursed no more frequently than every three years for children, birth through age 20, who meet the following criteria: 1) Pure tone average of 25dB for the frequencies of 500 Hz, 1000Hx and 2000Hz; or 2) High frequency average of 35dB for frequencies of 3000Hz, 4000Hx and 6000Hz.
- An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear, or who cannot benefit from a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a listening situation. It is restricted to a hand-held amplifier and headphones.
- Adjustments to hearing aids are included in the fitting and dispensing fee and are not reimbursable separately.
- Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately.

CLAIM AND COMPLIANCE AUDITING

Claim Auditing: Advanced Health is required to engage in both random and focused claim auditing. Random claim auditing occurs on a random and episodic basis, while focused claim auditing occurs whenever Advanced Health has detected potential irregularities among submitted claims. Providers will

always receive an advance notification when random claim auditing functions are being performed, and auditing staff will contact the provider to schedule a mutually agreeable time for an on-site review. The process for focused claim auditing does not always permit advance notification to the provider, depending on the circumstances. Focused claim auditing will always occur during normal business hours, between 8:00 AM and 5:00 PM, Mondays through Fridays. Providers are contractually required to make medical, claim, and financial records available and to cooperate in the claim auditing function.

Consistent with its privileged provider agreement, Southwest Oregon Independent Practice Association will be the entity performing claim auditing of physicians, physical therapists, nurse practitioners, physician assistants, and most behavioral health specialists.

Compliance Auditing: Advanced Health is required to engage in contractual compliance auditing that covers a broad range of potential concerns, e.g., implementation of Member rights and responsibilities; internal policies and procedures governing HIPAA, quality and accountability, freedom from seclusion and restraint; verification that staff Members have completed required in-service training; adequacy and safety of health information technology systems. Providers will always receive at least fourteen (14) days advance notification of compliance auditing, and a mutually agreeable time will be established for the compliance auditing process. In most cases, providers will be asked to submit various documents for desk review, thereby reducing the amount of time the provider is required to expend in the on-site compliance auditing function.

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

Advanced Health's culture, systems, and processes are structured around its overarching purpose of improving Member's care, their health outcomes, and their experiences of care. The Quality Management and Improvement (QMI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all Members, with a specific emphasis on those Members with diverse ethnic or cultural backgrounds or special health care needs.

The QMI system incorporates a continuous cycle of assessing the level of care and service for Members through initiatives including preventative health, acute and chronic care, behavioral health, oral health, over- and under-utilization, continuity, and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and the designation of adequate resources to support the interventions. Advanced Health requires all practitioners and providers to cooperate with all quality improvement activities, as well as to allow Advanced Health to use practitioner and/or provider performance data to ensure the success of the QMI Program.

Advanced Health will arrange for the delivery of appropriate care, with the primary goal being that of improving the health status of its Members. This will include the identification of Members at risk of developing conditions and the implementation of appropriate interventions. Whenever possible, Advanced Health's strategies will be evidence-based and designed to achieve demonstrable and sustainable improvement in the health status of its Members.

Advanced Health annually publishes a Transformation and Quality Strategy plan which incorporates all required elements of the Quality Assurance and Performance Improvement plan and the OHA's Health System Transformation strategies. The Transformation and Quality Strategy is reviewed and adopted by the Advanced Health Board of Directors.

QMI Program Structure

Advanced Health's board of directors has the ultimate oversight for the care and services provided to Members. The board of directors assigns accountability of the QMI Program to the Chief Medical Officer and the Senior Executive for Quality Assurance (the Executive Program Director). To support the QMI and engage stakeholders, Advanced Health convenes the Interagency Quality Committee which includes representatives from all sectors of the Advanced Health provider network. The purpose of the Interagency Quality Committee is to:

- Identify opportunities to transform the quality of care for Advanced Health's Members;
- Identify areas of improvement within the organization;
- Function as quality leaders to ensure information regarding improvement is dispersed and implemented among staff, providers, and clinics; and,
- Promote safe clinical practices.

This is accomplished through: a comprehensive, network-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve Member outcomes; and the education of Members, providers, clinics, and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing and Re-Credentialing programs.

Practitioner Involvement

Advanced Health recognizes the integral role that practitioner involvement plays in the success of the QMI Program. For this reason, there is an intentional overlap in the roles of the Interagency Quality Committee and the Clinical Advisory Panel, as the Clinical Advisory Panel, by design, includes provider representation from mental health, substance abuse and addictions, oral health, medical specialty services, and primary health care.

Quality Management Goals and Objectives

Advanced Health's integrated medical, behavioral, and oral health care model is committed to Continuous Quality Improvement (CQI) to conduct meaningful activities internally and externally to ensure Members receive appropriate care to improve their health and well-being. A focus on, and attitude toward, improvement processes to enhance the quality of Member outcomes is embedded in how Advanced Health conducts internal and external business. QMI Program activities include review and evaluation of medical, behavioral, and oral health care furnished to Members. The QMI Program is structured to aggregate, monitor, analyze, process, and implement quality measures internally and externally to improve outcomes and the overall health of the community.

Advanced Health's commitment to the integrated model is reflected in the following objectives:

- Build and promote quality throughout Advanced Health's organizational structure, processes, and

practitioner/provider community;
- Promote Member safety through monitoring data, collaborating with practitioners, evaluating qualifications and clinically appropriate decision-making, and educating Members on clinical safety and health care programs;
- Ensure timely access to appropriate health care services, availability of services, and second opinions;
- Ensure that cultural needs and preferences are delivered;
- Ensure that Members receive quality care in a culturally and linguistically appropriate manner;
- Ensure that Members receive care that is trauma-informed;
- Ensure access to services for Members of priority population groups or those with special or complex health care needs and/or serious behavioral health care needs;
- Ensuring the timely and comprehensive completion of a Health Systems Architecture Equity Assessment and resultant plan;
- Ensure Member and provider satisfaction; and,
- Maintain compliance with state and federal regulatory requirements and accreditation standards.

Performance Improvement Process

Advanced Health's quality team reviews and adopts an annual Quality, Accountability, and Performance Improvement (QAPI) Plan based on managed care industry standards. The QAPI incorporates traditional quality/risk/utilization management approaches to identify problems, issues, and trends, with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinic focus area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects (PIPs), focus studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. The results of these studies are used to evaluate the appropriateness, level-of-care, and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Advanced Health to monitor improvement over time.

At any time, Advanced Health's providers may request additional information on the QAPI, including a description of current QMI priorities and a report on Advanced Health's progress in meeting QAPI objectives.

Patient-Centered Primary Care Home (PCPCH)

The Patient-Centered Primary Care Home (PCPCH) Program is but one component of Oregon's efforts to fulfill a vision of better health, better care, and lower health care costs for all Oregonians. By recognizing clinics that offer high-quality, patient-centered care, Advanced Health can begin breaking down the barriers that stand between patients and good health. The PCPCH Program is housed in the Oregon Health Authority's Transformation Center. The PCPCH Program administers the application, recognition, and verification process for practices applying to become recognized PCPCHs. PCPCHs are governed by OAR 409-055-000 to 409-055-0090. All primary care practices within Advanced Health's network are encouraged to attain PCPCH recognition. Practices that already hold PCPCH recognition are encouraged

to pursue the attainment of a higher PCPCH tier status than the one currently recognized. Technical assistance is available from Advanced Health staff through the Quality Department.

Patient Safety and Level-of-Care

At Advanced Health, patient safety is a key focus, and this focus is shared by providers, hospital administrators, and health care executives. Monitoring and promoting patient safety are integrated through multiple activities, but primarily through the identification of potential and/or actual level-of-care events. A potential level-of-care issue is any alleged act or behavior that may be detrimental to the level of the safety of patient care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including the death of a Member.

At Advanced Health, level-of-care issues are addressed by the Chief Medical Officer and the Clinical Advisory Panel. Advanced Health employees, participating providers, panel practitioners, facilities, ancillary providers, and Members or Member representatives may directly advise the Chief Medical Officer or board of directors regarding any potential level-of-care issue.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). It is used to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its Members. As federal and state governments move toward a health care industry that is driven by quality, HEDIS rates are becoming increasingly important, not only to the health plan but to individual providers.

HEDIS rates are calculated in two ways: administrative data; and hybrid data. Administrative data consists of the claim and encounter data. Examples include breast cancer screening (routine mammography), use of disease-modifying anti-rheumatic drugs for Members with rheumatoid arthritis, osteoporosis management in women who have had a fracture, access to primary health care services, and mental health utilization. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires a review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data, and submission using appropriate CPT II, ICD-10, and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include adult BMI assessment; comprehensive diabetes care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressure), medication review post-hospitalization, and colorectal cancer screening.

Except as required by the annual quality incentive metric process, Advanced Health does not additionally acquire hybrid data through a records review process. However, should Advanced Health seek national accreditation as a Managed Care Entity (MCE), record review processes may become necessary. Under such a circumstance, the provider's prompt cooperation with the medical record review process will be greatly needed and appreciated.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a Member satisfaction survey that provides information about the experiences of Members in relationship to Advanced Health and its provider network and gives a general indication of the degree to which Members' expectations are being met. OHA fields an annual CAHPS survey for all CCOs and reports results on a number of patient experience of care quality measures. Member responses to the CAHPS survey are used in various aspects of the quality program, including monitoring access and availability. CAHPS survey material that may reflect on the services furnished by individual providers includes, but is not limited to:

- Wait times for appointments;
- Whether Members perceive that they are receiving needed care, including diagnostic tests, referrals to specialists, and prescriptions; and,
- How well the provider communicated with the Member.

Health System Equity Architecture Assessment and Plan

Advanced Health will perform a comprehensive organizational and systemic health equity assessment. The results of the assessment will be used to identify strengths and opportunities and will inform the annual Health Equity Plan. The process is designed to examine Advanced Health's overall health systems architecture, with an eye toward equity and inclusion. In the process of completing the assessment, Advanced Health may distribute surveys to providers. Thoughtful completion and timely return of the surveys will be appreciated.

Annual CCO Quality Incentive Program

On an annual basis, the Oregon Health Authority establishes incentive and performance metrics for its coordinated care organizations. The Oregon Health Authority uses quality health metrics to document how well the State is improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care services. This documentation is required under Oregon's waivers for the Oregon Health Plan with the federal Centers for Medicaid and Medicare Services. In the interests of transparency, annual metric attainment and performance rates are calculated and publicly posted by the Oregon Health Authority, thereby permitting Members and potential Members to identify those coordinated care organizations that are performing at the highest rates. The Oregon Health Authority withholds capitation payments to Advanced Health and returns those withheld amounts in direct proportion to the degree to which Advanced Health has attained its performance metrics. For this reason, the performance metrics are often referred to as *incentive metrics.* Advanced Health's contract with the Oregon Health Authority requires that providers participate in the distribution of any financial incentives earned through the performance metric program. In addition, those community-based social service organizations that contribute to the attainment of certain incentive metrics are required to be rewarded for their work from among the pool of financial resources made available to the coordinated care organization for metric attainment.

Performance and incentive metrics for 2023 include or relate to:

- Childhood immunization status;
- Immunizations for adolescents;
- Child well-care visits for ages 3 through 6;
- Prenatal and postpartum care;

- Screening for clinical depression and follow-up;
- Cigarette smoking prevalence;
- Alcohol and drug misuse: screening, brief intervention, and referral to treatment;
- Preventive dental services for ages 1 – 5 and 6 – 14;
- Oral evaluations for adults with diabetes;
- Mental, physical, and oral health assessments for children in state custody;
- Diabetes HbA1c poor control;
- Initiation and engagement in substance use disorder treatment;
- Meaningful access to health care for persons with limited English proficiency (interpreter services); and
- Health Aspects of Kindergarten Readiness: CCO System-level social-emotional health
- Social Needs Screening and Referral

Providers requiring additional information regarding the performance and incentive metrics program should immediately contact the Chief Medical Officer, Provider Services Representative, or Executive Program Director.

OHA Important Links

- Billing tips .....https://www.oregon.gov/oha/HSD/OHP/Pages/Billing.aspx
- COVID-19.....https://www.oregon.gov/oha/HSD/OHP/Pages/COVID-19.aspx
- Eligibility verification .... https://www.oregon.gov/oha/HSD/OHP/Pages/Eligibility-Verification.aspx
- Enroll as an OHP provider ..... https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx
- Fee-for-service fee schedule... https://www.oregon.gov/oha/HSD/OHP/Pages/EULA.aspx
- Interpreter services..... https://www.oregon.gov/oha/HSD/OHP/Pages/Interpreter-Services.aspx
- Keys to Success .. https://www.oregon.gov/oha/HSD/OHP/Tools/Keys%20to%20Success%20-%20Partnering%20with%20OHP.pdf
- Policies, rules and guidelines ... https://www.oregon.gov/oha/HSD/OHP/Pages/EULA.aspx
- Prior authorizations..... https://www.oregon.gov/oha/HSD/OHP/Pages/PA.aspx
- Prioritized List.....https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx
- Provider Matters ebulletin ..... https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Matters.aspx
- Provider Portal resources..... https://www.oregon.gov/oha/HSD/OHP/Pages/webportal.aspx
- What materials do you need? .... https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-New.aspx
- Your remittance advice .... https://www.oregon.gov/oha/HSD/OHP/Pages/Remittance-Advice.aspx