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## A INTRODUCTION

### CareOregon Vision

Healthy Oregonians regardless of income or social circumstances

### CareOregon Mission

To assure Oregon's vulnerable populations receive access to high quality healthcare from a stable network by a well-managed, financially sound organization

### CareOregon Standards of Service

CareOregon's goal is to ensure the greatest possible health benefit to our members through the effective use of State Medicaid funding.

We are equally committed to:

- Providing medically effective health care within Medicaid guidelines
- Promoting the health of every member
- Providing exceptional and proactive service to our members and providers
- Treating all contacts with dignity, respect and understanding
- Working in partnership with our members, their extended health support groups and the providers that help make up their medical homes

CareOregon understands that in order to accomplish these goals we must advocate for and on behalf of our members.

## A INTRODUCTION

From a health services perspective, *generally*, this means facilitating care that is:

- Safe
- Effective
- Efficient
- Patient centered (culturally appropriate and linguistically sensitive)
- Timely
- Equitable<sup>1</sup>

*Specifically*, this means using appropriate clinical judgment in the application of approved criteria and guidelines to evaluate the member's circumstances and medical needs rather than adherence to literal standards. This is especially critical for members with complex medical or social issues, and for those who need additional support in understanding health care issues because of language or literacy barriers. In these cases, appropriately trained staff gather more information to help members make informed decisions that meet their needs within the health care benefit.

From a member and provider service perspective:

- We will be both proactive and responsive in our efforts to resolve member, provider and community concerns.
- In cases where we must decline care or services on the basis of coverage limitations or criteria not being met, we will do so in a polite and courteous manner always seeking alternative solutions in or outside of the organization to assist the member.
- Members and providers will always be informed of their right to appeal an initial decision and CareOregon will have a reasonable and expeditious process to evaluate and respond to this appeal.
- Correspondence regarding denials and appeals will be clear, respectful and informative.

These six quality standards are promoted by the National Institute of Medicine in their

publication: [Crossing the Quality Chasm.](#)



A  
Introduction

## **B MEMBERSHIP: THE OREGON HEALTH PLAN**

### **B 1.1 Medicaid Component of the Oregon Health Plan**

The Oregon Health Plan (OHP) has several components; one is the Medicaid program. Under the OHP, Oregon has extended Medicaid eligibility to all state residents with incomes up to 100% of the federal poverty level (FPL), as well as children and pregnant women who live under 185% of the FPL.

The Medicaid component of the OHP is often referred to as “the OHP.” This manual refers to the Medicaid component as the OHP.

The OHP has two benefit packages: OHP Plus and OHP Standard. CareOregon covers both.

### **B 1.2 DMAP**

The Medicaid program is administered by the Division of Medical Assistance Programs (DMAP).

### **B 1.3 Members' rights and responsibilities**

CareOregon mails the members' rights and responsibilities statement to new and existing members each year.

New and existing providers can review the members' rights and responsibilities statement in the members' handbook at

**[www.careoregon.org/member/index.html](http://www.careoregon.org/member/index.html)**.

#### **2010 Members' Rights**

- To be treated with dignity and respect
- To have the same rights and care choices as your providers' other patients
- To have access to your own health record

- To have corrections added to your health information
- To be active in your treatment plan
- To have honest discussions with your provider about treatment choices for your condition, regardless of cost or benefit coverage
- To refuse services or treatment, and be told the consequences of that decision
- To know that information in your medical records is confidential, with exceptions determined by law
- To sign advance directive forms, such as a living will and/or a power of attorney, that explain the care you want if you cannot make these decisions for yourself
- To know how to appeal a decision or file a complaint with the plan and receive a response
- To receive the level of service that you expect and deserve, as approved by your provider(s)
- To have a friend, family member or advocate with you during a medical appointment and at other times as needed within clinical guidelines
- To have a language interpreter with you during appointments at no charge to you
- To receive a notice that tells you how your health information may be used and shared
- To decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing
- To get a report on when and why your health information was shared for certain purposes

**B**

B1

Membership

### **B 1.3 Members' rights (continued)**

**B**

B1

Membership

- To choose a primary care provider (PCP) and to change your primary care provider as permitted
- To make an appointment with a mental health, chemical dependency or family planning provider without first getting a referral from your PCP
- To get information about your condition and covered and non-covered services so you can make an informed decision about treatment(s) recommended by your providers
- To receive written materials describing your rights, responsibilities, benefits available, how to get services and what to do in an emergency
- To have written materials explained in a way that you understand
- To receive necessary and reasonable services to diagnose your medical condition
- To receive covered services under the Oregon Health Plan that meet generally accepted standards of care and are medically appropriate
- To obtain covered preventive services
- To have access to urgent and emergency services 24 hours a day, seven days a week
- To get a referral from your PCP to specialists for medically appropriate covered services
- To have a clinical record maintained that documents conditions, services you received and any referrals made by your PCP to specialists
- To transfer a copy of your clinical record to another provider

### **B 1.3 Members' rights (continued)**

**B**

B1

Membership

- To be free from any form of restraint or seclusion (isolation) that is not medically necessary or is used by staff to bully or punish you. Staff may not restrain or isolate you for the staff's convenience or retaliation against you.
- To report violations to CareOregon and/or to the Oregon Health Plan.
- To receive written notices before a benefit or service level is denied or changed, unless this notice is not required by federal or state regulations
- To ask for an Administrative Hearing with the Department of Human Services
- To know as soon as possible that your provider cancelled an appointment with you
- To receive information about CareOregon and CareOregon's providers
- To make recommendations about CareOregon's member rights and responsibilities policy

If you believe your rights are being denied or your health information isn't being protected, you can file a complaint with your provider, CareOregon and/or the U.S. government.

You can ask your provider or CareOregon questions about your rights.

Call Customer Service if you want information about a provider's professional experience, such as current board certification status and the medical school he/she attended.

## 2010 Members' Responsibilities

- To treat CareOregon staff and providers with courtesy and respect
- To choose your primary care provider (PCP) as soon as possible after you become a member
- To participate in your health care decisions, unless you choose to give that responsibility to a friend or family member
- To ask questions about conditions, treatments and other issues related to your care that you do not understand
- To follow your provider's treatment plan after you and your provider agree upon your care
- To be on time for your appointments. Call your provider as soon as possible in advance if you must cancel or will arrive late for an appointment
- To get routine health exams and preventive services from your PCP
- To use urgent and emergency services only when appropriate. Contact your PCP within 72 hours after an emergency
- To call your PCP's office when you need non-emergency medical care. Know your PCP's office and after-hours phone number(s).
- To provide true and complete information to your health care providers and CareOregon about your medical history
- This includes information about your medications, previous illnesses, injuries and medical care, and your current health status.
- To help your PCP obtain information, such as your medical records, from other providers. You may be

asked to sign an authorization to release your medical information.

**B**

### **2010 Members' Responsibilities (continued)**

B1

Membership

- To tell your Department of Human Services (DHS) worker about any of the following changes in your household:
  - Home address or phone number changes
  - Any family member moves in or out of the household
  - Covered member is eligible for other medical insurance
  - A member becomes pregnant and/or the birth of a child
- To obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed
- To use information to make informed decisions about treatment before it is given
- To tell the practitioner or provider that your health care is covered under the Oregon Health Plan (OHP) before services are received and, if requested, to show the practitioner or other provider your Medical Care Identification form
- To pay for non-covered services
- To pay the monthly OHP premium on time if required
- To help CareOregon obtain amounts from other sources for your injuries. If you receive payment for an injury, you must pay CareOregon up to the amount it paid for your injury.
- To bring issues, complaints or grievances to the attention of the Plan

Contact CareOregon if you have any questions, concerns, problems or suggestions. Contact CareOregon **immediately** if you suspect fraud or abuse.

**B**

B1  
Membership

## **B2 ELIGIBILITY AND ENROLLMENT**

### **B 2.1 Applying for the Oregon Health Plan**

Application for eligibility is coordinated by Oregon Department of Human Services offices such as “Children, Adults and Families” and “Seniors and People with Disabilities.”

People may also apply directly through the OHP Application Center by calling toll-free 1-800-359-9517.

Eligibility screeners at federally funded health centers in Oregon and at Oregon Health & Science University help with the application process and answer questions.

### **B 2.2 Eligibility for OHP**

Applicants who meet eligibility requirements become eligible for the Oregon Health Plan Medicaid component.

The eligibility effective date for an OHP Plus recipient is retroactive to the recipient’s application date.

- **Adult recipients are eligible for the Oregon Health Plan for six months and must reapply at the end of each six-month period.**
- **Children must reapply every 12 months.**

If recipients do not reapply before their eligibility ends, their OHP eligibility terminates until they reapply.

### **B 2.3 Health Plan Enrollment**

CareOregon is a medical Managed Care Organization (MCO). When applying for the OHP, recipients choose an available MCO in their county of residence.

DMAP enrolls OHP recipients with their selected health plan shortly after they become eligible for the OHP. Recipients can be enrolled with their health plan on the first day of the month or on any Monday.

Counties have either mandatory MCO enrollment, with some exceptions, or voluntary enrollment with a health plan.

If an OHP recipient is not enrolled in a managed care plan, he/she receives services through the fee-for-service Medicaid program. These recipients are on an "open card." The fee-for-service program is managed by DMAP. Send claims to DMAP for payment.

## B 2.4 Verifying an OHP Recipient's Health Plan Enrollment

There are four ways to verify health plan enrollment:

DMAP sends recipients a DMAP Medical Care Identification (ID) when they enroll. Find the member's name on their DMAP Medical ID for the **current** month. Follow the row across to the Managed Care/TPA column.

### OR

Call the AIS (Automated Information System) at 1-800-522-2508. Enter your DMAP provider number.

### OR

Open the CareOregon Provider Portal at <http://www.careoregon.org/Providers/ProviderPortalLogin.aspx>. Only enrolled CareOregon members are in the Provider Portal. OHP recipients not enrolled with an MCO or enrolled with an MCO other than CareOregon are not in the Provider Portal.

If you do not have a Provider Portal logon, call CareOregon Customer Service.

### OR

Open DMAP's Medicaid Management Information System (MMIS) at

<https://www.oregon.gov/ProdPortal/Account/Secure%20Site/tafid/63/Default.aspx>. MMIS provides eligibility verification and health plan enrollment for all OHP enrollees.

If you do not have a MMIS logon, open the OHP Provider Web Portal for more information at

<http://www.oregon.gov/DHS/healthplan/webportal.shtml#training>

## B 2.5 Changing MCOs

Oregon Health Plan recipients may change their MCO only when their eligibility is re-determined, unless their caseworker makes an exception.

Changes in MCO enrollment are made by case-workers or the OHP Central Branch, not by CareOregon.

**B**

B2  
Eligibility  
and  
Enrollment

## **B3 PCP ASSIGNMENT AND SELECTION**

B3

### **B 3.1 Assigning a PCP to CareOregon Members**

PCP Assignment  
and Selection

All CareOregon members have a primary care provider (PCP) who manages their medical needs.

CareOregon members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

PCPs are automatically assigned when the member enrolls with CareOregon. Auto assignment is based on where the member lives.

Members have 30 days from the date of enrollment to change their PCP assignment.

### **B 3.2 Changing PCPs**

Newly enrolled CareOregon members receive a welcome packet that includes a directory of CareOregon PCPs.

Members can call our Customer Service department within the first 30 days of their enrollment with CareOregon to select a new PCP.

PCPs can help a member select their clinic as the PCP by calling the Customer Service department and requesting that a member be assigned as their patient.

After their first 30 days on CareOregon, members may change their PCP no more than twice in a six-month period. Exceptions will be made for members who have had a change of residence or who have been discharged from their PCP clinic.

PCP assignments become effective the day they are requested. However, newly assigned PCPs may not know about their assignments until they receive the next monthly member roster.

Members receive a CareOregon ID card (**section B 2.4**) when they enroll with CareOregon and any time they change their PCP.

### **B 3.3 Member Rosters**

PCP clinics can access and download their current clinic roster of members assigned to their clinic on the Provider Portal at:

**<http://www.careoregon.org/providers/ProviderPortalLogin.aspx>**

PCP assignments are effective the day they are requested. Call CareOregon Customer Service to verify PCP assignment or check the member's assignment using the Provider Portal.

### **B 3.4 Member ID Cards and Coverage Letter**

The Oregon Division of Medical Assistance Programs (DMAP) sends one Medical ID card when a member is first assigned to a PCP and when they change their PCP.

The ID Card has name, client number, type of plan member is eligible for, pharmacy plan information and the date the card was issued.

All eligible members in a household receive their own Medical ID cards.

#### **IMPORTANT:**

Member ID cards are intended primarily for the members' use. Do not rely on a member's ID card to accurately verify a member's assigned PCP, because members could show an outdated member ID card.

#### **DMAP Coverage Letter**

DMAP sends one coverage letter to a household. The letter shows information on all household members who have a DHS Medical ID card. DMAP sends a new coverage letter if a member asks for one or if coverage changes for any household member.

To see a sample coverage letter, visit **[www.orsilc.org/DHS/healthplan/notices\\_providers/2009/coverageletter.pdf](http://www.orsilc.org/DHS/healthplan/notices_providers/2009/coverageletter.pdf)**.

### **B 3.5 Verifying PCP Assignment of CareOregon Members**

To verify a member's assigned PCP:

- Check your monthly roster (PCPs only).

OR

- Open the provider portal at <http://www.careoregon.org/Providers/ProviderPortalLogin.aspx>

OR

- Call CareOregon's Customer Service department.

## **B4 DUAL ELIGIBLE MEMBERS**

“Dual eligible” members are eligible for both the Oregon Health Plan and Medicare.

Medicare has three parts:

- **Part A** covers facility care such as inpatient hospitalization, skilled nursing care and hospice care.
- **Part B** covers outpatient care including outpatient surgery and office visits.
- **Part D** covers prescription drugs.

Most Medicare enrollees are eligible for both Part A and Part B; however, some are eligible for only one part.

For more information about Medicare coverage and exclusions, visit the CMS website at <http://cms.hhs.gov>.

Medicare is always the member's *primary* insurance coverage and OHP is their *secondary* coverage. This means that Medicare is responsible for paying first for all of the member's care. If the member is enrolled in our Medicare Advantage (COA) plans, then claims are submitted to CareOregon to process the claim as primary. CareOregon OHP is responsible for coordinating its benefits and processing the claim as secondary.

See section H2 for billing information and section D1 for referral/ authorization information for dual eligible members.

B4  
Dual-eligible  
Members

## **B5 DISCHARGE AND DISENROLLMENT GUIDELINES**

### **B 5.1 Definitions**

- **Discharge:** A member is removed from the care of his or her assigned PCP.
- **Disenrollment:** A member is removed from his or her health plan.
- **Verbal abuse:** Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

### **B 5.2 Requirements**

CareOregon must follow the guidelines established by the Department of Human Services (DHS) regarding disenrolling members from the plan.

Although there are general DHS guidelines for discharging a member from a PCP, CareOregon is responsible for establishing specific discharge policies and procedures.

The CareOregon philosophy is to encourage members and their providers to resolve complaints, problems and concerns at the clinic level. However, before discharging a member or requesting that a member be disenrolled from CareOregon, the PCP must request CareOregon's involvement to help resolve the problem or concern.

If the clinic management decides to discharge the member, send a letter to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number.

Fax a copy of the discharge letter to 503-416-8117, Attn: Enrollment Department. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

B5

Discharge and  
Disenrollment  
Guidelines

**IMPORTANT: PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.**

**B**

B5  
Discharge and  
Disenrollment  
Guidelines

### **B 5.3 Key Points When Considering Discharging a Member**

In general, the key requisites when considering discharging a member include:

- Timely, early communication and collaboration with CareOregon Care Coordination staff to problem solve
- Thorough documentation of events, problems and behaviors
- A plan generated by the PCP to attempt to address the problem or concerns
- CareOregon strongly encourages using contracts and case conferences to address problems and concerns. (Call a CareOregon Care Coordinator for sample contracts and assistance.)
- Consider mental health diagnoses as part of the discharge and disenrollment process.

B5  
Discharge and  
Disenrollment  
Guidelines

### **B 5.4 Just Causes for Discharging a Member**

A member may be discharged from a PCP or disenrolled from CareOregon only with just cause. Just causes identified by DHS include but are not limited to the following:

- Missed appointments (except prenatal care patients)
- Drug-seeking behavior
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or CareOregon staff
- Verbal abuse
- Discharge from PCP by mutual agreement between the member and the provider
- Agreement by the provider and CareOregon that adequate, safe and effective care can no longer be provided
- Fraudulent or illegal acts committed by a member, such as permitting someone else to use his or her medical ID card, altering a prescription, or committing theft or another criminal act on any provider's premises.

*Note: The provider or provider staff must report any illegal acts to law enforcement authorities or to the Adult and Family Services Fraud Investigations Unit as appropriate. Call the Fraud Hotline at 1-888-FRAUD01 (1-888-372-8301).*

### **B 5.5 When a Member *Cannot* Be Discharged**

According to DMAP Administrative Rule 410-141-0080, members cannot be discharged from a PCP or disenrolled from CareOregon solely because of any of the following reasons:

- The member has a physical or mental disability.
- The member has an adverse change in health.
- The PCP or CareOregon believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises his/her option to make decisions regarding his/her medical care and the provider/plan disagrees with the member's decisions.

**B 5.6 Discharging a Member**

Follow these procedures to discharge a member from a PCP or to request disenrollment of a member from CareOregon.

B5  
Discharge and  
Disenrollment  
Guidelines

**PROCESS FOR DISCHARGING A MEMBER**

**Missed Appointments**

**RESPONSIBILITY**

**PCP or PCP Staff**

**ACTION**

1. If a member misses an appointment, consider sending a letter to the member emphasizing the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation.
2. If a member misses two appointments in a row after the initial office visit or three appointments over a six-month period, send a letter informing the patient that she/he must contact the clinic manager or other designated staff person before the member can receive further care.
3. Meet with the member. Ask the member to sign a completed contract outlining that she/he must contact the clinic manager or other designated staff person.
4. Fax a copy of the signed contract to the member's caseworker.
5. If the clinic management decides to discharge the member, send a letter to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's

name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.

**IMPORTANT:** PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

**B**

B5  
Discharge and  
Disenrollment  
Guidelines

**CareOregon Care  
Coordinator**

6. Send relevant documentation to CareOregon Provider Services, including chart notes, copies of letter(s) sent to the member, signed contracts, and/or documentation of case conferences.

Fax a copy of the discharge letter to 503-416-8117, Attn: Enrollment Department.

7. Work with CareOregon Customer Service to assign the member to a new PCP.

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**PROCESS FOR DISCHARGING A MEMBER**

**Drug-seeking Behavior  
RESPONSIBILITY**

**PCP or PCP Staff**

**ACTION**

1. Meet with the member to develop a plan to address possible drug-seeking behavior and document meeting. Consider chemical dependency treatment.

**CareOregon  
Care  
Coordinator**

2. At the PCP's request, tell the Pharmacy Benefits Manager (**Express Scripts**) to restrict the member to one designated pharmacy and/or prescriber

**PCP or PCP  
Staff**

3. Document any contract violation in member's medical record.  
  
If the provider cannot manage the member's care, try to find another provider within the primary care clinic to manage the member's care.  
If another provider is not available within that clinic and clinic management decides to discharge the member:

Send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.

**AND**

Fax a copy of the discharge letter to CareOregon, Attn: Enrollment Department, 503-416-8117.

**IMPORTANT:** PCPs must provide

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**CareOregon  
Care  
Coordinator**

urgent care for the discharged member for 30 days following notification of the member.

Work with CareOregon Customer Service to assign the member to a new PCP.

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**Member commits or threatens acts of physical violence and/or commits fraudulent or illegal activities**

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**RESPONSIBILITY**

**ACTION**

**PCP or PCP staff**

1. Immediately contact the police to file an official report.
2. Contact CareOregon Care Coordinator to describe the incident.
3. Fax chart notes and police report when available to Care Coordinator.

A member may be discharged in the following situations:

- Member commits act of violence to staff, property or other patients.
- Member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation. This includes but is not limited to acts of theft, vandalism and/or forgery.

**CareOregon Care Coordinator**

At Care Coordinator's discretion, contact DMAP Coordinator by phone to request disenrollment of member.

1. Fax written documentation to DMAP.
2. Inform PCP of DMAP decision regarding disenrollment.
  - If DMAP or Care Coordinator decides that disenrollment is not necessary, work with PCP to plan the discharge process and work with CareOregon Customer Services to assign the member to a new PCP.

**PCP or PCP staff**

- If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.

Notify the CareOregon Care Coordinator.

**IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

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## PROCESS FOR DISCHARGING A MEMBER

### Verbal Abuse – Verbal Abuse Justifying Discharge

**Verbal abuse** is abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

#### RESPONSIBILITY

**PCP or PCP staff**

#### ACTION

1. Document incident(s).
2. At discretion of Clinic Manager, contact police to file an official report.
3. Contact CareOregon Care Coordinator to describe incident.
4. Fax chart notes and police report, if one was filed, to CareOregon Care Coordinator.
5. If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.
6. Notify the CareOregon Care Coordinator.

**IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

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**CareOregon Care Coordinator**

1. At Care Coordinator's discretion, contact DMAP Coordinator by phone to request disenrollment.
2. Fax documentation to DMAP.
3. Inform PCP of DMAP decision regarding disenrollment.
4. If DMAP decides not to disenroll member or if Care Coordinator does not feel disenrollment is necessary, work with PCP to plan for appropriate discharge process.
5. Work with CareOregon Customer Service to assign the member to a new PCP.

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**Verbal Abuse – Vulgar Language**

**RESPONSIBILITY**  
**PCP or PCP staff**

**ACTION**

1. Document incident(s) in member's chart.
2. Schedule a meeting with the member to negotiate a behavioral contract that clarifies expected behavior and consequences for violations.
3. If contract is repeatedly violated, contact the CareOregon Care Coordinator to describe the incident(s).
4. Fax chart notes and any behavioral contracts to CareOregon Care Coordinator.
5. If discharge is mutually agreed upon by PCP and member, work with CareOregon Customer Service to assign the member to a new PCP.
6. If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.
7. Notify the CareOregon Care Coordinator.

**CareOregon  
 Care  
 Coordinator**

**PCP or PCP  
 staff**

**IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days

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after the member is notified of  
the discharge.

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**PROCESS FOR DISCHARGING A MEMBER**

**Discharge from PCP by mutual agreement between the member and the provider**

**RESPONSIBILITY**

**PCP or PCP staff**

**ACTION**

1. Document date and reason for mutual decision.
2. Try to find another provider within the primary care clinic to manage the member's care.
3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.
4. Notify the CareOregon Care Coordinator.  
**IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after

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**CareOregon Care Coordinator**

the member is notified of the discharge.

5. Work with CareOregon Customer Service to assign the member to a new PCP.

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Discharge and  
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**Provider and CareOregon agree that adequate, safe, effective care can no longer be provided for a member**

**RESPONSIBILITY**

**PCP or PCP staff**

**ACTION**

1. Document date and reason for mutual decision.
2. Try to find another provider within the primary care clinic to manage the member's care.
3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be process by CareOregon and the letter will be returned to the clinic.
4. Notify the CareOregon Care Coordinator.  
**IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

**CareOregon Care Coordinator**

5. Work with CareOregon Customer Service to assign the member to a new PCP.

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Discharge and  
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## **B6 MEMBER COMPLAINTS**

B6

Member  
Complaints

### **B 6.1 Guidelines**

CareOregon members have the right to file complaints in accordance with Oregon Administrative Rules (OAR) and Medicare and Medicaid Services (CMS) guidelines. CareOregon encourages members and providers to resolve complaints, problems and concerns directly with those involved. However, we provide formal procedures for addressing complaints and problems when they cannot be resolved otherwise.

Member complaints must be made to CareOregon. If they are not resolved, members have the right to request a hearing by the state's Office of Medical Assistance Programs (DMAP) through its hearing process. Members may call CareOregon Customer Service at 503-416-4100 or toll free at 800-224-4840 to file their complaint. For details, check the CareOregon OHP Plus or Standard Member Handbook or CareOregon Medicare Advantage Plus or Star Evidence of Coverage for details.

### **B 6.2 Resolving Complaints at the Provider's Office**

Members who have complaints about a specific provider, clinic staff or the provider site in general should contact the Clinic Manager for help in addressing the issue.

If a member remains dissatisfied with the provider's response to his/her complaint, the member should contact CareOregon Customer Service.

Providers may contact CareOregon Customer Service Department for help in resolving members' complaints.

### **B 6.3 Resolving Complaints at CareOregon**

CareOregon Customer Service staff logs all complaints in a database.

The CareOregon Quality Improvement department tracks and analyzes all complaints documented by Customer Service staff and follow up with appropriate parties until the issue is resolved.

Customer Service staff facilitates the member complaint process. Other staff in units such as CareSupport, Pharmacy, DME, Authorizations and the Chief Medical Officer is involved in the process when appropriate. See section D4 for information about medical appeals.

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Member  
Complaints

#### **B 6.4 Oregon Health Plan Complaint Forms**

If a CareOregon OHP Plus or Standard member is uncomfortable contacting CareOregon, he/she may submit a complaint to DMAP using an [Oregon Health Plan Complaint Form 3001](#) or contact the Client Services Unit of the Division of Medical Assistance Program at 1-800-273-0557 or TTY: 503-378-6791.

OHP Complaint Forms are available from DMAP Customer Service Department at 1-800-224-4840 and state caseworkers.

#### **B 6.5 Medicare Advantage Complaints**

CareOregon Advantage members may also submit their complaint to Acumentra Health at 503-279-0100

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Member  
Complaints



## C1 SERVICES COVERED BY THE OREGON HEALTH PLAN

C1

Services

### C 1.1 PRIORITIZED LIST OF HEALTH SERVICES

The Oregon Health Plan (OHP) covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits.

The Division of Medical Assistance Programs (DMAP) sends copies of the prioritized list to Medicaid providers. To determine if a service is covered by CareOregon, check the prioritized list at [www.or-medicaid.gov/ProdPortal/default.aspx](http://www.or-medicaid.gov/ProdPortal/default.aspx).

The line on the prioritized list determines whether or not a treatment is covered by the OHP.

- Diagnosis and treatment pairs that fall **above the line** are covered by the OHP and CareOregon.
- Diagnosis and treatment pairs that rank **below the line** are not covered benefits of either the OHP or CareOregon. Services below the line generally include conditions that improve by themselves, conditions for which no effective treatments are available or cosmetic treatments.

If you cannot access this list, call DMAP Provider Services at 1-800-336-6016. If a service is not covered by the OHP and you decide that treatment is essential, send additional information, such as chart notes, to CareOregon's MBA staff with the authorization request.

**Requests for non-covered services are denied automatically if additional information is not included with an authorization request.**



## C 1.2 Services Covered by CareOregon

- Primary care and preventive services
- Specialty services
- Maternity care
- Family planning
- Inpatient hospital and extended care (hospice and skilled nursing facility)
- Prescriptions
- Laboratory and X-ray
- Durable medical equipment and supplies
- Home health
- Physical, occupational and speech therapy
- Ambulance transportation
- Vision services
- Mental health services (COA members only)
- Chemical dependency services

C1  
Services

## C 1.3 Services Covered by DMAP

The following services are covered by DMAP **regardless of whether the member is enrolled with CareOregon.**

- Abortion (voluntary pregnancy termination)
- Maternity case management
- Physician aid in dying (death with dignity services)

Send bills for these services to DMAP. If you send a bill for these services to CareOregon, it will be returned to you.



## C 1.4 Services Not Covered by the Oregon Health Plan

You can provide services not covered under the Oregon Health Plan (OHP) to CareOregon members, but arrangements for reimbursement must be negotiated between you and the member. The member must sign a **Patient Responsibility for Uncovered Services form** before services are performed.

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Services

You may freely communicate with patients about their treatment options regardless of benefit coverage limitations.

CareOregon will not pay for services that are not covered by the OHP.

**IMPORTANT:** DMAP prohibits billing Oregon Health Plan Plus recipients for covered services.

See section H11 for information on billing members.

## C 1.5 Services Covered by Other Managed Care Plans

- **Mental health:** Mental health services are covered by the member's Mental Health Organization (MHO) for OHP members. For COA members, mental health services are coordinated through CareOregon. See section C6 for information about mental health coverage.
- **Dental:** Dental services are covered by the member's Dental Care Organization (DCO). See section C8 for information about dental coverage.



## C2 SKILLED NURSING FACILITY CARE

C2

Skilled Nursing  
Facility Care

### C 2.1 Placing a Member in a Nursing Facility

When a CareOregon member being discharged from the hospital must be placed in a skilled nursing facility, the hospital discharge planner and the CareOregon Concurrent Review RN coordinate placement.

Skilled nursing care requires prior authorization. You will be notified when your member is admitted to a skilled nursing facility.

- OHP members have a 20-day skilled nursing facility benefit.
- Medicare Advantage members have a 100-day skilled nursing facility benefit.

Continued stay is determined based on clinical review and member need.

### C 2.2 Managing Care of Members in a Nursing Facility

Primary care providers (PCPs) can choose whether or not to manage the care of their patients who are placed in a nursing facility.

- PCPs can choose to provide medical management to these patients.

OR

- PCPs can have the nursing facility's house physician provide medical management.

Members remain assigned to their existing PCP during a **temporary stay** in a nursing facility.

The house physician is paid a fee for service for their office visits with these members.

The CareOregon Concurrent Review RN monitors members while they are in the facility.

Arrangements for discharge to a lower level of care are coordinated by the CareOregon RN and the skilled facilities staff.



### **C3 HOSPICE CARE**

CareOregon covers hospice care when the member has a terminal illness and a life expectancy of six months or less. The goal of hospice care is comfort care only, to make the dying process as comfortable and tolerable as possible.

Hospice care requires authorization. Call CareOregon's Medical Benefits Assurance Unit to obtain an authorization.

Our Medical Benefits Assurance staff provide information about hospice care options within the CareOregon network.

C3  
Hospice Care



## C4 PHARMACY PROGRAM

### C 4.1 CareOregon Formularies

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Pharmacy Program

The **CareOregon Medicaid** Formulary is a list of covered drugs selected by the CareOregon Pharmacy and Therapeutics (P&T) Committee to treat medical conditions that are covered by the Oregon Health Plan. See Prioritized List of Health Services (section C1.1). The CareOregon Medicaid Formulary does not contain Mental Health drugs which are covered directly by the Division of Medical Assistance Programs (DMAP).

The **CareOregon Advantage Medicare** formulary is a list of covered drugs selected by the CareOregon Pharmacy and Therapeutics (P&T) Committee and approved by Centers for Medicare and Medicaid Services (CMS).

### C4.2 General Formulary Information

Formulary decisions are based on critical review of the available scientific evidence for efficacy, safety, outcomes, cost-effectiveness, value, the OHP Prioritized List of Health Services (for Medicaid) and CMS Medicare Part D regulations (for Medicare).

In general, the following are **not** covered:

- Brand Name Drugs if FDA approved and equivalent generic drugs are available, except select “narrow therapeutic index” drugs
- Drugs not listed in the formulary
- Drugs removed from the formulary by the P&T committee throughout the year and posted to [www.careoregon.org/provider/pharmacy.html](http://www.careoregon.org/provider/pharmacy.html) in updates
- Drugs used for non-medically accepted indications
- Drugs when used to treat conditions that are not covered by the OHP, e.g. Fibromyalgia, allergic rhinitis and chronic back pain (Medicaid only)
- Drugs used to promote fertility or to treat sexual dysfunction
- Drugs used for cosmetic purposes or hair growth



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Pharmacy Program

- Drugs used for the symptomatic relief of cough and colds
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride, and fluoride preparations
- Other drugs specifically excluded from coverage under Medicaid and/or Medicare, such as drugs not approved by the FDA and DESI drugs.

The formularies apply only to drugs provided by a pharmacy and do not apply to drugs used in inpatient settings or furnished by a provider. For more information on coverage of drugs furnished by a provider and administered in a clinic or facility, see section C 4.5.

The drugs listed in the CareOregon Medicaid Formulary do not have copays. The drugs listed in CareOregon Advantage Formulary might have copays which may change from year to year. For more information, see the CareOregon Medicare Advantage Plus or Star Evidence of Coverage.

Drugs that require prior authorization, step therapy, or age restriction or have quantity limits are designated as PA, ST, AR, and Qty Limit, respectively.

- Drugs labeled **PA or PA required** require prior authorization before a member can fill the prescription at a network pharmacy.
- Drugs labeled **ST or Step Therapy** are limited to coverage only when certain conditions have been met – for example, the member has an approved claim for a formulary alternative in their prescription profile. The member or provider must submit a Formulary Exception form if ST criteria are not met and the member does not have claims history of the prerequisite drug.
- Drugs labeled AR or age restriction require member to be younger than or older than a specific age. For example, a drug may be restricted to people under age 6 or over age 16. The member or provider must submit a Formulary Exception form if member does not meet age criteria.



- Drugs labeled **QTY** or **QTY Limit** are restricted to specific quantities. If a provider or member wants to exceed the limit, a Formulary Exception form must be submitted.

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Pharmacy Program

The formularies and formulary updates are on the CareOregon web site at:

**[www.careoregon.org/provider/pharmacy.html](http://www.careoregon.org/provider/pharmacy.html)**.

Please note, formulary updates are posted by the fifteenth of each month.

- 2011 CareOregon/Oregon Health Plan Formulary
- 2011 CareOregon Advantage Formulary

If you would like to receive a paper copy or additional copies of the formulary book or formulary updates or have questions or concerns about the pharmacy benefit or a formulary or have suggestions for formulary changes, call CareOregon Customer Service at 503-416-4100 or toll free at 800-224-4840, Monday -Friday 8 a.m. – 5 p.m. (CareOregon) or 8 a.m. – 8 p.m. (CareOregon Advantage).



### **C 4.3 Prior Authorizations and the Formulary Exception Process**

Prior authorization (PA) is required for the following:

- Drugs listed in the formulary or formulary updates as “PA”
- Drugs listed in the formulary or formulary updates as “ST” if the member does not have claims history of the prerequisite drug(s)
- Non-formulary drugs
- Drugs listed in the formulary or formulary updates with “AGE” restrictions prescribed to members who do not meet age criteria
- Drugs listed in the formulary or formulary updates with quantity limits (“QL”) that are prescribed in quantities greater than allowed
- Selected drugs administered incident-to-a physician’s service in a clinic or facility. For more information, refer to section C4.5

To obtain prior authorization or request a formulary exception, fax a completed Prior Authorization and Formulary Exception form available at [www.careoregon.org/provider/pharmacy.html](http://www.careoregon.org/provider/pharmacy.html). to 503-416-8109.

Providers will receive a faxed response which may include an approval, denial or a request for additional information in support of medical necessity within 24 to 72 hours.

If you have questions, call CareOregon at 503 416-4100 or toll free at 1-800-224-4840, Monday-Friday 8 am-5pm.

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Pharmacy Program



#### **C 4.4 Emergency and Transition Supply Policies**

CareOregon and CareOregon Advantage may provide a temporary five-day- or 60-90 day supply of non-formulary drugs with utilization restrictions in certain situations. The policies are intended to minimize disruption in care and allow members to receive during the prior authorization/formulary exception submission and review process.

##### **Emergency Supply**

CareOregon may cover a five-day emergency supply if a provider indicates a member has an acute or urgent need for a non-formulary or restricted formulary drug.

##### **Transition Supply**

CareOregon may cover a temporary 60- to 90-day supply of a non-formulary or restricted formulary drug used to treat chronic medical conditions for new members or members who transition from one level of care to another such as following a hospital or long-term-care (LTC) facility discharge.

##### **How to Request an Emergency or Transition Supply**

To request an emergency or transition supply during CareOregon business hours, Monday-Friday 8 a.m. to 5 p.m. call CareOregon at 503-416-4100 or 1-800-416-4840.

For assistance when CareOregon is closed, call Express Scripts at 1-877-526-2313.

C4

Pharmacy Program



### **C 4.5 Office-Administered Injectables Requiring Prior Authorization**

Some drugs require prior authorization when furnished by and administered incident-to- a physician's service in a clinic or facility. For more information refer to the policies "COA Medical Benefit Injectables Requiring Prior Authorization" and "OHP Medical Benefit Injectables Requiring Prior Authorization" at [www.careoregon.org/provider/pharmacy.html](http://www.careoregon.org/provider/pharmacy.html).

To request prior authorization for a "Medical Benefit Injectable":

1. Complete the appropriate Injectables Billed to the Medical Benefit Form available at [www.careoregon.org/provider/pharmacy.html](http://www.careoregon.org/provider/pharmacy.html).
2. Attach medical record information supporting medical necessity, including diagnosis, co-morbidities and treatment history to the form.
3. Fax the documents to CareOregon at 503 416 8109.

### **C 4.6 Contracted Pharmacies**

Search for CareOregon contracted participating pharmacies by city or county in the Provider Type field at [www.careoregon.org/member/psearch.html](http://www.careoregon.org/member/psearch.html).

Search for CareOregon Advantage contracted pharmacies in the COA Pharmacy Directory at [www.careoregon.org/medicare/answers.html](http://www.careoregon.org/medicare/answers.html).

Contracted pharmacies are also listed in the provider directory that members receive when they enroll.

Pharmacy providers who have questions related to pharmacy claims processing should call Express Scripts Customer Service at 1-800-824-0898.

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Pharmacy Program



### **C 4.7 Drug Denials and Appeals**

CareOregon's pharmacist and Medical Director are available to discuss drug denial decisions.

The benefit provisions, guidelines or criteria on which the denial decision was based are available upon request. Please call CareOregon Customer Service at 503-416-4100 or toll free 1-800-224-4840, Monday-Friday 8 a.m.-5p.m.

To appeal an adverse coverage determination or formulary exception decision, call CareOregon at 503-416-4100 or 1-800-224-4840.

CareOregon will request medical records for a thorough review of the appeal.

### **C4.8 Retro Authorizations**

CareOregon does not routinely authorize retroactive requests. For more information refer to D3.5.

C4

Pharmacy Program



## C5 MENTAL HEALTH SERVICES

All OHP and COA members have access to preventive and educational mental health services.

C5

Mental Health  
Services

### C 5.1 Mental Health Coverage for OHP Members

Treatment provided by a mental health provider, such as psychotherapy by a professional therapist or medication management by a psychiatrist, is covered under the OHP by the member's Mental Health Organization (MHO).

MHOs are paid by the state to coordinate the provision of these services. MHOs are separate from CareOregon.

OHP recipients do not choose their MHO. They are assigned to an MHO based on the MCO they select and the county where they live. The MHO is listed on the member's DMAP medical card. OHP members should contact their MHO to access mental health services.

### C 5.2 Mental Health Services for COA Members

For COA members, mental health services is covered and coordinated by CareOregon.

Mental health benefits for COA members include:

- Part A coverage – inpatient care (note: inpatient care at a psychiatric specialty hospital is limited to a lifetime benefit of 190 days).
- Part B coverage – outpatient care, including laboratory and radiology.
- Part D coverage – prescription care

Prior authorization is not required for outpatient services for Medicare covered services. Notification is required for inpatient hospitalization by census or facesheet. Fax notifications to 503-416-4720.

Members can self refer to any CareOregon contracted mental health provider for outpatient mental health services. These providers are listed in the "Mental Health" section of the CareOregon Provider Directory.

The Provider Directory is also on the CareOregon website, [www.careoregon/member/psearch.html](http://www.careoregon/member/psearch.html):

1. Select CareOregon plan type as **CareOregon**



**Advantage Plus or Star**

2. Looking for, select **Mental Health Provider**
3. You can limit search by **city and county or zip code.**

COA members can also contact CareOregon's Customer Service Department for assistance on how to access mental health services.

C5  
Mental Health  
Services



### **C 5.3 County MHOs in CareOregon's service area**

- Clackamas County Mental Health
- Clatsop County: Greater Oregon Behavioral Health, Inc (GOBHI)
- Columbia County: Greater Oregon Behavioral Health, Inc (GOBHI)
- Coos County: Jefferson Behavioral Health (JBH)
- Douglas County: Jefferson Behavioral Health (JBH)
- Jackson County: Jefferson Behavioral Health (JBH)
- Klamath County Mental Health
- Marion County: Mid-Valley Behavioral Care Network (BCN)
- Multnomah County Mental Health
- Polk County: Mid-Valley Behavioral Care Network (BCN)
- Umatilla County: Greater Oregon Behavioral Health, Inc (GOBHI)
- Washington County Department of Health and Human Services
- Yamhill County: Mid-Valley Behavioral Care Network (BCN)

C5  
Mental Health  
Services

### **C 5.4 Mental Health in the Primary Care Setting**

Primary care providers can treat members for all mental health diagnoses.

Mental health services, such as medication management or therapy, provided by a member's primary care provider is covered by CareOregon, not the MHO.

Treatment provided by a mental health provider, such as psychotherapy by a professional therapist or medication management by a psychiatrist, is covered under the OHP by the member's Mental Health Organization (MHO) based on the MCO they select and the county in which they live. The MHO is listed on the member's DMAP medical ID card. For COA members, mental health services are coordinated through CareOregon.

OHP members should contact their MHO to access mental health services. COA members should contact CareOregon's Customer Service Department for assistance on how to access mental health services.

## C6 CHEMICAL DEPENDENCY TREATMENT

### C 6.1 Definition

Oregon Health Plan chemical dependency services include diagnosis and treatment of alcohol and drug addiction. The chemical dependency benefit is covered by CareOregon, not by the MHO.

Oregon Health Plan covers chemical dependency services provided through local alcohol and drug treatment providers.

### C 6.2 Accessing Chemical Dependency Services

**IMPORTANT:** Chemical dependency (CD) services do not require a referral from the PCP.

CareOregon members receive a CareOregon Member Handbook when they enroll. This handbook describes their chemical dependency benefits and how to access care.

Members can self refer to any CareOregon contracted chemical dependency provider for a chemical dependency assessment. These providers are listed in the “Drug and Alcohol Dependency” section of the CareOregon Provider Directory that members receive when they enroll and twice each year after enrollment.

The Provider Directory is also on the CareOregon web site, [www.careoregon.org/member/psearch.html](http://www.careoregon.org/member/psearch.html):

1. Click **Oregon Health Plan**.
2. Click on the arrow below **search by specialty**.
3. On the drop-down menu, click **Drug and Alcohol Dependency Providers**.

Any provider who recognizes a chemical dependency problem in a CareOregon member may contact a CareOregon chemical dependency provider to coordinate an assessment.

At the initial assessment, the CD provider does a screening evaluation to determine the appropriate level of service (outpatient treatment, methadone maintenance or inpatient detox).

C6

Chemical  
Dependency  
Treatment

## Access Standards

As DMAP subcontractors, CareOregon chemical dependency providers must comply with access to care standards, in accordance with our DMAP contract. You can see a model DMAP managed care contract at [www.oregon.gov/DHS/healthplan/data\\_pubs/contracts/fchp/fchp\\_contract\\_06.pdf](http://www.oregon.gov/DHS/healthplan/data_pubs/contracts/fchp/fchp_contract_06.pdf).

- Members must be seen for **emergency** care within six hours after their request for care.
- Members, including pregnant women, must be seen for **urgent** care within 48 hours after their request for care.
- Members must be seen for **routine** care within 10 days after their request for care.

C6

Chemical  
Dependency  
Treatment

### C 6.3 Primary CD Providers and claims

Contracted providers may assess and treat any CareOregon member who meets state intake and placement criteria for appropriate level of care or higher.

The chemical dependency provider is responsible for the following actions:

- ensure the member's eligibility with CareOregon
- be sure the member is not in treatment elsewhere

A member's first CD claim received by CareOregon each month determines the member's primary CD provider for that month.

CareOregon may deny claims submitted by other CD providers for treating the member during that month.

**IMPORTANT:** If a member transfers to a different CD program mid-month, the original provider is responsible for notifying CareOregon of the change before the second provider submits a claim.

If there is clinical justification for a member to receive simultaneous treatment from two CD providers and those providers are coordinating treatment services for the member, both providers are responsible for notifying CareOregon of the arrangement before the second

provider submits a claim for the member's care.



C6  
Chemical  
Dependency  
Treatment

C

### C 6.4 Authorization of Services

CareOregon authorizes detox in a hospital setting if medical co-morbidities justify that level of care, or if sub-acute detox is not available in that service area.

To request authorization for hospital detox, follow the authorization procedure in **section D3.3**.

C6

Chemical  
Dependency  
Treatment

### C 6.5 Other Chemical Dependency Services

Other chemical dependency services (such as residential treatment and community-based support groups) may be available to members through public or private providers. However, these services are *not* included in the Oregon Health Plan benefit package and are not covered by CareOregon.

Members whose assessment has determined a need for non-covered services can get more information or access the services through the provider who performs the assessment. Even if the recommended treatment is not covered by CareOregon, the assessment is covered if performed by a contracted provider.

### C 6.6 Quality Review

Periodic chart audits and internal outcome measures obtained from administrative data are used to track quality of care provided by contracted CD providers. CareOregon also tracks providers' utilization and claims data.



## C7 DENTAL SERVICES

OHP recipients select a Dental Care Organization (DCO) in the same way they select their MCO. The member's selected DCO is listed on his/her DMAP medical card, along with the MCO and Mental Health Organization (MHO).

Send all dental care claims to the DCO listed on the member's DMAP medical card.

**NOTE:** Oregon Health Plan **Standard** patients are covered for a limited emergency dental benefit.

C7  
Dental Services



## C8 ROUTINE VISION SERVICES

CareOregon has contracted with Vision Services Plan (VSP) to provide routine vision services, such as refraction and dispensing of glasses, to our members.

**IMPORTANT:** Effective January 1, 2010, coverage is now only available for individuals less than 21 years old and pregnant adults who have coverage on OHP Plus. All other OHP patients are not covered unless they have a qualifying medical eye condition.

### Accessing Care from Contracted Vision Providers

CareOregon members receive a CareOregon Member Handbook when they enroll. This handbook describes their vision benefits and how to access care.

Routine vision services *do not* require a referral from the PCP. Members may schedule an appointment with any CareOregon contracted vision provider.

Contracted vision providers are listed in the provider directory that members receive when they enroll. A list of participating vision providers can also be found in the Directory of CareOregon Network Providers.

**IMPORTANT:** Do not refer members to these routine vision providers for medical eye care needs. Medical eye services are considered specialty visits. Members should be referred to a participating ophthalmologist or optometrist. To determine if services require an authorization, see Section D3.3 for Authorization Requirements.

C8  
Routine Vision  
Services

## C9 TOBACCO CESSATION



Tobacco cessation services are covered by CareOregon for OHP members only. Covered services include counseling, treatment, nicotine patches and prescriptions commonly used for tobacco cessation. Providers are encouraged to follow the 5A's model for treating tobacco use and dependence. No referral is required to provide tobacco cessation treatment and counseling to CareOregon OHP members.

C9  
Tobacco  
Cessation

### **Tobacco Cessation Treatment and Counseling Resources**

For CareOregon patients willing to make a quit attempt, Provider may refer patients for counseling or additional behavioral treatment to the Quit for Life Program through Alere Wellbeing (1-866-784-8454) or your clinic's internal cessation program. **You can bill a maximum of two times per member per 12-month period.**

You may provide a tobacco cessation counseling session or class to a CareOregon patient. **You can bill a maximum of ten times per member per 12-month period.**

**Billing:** See section H12 for information on billing for these tobacco cessation services.

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians, 2008 Update.  
<http://www.ahrq.gov/cinic/tobacco/tobaqrg.pdf>

**How to Quit:** Tobacco Information and Prevention  
[www.cdc.gov/tobacco/how2quit.htm](http://www.cdc.gov/tobacco/how2quit.htm)

**National Quit Line** 1-800-QUIT NOW  
National Cancer Institute's Smoking Quit Line  
(English or Español)

For free personalized help with quitting, call 1-877-44U-QUIT (1-877-448-7848) toll-free 9 a.m. to 4:30 p.m. Monday through Friday.

American Lung Association of Oregon

**[www.lungoregon.org/quit/index.htm](http://www.lungoregon.org/quit/index.htm)**  
E-mail **[healthinfo@lungoregon.org](mailto:healthinfo@lungoregon.org)** or call  
503-924-4094, ext. 10.



C9  
Tobacco  
Cessation



**For pregnant smokers**

Smoke-Free Families is a national program working to help pregnant smokers quit, and publicize effective treatments.

**[www.smokefreefamilies.tobacco-cessation.org](http://www.smokefreefamilies.tobacco-cessation.org)**

Smoking and Pregnancy, American Lung Association

**[www.lungusa.org/stop-smoking/about-smoking/facts-figures/women-and-tobacco-use.html](http://www.lungusa.org/stop-smoking/about-smoking/facts-figures/women-and-tobacco-use.html)**

Call 1-800-LUNG-USA (1-800-586-4872).

**Español**

**[www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=33214](http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=33214)**

C9

Tobacco  
Cessation

**D REFERRALS AND AUTHORIZATIONS**

CareOregon's Medical Benefits Assurance Unit sets authorization requirements for the following services:

- Ancillary tests and treatment
- Durable medical equipment and supplies
- Facility admits and lengths of stay
- Home health services including infusions and enteral/parenteral services
- Hospice
- Office visits and procedures
- Orthotic and prosthetics

**D1 DUAL-ELIGIBLE MEMBERS (Medicare and Medicaid)**

See section B4 for more information about dual eligibility.

Providers must know the type of Medicare coverage a member has and if the service provided is covered.

CareOregon does NOT process prior authorization requests for services covered by fee-for-service Medicare for members who have primary health insurance coverage through Medicare (Part A and/or Part B). That includes office visits, facility stays, DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) and any other Medicare-covered service.

See section J in this manual for information about CareOregon Advantage (Medicare) members.

D

Referrals and  
Authorizations

## D2 REFERRALS

D2

Referrals

### D 2.1 Definition

A **referral** is defined as the act of one professional recommending that another professional evaluate or provide treatment to their patient, our member. For example, a primary care provider refers their patient to a cardiologist or the cardiologist, after seeing the patient, refers the patient back to his/her primary care provider.

### D 2.2 Refer to Contracted Providers/Facilities

To obtain the most current information on contracted clinicians and facilities, contact CareOregon Customer Service at 503-416-4100 or 1-800-224-4840.

Authorizations may be required for non-contracted providers. See **authorization guidelines** on the CareOregon web site for details.

Specialists must check a patient's eligibility **before** the appointment. To verify eligibility, visit the Provider Portal page on our web site, **<http://www.careoregon.org/Providers/ProviderPortalLogin.aspx>**

If you cannot access the page, call CareOregon Customer Service.

## **D3 AUTHORIZATIONS**

### **D 3.1 Definition**

An **authorization** is defined as the process of obtaining confirmation that the intended service is a covered benefit and that CareOregon Advantage or CareOregon OHP will pay for the service.

D3

Authorizations

### D 3.2 Criteria for Utilization Management Decisions

D3

Authorizations

The table below describes criteria used for utilization management decisions for CareOregon Advantage (COA) and CareOregon OHP.

UM Activity	Criteria Used
<p><u>Medical/Surgical</u></p> <p>Prior Authorization</p> <p>Concurrent Review</p> <p>Retrospective Review (Retroactive Authorizations)</p>	<p><u>OHP (Medicaid)</u></p> <ul style="list-style-type: none"> <li>• Member eligibility (OHP Plus or Standard)</li> <li>• OHP benefits (Prioritized List and Provider Guides) <a href="http://www.dhs.state.or.us/policy/healthplan/guides/main.html">http://www.dhs.state.or.us/policy/healthplan/guides/main.html</a></li> </ul> <p><u>COA (Medicare)</u></p> <ul style="list-style-type: none"> <li>• CareOregon authorization policies <a href="http://www.careoregon.org/provider/policies.html">http://www.careoregon.org/provider/policies.html</a></li> <li>• InterQual<sup>®</sup> criteria</li> <li>• Medical literature</li> </ul> <p><u>COA (Medicare)</u></p> <ul style="list-style-type: none"> <li>• Member eligibility</li> <li>• National and Local Coverage Determinations – Parts B and A (NCD/LCD) <a href="http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd">http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd</a> <a href="https://www.noridianmedicare.com/p-meddb/">https://www.noridianmedicare.com/p-meddb/</a> <a href="https://www.noridianmedicare.com/p-meda/">https://www.noridianmedicare.com/p-meda/</a></li> <li>• Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals</li> <li>• InterQual<sup>®</sup> criteria</li> <li>• CareOregon authorization policies <a href="http://www.careoregon.org/provider/policies.html">http://www.careoregon.org/provider/policies.html</a></li> </ul>
<p><u>Pharmacy</u></p> <p>Prior Authorization</p> <p>Retrospective Review (Retroactive Authorizations)</p>	<p><u>OHP (Medicaid)</u></p> <ul style="list-style-type: none"> <li>• Member eligibility</li> <li>• OHP benefits (Prioritized List and Provider Guides) <a href="http://www.dhs.state.or.us/policy/healthplan/guides/main.html">http://www.dhs.state.or.us/policy/healthplan/guides/main.html</a></li> <li>• CareOregon Medicaid Guidelines for OHP <a href="http://www.careoregon.org/provider/pharmacy.html">www.careoregon.org/provider/pharmacy.html</a></li> </ul> <p><u>COA (Medicare)</u></p> <ul style="list-style-type: none"> <li>• Member eligibility</li> <li>• National and Local Coverage Determinations – Parts B and A (NCD/LCD) <a href="http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd">http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd</a> <a href="https://www.noridianmedicare.com/p-meddb/">https://www.noridianmedicare.com/p-meddb/</a> <a href="https://www.noridianmedicare.com/p-meda/">https://www.noridianmedicare.com/p-meda/</a></li> <li>• Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals</li> <li>• Medicare Prescription Drug Benefit Manual</li> </ul>

	<p><a href="http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&amp;filterByDID=99&amp;sortByDID=1&amp;sortOrder=ascending&amp;itemID=CMS050485&amp;intNumPerPage=10">http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&amp;filterByDID=99&amp;sortByDID=1&amp;sortOrder=ascending&amp;itemID=CMS050485&amp;intNumPerPage=10</a></p> <ul style="list-style-type: none"><li>• CareOregon Advantage PA Guidelines for COA <a href="http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf">http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf</a></li></ul>	D3
		Authorizations

### **D 3.3 Requirements**

CareOregon Medicare Advantage and CareOregon OHP do not require a referral. Some specialty care may require an authorization. To determine which services require authorization, see the CareOregon website and review the following:

- Authorization Guidelines by Plan (member's primary insurance)
- CPT Code List
- DME Code list

There are "Frequently Asked Questions (FAQs)" documents also on the website which provides additional background information and detail about the authorization requirements.

Authorization forms are also posted on the website. There is a form for:

- Office/Clinic visits and procedures
- Facility procedures and admissions, including Ambulatory Surgery Centers
- DMEPOS, Home Health and Infusion

Failure to obtain an authorization for any service that requires it, including a facility length of stay, will result in claim payment denial.

### D 3.4 Responsibilities

The primary care provider is responsible for obtaining an authorization for specialty or ancillary services that require an authorization WHEN the specialist or ancillary provider has not previously seen the member. Once the specialist or ancillary provider has seen the member and the services requires an authorization, the specialist or ancillary provider is responsible for obtaining the authorization.

- For **elective** ambulatory surgery and facility admissions, the admitting or performing provider is responsible for obtaining the authorization. The facility is responsible for verifying that an authorization was issued.
- For **urgent/emergent** facility admissions, the facility is responsible for notifying CareOregon's Medical Benefits Assurance Unit of the admission and for obtaining an authorization.
- For **inpatient** stays, the facility is responsible for providing CareOregon's concurrent review staff with ongoing clinical review information daily or as requested in order to authorize the length of stay.
- For **obstetrical admissions**, the facility must notify CareOregon of all admissions within one business day of the member's admission.

For deliveries, the facility must notify CareOregon of the date of delivery, type of delivery and discharge date. Hospital stays beyond federal guidelines (two days for vaginal delivery, four days for caesarean section) require authorization.

D3

Authorizations

### **D 3.5 Retroactive Authorization Requests**

CareOregon does not routinely authorize retroactive requests. When requests are submitted, decisions are made on a case-by-case basis taking into consideration the reason why a prospective authorization request was not submitted. Examples of when a retroactive authorization request may be approved are:

- provider can show that it was not possible to identify the member as a CareOregon member before the service was performed
- member was retroactively assigned to CareOregon
- delay or confusion by the member's other primary insurance or third party resource
- service was medically urgent and a delay in obtaining an authorization would have placed the member at significant risk for adverse health outcome

For a service that was provided and an authorization determination was not obtained, the rendering provider is responsible for submitting an authorization request, if they are of the opinion that the situation qualifies. If so, describe why the authorization is being made retroactively and include relevant chart notes.

Regardless of whether a retroactive authorization was issued, claims must be submitted to CareOregon within the timeline required for "timely" claims submittal in order for claim payment to occur. See the "Billing and Payment" section for the timely filing guidelines as they do differ based on the member's insurance coverage (Medicare or OHP).

### D. 3.6 Authorization Determinations

**Prior authorization** requests that are submitted with complete information, including correct coding, with relevant chart notes attached, allow CareOregon's Medical Benefits Assurance Unit staff to make timely authorization determinations. Medicare and the Oregon Health Plan allow up to 14 calendar days to make prior authorization determinations. Additional time is allowed if CareOregon does not receive all the information needed to make a benefit determination. Prior authorization decisions are based on Medicare or Oregon Health Plan benefit rules, guidelines and limits, CareOregon policies and, as appropriate, evidence-based practice guidelines.

**Concurrent review** determinations are made within 24 hours of notification. CareOregon may deny days if requested information is not provided in a timely manner. Review determinations are based on Interqual criteria for both the level of care and length of stay.

In all cases, authorization determinations are based solely on plan benefits, medical appropriateness and the least costly alternative for the service requested. CareOregon does not reward staff for denying prior authorizations or facility admission or length-of-stay authorizations.

Call the CareOregon Customer Service Department to request the criteria we use for utilization management decision making.

D3

Authorizations

**D 3.7 Authorization Time Frames and Number of Visits**

Authorization time frames and number of visits approved differ based on the type of service being authorized and any benefit limits that may exist. The authorization details are typed in the authorization fax back that you receive. A new authorization is required if the authorization has expired or the number of visits have been exhausted.

D3  
Authorizations

**D 3.8 Readmissions to Diagnosis Related Groups (DRG) Hospitals**

The following readmissions within 15 days of discharge are considered part of the initial admission and are included in payment for the initial admission:

- Additional surgery or follow-up care that was planned at the time of discharge
- Treatment for the same condition due to an inadequate discharge plan

## D4 DENIALS AND APPEALS OF AUTHORIZATIONS

D4

Denials and Appeals

### D 4.1 Denials

- **Benefit exclusion** denials (benefit specifically excluded) are made by Medical Benefit Assurance staff.
- **All other** denials, including facility admissions and lengths of stay, are made by a Medical Director.

Decision making, which includes medical/surgical services, pharmacy and chemical dependency, is based only on appropriate care, coverage guidelines and rules. CareOregon does not reward staff for denying authorization requests and we do not use financial incentives to reward underutilization.

CareOregon's physician reviewers are available to discuss denial decisions. Please call Customer Service to schedule a time to speak with a physician reviewer.

**D 4.2 Appeals**

Medicare and Medicaid/OHP providers may appeal on behalf of the member.

Denial letters tell members that they may contact CareOregon to request an appeal. Appeals must be requested within 45 days after the date on the denial letter.

The Medical Director reviews all appeal requests. CareOregon has 16 days to review and make a determination on OHP appeals and 30 days on Medicare appeals.

The decision to uphold the denial or approve the requested service is sent in writing to the member, PCP or requesting provider and specialist (when applicable) within one week after the decision.

Members who want to appeal directly to the Department of Human Services (DHS) and bypass CareOregon's appeal process must follow the instructions in the denial letter and complete the enclosed hearing request form.

**Hearings must be requested within 45 days after the date on the denial letter.**

When an appeal is made to DHS, it is processed by CareOregon; however, the final decision is made by an administrative law judge contracted by DHS to hear appeals.

**D 4.3 DMAP Appeal Process (Hearings)**

DMAP has an appeal process for members who are dissatisfied with CareOregon's response to a complaint or to an appeal of a service denial.

The DMAP appeal timelines and the process for requesting an appeal are outlined in the denial letter.

Members may get more information about this process by contacting CareOregon's Customer Service department or their caseworker.



D4

Denials and Appeals

**E OTHER SERVICES****E1 INTERPRETATION**

CareOregon coordinates interpretation services for members' medical appointments for covered services through our preferred vendor, Passport to Languages (PTL).

To arrange for an interpreter to be present during an appointment, complete the **CareOregon Interpreter Request form**, available on the CareOregon website. Fax it to PTL at **503-297-1703** at least two business days before the appointment.

You can also access PTL's online system to request and confirm an interpreter at the following website:

**[www.passporttolanguages.com](http://www.passporttolanguages.com)**

PTL's Customer Service staff sends a fax or email to the provider's office to confirm that interpreter arrangements are complete.

For urgent needs (fewer than 48 hours notice), call PTL's Customer Service department at 503-297-2707 to arrange for an interpreter.

**IMPORTANT:** Providers may choose to coordinate interpretation services themselves instead of through CareOregon; however, the provider will be responsible for paying for interpretation services. **CareOregon only pays for interpretation services that are coordinated through our preferred vendor, Passport to Languages.**

**E**

E1

Interpretation

**E**

## **E2 EXCEPTIONAL NEEDS CARE COORDINATION (ENCC)**

CareOregon is required by DMAP to provide exceptional needs care coordination (ENCC) to older, blind and/or disabled CareOregon members. CareOregon also provides ENCC services to any CareOregon member who has special needs or who is at risk for adverse outcomes.

The first level of intervention occurs with the CareOregon Customer Service Representative (MSR). Complex member needs are addressed by the CareSupport Department.

### **E 2.1 ENCC Services**

ENCC services include:

- Assist members and providers to ensure timely access to needed services
- Coordinate with provider to ensure that members' special needs are considered in treatment planning
- Assist providers in coordinating services and planning discharge
- Assist with coordinating community support and social service interactions with medical care systems

E2

Exceptional Needs  
Care Coordination

## **E 2.2 ENCC Referrals**

Potential candidates for CareOregon ENCC service referral include:

- Members who have difficulties with self-management skills
- Members who have difficulty accessing providers
- Members who have difficulty receiving medical services
- Members with issues requiring community support
- Members who need help with discharge planning or care coordination
- Providers who need help dealing with members who show inappropriate, disruptive or threatening behaviors

### **Who can make a referral for ENCC services?**

- Member
- Member's authorized representative
- Provider
- Oregon State agency staff

### **How to make a referral:**

1. Call 503-416-4100 or 1-800-224-4840, daily 8 a.m. - 8 p.m. TTY/TDD users call 1-800-735-2900.
2. Explain the reason for your call.
3. The Customer Service Representative either addresses the service need or forwards the call to a Health Care Guide in the CareSupport Department.

E2

Exceptional Needs  
Care Coordination

**E****E3 TRANSPORTATION FOR OHP PLUS MEMBERS**

Transportation to medical appointments is a benefit to OHP Plus members and is paid directly by DMAP. In counties that do not have a medical transportation carrier, contact the member's caseworker or local DHS office. Members may contact their caseworker or local Adult and Family Services (AFS) branch to get information about transportation options in their area.

**Multnomah, Clackamas and Washington counties**

TriMet Medical Transportation Program

Ride scheduling: 541-802-8700

TTY: 503-802-8717

Fax: 503-802-8748

TriMet's Medical Transportation Program (MTP) provides free rides to covered medical appointments for Oregon Health Plan Plus members who have no other transportation options.

- CareOregon members may call Tri-Met Medical Transportation, 800-889-8726, to obtain bus tickets.
- For members who require a cab, the provider's office may call for the member.

E3

Transportation for  
OHP Plus Members

**E****TriMet LIFT Program**

Phone: 503-802-8200  
TTY: 503-802-8058  
Fax: 503-802-8229  
Hours: 8 a.m.-5 p.m. weekdays

To be eligible for the LIFT Program, riders must have a disability or disabling health condition **and** their disability or health condition must prevent them from independently using TriMet bus and/or MAX service some or all of the time (without assistance, other than from the bus driver).

Lift transportation may be provided by bus, taxi, accessible van, secure transport or stretcher car.

- The LIFT service area boundary is three-fourths of a mile beyond the outermost portions of TriMet's Bus and MAX lines.
- LIFT does not serve locations outside the TriMet District.
- LIFT service operates during the same hours as bus and MAX services, generally 4:30 a.m. – 2:30 a.m., seven days a week.
- Rides may be scheduled between 7 a.m. and 8 p.m. every day except Sunday.
- LIFT does not provide emergency transportation, but same-day rides may be scheduled with verification from an attending physician or medical facility.

**IMPORTANT:** All rides must be reserved in advance no later than 5 p.m. the day before the trip. The *LIFT Rider's Guide* has information on the LIFT reservation process.

E3

Transportation for  
OHP Plus Members

**E**

**Benton County**

Cascades West Ride Line  
541-924-8738 or 1-866-724-2975  
24 hours a day, seven days a week

**Columbia, Clatsop and Tillamook counties**

Northwest Ride Center  
Toll-free: 1-866-811-1001; local: 503-861-0657

Northwest Ride Center reimburses members directly for covered medical transportation costs that have been prior approved. To receive reimbursement before a trip, call Northwest Ride Center to arrange reimbursement for mileage, meals, or lodging related to medical transportation

**Coos, Curry, Douglas, Jackson and Josephine counties**

TransLink  
Toll-free: 1 (888) 518-8162; local: 541- 842-2071

**Crook, Jefferson and Deschutes counties**

Cascades East Ride Center  
541- 385-8680, Toll free: 1-866-385-8680  
TTY relay service: 1-800-735-2900,  
Fax: 541- 548-9548

**Gilliam, Hood River, Sherman, Wasco and Wheeler counties**

Mid-Columbia Medical Transportation  
Toll-free: 1-877-875-4657; local: 541- 298-5345

**Jefferson County**

Cascades East Ride Center  
541-385-8680, toll-free 1-877-389-1122,  
Monday through Friday, 8 a.m. to 4 p.m.

**Klamath and Lake counties**

TransLink  
541-842-2060, toll-free 1-888-518-8160  
24 hours a day, seven days a week  
Office hours: 7:00 a.m. to 7:00 p.m. Monday through Friday, except holidays

E3

Transportation for  
OHP Plus Members



**Lane County  
RideSource**

Call 24 hours a day, seven days a week.  
Local 541-682-5566 (Eugene-Springfield calling area)  
Toll-free 1-877-800-9899

**Lane County outside Eugene-Springfield  
calling area**

TTY/TDD 1-800-735-2900  
Office hours 8 a.m. to 5 p.m.,  
Monday through Friday, except holidays

**Marion, Polk and Yamhill counties**

541-315-5544

**Morrow and Umatilla counties**

541-298-5345 or 1-877-875-4657  
Office hours are 8:00 a.m. to 5:00 p.m.,  
Monday through Friday, except for holidays.

For more information:  
Contact Debbie Wert, Transportation Advisor  
500 Summer St. NE, E-23  
Salem, OR 97301-1098  
541-945-5752 (voice)  
541-378-2897 (fax)  
debbie.wert@state.or.us

**Cowlitz County, WA**

Voice: 360- 694-9997  
Toll-free Voice and TDD: 1-800-752-9422  
FAX: 360-694-1446

**Walla Walla County, WA**

Voice: 509-248-6793  
Toll-free voice: 1-800-233-1624  
TDD: 509-453-1302  
Toll-free TDD: 1-800-606-1302  
FAX: 509-574-5085

E3

Transportation for  
OHP Plus Members

## E4 HEALTH PROMOTION MATERIALS

The goal of the CareOregon Health Promotion and Education program is to provide information to our members on specific health care procedures, instruction in self-management of health care, health promotion, and disease and accident prevention.

CareOregon offers health promotion and educational opportunities to our members directly and through community partnerships.

CareOregon provides written health information to our members in English, Russian, Spanish and Vietnamese. Providers can order these materials in some or all of the four languages.

- **Healthwise Handbook.** This self-care guide provides answers to hundreds of everyday health questions, including when to call a doctor, home treatment and prevention. English and Spanish handbooks are available.
- **Diabetes Diaries.** English, Spanish, Russian and Vietnamese.
- **CareMoms Pregnancy materials.** Newly enrolled pregnant women are mailed an information packet designed to supplement the information received from their OB Primary Care Provider. Available in English and Spanish. Some of the topics addressed in the packet are:
  - Proper use of seat belts
  - Domestic violence
  - Dental Health
  - Reading for healthy development
- **Well-child flyers** are for parents of babies from prenatal through 13 months. Available in English and Spanish.
- **Tobacco cessation materials.** Available in English and Spanish.
  - Good Information for Smokers: Quit Smoking
  - Quitting helps you heal faster: hospital visit
  - You Can Quit Smoking Consumer

E4

Health Promotion  
Materials

**Guide**

- You Can Quit Smoking: Personalized Quit Plan
- You Can Quit Smoking: 5 days to quit date
- You Can Quit Smoking: Card

**E**

E4

Health Promotion  
Materials

Contact your Network Relations Associate for information on ordering these health promotion materials.

To reorder materials, contact Communications support at 503-416-1741 or e-mail [materials@careoregon.org](mailto:materials@careoregon.org).

The CareOregon web site has health information and links to health education resources. The information and links encourage patient self-management, and effective communication with medical providers.

- **Living Well With Chronic Conditions.** This evidence-based six-week workshop developed by Stanford University teaches self-management skills to members living with a chronic condition. Classes are held throughout Oregon and southern Washington.

For more information about this program and workshop schedules can be obtained using the following link, "State of Oregon Living Well with Chronic Conditions"

**<http://www.oregon.gov/DHS/ph/livingwell/>**

- Our quarterly **member newsletter, CareLink.**

**E5 NETWORK RELATIONS ASSOCIATES**

CareOregon Network Relations Associates (NRAs) are assigned to one of three teams in the Provider Services Department; PCP, Specialty and Hospital. The teams are designed to meet the service needs of our contracted clinics, facilities and vendors in Oregon and parts of Southwest Washington.

To find an NRA for your provider type, visit [www.careoregon.org/provider/documents/NRA\\_territories.pdf](http://www.careoregon.org/provider/documents/NRA_territories.pdf) or call our Customer Service department at 503-416-4100. They will forward your call to an NRA.

Network Relations Associates are a link between our clinician network and CareOregon staff. They help clinic staff with questions or concerns about our Medicaid (Oregon Health Plan) and Medicare Advantage plans.

The Network Relations staff maintains contractual agreements to develop a comprehensive network, ensuring member access. If you want to become a contracted clinic, facility or vendor with CareOregon or you are contracted and have questions about your agreement, contact an NRA.

Network Relations Associates provide the following information and trainings on site. Contact us to schedule:

- Orientation to health plan operations, policies and procedures (upon contracting)
- Refresher orientations for new clinic, billing or management staff as needed
- Targeted in-depth training on specific topics
- Training on using our online resources such as Provider Portal (verifies member eligibility, authorizations and claims/payment detail) and the CareOregon website

E5

Network Relations  
Associates

**IMPORTANT:** E-mail or fax your updates to the Network Relations teams about changes such as new and terminated providers or clinic staff, locations, telephone numbers and e-mail addresses. Timely updates facilitate accurate directory listings, mailings, correct claims payment, system access for your staff and (for primary care clinics) appropriate member assignments.

Network Relations teams collaborate with clinicians, DMAP, CMS and other partners to address healthcare-related issues in the communities we all serve. We see our role as a partnership. Do not hesitate to contact us to discuss solutions/ideas or schedule a meeting or training. If you cannot reach an NRA, contact the NRA supervisor for assistance.

**E**

E5

Network Relations  
Associates

## **E6 CLINICAL PRACTICE GUIDELINES**

CareOregon, through its Quality Improvement Committee (QIC), reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses.

Practice guidelines are posted on our website, <http://www.careoregon.org/provider/promotion.html>. Updates are made periodically and are highlighted in our quarterly provider newsletter, CareNews.

Paper copies of these guidelines are available upon request. Please call customer service at 503-416-4100 and ask to speak to someone in our Quality Improvement Department.

**E**

E6  
Clinical Practice  
Guidelines

**F****F PRIMARY CARE AND NON-PRIMARY CARE**

F1

**F1 DEFINITION**

Definition

**Primary care** is defined as comprehensive, continuous, first contact care that focuses on preventive care and care of common conditions. CareOregon's model of managed care is based on a foundation of primary care services.

**Non-Primary care** is defined as services that are not considered primary care services. PCPs can choose to provide non-primary care services to their patients or to refer patients to specialists for provision of these services (see sections F3 for examples of non-primary care services).

**F2 PRIMARY CARE SERVICES**

CareOregon's primary care providers are responsible for providing primary care services to their assigned patients.

General categories of primary care services:

- Preventive services, health maintenance and disease screening such as:
  - Well child care
  - Immunizations
  - Blood pressure screening
  - Physical exams, including annual gynecological exams
- Managing common chronic primary care problems such as:
  - Diabetes
  - Hypertension
  - Chronic lung disease
  - Asthma
  - Arthritis
  - Seizure disorders
  - Peptic ulcer disease
  - Ischemic heart disease
  - Other similar conditions managed in the office
- Managing common acute primary care problems such as:
  - Respiratory infections
  - Urinary infection
  - Gastroenteritis
  - Acute musculoskeletal strains, sprains and contusions
  - Vaginitis
  - Hemorrhoids
  - Depression
  - Anxiety disorders
  - Other similar conditions managed in the office and minor outpatient procedures

F2  
Primary Care  
Services

- Coordinating care including such services as:
  - Referring patients for specialty care needs, communicating with specialists and managing the ongoing referral process
  - Coordinating hospital care and discharge planning, including planning done by a consultant

**F**

F2

Primary Care  
Services

### F3 NON-PRIMARY CARE SERVICES

PCPs are responsible for managing *all* of the medical care needs of their assigned CareOregon members. This means PCPs are responsible for either providing or coordinating services that are not considered primary care services.

PCPs can choose to provide non-primary care services to their patients or to refer patients to specialists for provision of these services (see sections D2 and D3 for information on the referral and authorization process).

The following are examples of services considered non-primary care services:

- Inpatient physician care
- Obstetric care
- Prenatal care
- Non-primary laboratory including all lab tests not waived by the CLIA regulations
- Radiology services including X-ray interpretation
- Consultant care
- Home and nursing home visits including hospice care
- Prescription drugs including medications dispensed from the office
- Outpatient procedures such as:
  - ECG tracing and interpretation
  - Spirometry
  - Fracture care including casting
  - Colposcopy
  - Endometrial Biopsy
  - Sigmoidoscopy
- Family planning including:
  - IUD Insertion
  - Birth Control Pills
  - Vasectomy
  - Emergency Contraception

F3

Non-Primary  
Care Services

**F4 RESPONSIBILITIES OF THE PCP**

Primary care providers will provide at least the following level of service to those CareOregon members assigned to them:

- Maintain in the member's record a comprehensive problem list which lists all medical, surgical and psycho-social problems for each patient.
- Maintain a comprehensive medication list that includes all prescription medications that the member is taking and their medication allergies. This includes medications prescribed by specialists.
- Provide accessible outpatient care within four weeks for any routine visit (e.g. preventive care).
- Provide accessible outpatient care within 24 hours for any member with an urgent problem.
- Provide access to telephone advice for member questions 24 hours per day.
- Provide preventive services as recommended by the US Preventive Services Task Force.
- Provide immunizations as recommended by the Centers for Disease Control.
- Arrange and authorize specialty consultation with a network consultant within four weeks for any member with a non-urgent problem needing such consultation.
- Arrange and authorize specialty consultation with a network consultant within 24 hours for any member with an urgent problem needing such consultation.
- Ensure specific written communication including initial diagnosis and procedures requested as part of each referral.
- Arrange for hospitalization in a network institution when required. Arrangements include identifying the responsible attending physician or providing that service and member's care plan to facility within 24 hours of the initial call.

F4  
Responsibilities  
of the PCP

**F**

- Coordinate hospital care for every hospitalized member including participation in planning for post-discharge care.
- Coordinate nursing home care for each member in a nursing home.
- Provide interpretation services by staff, telephonically by a qualified interpretation service or onsite by a qualified interpretation service.
- Provider shall have a policy and/or procedure to arrange for and provide access to an appropriate back-up physician or practitioner for any leaves of absence.

F4

Responsibilities  
of the PCP

**F5 ACCESS TO CARE: PRIMARY CARE AND NON-PRIMARY CARE**

It is the policy of CareOregon to ensure that our members have access to timely, appropriate preventive and curative health services that are delivered in a patient-friendly and culturally competent manner. CareOregon requires practitioners to have policies and procedures that prohibit discrimination in the delivery of health care services.

**F 5.1 Appointment Availability and Standard Scheduling Procedures**

Routine and follow-up appointments should be scheduled to occur as medically appropriate within four weeks.

Urgent care cases should be scheduled to be seen within 48 hours or as indicated in initial screening.

Appointments for initial history and physical assessment should be scheduled in longer appointment slots to allow for preventive care and health education as needed.

Members should wait no longer than an average of 20 minutes for scheduled appointments.

Providers should apply the same standards to their CareOregon members (including hours of operation) as they do to their commercially insured or private pay patients. Providers should not keep CareOregon members waiting longer than commercially insured or private pay patients.

F5

Access to Care:  
Primary Care and  
Non-Primary Care

## F 5.2 Non-Scheduled Walk-ins

In accordance with DMAP requirements, CareOregon has established guidelines for walk-ins. Your procedure for triaging walk-ins should include the following actions:

1. When a member walks in without an appointment, office staff record the member's demographic information (name, address, etc.) and presenting problem and send this information to the triage nurse or provider.
2. The triage nurse or provider performs a preliminary assessment of the member's condition.
  - Members with **emergent** conditions are seen immediately and/or referred for transport to the nearest hospital.
  - Members with **urgent** conditions are seen within two hours, depending on the severity of the condition, and/or referred for transport to the nearest hospital.
  - Members who present with a **non-urgent** condition are scheduled for an appointment as medically appropriate.

F5

Access to Care:  
Primary Care and  
Non-Primary Care

### **F 5.3 Follow-up of Missed Appointments**

To ensure optimum health services and outcomes, CareOregon participating providers should document and follow up with members who do not keep their scheduled appointments.

Providers should have a procedure for follow-up of missed appointments that includes the following features:

- Documentation on the same day in the member's medical record of the date, type of appointment and failure to keep the appointment.
- Review of the member's medical record by the triage nurse or provider.
- An assessment of the need for and type of follow up to occur (e.g. telephone contact, attempt to reschedule, failed appointment letter) by the triage nurse or provider.
- If telephone contact is required, the provider or triage nurse should call the client. Otherwise, non-medical support staff can follow up as specified by the provider or triage nurse.

It is important to have written documentation of continually missed appointments if you wish to pursue discharging such members from your care (see section B5 for more information on the discharge and disenrollment process).

CareOregon RN Care Coordination staff are available to help providers having problems with members missing repeated appointments.

F5

Access to Care:  
Primary Care and  
Non-Primary Care

## F 5.4 Twenty-four-hour Telephone Access

CareOregon has a commitment to its members to provide 24-hour telephone access to health care.

CareOregon primary care providers must have a telephone triage system with the following features:

### During Office Hours

A primary care provider (physician, nurse practitioner or physician's assistant) or registered nurse triages member calls to determine appropriate care and assist the member with advice, an appointment or a referral. Calls may be answered by but not screened by support staff. If calls are answered by support staff, the member should be informed of the estimated response time (not to exceed 30 minutes).

The nature of the call and intervention are documented in the member's medical record.

Interpreter services are available for telephone calls (see sections E1 and G3 for more information about interpretation).

### After Hours

The Provider Services team conducts an annual after-hours survey to ensure that the following criteria are met. If you have questions, contact a Network Relations Associate at [www.careoregon.org/provider/documents/NRA\\_territories.pdf](http://www.careoregon.org/provider/documents/NRA_territories.pdf).

After-hours access options for members include:

- **Answering Service**

**Urgent** situations: Person who answers phone must offer to either page the doctor on call and call the member back or transfer member's call directly to doctor on call.

**Emergency** situations: Person tells member to call 911 or go to nearest emergency room if member feels it is too emergent to wait for doctor to call them.

F5

Access to Care:  
Primary Care and  
Non-Primary Care

**F**

- **Answering Machine**

**Urgent** situations: Message gives instructions on how to page doctor for urgent situations or tells member to go to hospital emergency room or urgent care if situation cannot wait until next business day.

**Emergency** situations: Message must provide information on accessing emergency services, i.e. call 911 or go to nearest emergency room if member feels situation is emergent.

F5

Access to Care:  
Primary Care and  
Non-Primary Care

### **F 5.5 Practice Capacity and Restrictions**

During the contracting process, CareOregon and primary care practices negotiate an initial monthly and maximum capacity number for the total number of CareOregon members to be assigned to the practice and set up appropriate practice restrictions, if applicable.

Members are directly assigned at the practice level. If a primary care practitioner leaves a group practice, the remaining practitioners are expected to absorb members served by the departing PCP. If extenuating circumstances exist, exceptions may be made on a case-by-case basis.

Primary care practices that want to change capacity after initial contractual consensus is settled may contact a Network Relations Associate. When possible, a 30-day notice, written or electronic, is required to minimize network access disruptions. However, changes may be implemented sooner under extenuating circumstances. A Network Relations Associate will work with you to reach a mutually beneficial agreement on capacity changes.

To reach a Network Relations Associate, call Customer Service at 1-503-416-4100 or toll free at 1-800-224-4840 or visit [www.careoregon.org/provider/resourclist.html](http://www.careoregon.org/provider/resourclist.html). For more information on the role of the Network Relations Associate, see section E5.

## G STANDARDS OF CARE

CareOregon providers must comply with the following standards of care, in accordance with the Oregon Administrative Rules governing the Oregon Health Plan and Centers for Medicare & Medicaid Services governing Medicare.

G1  
Medical Records

### G 1 MEDICAL RECORDS

CareOregon has guidelines for medical record keeping. Please review and incorporate CareOregon's guidelines for medical record into your practice. Our Network Relations Associates provide feedback and support to help you meet the guidelines.

#### **Criteria for what constitutes a complete medical record**

- Each medical record must contain information for one patient only.
- Medical records must have dated legible entries for each patient visit. Entries are identified by author.

A medical record is reviewed and completed by a responsible provider before it is filed. Records are organized and stored in a manner that allows easy retrieval.

- Signatures are full and legible and include the writer's title. Acceptable forms of signatures include handwritten, electronic signatures or facsimiles of original written or electronic signatures. Stamped signatures are not acceptable.
- A medical record is reviewed and completed by a responsible provider before it is filed.
- Records are organized and stored in a manner that allows easy retrieval and ensures confidentiality.
- Medical records are stored securely.
- Only authorized personnel have access to medical records.
- Clinic staff receive periodic training in patient information

confidentiality.



G1  
Medical Records

Each medical record should contain the following information:

- Patient's name, date of birth, sex, address, telephone number and any other identifying numbers (as applicable)
- Name, address and telephone of patient's next of kin, legal guardian or other responsible party
- A problem list with significant illnesses and medical conditions
- A medication list including an indication of allergies and adverse reactions to medications and documentation if no allergies are identified
- History of presenting problems and a record of a physical exam for the presenting problem(s)
- Laboratory and other studies ordered, as appropriate, and initialed by the primary care physician
- Working diagnoses for presenting problems
- Plans of action (treatment plan) consistent with diagnoses
- Documentation of referrals to and consultations with other providers
- Documentation of appropriate follow-up
- Emergency room and screening services reports
- Baseline documentation of tobacco and alcohol use
- Documentation of past and present use/misuse of illegal, prescribed and over-the-counter drugs
- Documentation of behavioral health status assessments as appropriate,
- Copies of signed release of information forms
- Copies of medical and/or mental health directives

G1

Medical Records

To correct an entry in a medical record, cross through the error one time with ink. Initial and date the cross-through. *Do not write "error."*

## Medical Record Review

CareOregon reviews medical records of contracted primary care providers on a regular schedule. CareOregon staff adhere to HIPAA-mandated confidentiality standards.

G1

Medical Records

To review the Medicare, Medicaid and NCQA (National Committee for Quality Assurance) rules that direct the audit process, contact your Network Relations Associate.

1. CareOregon's Quality Improvement (QI) staff identify a sample of contracted clinics to be reviewed.
2. QI mails a letter with patients' names to each clinic. We ask clinic staff to send us a copy of each patient's medical records.
3. QI Coordinators (registered nurses) review the medical records for legibility, content, organization and completeness.
4. The QI Department mails audit results to providers. A passing score is 90% or greater. A provider who does not receive a score of at least 90% is evaluated by the CareOregon Medical Director and/or by the internal Peer Review Committee. CareOregon may ask a provider to send us a written corrective action plan. Additional audits may occur.

Reviewers verify that the medical records contain the following documentation:

- Member information identified on each page by two (2) patient identifiers
- A problem list, with significant medical and/or psychological illnesses
- Presenting complaints, physical examinations, diagnoses, treatment plans and referrals or consultations as appropriate to each visit
- Lab results and diagnostic test reports
- Prescribed medications, including dosages and dates of initial/refill prescriptions
- Allergies and adverse reactions or documentation of no known allergies or history of adverse reactions

- Advance Directives:
  - Documentation of discussion of all members if condition warrants advance medical planning.
  - Medicare members – documentation must reflect whether or not an Advance Directive has been executed.
  - Documentation of discussion must be noted in a prominent location in the medical record.
- Health education, preventive screening and anticipatory guidance, as appropriate
- Provider identification or signature for each review visit note. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable.

A CareOregon-contracted provider who refuses to cooperate with the medical record review process, the Chief Medical Officer and/or a QI Coordinator regarding a corrective action plan or who is unable to meet quality requirements may have his/her contract terminated with cause.

For more information, please contact Customer Service at 1-503-416-4100 or toll free at 1-800-224-4840 or visit [www.careoregon.org/provider/resourclist.html](http://www.careoregon.org/provider/resourclist.html).

**G2 CONFIDENTIALITY**

Healthcare providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Act's (HIPAA) transactions must adhere to the HIPAA Privacy and Security regulations.

Providers must provide privacy and security training to any staff that have contact with individually identifiable health information.

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 clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disk or optical media formats.

Disclose health information in medical or financial records only to the patient or legal guardian unless the patient or legal guardian authorizes the disclosure to another person 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 state and county health divisions and to disaster relief agencies.

G2

Confidentiality

**G**

All health care personnel who generate, use, or otherwise deal with individually identifiable health information must uphold the patient's right to privacy.

Take extra care not to discuss patient information (financial and 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.

Providers' employees (including physicians) must not have unapproved access to their own records or records of anyone known to them who is not under their care. CareOregon staff adheres to the HIPAA-mandated confidentiality standards.

G2

Confidentiality

**G****G3 INTERPRETATION**

All participating CareOregon providers must make interpretation services available to CareOregon members.

Interpretation must be available during and after hours for advice, appointment scheduling, and provision of care.

Interpretation can be provided by staff, or by a qualified interpretation service either on site or over the telephone.

Interpretation should *not* be provided by a member of the patient's family.

CareOregon will pay for and coordinate interpretation services for our members' medical appointments. (See section E1 for more information about arranging interpretation services.)

G3  
Interpretation

G**G4 RELEASE OF INFORMATION**

Providers must obtain an authorization to release individually identifiable health information whenever information is released about the patient, unless the release is for payment, treatment of the patient, or the healthcare operations of another organization that is providing healthcare or payment for healthcare for the patient.

- A general release of information form is not necessary for CareOregon and the providers to communicate regarding treatment or payment for treatment of CareOregon members, according to HIPAA privacy regulations.
- The general authorization form is not valid for HIV, STD, genetic, mental health or alcohol and drug treatment information. **Do not release this information unless the member signs an authorization** specifying that these types of records may be released.

G4  
Release of  
Information

## G5 STERILIZATIONS & HYSTERECTOMIES

### G 5.1 Requirements

Oregon law requires that informed consent be obtained from any individual wanting voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy.

It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. Therefore, CareOregon cannot reimburse providers for these procedures without proof of informed consent.

### G 5.2 Voluntary Sterilization

For a tubal ligation or vasectomy, the patient must sign the Consent to Sterilization form in English and Spanish at least 30 days, but not more than 180 days, prior to the sterilization procedure.

- In case of **premature delivery** the sterilization may be performed fewer than 30 days but more than 72 hours after the date that the member signs the consent form. The member's expected date of delivery must be entered.
- In case of **emergency abdominal surgery** the sterilization may be performed fewer than 30 days but more than 72 hours after the date of the individual's signature on the consent form. The circumstances of the emergency must be described.

The person obtaining the consent must sign and date the form. The date should be the date the patient signs or after. *It cannot be on the date of service or later.* The person obtaining consent must provide the address of the facility where consent was obtained.

If an interpreter assists the patient in completing the form, the interpreter must also sign and date the form.

The physician must sign and date the form either on or after the date the sterilization was performed.

G5

Sterilizations and  
Hysterectomies

**G**

G5

Sterilizations and  
Hysterectomies

Fully and accurately completed consent forms, including the physician's signature, should be submitted with all sterilization claims. Incomplete forms are invalid and will be returned to the provider for correction.

CareOregon cannot pay for sterilizations if the member has not correctly completed a consent form.

### **G 5.3 Hysterectomies**

Hysterectomies performed for the sole purpose of sterilization are not a covered benefit.

Patients who are not already sterile must sign the **Hysterectomy Consent form in English and Spanish.**

Physicians must complete Part I including the portion "medical reasons for recommending a hysterectomy for this patient." CareOregon will return the form to the provider if this portion is omitted.

Patients who are already sterile are not required to sign a consent form. In these cases, the physician must complete Part II including cause and date (if known) of sterility, e.g. "tubal ligation 1992."

In cases of life threatening emergency when consent cannot be obtained, the physician must complete Part II including the nature of the emergency that made prior acknowledgement impossible.

**G****G6 ADVANCE DIRECTIVES**

To comply with federal and state legislation regarding a patient's right to know about advance directives, CareOregon must inform its members about advance directives. CareOregon provides this in the following ways:

- CareOregon OHP Member Handbook has information about advance directives and how to obtain copies.
- Advance Directive forms can be found at: [www.oregon.gov/DCBS/SHIBA/docs/advance\\_directive\\_form.pdf](http://www.oregon.gov/DCBS/SHIBA/docs/advance_directive_form.pdf)

Members can call CareOregon Customer Service to obtain an advance directive form and instructions on completing it.

CareOregon expects primary care providers to discuss advance directives with their patients who are age or diagnosis appropriate.

CareOregon primary care providers are responsible for keeping copies of members' completed advance directives in their medical records. For CareOregon Medicare Advantage members, documentation whether or not the member has executed an advance directive must be noted in a prominent location of their medical record.

The presence of discussion(s) regarding an advance directive is subject to review according to the CareOregon primary care provider medical review process. See section G1, Medical Records for more information.

G6  
Advance  
Directives



**G7 PHYSICAL ACCESS**

All participating CareOregon provider sites must comply with the requirements of the Americans with Disabilities Act of 1990, including but not limited to street level access or accessible ramp into the facility and wheelchair access to the lavatory.

G7  
Physical Access



## H BILLING AND PAYMENT

### H1 BILLING ADDRESS

CareOregon  
 PO Box 40328  
 Portland OR 97240-9934  
 503-416-4100  
 1-800-224-4840 toll free

H1

Billing Address

H2

Submit Claims

### H2 SUBMIT CLAIMS

To submit claims electronically, use **EDI Payer ID 93975**.

For information on billing claims electronically, contact Emdeon toll free at 1-877-363-3666 or

**[www.emdeon.com/ProviderSolutions/provider\\_billingmanagement.php](http://www.emdeon.com/ProviderSolutions/provider_billingmanagement.php)**.

To submit claims using the standard CMS (formerly HCFA) 1500 or UB04 claim forms. For more information, see instructions for completing the CMS 1500 or UB04 forms at

**[www.cms.hhs.gov/manuals/downloads/clm104c26.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf)**

and

**[www.cms.hhs.gov/manuals/downloads/clm104c25.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf)**

Incomplete claims are denied for resubmission with the missing information.

Claims must include the member's ICD9 code to the highest level of specificity and the appropriate procedure codes(s). See OARs **410-130-0160** and **410-120-1280**.

CareOregon denies the following claims for services. Resubmit the claim with a valid diagnosis code.

- Claims that use non-primary diagnosis codes for the primary or sole diagnosis
- Claims for services billed with an E-code as primary or sole diagnosis
- Claims with an invalid diagnosis or invalid procedure or revenue code

CareOregon and DMAP use the Ingenix version of the ICD-9 as a guideline.

CareOregon is actively preparing for the change to ICD-10. CMS has mandated the 30 year old ICD-9 diagnostic coding system be replaced by the more flexible ICD-10 CM and PCS system.



The deadline for nationwide conversion is October 2013. Part of the preparation for this change includes updating from the HIPAA 4010 transaction record to the 5010 version to accommodate the new seven digit diagnosis and procedure codes. The deadline for full implementation of the 5010 is January 2012.

We are on track to begin external testing of the 5010 by the required January 2011 date.

For more ICD-10 and 5010 information including key dates, please visit

**[http://www.cms.hhs.gov/ICD10/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage)**

H1  
Billing Address  
H2  
Submit Claims



For specific claims questions, do **one** of the following actions:

- E-mail **[claimshelp@careoregon.org](mailto:claimshelp@careoregon.org)**.
- Call 503-416-4100 or toll-free at 1-800-224-4840. Press option 3 to speak with a Customer Service Representative.
- Fax 503-416-8115.

H2

Submit Claims

### H3 AUTHORIZATIONS

CareOregon denies claims submitted for services that require an authorization if the authorization was not obtained. (See section D, **Medical Benefits Assurance**, for information on authorizations.)

THE PROVIDER PORTAL application is a confidential online system that allows clinics and vendors to check the status of their CareOregon authorizations, claims and verify member eligibility.

To register for THE PROVIDER PORTAL, visit <https://healthtrioconnect.com/register/nonmember/userinfo/UserInformation?payor=1036&portal=Provider>. If you have any questions, please contact CareOregon Customer Service at 503-416-4100 or toll free at 1-800-224-4840.

H3  
Authorizations  
H4  
Timely Filing

### H4 TIMELY FILING

Claims must be submitted no more than four months (120 days) after the date of service

Oregon Health Plan Administrative Rule 410-141-0420 in Part 1 of the OHP Administrative Rules at [www.dhs.state.or.us/policy/healthplan/guides/ohp/141rb0410.pdf](http://www.dhs.state.or.us/policy/healthplan/guides/ohp/141rb0410.pdf)

Claims received after the 120-day deadlines are denied. Exceptions to the timely filing requirement include:

- Maternity-related expenses and newborn services
- Delay or confusion by other primary insurance or third party resources, including Medicare
- Retroactive eligibility changes by DMAP
- Claims denied by Worker's Compensation

The absence of legal capacity is the only exception to this policy.

## H5 TIMELY PAYMENT

- CareOregon pays the provider by the 45th day after a clean claim is received.
- A clean claim can be processed accurately without additional information. For example, information is complete and correct and all ICD9 and CPT codes are valid.

H5

Timely Payment

H6

Claims Appeals

## H6 CLAIMS APPEALS

### CareOregon/Medicaid and CareOregon Advantage/Medicare

Contact CareOregon's Claims Department to appeal an action. An action, as applied to the Prepaid Health Plan, includes but is not limited to the denial, in whole or in part, of payment for service.

**IMPORTANT:** CareOregon must receive appeals no more than 365 days after the date the claim was paid or denied.

**Submit provider appeals in writing.** Include the reason for the dispute and any relevant information and/or documentation related to the dispute.

If the claim was denied because of authorization issues, please send current medical documentation with the appeal.

Mail or fax written claim appeals to:  
CareOregon Claims Department  
Attn: Provider Appeals Coordinator  
PO Box 40328  
Portland OR 97240-9934

Fax to Provider Appeals Coordinator at 503-416-8112 or toll-free to 1-800-874-3916.

CareOregon resolves the appeal and sends a notice of determination to the provider no later than 45 calendar days after the day the appeal is received.

An extension of 14 calendar days may be granted if either the provider or CareOregon requests it and if the extension meets criteria defined in OARS 410-141-0262.



## H7 SERVICES COVERED BY DMAP

Claims for the following services are paid by DMAP. The claimant does not need to be a CareOregon member.

- Abortion/voluntary pregnancy termination (Fully Capitated Health Plan Contract with DMAP, Statement of Work in Section 5, [www.oregon.gov/DHS/healthplan/data\\_pubs/contracts/fchp/fchp\\_contract\\_06.pdf](http://www.oregon.gov/DHS/healthplan/data_pubs/contracts/fchp/fchp_contract_06.pdf))
- Death with dignity/physician aid in dying – OAR 410-130-0670
- Maternity case management – OAR 410-130-0595

Send bills for these services to:

DMAP  
PO Box 14955  
Salem, OR 97309

See rules in DMAP General Rules, [www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html)

H7  
Services Covered  
by DMAP



### **Timely Filing Guidelines**

Eligible claims for covered services must be received within 120 days after the date of service. If a claim meets one of the following criteria and proof is submitted, CareOregon may choose to waive the 120-day timely filing rule:

- Newborns
- Medicare coverage
- Other insurance coverage
- Maternity-related expenses
- Claims denied by Workers' Compensation
- Claims processed or adjusted after retroactive eligibility changes

The absence of legal capacity is the only exception to this policy.

H7  
Services Covered  
by DMAP

## H8 COORDINATION OF BENEFITS

If there is a primary carrier, such as Medicare or private insurance, and CareOregon is the secondary payor or for any third party resources paying as primary (i.e., workers' compensation, MVA), submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received. Claims must be received within 120 days from the date the claim was processed on the primary EOB.

If the member has CareOregon Medicare Advantage Plus, the primary EOB does not need to be submitted.

For third party resources, include detailed information documenting payment, allowances and claim denial reason if applicable.

### Calculating Coordination of Benefits

On claims with primary payers including Medicare and private insurance, the total benefits that a member receives from CareOregon and the other medical plan cannot exceed what the CareOregon normal benefit would have been by itself.

For clients with other third party resources (including Medicare), CareOregon compares our payment to the other carrier's payment to determine amount payable.

- If CareOregon's payment is **equal to or less** than the other carrier's payment, the benefit is zero.
- If CareOregon's payment is **greater** than the other carrier's payment, CareOregon pays the difference, but does not exceed the patient's responsibility.

H8

Coordination of  
Benefits



**EXAMPLE #1**

Total billed .....	\$ 100
Other plan paid .....	\$ 40
Patient responsibility.....	\$ 60
CareOregon normal benefit .....	\$ 80
<b>CareOregon pays.....</b>	<b>\$ 40</b>

H8  
Coordination of  
Benefits

**EXAMPLE #2**

Total billed .....	\$ 100
Other plan paid .....	\$ 40
Patient responsibility.....	\$ 60
CareOregon normal benefit .....	\$ 0
<b>CareOregon pays.....</b>	<b>\$ 0</b>

**EXAMPLE #3**

Total billed .....	\$ 100
Other plan paid .....	\$ 24
Patient responsibility.....	\$ 76
CareOregon normal benefit .....	\$ 65
<b>CareOregon pays.....</b>	<b>\$ 41</b>



## H9 CLINICAL EDITING

CareOregon uses a clinical editing system to ensure the efficiency and accuracy of our claims payment system.

Actions of the clinical editing system include:

- Rebundling lab, x-ray, medicine, anesthesia and surgical procedure codes
- Denial warning message when surgery is inconsistent with the diagnosis
- Denial warning message on claims when a patient's age does not fall into the normal age range for the procedure or diagnosis
- Denial of a procedure considered integral to another billed procedure
- Denial of procedures not customarily billed on the same day as a surgical procedure
- Denial of services normally included as follow-up care associated with a surgical procedure

Valid exceptions to clinical editing exist. CareOregon reviews records for unusual or extraordinary circumstances that may influence the benefit.

H9

Clinical Editing

## H10 BILL THE MEMBER

State and federal regulations prohibit billing Oregon Health Plan recipients for OHP-covered services, except for coinsurance, co-payments and deductibles expressly authorized by the General Rules, OHP Rules and/or federal rules.

State Regulation: DMAP General Rules, rule 410-120-1280 at

<http://www.dhs.state.or.us/policy/healthplan/guides/genrules/120rb032610.pdf>

Members cannot be billed for the following covered services:

- Services that were denied due to lack of an authorization
- Services that were denied because the member was assigned to a PCP other than the one who rendered the services
- “Balance billing” for the amount not paid to the provider by CareOregon

Generally, a provider may legally bill an Oregon Health Plan recipient in the following two circumstances: (refer to above OAR for other examples)

- **The service provided is not covered by the OHP and the member signed a Patient Responsibility for Uncovered Services Form before he/she was seen.**  
**[www.careoregon.org/provider/documents/Patient Resp for uncvrd services CO.pdf](http://www.careoregon.org/provider/documents/Patient_Resp_for_uncvrd_services_CO.pdf)**

The form must include the specific service that is not covered under the OHP, the date of the service and the approximate cost of the service. The estimated cost of the covered service, including all related charges, cannot exceed the maximum DMAP reimbursable rate or managed care plan rate.

The form must be written in the primary language of the member.

H10  
Bill the Member

- **The member did not tell the provider that he/she had Medicaid insurance and the provider tried to obtain insurance information.**

The provider must document attempts to obtain information on insurance or document a member's statement of non-insurance.

Billing or sending a statement to a member does not qualify as an attempt to obtain insurance information.



H10

Bill the Member



**Federal Regulation: 42 CFR 447.15 at  
[www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr447\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr447_99.html)**

[Code of Federal Regulations]  
[Title 42, Volume 3, Parts 430 to End]  
[Revised as of October 1, 1999]  
From the U.S. Government Printing Office via GPO  
Access

[CITE: 42CFR447.15]  
[Page 255] PART 447-- PAYMENTS FOR SERVICES--  
Table of Contents  
Subpart A -- Payments: General Provisions  
Sec. 447.15 Acceptance of state payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with Sec. 431.55(g) or Sec. 447.53.

**The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.**

[50 FR 23013, May 30, 1985]

H10

Bill the Member

**H11 HYSTERECTOMY AND STERILIZATION**

Oregon law requires that informed consent be obtained from any Oregon Health Plan member who wants a hysterectomy or voluntary sterilization (tubal ligation or vasectomy). State and federal money cannot be used to pay for voluntary hysterectomies and sterilizations that are performed without proper informed consent.

Providers must submit a completed and signed consent form with hysterectomy and sterilization claims. CareOregon will not pay claims submitted without a completed and signed consent form.

**Hysterectomy** Consent form:

<http://dhsforms.hr.state.or.us/Forms/Served/OE0741.pdf>

**IMPORTANT:** Be sure the member signs the correct sterilization consent form.

- DMAP 742A is for people age **21 years and older**.  
<http://dhsforms.hr.state.or.us/Forms/Served/OE0742a.pdf>
- DMAP 742B is for people who are **at least age 15 but not older than 20 years**.  
<http://dhsforms.hr.state.or.us/Forms/Served/OE0742b.pdf>

**Spanish consent forms**

- **Hysterectomy** Consent, Spanish:  
<http://dhsforms.hr.state.or.us/Forms/Served/OS0741.pdf>
- Consent to **Sterilization, Spanish: age 21 and older**  
<http://dhsforms.hr.state.or.us/Forms/Served/OS0742A.pdf>
- Consent to **Sterilization, Spanish: ages 15-20**  
<http://dhsforms.hr.state.or.us/Forms/Served/OS0742B.pdf>

H11

Hysterectomy and  
Sterilization



**DMAP Hysterectomy and Sterilization Procedures Manual,**

**[www.dhs.state.or.us/policy/healthplan/guides/medsurg/hyst-steril0208.pdf](http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/hyst-steril0208.pdf)**

- General coverage information
- Common reasons claims are denied
- Accepted claim form samples
- Frequently asked questions (FAQs)
- Examples of billing errors and corrective actions

See section G5 for more information about the consent process.

For information on hysterectomy and sterilization forms and billing changes, visit

**[www.oregon.gov/DHS/healthplan/notices\\_providers/2008/hyster-steril.pdf](http://www.oregon.gov/DHS/healthplan/notices_providers/2008/hyster-steril.pdf)**

H11

Hysterectomy and  
Sterilization



## H12 TOBACCO CESSATION BILLING

Bill tobacco cessation treatment and counseling as follows:

- **Tobacco Cessation Treatment (Quit for Life Program through Alere Wellbeing)**  
CPT: 99406  
Diagnosis Code: 305.1 in the primary diagnosis position  
Place of service restrictions: 03, 11, 12, 49, 50, 71  
Maximum benefit: 1 program in a 12-month rolling period
- **Tobacco Cessation Counseling**  
CPT: G0436, G0437, G9016, 99406 and 99407  
Diagnosis Code: 305.1 in the primary diagnosis position  
Place of service restrictions: 03, 11, 12, 49, 50, 71  
Maximum benefit: 10 times in a 12-month rolling period

See section C9 for information on tobacco cessation treatment and counseling.

H12  
Tobacco Cessation  
Billing

## H13 VACCINES FOR CHILDREN (VFC) BILLING

[www.oregon.gov/DHS/ph/imm/vfc/index.shtml](http://www.oregon.gov/DHS/ph/imm/vfc/index.shtml)

CareOregon does not reimburse for the cost of vaccine serums covered by the Vaccines for Children Program; however, we do reimburse fees associated with administering the vaccine.

H13

Vaccines for  
Children  
(VFC) Billing

### Billing procedure

[www.dhs.state.or.us/policy/healthplan/guides/medsurg/130rb0910corr.pdf](http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/130rb0910corr.pdf)

When administering a VFC vaccine(s), **bill the appropriate vaccine code(s) with modifier -26 or –SL**. Do not bill an evaluation and management code if the sole purpose of the visit is to administer the vaccination.

CareOregon reimburses \$15.19 for the vaccine code with modifier -26 or –SL.

When a vaccine is administered as part of an evaluation and management service (e.g., well-child visit), bill the appropriate vaccine code with modifier -26, or -SL for each injection in addition to the evaluation and management code.

Do not bill with codes 90465 through 90474 or 99211 as they are not reimbursed.



## Vaccines for Children

**Refer to Table 0255-1, Vaccines for Immunization Codes provided through the VFC Program.**

Use standard billing procedures for vaccines that are not part of the VFC program.

CareOregon allows both the vaccine and administration codes 90471 – 90472 for these vaccines.

H13  
Vaccines for  
Children  
(VFC) Billing



## H14 CHILDBIRTH EDUCATION

Childbirth Education is not a covered benefit on the Oregon Health Plan. CareOregon reimburses for childbirth education for OHP Plus members only.

The maximum benefit is \$50.00 per pregnancy for the class sessions. If the class sessions exceed \$50.00, providers can bill the member for the balance after the member signs a Patient Responsibility for Uncovered Services Form before she is seen. See Section H10 for information on, Billing the Member.

**Providers must bill with the following appropriate codes:**

- HCPC codes S9436 through S9439 or S9442
- Diagnosis codes 650 through 659.9 or V22.0 through V22.1

H13  
Vaccines for  
Children  
(VFC) Billing



H13  
Vaccines for  
Children  
(VFC) Billing

**H15 OVERPAYMENT RECOVERY**

CareOregon uses an auto-debit system to recover identified overpayments.

When an overpayment is identified, the appropriate group of claims is reversed and claims payments are automatically debited until the outstanding overpayment balance is settled.

If there are insufficient funds to recover the overpayment, the debit is carried over to future claims payments until recovery is satisfied.

H14  
Overpayment  
Recovery

**H16 LOCUM TENENS CLAIMS AND PAYMENTS**

CareOregon allows licensed providers acting in a Locum Tenens capacity to temporarily submit claims under another licensed provider's NPI number when that provider is on leave from his/her practice. The Locum Tenens provider must have the same billing type or specialty as the provider on leave, e.g., a physician must substitute for another physician.

CareOregon is not responsible for compensation arrangements between the provider on leave and the Locum Tenens provider. CareOregon sends a payment to the billing office of the provider on leave. Per CMS guidelines, CareOregon allows Locum Tenens to substitute for another physician for 60 days. Providers serving in a Locum Tenens capacity should bill with Modifier Q6 to indicate the Locum Tenens arrangement.



## **H17 INTERIM BILLING**

CareOregon reimburses for the first and subsequent interim billings for facilities not reimbursed at Diagnosis Related Group (DRG) rates. Interim claims must be submitted in sequential order and in 30-day increments or on a monthly basis. Each claim must include all applicable diagnoses and procedures.

Facilities reimbursed based on DRG methodology are paid when the patient is discharged and the final billing is received.

All authorization guidelines apply.

H14  
Overpayment  
Recovery

## **I QUALITY IMPROVEMENT AND CREDENTIALING**

11

Quality Improvement  
and Credentialing

### **I 1.1 Program Goals**

The goal of CareOregon's Quality Improvement Program is to focus on improvements that make health care more:

- safe
- effective
- patient centered
- timely
- efficient
- equitable

### **I 1.2 Program Objectives**

The objectives for the Quality Improvement (QI) process are driven by CareOregon's mission and vision.

- Ensure that members receive maximal health benefits from the resources available to CareOregon
- Monitor the health status of our members to identify areas that most significantly impact health status and/or quality of life
- Ensure the optimal use of health strategies known to be effective, including prevention, risk reduction and evidence-based practices
- Develop population-based health improvement initiatives that can best be implemented at a health plan level
- Ensure quality and accountability through measurement of performance and utilization

- Provide enhanced support for those with special health care needs through:
  - Proactive identification of those at risk
  - Case management and coordination of fragmented services
  - Promotion of improved chronic care practices
- Coordinate fragmented services by supporting integrated models of mental and physical health care services.
- Participate in efforts that improve health care for all Oregonians by:
  - Supporting community, state and national health initiatives
  - Building partnerships with other health care organizations
  - Pursuing research on new models of health care design and delivery
- Seek collaboration within the community to identify and eliminate health care disparities.

To meet these objectives, we have a process for prioritizing QI projects that is consistent with CareOregon's mission, vision, guiding principles and values and is based on the following parameters:

- Improve our members' satisfaction.
- Focus on high volume, high risk areas that have a significant impact on members' health.
- Have measurable outcomes in terms of quality of life and/or health resource utilization.
- Involve programs or interventions that are confirmed to improve outcomes, or that can be evaluated to find out if outcomes will improve.
- Support, or be synergistic with, other efforts on the issue: e.g., efforts by provider groups, community groups and other health plans.
- Promote or improve models of care that can be broadly generalized in the health care system – for example, the chronic care model.
- Improve health or strengthen the provider network more than other interventions available to CareOregon, given available resources.
- Focus on areas that have a significant impact on a population with exceptional needs and those individuals with potential for risk.

### I 1.3 Quality Improvement Structure

The Quality and Network Committee (subcommittee of the Board of Directors) is the oversight body for CareOregon's quality improvement program.

The Quality and Network Committee subcommittee formed the Quality Improvement Management Committee to oversee the quality improvement program.

The Quality Improvement Management Committee (QIMC) oversees CareOregon's QI programs through the reporting of the various QI committees.

#### QI program committees

- **Pharmacy and Therapeutics**

Accountable for oversight of the CareOregon pharmacy program, the development and maintenance of the CareOregon formulary and programs that impact utilization

- **Medical Benefits Assurance**

Accountable for oversight of the CareOregon Medical Benefits Assurance Unit, determination of second-level appeals to OHP and approval of medical policies and new technology assessments

- **Quality Improvement**

Advisory committee that provides oversight and direction for CareOregon initiatives that impact the quality of care for our members

- **Peer Review**

Accountable for monitoring and ensuring the quality of care and service provided by individual contracted providers

- **Service Quality**

Accountable for identification of issues impacting the satisfaction of our members through the analysis and integration of information from multiple sources

- **Credentialing**

Accountable to ensure that CareOregon offers a high quality panel of providers to our members. It is also accountable for delegation oversight.

## **I 1.4 Scope of Service and Issues Reviewed**

The CareOregon QI Program defines the processes that are measured and monitored.

Major plan components include processes involved with quality outcomes, patient safety and service as it pertains to access, availability and satisfaction. The scope of service also includes any and all regulatory requirements.

CareOregon has determined that areas in which our members receive care and service should be monitored and evaluated for opportunities for improvement.

These areas include:

- Hospitals
- Urgent care centers
- Primary care clinics
- Community health centers
- Consultation services
- Vision clinics
- Dialysis centers
- Hospices
- Skilled nursing facilities
- Drug and alcohol dependency facilities
- Health departments

The areas listed above encompass the care and services delivered by our network providers. Network providers of care to our members are all primary care providers and specialists.

Behavioral health providers are included in the QI process. These providers offer chemical dependency treatment, smoking cessation and mental health services.

Issues reviewed by the QI Committee include, but may not be limited to:

- Selected Health Employer Data Information Set (HEDIS) indicators
- access to care
- patient satisfaction
- outcomes of care
- patient safety
- compliance with government regulations

Data sources may include claims data, medical record data, patient complaints (grievances), case management reports, pharmacy data, satisfaction surveys and QI projects.

Research analysts, quality program staff and Information System (IS) staff may use data elements to develop a reporting format that is reviewed and evaluated by the QI Committee.

The QI Committee uses data to make recommendations for interventions aimed towards improvement.

Any member-specific or provider-specific data is considered confidential and treated according to CareOregon policy. This policy is fully congruent with HIPAA regulations.

The appropriate sources receive feedback with findings, conclusions and recommendations.

The QI Program staff prepares a yearly evaluation of the program and presents it to the QI Committee for review. The following year's program is built from this evaluation.

## **I2 CREDENTIALING**

### **I 2.1 General Guidelines**

I2

Credentialing

Most providers must complete a credentialing application when contracting with CareOregon. Providers who are subject to the credentialing process include:

- Certified Nurse Midwife
- Doctor of Medicine
- Doctor of Naturopathy
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Nurse Practitioner
- Physician Assistant
- Occupational Therapist
- Speech Therapist
- Physical Therapist
- Audiologist
- Behavioral Health/Chemical Dependency Specialist

CareOregon reviews providers' practice utilization data, member complaints, quality of care assessments and any changes in application status on an ongoing basis.

CareOregon Credentialing has implemented a policy, "professional misconduct," to ensure the safety of our members. This policy guides the Credentialing Committee in the decision-making process when incidents of inappropriate sexual behavior are identified. If you have questions, contact your Network Relations Associate.

During the credentialing process, the CareOregon Credentialing Committee may deny, suspend or terminate a provider's participation with the plan. The revised Fair Hearing Policy outlines the process for providers to appeal and/or challenge an adverse action. Fair hearing is offered to both initial and recredentialed providers.

If you have questions, contact your network relations

associate.



## 12.2 Initial Credentialing

Prospective CareOregon providers must submit a signed and dated Oregon Practitioner Credentialing Application and the following information to CareOregon:

- signed and dated attestation questions
- Attachment A, referring to the attestation questions answered “yes”
- signed and dated Authorization and Release of Information form
- evidence of current licensure by State of Oregon (copy of wallet-sized license is sufficient)
- evidence of current DEA certification or prescriptive privileges, if applicable
- evidence of current professional liability insurance coverage in the amount of no less than \$1 million per incident, \$3 million aggregate, or equivalent protection
- copies of specialty board certificate(s), if applicable
- copy of current curriculum vitae

**IMPORTANT:** The applicant must inform CareOregon within 30 days if changes occur to any statements on the application.

CareOregon’s Credentialing Committee reviews the initial application documents including the provider’s application, attached documents, verification of state licensure, National Practitioner Data Bank report, closed claim reports, license action report, Medicare Opt-Out Report, any patient complaints about the provider and site visit reviews (for PCPs only).

Education, work history and call coverage are also elements of the review process.

The Credentialing Committee may request additional information, if necessary.

The Credentialing Committee recommends acceptance or rejection of the application. The CareOregon Network and Quality Committee (a subcommittee of the board) grants final approval.

## 12.3 Recredentialing

All credentialed providers are recredentialed at least once every three years. Ninety days before the provider's recredentialing date, CareOregon sends a recredentialing packet to the provider.

The following information is needed to complete the recredentialing process:

- Copy of state license
- Current DEA registration and proof of prescriptive privileges, if applicable
- Current professional liability insurance coverage in the amount of \$1 million per incident, \$3 million aggregate or equivalent protection
- The Oregon Practitioner Recredentialing Application, including:
  - Signed and dated attestation questions
  - Attachment A, referring to attestation questions answered "yes"
  - Signed and dated Authorization and Release of Information form

The CareOregon Credentialing Committee considers this information with the National Practitioner Data Bank inquiry results, closed claim reports, license action report, Medicare Opt-Out Report and member complaints.

Failure to provide recredentialing information in a timely manner may be brought to the attention of the CareOregon Credentialing Committee. Noncompliance may result in a recommendation to send the provider a notice of termination.

## I 2.4 Providers' Rights: Policy and Procedures

**Initial credentialing:** the application for provider status of a provider who is new to the CareOregon panel or a provider who has terminated more than thirty (30) days prior to applying and is requesting reinstatement

**Recredentialing:** the process of periodically re-evaluating current panel providers for continuing competency to provide high quality services to CareOregon members

### BACKGROUND

CareOregon and CareOregon Advantage consider it essential to maintain a provider panel that has the legal authority, relevant training and experience to provide care for our members. Provider rights ensure that all participants in the credentialing process are aware of their rights during the credentialing process. CareOregon advocates for provider rights to be readily accessible and understandable to all providers. CareOregon's process adheres to standards established by the National Committee for Quality Assurance (NCQA), Medicare Manual, Ch. 6, and Oregon Administrative Rules (410-141-0120).

### POLICY

The CareOregon Credentialing Unit adheres to the following provider rights and notifies each provider of these rights during initial credentialing and at the beginning of each recredentialing cycle. This policy applies to all records maintained on behalf of the CareOregon provider panel and is limited to the credentials and performance improvement files of individual practitioners.

**NOTE:** References from peers and other recommendations are protected information that is excluded from this list of rights.

CareOregon has adopted the following statement of provider rights that applies to all contracted medical professional providers. Providers are notified of these rights in two ways:

- The Provider Rights document is included with the Initial/Recredentialing Application.
- Provider rights are documented in the Provider Manual.

Providers in the credentialing/recredentialing process have the following rights:

- To be free from discrimination in terms of participation, reimbursement or indemnification solely on the basis of licensure, as long as providers are acting within the lawful scope of licensure/certification
- To be notified in writing of any decision that denies participation on the CareOregon panel
- To be aware of applicable credentialing/recredentialing policies and procedures
- To review information submitted by the applicant to support the credentialing application
- To correct erroneous information submitted by third parties that does not fall under the Oregon Peer Review Statute protections (Section 41.675).
- To be informed of the status of the provider's credentialing or recredentialing application on request, and to have that request granted within a reasonable period of time
- To be notified of these rights

Source: NCQA Standard CR 1, Element B;  
42 CFR 422.202(a) and (c)

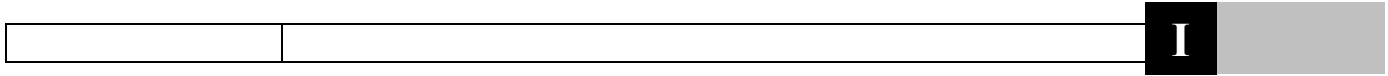
**PROCEDURES**



12

Credentialing

Responsibility	Actions
<p><b>Provider</b></p>	<p>A provider has the right to examine his/her credentialing folder.</p> <ol style="list-style-type: none"> <li>Request to review your credentialing file by asking (written, electronic or telephone) the CareOregon Quality Improvement Manager/Chief Medical Officer to schedule a review time. Make this request at least 24 hours in advance of your preferred review time. You must present a driver's license or other photo identification before reviewing the file.</li> </ol> <p>Staff from the Quality Management Department/ Credentialing Unit must supervise a provider during the examination/review.</p> <p>Sufficient time must be allowed for providers to review their credentialing file. Review time must be mutually agreed upon by the provider and credentialing specialist. Records may not be removed or copied unless expressly permitted by the chief medical officer or a designated representative.</p> <p>You have the right to receive a copy of any document(s) in your credentialing folder that you submitted or that were addressed or copied to you.</p> <p>If you file an appeal, you are entitled to full access to your credentialing/recredentialing <b>and</b> quality improvement (QI) folder(s).</p> <ol style="list-style-type: none"> <li>After you review your file according to this policy and procedure, you may submit a written request to the chief medical officer that asks for corrections or deletions of information in the file. The request must include a statement of the basis for the action requested.</li> </ol>





Responsibility	Actions
<b>Chief Medical Officer</b>	Review a provider's requests for correction or deletion of information within thirty (30) days and recommend to the Credentialing Committee whether or not to honor the request(s).
<b>Credentialing Committee</b>	Notify the provider in writing within two (2) weeks after the committee's decision. The decision of the Credentialing Committee is final.
<b>Provider</b>	<p>You may clarify discrepancies by providing documentation such as a license, malpractice claims history or board certification decisions. <b>You must submit this information in writing (electronic or hard copy) within two weeks after receiving the request.</b></p> <p>Information obtained from you becomes part of the credentialing application.</p>
<b>Credentialing Specialists</b>	<ol style="list-style-type: none"> <li>1. Send a copy of the document to the provider if he/she does not have it. Review new information with the provider by phone.</li> <li>2. Write a summary memo based on the provider's own words. Note the review date on the memo and initial the date.</li> <li>3. If the provider does not provide information that clarifies discrepancies within the two-week time frame, process the application. Assess extensions on a case-by-case basis.</li> <li>4. Inform the Quality Improvement (QI) manager of any delinquencies related to providers and information discrepancies.</li> </ol>

Sources:

- Oregon Administrative Rules (410-141-0120)
- Medicare Manual, Ch. 6
- National Committee for Quality Assurance (NCQA), Oregon Peer Review Statute protections (Section 41.675)
- Standard CR 1, Element B; 42 CFR 422.202(a) and (c)

## **I2.5 Organizational Credentialing**

CareOregon credentials institutional providers or suppliers such as hospitals, skilled nursing facilities, home care agencies, behavioral health services, clinical laboratories, outpatient speech and physical therapists, ambulatory surgery centers, end stage renal disease services, outpatient diabetes self-management training, portable X-ray providers, rural health centers and Federally Qualified Health Centers. A standardized application is used for this process.

## J MEDICARE ADVANTAGE

CareOregon operates Medicare health plans called CareOregon Advantage (COA) Star HMO-POS plan and CareOregon Advantage (COA) Plus HMO-POS SNP, which participates in the Medicare program. COA Plus HMO-POS SNP is a Special Needs Plan for dual eligible beneficiaries. These beneficiaries qualify for both Medicare and Medicaid coverage. As a Medicare Plan, CareOregon Advantage also administers Part D, which is the Medicare prescription drug program.

J1  
Medicare  
Advantage  
Requirements

The CareOregon Advantage service area includes the following Oregon counties: Clackamas, Clatsop, Columbia, Jackson, Josephine, Marion, Multnomah, Polk and Washington.

As a participating provider in CareOregon, your provider agreement contains a Medicare Addendum that describes provider responsibilities for CareOregon Advantage. Some of those responsibilities, as well as requirements of CareOregon Advantage as a Medicare health plan, are listed below. For more information about CareOregon Advantage, visit our web site: [www.careoregonadvantage.org](http://www.careoregonadvantage.org).

### J 1 Medicare Advantage Requirements (Policies and Procedures)

- J 1.1 COA and participating providers may not deny, limit or condition the coverage or furnishing of covered services to COA members on the basis of any factor related to health status. Health status includes, but is not limited to, the following: (1) medical condition, including mental as well as physical illness; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information and (6) evidence of insurability, including conditions arising out of acts of domestic violence. (42CFR 422.110[a])
- J 1.2 COA pays for emergency and urgently needed covered services as required in 42CFR 422.113 and consistent with CareOregon policies for referrals and authorizations. (42CFR 422.100(b); 42CFR 422.112[b])

- J 1.3 COA will cover renal dialysis services provided while the member is temporarily outside the COA service area. (42CFR 422.100[b])
- J 1.4 Medicare Advantage allows members to directly access (through self-referral) mammography screening and influenza vaccinations. (42CFR 422.100[h])
- J 1.5 COA and participating providers may not impose cost-sharing for influenza vaccine and pneumococcal vaccine for COA members. (42CFR 422.100[h])
- J 1.6 COA will maintain and monitor a network of participating providers that is sufficient to provide adequate access to covered services to COA members. (42CFR 422.112(a))
- J 1.7 Medicare Advantage allows members the option of direct access to a women's health specialist within the COA provider network for routine and preventive women's health care services. (42CFR 422.112(a))
- J 1.8 COA shall have credentialing and re-credentialing policies and procedures to select and evaluate participating providers and notify providers in writing of the reason for denial, suspension or termination. (42CFR 422.204)
- J 1.9 COA and participating providers may not distribute any marketing materials or election forms without prior approval from CMS. (42CFR 422.80)
- J 1.10 Medicare Advantage requires that COA use its best effort to conduct an initial assessment of each member's health care needs within 90 days of enrollment. After the initial health risk assessment, COA may contact participating provider(s) to jointly develop a treatment plan for members with significant health risk. (42CFR 422.112(b))

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- J 1.11 Medicare Advantage requires that COA have policies and procedures for advance directives for COA adult members. Participating providers must document in a prominent part of the medical record whether or not the COA member has executed an advance directive. (42CFR 422.128)
- J 1.12 Participating providers will provide covered services in a manner consistent with professionally recognized standards of health care. (42CFR 422.502(a))
- J 1.13 COA does not place participating providers at substantial financial risk as defined in 42CFR 422.208, physician incentive plans. Participating providers agree to submit to COA any documentation regarding compliance with physician incentive plan regulations. Neither participating providers nor COA shall make any payment to a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any COA member. (42CFR 22.208)
- J 1.14 Participating provider payments from COA are, in whole or in part, from federal funds. (42CFR 422.502(h))
- J 1.15 Medicare Advantage requires that COA and participating providers submit to CMS all information that is necessary for CMS to administer and evaluate COA. COA will establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare benefits. (42CFR 422.64(a) and 42CFR 422.502(a) and (42CFR 422.502(f))
- J 1.16 Participating providers and COA agree to adhere to the 90-day termination notification provision in the provider agreement to ensure that COA makes a good faith effort to provide written notice of a participating provider termination to all members seen on a regular basis by the provider 30 days prior to the termination. (42CFR 422.111(e) and 42CFR 422.204)

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- J 1.17 Participating providers agree to provide encounter data with all information required by CMS. Participating providers further certify that all information provided to COA for each member encounter is true, accurate and complete. Any falsification or concealment of material fact by participating providers when submitting claims may be prosecuted under federal and state laws. (42CFR 422.502(a))
- J 1.18 Participating providers agree to cooperate with and submit information to all independent quality review and improvement organizations approved by CMS to perform external review activities. (42CFR 422.154)
- J 1.19 Participating providers agree to adhere to the requirements of the quality improvement program (see section I.1). COA shall establish a mechanism to consult with participating providers regarding COA medical policies, quality improvement programs and medical management procedures. (42CFR 422.202[b])
- J 1.20 COA shall disclose to CMS disenrollment rates for Medicare members for the previous two years, information on Medicare member satisfaction and information on health outcomes. (42CFR 422.502(f))

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- J 1.21 Medicare Advantage requires that COA and participating providers comply with all federal, state and local laws; regulations; executive orders and ordinances.

Participating providers expressly agree to comply with (I) Title VI of Civil Rights Act of 1964; (II) The Rehabilitation Act of 1973; (III) Title II of the Americans with Disabilities Act of 1990 and ORS 659.425; (IV) The Age Discrimination Act of 1975 (45 CFR part 91); (V) laws applicable to recipients of federal funds; (VI) The Health Insurance Portability and Accountability Act of 1996 and (VII) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations. (42CFR 422.502[h] and 45CFR 160 and 45CFR 164)

- J 1.22 Medicare Advantage prohibits COA from contracting with participating providers (individuals or entities that employ individuals) who are excluded from participation in the Medicare program. (42CFR 422.752)
- J 1.23 COA and participating providers agree to adhere to member appeal and grievance procedures. (42CFR 422.562[a])
- J 1.24 COA may not prohibit or otherwise restrict participating providers, acting within the lawful scope of practice, from advising or advocating on behalf of a COA member about (1) the member's health status; (2) the risks, benefits and consequences of treatment or non-treatment; and (3) the opportunity for the member to refuse treatment and to express preferences about future treatment. (42CFR 422.206[a])

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**J2 TERMS AND CONDITIONS FOR PAYMENT**

CareOregon offers CareOregon Advantage (COA) Star HMO-POS plan and CareOregon Advantage (COA) Plus HMO-POS SNP. Members can use any primary care physician or specialty provider that agrees to treat the member and accepts these Terms and Conditions of payment, as long as provider is eligible to provide health care services under Medicare Part A and Part B (“Original Medicare”) or eligible to be paid by COA Star HMO-POS or COA Plus HMO-POS SNP for benefits not covered under Original Medicare.

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CareOregon has signed contracts with some providers. These providers are our network providers. The list of network providers can be accessed on our website at [www.careoregon.org](http://www.careoregon.org).

Our members can still receive services from non-network providers who do not have a signed contract with us, as long as the provider meets the below deeming criteria. These deemed providers are subject to all the Terms and Conditions of payment described in this document.

**Provider is deemed to accept COA Star HMO-POS and COA Plus HMO-POS SNP Terms and Conditions for payment**

1. The provider is aware, in advance of furnishing health care services, that the patient is a member of COA Star HMO-POS or COA Plus HMO-POS SNP. All of our members receive a member ID card that clearly identifies them as POS members. The provider may verify eligibility by calling our Customer Service Department at 503-416-4100 or online at [www.careoregon.org](http://www.careoregon.org)
2. The provider either has a copy of, or has reasonable access to, our Terms and Conditions of payment (this document). The Terms and Conditions are available on our website at [www.careoregon.org](http://www.careoregon.org) via our provider manual. The Terms and Conditions may also be obtained by calling our Customer Service Department at 503-416-4100 or 800-224-4840.
3. The provider furnishes covered services to a COA Star HMO-POS or COA Plus HMO-POS SNP member.

If all these conditions are met, the provider is deemed to have agreed to COA Star HMO-POS and COA Plus HMO-POS SNP Terms and Conditions of payment for that specific member visit. As a provider, you can decide whether or not to accept these Terms and Conditions of payment each time you see a COA Star HMO-POS or COA Plus HMO-POS SNP member. A decision to treat one plan member does not obligate you to treat other COA Star HMO-POS or COA Plus HMO-POS SNP members.

If you do not wish to accept these Terms and Conditions of payment, then you should only furnish emergency services to a COA Star HMO-POS or COA Plus HMO-POS SNP member. Nonetheless, if you do furnish non-emergency services, you will be subject to these Terms and Conditions whether you have explicitly agreed to them or not.

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### **Provider qualifications and requirements**

In order to be paid by CareOregon for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to CareOregon, in accordance to HIPPA requirements.
- Be licensed or certified by the state and furnish services to a COA Star HMO-POS or COA Plus HMO-POS SNP member within the scope of your licensure and/or certification.
- Provide only services that are covered by the Member's plan benefits and that are medically necessary by Medicare definitions. Obtain prior authorization for services when required.
- Not have opted out of participation in the Medicare program.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights, HIPAA that apply to covered services furnished to members.
- Agree to cooperate with CareOregon to resolve any member grievance involving the provider within the time frame required under federal law.
- Not charge the member in excess of cost-sharing under any condition.

### **Plan payment**

CareOregon reimburses deemed providers at the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, minus any member required cost-sharing, for all medical necessary services covered by Medicare. Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost-sharing, as payment in full.

### **Balance billing of members**

A provider may collect only applicable benefit plan cost-sharing amounts from COA Star HMO-POS or COA Plus HMO-POS SNP and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish benefit plan covered services to COA Star HMO-POS or COA Plus HMO-POS SNP members.

### **Hold harmless requirements**

In no event, including, but not limited to, nonpayment by Care-

Oregon, insolvency of CareOregon, and/or breach of these Terms and Conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement form, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these Terms and Conditions.

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### **Filing a claim for payment**

You must submit a claim to CareOregon for covered services within the same time frame you would under Original Medicare. Failure to submit timely claims may result in non-payment.

Submit claims using an industry standard claim form (CMS-1500, UB-04), or the appropriate electronic filing format. Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Diagnosis codes are required to be billed to the highest level of specificity.

Whenever possible, claims should be submitted electronically. For your clearinghouse's information, CareOregon's EDI# is 93975. For paper claim submission, mail paper claims to the following address:

**Claims, CareOregon  
P.O. Box 40328  
Portland, OR 97240-0328**

### **Coordination of benefits**

All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to CareOregon at the time of billing.

If you have general questions about COA Star HMO-POS or COA Plus HMO-POS SNP plans Terms and Conditions of payment, contact our Customer Service Department at 503-416-4100 or 800-224-4840.



**J3 SUMMARY OF COVERED SERVICES**

Please review the CareOregon Advantage Summary of Benefits for detailed information about covered services.

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## **J4 REFERRALS AND AUTHORIZATIONS**

For Medicare members who are enrolled with CareOregon Medicare Advantage Plus or Star, see Sections D2, D3 and D4 for detailed information on authorization requirements

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## **J5 MEMBER RIGHTS AND RESPONSIBILITIES**

### **J5.1 Member's Rights**

- To be provided information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.) If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that are accessible and appropriate for you
- To be treated with fairness and respect at all times
- To be ensured that timely access to your covered services and drugs
- To choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services
- To go to a women's health specialist (such as a gynecologist) without a referral
- To get your prescriptions filled or refilled at any of our network pharmacies without long delays
- To receive protection of the privacy of your personal health information
- To look at your medical records held at the plan, and to get a copy of your records
- To ask us to make additions or corrections to your medical records.
- To know how your health information has been shared with others for any purposes that are not routine
- To receive information about the plan, its network of providers, and your covered services
- To receive information about the plan, its network of providers, and your covered services
- To get information from us about the

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qualifications of the providers and pharmacies in our network and how we pay the providers in our network

- To receive confidential communications from CareOregon
- To receive support for your right to make decisions about your care, as well as participate fully in decision about your health care
- To be told about all of your treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely
- To be told about any risks involved in your care
- To be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments
- To refuse any recommended treatment, or to stop taking your medication
- To receive an explanation from us if a provider has denied care that you believe you should receive
- To give instructions about what is to be done if you are not able to make medical decisions yourself
- To make complaints and ask us to reconsider decisions we have made
- To get a summary of information about the appeals and complaints that other members have filed against our plan in the past

### **J5.2 Member's Responsibilities**

- Get familiar with your covered services and the rules you must follow to get these covered services
- If you have any other health insurance

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coverage or prescription drug coverage in addition to our plan, you are required to tell us

- Tell your doctor and other health care providers that you are enrolled in our plan
- Show your plan membership card whenever you get your medical care or Part D prescription drugs
- If you receive extra help, be sure to show your state Medicaid card. Your state Medicaid program may cover some prescription drugs not normally covered on a Medicare drug plan
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care
- Follow the treatment plans and instructions that you and your doctors agree upon.
- If you have any questions, be sure to ask
- Be considerate
- To respect the rights of other patients
- To act in a way that helps the smooth running of your doctor's office, hospitals, and other offices
- You must pay your plan premiums to continue being a member of our plan
- In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B
- For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug
- Tells us if you move outside or within our plan service area
- Call Customer Service for help if you have questions or concerns

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