



CareOregon®



Provider Manual

2018

Helpful Contact Information

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| CareOregon Provider Services | 503-416-4100 or 800-224-4840 |
| CareOregon Connect (Provider Portal) | http://www.careoregon.org/providers/provider-portal |
|  CareOregon® Provider Directory | http://coapps.careoregon.org/ |
|  CareOregon® Advantage Provider Directory | http://www.careoregonadvantage.org/provider-directory |
|  Yamhill Community Care™ Provider Directory | http://www.yamhillcco.org/for-members/provider-search |
|  Jackson Care Connect™ Provider Directory | http://www.jacksoncareconnect.org/for-members/provider-search |
|  Columbia Pacific CCO Provider Directory | http://www.colpachealth.org/for-members/provider-search |
| Billing & Payment Address | CareOregon PO Box 40328 Portland, Oregon 97240-0328 Electronic Payer ID: #93975 |

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Welcome to CareOregon

CareOregon Vision

Healthy communities for all individuals regardless of income or social circumstances

CareOregon Mission

Cultivating individual well-being and community health through shared learning and innovation

CareOregon Standards of Service

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

We are equally committed to:

- Providing medically effective health care within state and federal 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.

Philosophy

From a health services perspective, CareOregon promotes care that is based upon the National Institute of Medicine's six quality standards:

- Safe
- Effective
- Efficient
- Patient-centered (culturally appropriate and linguistically sensitive)
- Timely
- Equitable

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.

Members

How an Individual becomes a “CareOregon member”

Individuals become members in CareOregon by joining a CareOregon-affiliated health plan. CareOregon participates in both Medicaid and Medicare Advantage health plans. An individual must meet eligibility criteria and successfully apply to become a member of one or both types of plans. For matters of this manual, all members of a CareOregon-affiliated health plan (CCO or Medicare) will be referenced as “CareOregon members.”

The Oregon Health Plan and Coordinated Care Organizations (CCOs)

The Oregon Health Plan (OHP) is the Oregon Medicaid program administered by the Division of Medical Assistance Programs (DMAP) at the State of Oregon. It has extended Medicaid eligibility to all state residents with incomes up to 138% of the federal poverty level (FPL), as well as children whose family income is up to 300% of the FPL.

Coordinated Care Organizations, or CCOs, were developed by the state to manage and pay for health care at a local community level. Through an integrated model (combining physical, behavioral and dental health), CCOs focus on prevention, chronic disease management, and educating members who may be high utilizers in need of additional assistance. CareOregon administers benefits for four CCOs throughout Oregon.

Medicare Advantage - CareOregon Advantage (COA)

CareOregon operates two Medicare Advantage health plans. CareOregon Advantage (COA) Star HMO plan is for anyone who qualifies for Medicare benefits and has Part A and B. CareOregon Advantage (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 Advantage Plan, CareOregon Advantage also administers Part D, which offers Medicare prescription drug coverage.

OHP Eligibility

Applicants who meet eligibility requirements become eligible for OHP.

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

Adult recipients are eligible for OHP 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.

Applying for the Oregon Health Plan

Application for eligibility is coordinated by Oregon Health Authority offices.

People may also apply directly at www.oregonhealthcare.gov or through the OHP Application Center by calling toll-free 800-359-9517.

Eligibility screeners at federally funded health centers in Oregon are available to help with the application process and answer questions.

Health Plan Enrollment

CareOregon is a medical Managed Care Organization (MCO) and participates in a variety of different Coordinated Care Organizations (CCO) To CCO members, the appearance is one of CareOregon being a “partner.” All material they will receive is branded per their respective CCO.

The following are a list of CCOs that CareOregon participates in:

- Health Share of Oregon
- Jackson Care Connect
- Columbia Pacific CCO
- Yamhill Community Care Organization

When applying for the OHP, recipients may choose an available CCO in their area. Those that do not are appointed randomly to their CCO by DMAP.

DMAP enrolls OHP recipients 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 or CCO enrollment, with some exceptions, or voluntary enrollment with a health plan.

If an OHP recipient is not enrolled in a CCO, he/she receives services through the fee-for-service Medicaid program. The fee-for-service program is managed by DMAP. Claims for these members must be submitted to DMAP for processing.

OHP Members’ Rights and Responsibilities

CareOregon CCO members receive their rights and responsibilities statement in their member handbook at onboarding and with each subsequent revision of the handbook. It is also made available online at their respective CCO website.

These are also available in the [OHP Client Handbook](#).

New and existing providers can review the members’ rights and responsibilities statement in the members’ respective CCO handbook or online at each CCO’s website.

Members' Rights

- Treated with respect and dignity, the same as other patients
- Free to choose your provider
- Urged to tell your provider about all your health concerns
- Able to have a friend or helper come to your appointments, and an interpreter if you want one
- Told about all of your OHP-covered and non-covered treatment options
- Allowed to help make decisions about your health care, including refusing treatment, without being held down, kept away from other people or forced to do something you don't want to do
- Given a referral or second opinion, if you need it
- Given care when you need it, 24 hours a day and 7 days a week
- Free to get mental health and family planning services without a referral
- Free to get help with addiction to cigarettes, alcohol and drugs without a referral
- Given handbooks and letters that you can understand
- Able to see and get a copy of your health records
- Able to limit who can see your health records
- Sent a Notice of Action letter if you are denied a service or there is a change in service level
- Given information and help to appeal denials and ask for a hearing
- Allowed to make complaints and get a response without a bad reaction from your plan or provider
- Free to ask the Oregon Health Authority Ombudsperson for help with problems at 503-947-2346 or toll free 877-642-0450, TTY 711

Members' Responsibilities

- Find a doctor or other provider you can work with and tell them all about your health
- Treat providers and their staff with the same respect you want
- Bring your medical ID cards to appointments, tell the receptionist that you have OHP and any other health insurance, and let them know if you were hurt in an accident
- Be on time for appointments
- Call your provider at least one day before if you can't make it to an appointment
- Have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy
- Follow your providers' and pharmacists' directions, or ask for another choice
- Be honest with your providers to get the best service possible
- Call your case worker when you move, are pregnant or no longer pregnant

Member Appeals and Grievance Rights

An enrollee has the right to file a grievance, appeal, or request a contested case hearing.

- **Timing**
 - (1) A member may file a grievance at any time. The CCO will notify the Member, within 5 business days from the date of receipt of the Grievance, of one of the following: (a) A decision on the Grievance has been made and what that decision is; or (b) That there will be a delay in the Contractor's decision, of up to 30 days. The written notice will specify why the additional time is necessary.
 - (2) If the CCO denies, stops or reduces a medical service a provider has ordered, the CCO will mail the enrollee a Notice of Adverse Benefit Determination (NOABD) letter explaining why the decision was made. If the Member or Provider disagrees with this decision, they may file an Appeal within 60 days from the date on the NOABD. The Member will receive a Notice of Appeal Resolution (NOAR) letter within 16 days with the CCO's decision.
 - (3) If the decision is upheld, the Member can file a Contested Case Hearing request with CCO or OHA, no later than 120 days from the date of the Notice of Appeal Resolution (NOAR). Or, if the CCO fails to adhere to the notice and timing requirements, OHA may deem that the CCO appeals process is exhausted.
- **Filing Procedures/Requirements**
 - (1) A Member, Provider, or Member Representative may file a Grievance, a CCO level Appeal, and may request a Contested Case Hearing;
 - (2) A Member may file a Grievance, either orally or in writing, with OHA or the CCO.
 - (3) A Provider acting on behalf of the Member, and with the Member's written consent, may file an Appeal, either orally or in writing.
 - (4) If the Member and their provider believe that the Member has an urgent medical problem that cannot wait for a regular appeal, an expedited appeal can be requested. Members should include a statement from their provider or ask the provider to call the CCO to explain why it is urgent. If the CCO agrees that it is urgent, a decision will be made in 72 hours.

- (5) The CCO can provide assistance to the enrollee with filing grievances and appeals.
- (6) A Contested Case Hearing can be requested by submitting Form MSC 0443. This form will be included with the NOAR or may be requested by calling the CCO or OHA.
- (7) Include as parties to the Contested Case Hearing: The Member and the Representative; CCO; and the legal representative of a deceased Member's estate.
- (8) A member, or provider, who believes that taking the time for a standard resolution of a Contested Case Hearing could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing.
- (9) OHA's toll-free number is 800-273-0557; CPCCO's toll-free number is 855-722-8206; JCC's toll-free number is 855-722-8208.

An enrollee has the right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or state fair hearing filing.

- Timing
 - (1) Request must be made within 10 days after the date of the Notice of Adverse Benefit Determination (NOABD); or
 - (2) The intended effective date of the Action proposed in the notice.
- The CCO shall continue the Member's benefits if:
 - (1) The Member or Member's Representative files the Appeal or Administrative Hearing request timely;
 - (2) The Appeal or Administrative Hearing request involves the termination, suspension, or reduction of a previously authorized service;
 - (3) The Services were ordered by an authorized Provider;
 - (4) The period covered by the original authorization has not expired; and
 - (5) The Member files timely for continuation of benefits.
- If, at the Member's request, the CCO continues or reinstates the Member's benefits while the Appeal is in process, the benefits must be continued until one of the following occurs:
 - (1) The Member withdraws the Appeal or Contested Care Hearing;
 - (2) The Member does not request a Contested Case Hearing within 10 days from when the CCO mails the Notice of Appeal Resolution (NOAR) to the members appeal;
 - (3) A Contested Case Hearing decision adverse to the Member is made;
 - (4) OHA issues an Appeal decision adverse to the Member; or
 - (5) The authorization expires or authorization service limits are met.
- If the final resolution of the Appeal or Contested Case Hearing is adverse to the Member (upholds the CCO's original decision), the CCO may recover from the Member the cost of the services furnished to the Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

Verifying an OHP Recipient's Health Plan Enrollment

There are four ways to verify health plan enrollment:

- 1) 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

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

OR

- 3) CareOregon Connect, CareOregon's provider portal, at <http://www.careoregon.org/providers/provider-portal>. Only enrolled CareOregon members are in CareOregon Connect. OHP recipients enrolled with a CCO other than CareOregon will not be found in CareOregon Connect. Recipients also receive a member ID Card from their respective CCO that can be used to prove eligibility as a member.

Please visit the provided link above to establish access or to view tutorials for CareOregon Connect.

OR

- 4) DMAP's Medicaid Management Information System (MMIS) at <https://www.or-medicaid.gov/ProdPortal/>. MMIS provides eligibility verification and health plan enrollment for all OHP enrollees. Access can be facilitated through the link provided above.

PCP ASSIGNMENT AND SELECTION

Assigning a PCP to CareOregon Members

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.

Changing PCPs

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

PCPs can help a member select their clinic as the PCP by calling Customer Service or faxing the PCP Reassignment Request Form found at <http://www.careoregon.org/providers/support/policies-and-forms>.

After their first 30 days with their CCO, 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 download their member roster.

Members receive an ID card from their respective CareOregon-affiliated CCO when they enroll and any time they change their PCP, their components within the CCO (i.e change to another DCO or MHO) or when they change their name, benefits or household members.

Member Rosters

PCP clinics can access their current clinic roster of members assigned to their clinic on CareOregon Connect at:

<http://www.careoregon.org/providers/provider-portal>

Call CareOregon Customer Service to verify PCP assignment or check the member's assignment using CareOregon Connect.

Member Complaints

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

If they are not resolved, OHP members have the right to request a hearing by the state's Department of Medical Assistance Programs (DMAP) through its hearing process. Members may call the Customer Service of their CCO to file their complaint.

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.

Mental health providers are required to address complaints consistent with Grievances and Appeals sections as required by Oregon Administrative Rules 309-19 and 309-22.

If a member remains dissatisfied with the provider's response to the complaint, the member should contact their CCO's Customer Service.

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

Resolving Complaints at CareOregon

CareOregon Customer Service logs received complaints and facilitates the member complaint process. Other staff in units such as Care Coordination, Pharmacy, DME, Authorizations and the Senior Medical Director are involved in the process when appropriate.

CareOregon Quality Assurance monitors and analyzes all complaints documented by Customer Service and follows up with appropriate parties until the issue is resolved.

Oregon Health Plan Complaint Forms

If a CareOregon OHP 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 800-273-0557 or TTY: 711.

OHP Complaint Forms are available online at
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3001.pdf

Medicare Advantage Complaints

CareOregon Advantage members may also submit their complaint to Livanta, Oregon's Quality Improvement Organization at 877-588-1123.

Restraint and Seclusion

In compliance with Federal and State law, CareOregon recognizes that each member has the right to be free from any form of restraint or seclusion as means of coercion, discipline, convenience or retaliation.

Restraint is:

- A. Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely; or
- B. A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom or movement and is not a standard treatment or dosage.

Seclusion is the involuntary confinement of a patient in an area or room from which the patient is physically prevented from leaving.

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, clinic staff or others from harm. The type of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member, clinic staff, and/or others from harm. In addition, the nature of the restraint or seclusion must take into consideration the age, medical and emotional state of the member. Under no circumstance may a patient be secluded for more than one (1) hour.

The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by this policy, the provider policy, and in accordance with state law. In addition, the use of restraint or seclusion must be in accordance with the order of a physician or other licensed health care professional who is responsible for the care of the patient.

CareOregon requires contracted providers to have a policy and procedure regarding use of restraint and seclusion as required under the Code of Federal Regulations and also requires the contracted provider to provide a copy of their policy to CareOregon upon request. If a provider is not required to maintain a policy regarding the use of restraints and seclusion, CareOregon requires that the provider submit a Prohibited Procedure or written statement to that effect.

(42CFR, 438.100 (v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation)

Benefits

Medicare Benefits

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. To be a beneficiary with either CareOregon Advantage plan, a member must have Part A and B.

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

To see benefit information for CareOregon Advantage Plus (HMO-POS SNP) you can view them in the current [Plus Summary of Benefits here](#).

To see benefit information for CareOregon Advantage Star (HMO-POS) you can view them in the current [Star Summary of Benefits here](#).

Services covered by the Oregon Health Plan

Prioritized List of Health Services

The 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.

To determine if a service is covered by CareOregon, check the prioritized list on the MMIS portal which may be found at the following link:

<https://www.or-medicaid.gov/ProdPortal/>

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.

The list can also be accessed by calling DMAP Provider Services at 800-336-6016. If a service is not covered by the OHP and a provider decides that treatment is essential, an authorization request may be submitted with relevant documentation to the Prior Authorization department.

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

Services Covered by CareOregon

- Primary care and preventive services
- Specialty services
- Maternity care
- Family planning
- Abortion (voluntary pregnancy termination)
- 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 and JCC members only)
- Chemical dependency services
- Sterilizations & hysterectomies

Sterilizations & Hysterectomies

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. For more information about claims for these procedures, please see the [“Claims”](#) section.

Voluntary Sterilization

For a tubal ligation or vasectomy, the patient must sign the **Consent to Sterilization form** (available in both 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.

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.

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** (available in both 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.

Skilled Nursing Facility Care

OHP members have a 20-day skilled nursing facility benefit. COA members have a 100-day skilled nursing facility benefit. Continued stay is determined based on clinical review and member need.

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.

Managing Care of Members in a Nursing Facility

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.

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 does not require authorization from CareOregon.

Mental Health Treatment Services

All OHP and COA members have access to mental health treatment services. CareOregon strives to ensure members are treated in the least restrictive, community-based setting possible.

Mental Health Treatment 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), an entity which may be separate from CareOregon.

OHP recipients do not choose their MHO. They are assigned to an MHO based on the CCO they select and the county where they live. Although CareOregon coordinates with the MHO, members should contact their MHO to access mental health services.

County MHOs in CareOregon's service area

- Clackamas County: Clackamas County Mental Health
- Clatsop County: Greater Oregon Behavioral Health, Inc (GOBHI)
- Columbia County: GOBHI
- Jackson County: Jackson Care Connect
- Multnomah County: Multnomah County Mental Health
- Tillamook County: GOBHI
- Washington County: Washington County Department of Health and Human Services
- Yamhill County: Yamhill County Health and Human Services

Mental Health Services for COA Members

For COA members, mental health services are 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

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

Contracted providers are listed in the “Mental Health” section of the CareOregon Advantage Provider Directory which may be found at the following link: <https://www.careoregonadvantage.org/provider-directory>

Mental Health in the Primary Care Setting

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

Limited mental health services provided by a PCP, such as medication management when billed with an E&M code, is covered by CareOregon, not the MHO.

Chemical Dependency

Chemical Dependency Coverage for OHP members

The Oregon Health Plan chemical dependency (CD) benefit includes coverage for the diagnosis and treatment of substance use disorders. In Clackamas, Multnomah, and Washington Counties, the CD benefit is covered by the county of member residence. In all other service areas, the CD benefit is covered by CareOregon.

Accessing Chemical Dependency Services Covered by CareOregon

IMPORTANT: Chemical dependency services do not require a referral from the PCP.

Members can self-refer to any CareOregon contracted CD treatment provider for a CD assessment. These providers are listed in the “Drug and Alcohol Dependency” section of the CareOregon Online Provider Directory

The Provider Directory may be found at the following link: <http://coapps.careoregon.org/>

Any provider who assesses a CD problem in a CareOregon member or needs additional consultation may contact a CareOregon CD treatment provider to coordinate an assessment.

At the initial assessment, the CD provider conducts a screening evaluation to determine the appropriate level of service (outpatient treatment, methadone maintenance or inpatient detoxification) and will coordinate with the referring provider if authorized by the member.

Primary CD Providers and Claims

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

The CD provider is responsible for the following actions:

- ensure the member's eligibility with CareOregon
- verify 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 as the claim may be denied.

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.

Authorization of Services

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

To request authorization for hospital detoxification, follow the authorization procedure in the ["Requirements"](#) section.

Dental Health Services

Members have dental health benefits, as well as physical and mental health benefits. Dental benefits are provided through our partner dental care plans. The dental plan is listed on the member's CCO ID card and OHP coverage letter. Members can choose or change their dental plan by calling their CCO. They can choose or change their dentist by calling their dental plan.

| CCO | CCO Phone # | Partner Dental Care Plans | DCO Phone # |
|---|--------------|--|--|
|  | 888-519-3845 | Access Dental Advantage Dental Capitol Dental CareOregon Dental Family Dental Care Kaiser Managed Dental Care of Oregon ODS Community Health Willamette Dental | 877-213-0357 866-268-9631 800-525-6800 888-440-9912 866-875-1199 800-813-2000 800-538-9604 800-342-0526 855-433-6825 |
|  | 855-722-8206 | Advantage Dental Capitol Dental ODS Community Health Willamette Dental | 866-268-9631 800-525-6800 800-342-0526 855-433-6825 |
|  | 855-722-8208 | Advantage Dental Capitol Dental ODS Community Health Willamette Dental | 866-268-9631 800-525-6800 800-342-0526 855-433-6825 |
|  | 855-722-8205 | Capitol Dental | 800-525-6800 |

Dental Benefits and Services

There are two levels of dental benefits:

- OHP Supplemental for pregnant women and members under 21 years of age
- OHP for all other adults

Some services may be limited or need prior approval.

| Benefit Summary | OHP Supplemental (for pregnant women and members under age 21) | OHP (for all other adults) |
|--|--|-------------------------------|
| Emergency Services | | |
| Emergency Stabilization (in or out of service area) Examples: <ul style="list-style-type: none"> • Extreme pain or infection • Bleeding or swelling • Injuries to the teeth or gum | ✓ | ✓ |
| Preventive Services | | |
| Exams | ✓ | ✓ |
| Cleaning | ✓ | ✓ |
| Fluoride treatment | ✓ | ✓ |
| X-rays | ✓ | ✓ |
| Sealants | Limited to age 15 and under | Not covered |
| Restorative and Prosthodontic Services | | |
| Fillings | ✓ | ✓ |
| Partial dentures | ✓ | Limited |
| Complete dentures | Limited | Limited |
| Crowns | Limited | Limited |
| Oral Surgery and Endodontics | | |
| Extractions | ✓ | ✓ |
| Root canal therapy | ✓ | Limited |

Referrals to other providers and specialists

If a member requires a dental specialist or other dental provider, the member should first make an appointment with their primary dental provider. The PDP will decide which services and tests are needed and will refer the member to a specialist, if necessary. The member's dental plan must approve the referral before the member visits a specialist.

Emergency and Urgent Dental Care Services

Emergency dental care is available 24 hours a day, 7 days a week. An emergency is a serious problem that needs immediate care (ie. an injury or sudden severe condition). Some examples of dental emergencies are:

- Bad infection
- Bad abscesses
- Severe tooth pain
- A tooth that is knocked out

Urgent dental care is dental care that needs prompt, but not immediate treatment. Some examples of urgent dental situations are:

- A toothache
- Swollen gums
- A lost filling

Local Care for Emergency and Urgent Dental Care

If the member has a primary dental provider, call them right away. If it is after office hours, the answering service will forward your call to an on-call dentist, who will call you back. They will decide if the member needs to go to an emergency room, to an urgent care center or if they should make an appointment with their primary dental provider for the next day.

If the member does not have a primary dental provider yet, they should call the closest office in their dental plan's provider directory or visit their dental plan's website for an online provider list.

Out of Area Emergency and Urgent Dental Care

If the member is traveling outside of the CCO service area and has an emergency, they should first try to call their primary dental provider or their dental plan. After seeing a dentist for a dental emergency, the member should call their primary dental provider to arrange for further care if needed.

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.

Coverage is 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.

Please note: *VSP is not available in Tillamook County.*

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

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 the “Requirements” section for Authorization Requirements.

Tobacco Cessation

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

<http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html>

For CareOregon members willing to make a quit attempt, providers may refer members for counseling or additional behavioral treatment to the Quit for Life Program through Alere Wellbeing (866-784-8454) or your clinic’s internal cessation program.

Qualified providers may provide a tobacco cessation counseling session or class to a CareOregon member.

How to Quit: Tobacco Information and Prevention www.cdc.gov/tobacco/how2quit.htm
National Quit Line: 1-800-QUIT NOW

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
E-mail: healthinfo@lungoregon.org, or call 503-924-4094, ext. 10.

For pregnant smokers:

Smoke-Free Families is a national program working to help pregnant smokers quit, and publicize effective treatments. <http://tobacco-cessation.org/sf/index.htm>

Smoking and Pregnancy, American Lung Association:
<http://www.lungusa.org/stop-smoking/about-smoking/facts-figures/women-and-tobacco-use.html>

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

Many treatment options are available to assist members in tobacco cessation efforts. These include medications, telephonic counseling, provider interventions, and other community support. Resources can be found at the following link:

<http://www.careoregon.org/members/health-and-wellness/staying-healthy/quitting-tobacco>

Services Covered by DMAP

DMAP covers physician aid in dying (death with dignity services) **regardless of whether the member is enrolled with CareOregon.**

Claims for this service must be sent to DMAP. If a claim is received by CareOregon for these services, it will be returned.

Services Not Covered by the Oregon Health Plan

Providers can provide services not covered under the OHP to CareOregon members, but arrangements for reimbursement must be negotiated between you and the member. The member must sign an **OHP Client Agreement to Pay for Health Services form** before services are performed. This form may be located at the following link: <http://www.oregon.gov/oha/healthplan/pages/forms.aspx>

Providers 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 recipients for covered services. You can read more in the "[Member Billing](#)" section

Member Care and Support Services

Primary Care and Non-Primary Care

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.

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
- 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

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 [“Referrals and Authorizations,”](#) 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
- Mental health treatment not provided in a primary care setting
- 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

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.
- 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.

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.

Physical Access

All participating CareOregon provider clinics 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.

Appointment Availability and Standard Scheduling Procedures

Specific scheduling standards for mental health providers can be found in the Mental Health Practice Guidelines.

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.

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.

Non-Scheduled Walk-ins

Provider procedures for triaging walk-ins must 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.

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 Appendix A for more information on the discharge and disenrollment process).

Mental health providers may not discharge members based on missed appointments, as applicable to 410-141-0080.

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

24-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:

- **Access 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 assists 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 the ["Interpretation"](#) section for more information about interpretation).

- **Access 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 Provider Relations Specialist at <http://www.careoregon.org/providers/support>

After-hours access options for members must include one or the other:

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.

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.

Quality Assurance Program

CareOregon's Quality Program is the mechanism through which CareOregon provides structure and processes to ensure that care provided to members is accessible, cost effective, and improves health outcomes. It is designed to support achievement of clinical and operational performance goals and to ensure that CareOregon meets its regulatory and contractual deliverables to the Oregon Health Authority (OHA), the Centers for Medicare and Medicaid Services (CMS), and other relevant accrediting bodies.

The Quality Program reflects the imperative of the Triple Aim to improve the member's experience of care, improve the health of populations, and reduce the per capita cost of care. CareOregon pursues these aims through the implementation of programs and strategies that have the following objectives:

- 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
- Ensure quality and accountability through achievement of relevant clinical performance metrics
- 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.
- Create and support the capacity development of community providers to facilitate clinical change

The effectiveness of the Quality Program is monitored through CareOregon's Quality Committee, which reports directly to the Network and Quality Committee of the CareOregon Board of Directors. The Quality Committee is structured to directly support the delivery system in building the infrastructure to support population health, deliver high-risk member interventions, and improve clinical processes and workflows that impact clinical performance metrics. The Quality Committee includes contracted providers (primary care, specialty care, behavioral health), and CareOregon staff (QI, QA, plan operations, network and clinical support, clinical innovation).

Clinical Practice Guidelines

CareOregon, through its Quality Committee 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 at the following link:

<http://www.careoregon.org/providers/best-practice-guidelines>.

Mental health practice guidelines are posted at the following link:

<http://jacksoncareconnect.org/for-providers/policies-and-forms>

Paper copies of these guidelines are available upon request. Please call CareOregon Customer Service at 503-416-4100 and ask to speak to someone in our Quality Assurance Department.

Medical Records

CareOregon has guidelines for medical record keeping. Please review and incorporate CareOregon's guidelines for medical records into your practice.

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.
- 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 compliant with applicable privacy laws.
- Medical records are stored securely.

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
- Advance Directives, guardianship, power of attorney or other legal healthcare arrangements, when applicable
- 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 as well
- History of presenting problems and a record of a physical exam for the presenting problem(s)
- Diagnoses for presenting problems
- Plans of action (treatment plan) consistent with diagnoses
- Vital signs, height, weight, etc
- Laboratory and other studies ordered, as appropriate, and initialed by the primary care provider
- Documentation of referrals to and consultations with other providers
- Documentation of appropriate follow-up
- Emergency room and other 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
- Copies of signed release of information forms
- Copies of medical and/or mental health directives
- Age-appropriate screenings and developmental assessments
- Copies of advance directives and/or mental health declarations.

Medical records for mental health services covered by Jackson Care Connect must adhere to applicable OARs or can be viewed at [the following link](#).

Medical Record Review

CareOregon reviews medical records of contracted primary care and mental health providers on a regular schedule or as the need arises. CareOregon staff adhere to HIPAA-mandated confidentiality standards.

A CareOregon contracted provider who refuses to cooperate with the medical record review process, Peer Review requirements, corrective action plans, or who is unable to meet [provider qualifications and requirements](#) may have his/her contract terminated with cause.

Confidentiality

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 as well as 42 CFR Part 2, as applicable.

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.

Disclosure of health information in medical or financial records can only be 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.

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.

Interpretation

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

Interpretation must be available during and after hours for consultation 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's interpretative services do not cover the following occurrences:

- Appointment reminders
- Scheduling or rescheduling appointments
- Relaying test results
- Registration for procedures/admissions
- Telephonic services less than 10 minutes in duration

CareOregon coordinates and pays for 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 at:

<http://www.careoregon.org/providers/support/policies-and-forms>

Fax it to PTL at **503-297-1703** at least two business days before the appointment.

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

<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.**

Intensive Case Management (ICM)

As part of its function as a health plan, CareOregon provides intensive case management to older, blind and/or disabled CareOregon OHP members. CareOregon also provides ICM services to any CareOregon member who has special needs or who is at risk for adverse outcomes. ICM services include:

- Assisting members and providers to ensure timely access to needed services
- Coordination with providers to ensure that members' special needs are considered in treatment planning
- Assisting providers to coordinate services and plan discharges
- Assisting members to transition from one level of care to another
- Assisting members to access appropriate end-of-life care resources
- Assisting with the coordination of community support and social service interactions within medical care systems

ICM Referrals

Potential candidates for CareOregon ICM services 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 assistance treating members who show inappropriate, disruptive or threatening behaviors

To make a referral:

1. Call 503-416-4100 or 800-224-4840, daily 8 a.m. - 8 p.m. TTY/TDD users call 711.
2. Explain the reason for the call.

The Customer Service Representative either addresses the service need or forwards the call to a Health Care Coordinator on the Care Coordination Team.

Transportation for OHP members

Non-emergent medical transportation to medical appointments is a benefit to OHP members.

Multnomah, Clackamas and Washington counties:

Ride To Care

Ride scheduling: 503-416-3955

TTY: 503-802-8058

Toll-free: 855-321-4899

Website: www.ridetocare.com

Hours: 7 a.m. – 7 p.m., Monday through Saturday

Ride To Care provides free rides to covered medical appointments for Oregon Health Plan Plus members who have no other transportation options.

- CareOregon members must call Ride To Care to schedule a ride at least two business days in advance of their appointment. Members may schedule a trip up to 90 days before their appointment date.
- CareOregon members need to have available their Oregon Health Plan number, time and date of their appointment and name, complete address and phone number of their medical caregiver.
- Ride To Care can help provide transportation for members with short notice. Members need to tell the operator if they have urgent transportation needs. For example, a ride to an urgent care clinic, or if the member requires transportation to and from dialysis or chemotherapy.
- Ride To Care has interpreters available for non-English speaking members. This service is free. Members can call Ride To Care and say the language they speak and stay on the line. A Ride To Care representative and interpreter will help them.
- CareOregon members may call Ride To Care, 855-321-4899, to obtain bus tickets.
- Ride To Care operators are there in person to answer calls 24 hours a day, 7 days a week, 365 days a year.

Ride To Care LIFT Program

Phone: 503-416-3955

TTY: 503-802-8058

Hours: 7 a.m. – 7 p.m., Monday through Saturday

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.

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.

Columbia, Clatsop and Tillamook counties

RideCare (Sunset Empire Transportation District)

Toll-free: 866-811-1001; local: 503-861-0657

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

Jackson County

TransLink (Rogue Valley Transportation District)

Toll-free: 888-518-8160; local: 541-842-2060

Marion, Polk and Yamhill counties

Yamhill CCO WellRide

Toll-free: 844-256-5720

Hours: 7:30am – 6:00pm, Monday - Friday

NOTE: Yamhill CCO members should arrange rides at least 2 days before their appointments, or as soon as their appointment is scheduled.

Health Promotion Materials

CareOregon provides information to our members on specific health care procedures, promotion, and instruction in self-management of their health.

CareOregon offers health promotion and educational opportunities to our members directly through targeted mailing, resources available on the CareOregon website and through community partnerships.

Doing Business with CareOregon

Provider Relations

CareOregon Provider Relations Specialists (PRSs) are assigned to PCPs, specialists and hospitals based on geographic territories and health systems. Provider Relations Specialists are a link between our clinician network and CareOregon staff. They help clinic staff with questions or needs regarding our Medicaid (Oregon Health Plan) and Medicare Advantage plans and members.

Provider Relations Specialists provide training on the following topics:

- Orientation to health plan operations, policies and procedures (upon contracting)
- Refresher orientations for clinic, billing or management staff as needed
- Online resources such as CareOregon Connect and the CareOregon website(s)

To contact a PRS, visit <http://www.careoregon.org/providers/support>

The Provider Relations Specialists also manage contractual relationships to develop an informed and comprehensive network, ensuring member access.

IMPORTANT: Please e-mail updates to the Provider Relations team about changes, such as new and terminated providers or clinic staff, locations, telephone numbers and e-mail addresses.

The email address is ProviderUpdates@careoregon.org

Timely updates facilitate accurate directory listings, mailings, correct claims payment, system access for your staff and (for primary care clinics) appropriate member assignments.

Provider Relations Specialists collaborate with clinicians, OHA, 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 a PRS, contact Customer Service for assistance.

Contracting

If a provider is interested in contracting with CareOregon, the Provider Relations Specialist can be contacted to initiate the process. If it is determined that a contractual relationship is needed, the Provider Relations Specialist will require the provider to submit the following:

- Current W-9 Request for Taxpayer Identification Number and Certification
- Completed Compliance and Fraud, Waste, and Abuse Attestation form
- Completed Provider Information Form

Once received, the Provider Relations Specialist will coordinate the development of a contract. Once the contract has been executed, credentialing may be required prior to claims being reimbursed at the contracted amounts.

Practice Capacity and Restrictions

During the contracting process, CareOregon and primary care practices agree to 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.

Primary care practices that wish to request a change of capacity may contact a Provider Relations Specialist. A 30-day notice, written or electronic, is required to minimize network access disruptions. However, changes may be implemented sooner under extenuating circumstances.

Credentialing

General Guidelines

When contracting with CareOregon, the following providers are subject to the credentialing process:

- Audiologist
- Behavioral Health Specialist (LCSW, LMFT, LPC, PHD, PsyD)
- Certified Nurse Midwife
- Clinical Pharmacist
- Doctor of Dental Surgery
- Doctor of Dental Medicine
- Denturist
- Doctor of Medicine
- Doctor of Naturopathy
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Expanded Practice Dental Practitioners
- Licensed Acupuncturist
- Licensed Electrologist
- Nurse Practitioners
- Occupational Therapist
- Physician Assistant
- Speech Therapist
- Physical Therapist

During the credentialing process, the CareOregon Credentialing Committee may deny, suspend or terminate a provider's participation with the plan.

The 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.

It is the responsibility of the provider to notify CareOregon of any changes in the available rendering providers and to submit appropriate credentialing information as per contract requirements. Failure to do so will result in reimbursement at non-participating rates.

Initial Credentialing

Prospective providers intending to contract with CareOregon must submit a signed and dated Oregon Practitioner Credentialing Application in addition to the following information:

- 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
- Clinic restraint and seclusion policy or a statement on letterhead attesting that the practice is prohibited

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, and site visit reviews (for PCPs and Primary Dental Providers only). They may request additional information, if necessary, and will recommend acceptance or rejection of the application. The CareOregon Network and Quality Committee (a subcommittee of the board) grants final approval.

Recredentialing

All credentialed providers are recredentialled at least once every three years. Ninety days before the provider's recredentialing date, CareOregon will send 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, updated clinic Seclusion and Restraint policies, 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 additional actions that may include a recommendation to send the provider a notice of termination.

Provider Rights

CareOregon considers it essential to maintain a provider panel that has the legal authority, relevant training and experience to provide care for all members. Provider rights ensure that all participants are aware of their rights during the credentialing process. CareOregon advocates for provider rights to be readily accessible and understandable to all providers, available at the time of initial credentialing and at the beginning of each recredentialing cycle. This policy applies to all records maintained on behalf of CareOregon, including the credentials and performance improvement files of individual providers. Peer references, recommendations, or other peer review protected information is excluded from this list of rights. 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.

CareOregon has adopted the following Provider Rights that shall apply to all contracted medical professional providers.

It is the right of each participating provider involved in the credentialing/recredentialing process:

- To be free from discriminatory practices such as discrimination based solely on the applicants race, ethnicity, gender, national identity, age, sexual orientation, or other types of procedures or by the type of patients the provider specializes in. Providers are free from discrimination based on serving high-risk populations or specializing in conditions that require costly treatment.
- To have the right 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 via Provider Rights Policy and Procedure and by other means.

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.

CareOregon assesses organizations to ensure that each facility is in good standing with state and federal regulatory bodies and/or reviewed and accredited by an approved body. Hospitals, home health agencies, skilled nursing facilities and free standing surgical centers must also be reviewed and/or approved by an accrediting body.

Claims

Submit Claims

To submit claims electronically, use EDI Payer ID 93975.

Contact your practice management system vendor or clearinghouse to initiate electronic claim submission. CareOregon accepts HIPAA-compliant 837 electronic claims through our clearinghouse, Change Healthcare. Change Healthcare will validate the claims for HIPAA compliance and send them directly to CareOregon.

Change Healthcare offers several solutions for providers without a practice management system or clearinghouse, contact them at 866-369-8805 for medical claims and 888-255-7293 for dental claims.

If you need assistance with claims you submitted but CareOregon has not received, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse or vendor. They will be able to confirm their receipt of the claim and if their submission to Change Healthcare was successful.

For more information, see instructions for completing the CMS 1500 or UB04 forms at www.cms.hhs.gov/manuals/downloads/clm104c26.pdf and www.cms.hhs.gov/manuals/downloads/clm104c25.pdf

Incomplete claims are denied for resubmission with the missing information.

Claims must include the member's diagnostic code(s) 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:

- Claims that use non-primary diagnosis codes for the primary or sole diagnosis
- Claims with an invalid diagnosis or invalid procedure or revenue code
- Claims for services that require an authorization but no authorization was obtained

They may be resubmitted with a valid diagnosis code. CareOregon use the Ingenix version of the ICD-10 as a guideline.

For specific claims questions,

- e-mail claimshelp@careoregon.org
- Call CareOregon Customer Service

Timely Filing

Eligible claims for covered services for CareOregon Advantage claims must be received within 1 calendar year from the date of service. Eligible claims for covered services for Medicaid members must be received within 120 days from the date of service per Oregon Administrative Rule 410-141-3420 (1).

CareOregon may choose to waive the timely filing rule for Medicaid if a claim meets one of the following criteria and proof is submitted:

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

DMAP ID Number

As a contracted CareOregon provider serving OHP members, providers must have an active DMAP ID in order to maintain contract status and be eligible for payment. In order to process a claim, the rendering, attending and billing provider's National Provider Identifier (NPI) is verified as eligible to receive payment by DMAP and enrolled with an ID number. The DMAP ID number is considered a minimum requirement for claims processing and must be maintained.

A rendering, attending or billing provider's DMAP ID can be inactivated due to a number of reasons, such as license expiration, returned mail, etc.

To verify active enrollment status with DMAP:

- Click on the following link:
<https://www.or-medicaid.gov/ProdPortal/Home/ValidateNPI/tabId/125/Default.aspx>
- Enter the provider NPI and date of inquiry (e.g. date of service)
- Click on search button

If the provider NPI is not actively enrolled for the date of service entered, submit claims to CareOregon and simultaneously complete and submit the Oregon Medicaid ID Application Form as instructed at the following link:

<http://www.careoregon.org/providers/support/policies-and-forms>.

CareOregon will enroll the NPI and automatically reprocess any previously denied claims received with the dates of service within the previous calendar year for that reason.

CareOregon does not enroll out-of-area and non-participating providers without first receiving a claim; it is appropriate to submit both claims and DMAP ID Application Form simultaneously. CareOregon will not enroll providers until a claim has been received. Incomplete Oregon Medicaid ID Application Forms received will not be processed.

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:

- Re-bundling 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.

Readmissions to Diagnosis Related Groups (DRG) Hospitals

The following readmissions within 30 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

Timely Payment

CareOregon pays providers 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 diagnostic and CPT codes are valid.

Claims Appeals

CareOregon/Medicaid and CareOregon Advantage/Medicare

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

Reconsideration for Payment

- Denied for missing information/documentation not including authorization related denials
- Duplicate claims
- Timely filing denials

Post Service Provider Claim Appeal

- Previously upheld reconsiderations for payment
- Authorization related denials
- Contract rate
- Excluded benefits

IMPORTANT: CareOregon must receive appeals no more than 365 days from the remittance advice date of when the claim was originally processed.

Submit provider reconsideration/appeal request in writing by completing the **Provider Post Service Claim Reconsideration/Appeal Form** which may be found at:

<http://www.careoregon.org/providers/support/policies-and-forms>

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 claim appeals to:
CareOregon Claims Department
Reconsideration/Claim Appeals
PO Box 40328
Portland OR 97240-0328

For Medicare Advantage claims, please fax claim appeals to ATTN: Claim Appeals Coordinator at 503-416-1330.

For Medicaid claims, please fax claim appeals to ATTN: Claim Appeals Coordinator at 503-416-8115

CareOregon directly 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.

Member Billing

State and federal regulations require that a provider accepting Medicaid payment, accept it as payment in full. Furthermore, they are prohibited from billing Oregon Health Plan recipients for missed appointments and OHP-covered services, except for coinsurance, copayments and deductibles expressly authorized by the General Rules, OHP Rules and/or federal rules.

As allowed by 42 CFR 447.15 and per Oregon Administrative Rule 410-120-1280, 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 OHP recipient in the following two circumstances: (refer to above OAR for other examples)

1. The service provided is not covered by the OHP and the member signed an OHP Client Agreement to Pay for Health Services form before the member was seen. This form can be found at the following link:

<http://www.oregon.gov/oha/healthplan/pages/providers.aspx>

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.

2. 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. A member's eligibility can be verified by accessing CareOregon Connect at <http://www.careoregon.org/providers/provider-portal> or the state of Oregon's MMIS portal at <https://www.or-medicaid.gov/ProdPortal/>.

Coordination of Benefits

If there is a primary carrier, such as Medicare or private insurance, or third party resource, such as worker's compensation, and CareOregon is the secondary payor, 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 Advantage Plus, the primary EOB does not need to be submitted.

If the member has both Medicare and Medicaid, Medicare may not be required to be billed first if the claim meets criteria outlined in 410-172-0860.

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 members with other primary payors, 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 (see examples #1 and #2).
- If CareOregon's payment is **greater** than the other carrier's payment, CareOregon pays the difference, but does not exceed the member's responsibility (see example #3).

EXAMPLE #1

| | |
|---------------------------------|-------------|
| Total billed | \$100 |
| Other plan paid | \$40 |
| Member responsibility..... | \$60 |
| CareOregon normal benefit | \$80 |
| CareOregon pays..... | \$40 |

EXAMPLE #2

| | |
|---------------------------------|------------|
| Total billed | \$100 |
| Other plan paid | \$40 |
| Member responsibility..... | \$60 |
| CareOregon normal benefit | \$0 |
| CareOregon pays..... | \$0 |

EXAMPLE #3

| | |
|---------------------------------|-------------|
| Total billed | \$100 |
| Other plan paid | \$24 |
| Member responsibility..... | \$76 |
| CareOregon normal benefit | \$65 |
| CareOregon pays..... | \$41 |

Procedure Specific Claims

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 hysterectomies and voluntary sterilizations that are performed without proper informed consent. **Therefore, CareOregon cannot reimburse providers for these procedures without proof of informed consent.**

In order for CareOregon to pay any claims, providers must submit a completed and signed consent form with hysterectomy and sterilization claims.

The Hysterectomy Consent form can be found at:

https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he0741.pdf

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

- DMAP 742A is for people age **21 years and older**.
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he0742a.pdf
- DMAP 742B is for people who are **at least age 15 but not older than 20 years**.
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he0742b.pdf

Spanish consent forms

- **Hysterectomy** Consent, Spanish:
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/hs0741.pdf
- Consent to **Sterilization, Spanish: age 21 and older**
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/hs0742a.pdf
- Consent to **Sterilization, Spanish: ages 15-20**
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/hs0742b.pdf

Vaccines For Children (VFC) Billing

<http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/index.aspx>

CareOregon does not reimburse for the cost of vaccine serums covered by the Vaccines for Children (VFC) Program; however, we do reimburse fees associated with administering the vaccine for providers participating in the VFC Program. If a provider chooses not to participate in the VFC program, CareOregon will not reimburse for the cost of the vaccine serum and any fees associated with administering the vaccine.

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

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 an **OHP Client Agreement to Pay for Health Services Form** before the member is seen. See the "[Member billing](#)" section for more information.

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.

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.

Overpayment Recovery

When an overpayment is identified, CareOregon uses an auto-debit method recover funds. This process involves reversing the appropriate group of claims future claims payments are automatically debited until the outstanding overpayment balance is settled.

If, as a result of an audit, claims you submitted to CareOregon cannot be validated based on medical records and/or are not clinically indicated, those claims payments will be considered to be overpayments and are subject to recovery by CareOregon on behalf of the Oregon Health Authority and CMS. Please handle overpayment disputes as outlined in this manual and your provider agreement.

Fraud, Waste and Abuse

All participating CareOregon provider clinics must adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with Centers for Medicare and Medicaid Services (CMS) program requirements and fraud, waste and abuse. Training and education must occur at a minimum annually and must be a part of new employee orientation, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member.

CMS fraud, waste and abuse training can be found on our website at:

<http://www.careoregon.org/providers/support>

Provider Audits

CareOregon is committed to promoting quality improvement, payment integrity and minimizing fraud, waste, and abuse. CareOregon may periodically perform audits of paid claims which may call for records and clinical documentation to be submitted for review for HEDIS or other quality program initiatives; risk management purposes; or payment integrity monitoring and oversight practices. CareOregon may use extrapolation to establish the results of an audits' findings.

As a CareOregon contracted provider, refusal to cooperate with the medical record review as part of the audit process, Peer Review requirements, corrective action plans, or otherwise being unable to meet provider qualifications and requirements may result in contract termination.

Referrals and Authorizations

CareOregon's Health Services Operations manages the authorization requirements for the following services:

- Ancillary tests and treatment
- Some mental health services
- Durable medical equipment and supplies
- Facility admissions and lengths of stay
- Home health services, including infusions and enteral/parenteral services
- Hospice
- Office visits and procedures
- Orthotics and prosthetics

Referrals

A **referral** is the act of one professional recommending that another professional evaluate or provide treatment to their patient.

Refer to Contracted Providers/Facilities

Services covered by CareOregon Medicare Advantage and CareOregon OHP do not require referrals. To obtain the most current information on contracted clinicians and facilities, contact CareOregon Customer Service or search the Provider Directory, which may be found at the following links:

Health Share/CareOregon: <http://coapps.careoregon.org>

Columbia Pacific CCO: <http://www.colpachealth.org/for-members/provider-search>

Jackson Care Connect: <http://www.jacksoncareconnect.org/for-members/provider-search>

Yamhill CCO: <http://www.yamhillcco.org/for-members/provider-search>

CareOregon Advantage: <http://www.careoregonadvantage.org/provider-directory>

Authorizations

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

Criteria for Utilization Management Decisions

The table below identifies criteria used for utilization management (UM) decisions for CareOregon Medicare 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</p> <p>Review (Retroactive Authorizations)</p> | <p><u>OHP (Medicaid)</u></p> <ul style="list-style-type: none"> • Member eligibility (OHP Plus) • OHP benefits (Prioritized List and Provider Guides) http://www.oregon.gov/OHA/healthplan/pages/policies.aspx • CareOregon authorization policies • http://www.careoregon.org/providers/support/policies-and-forms • InterQual[®] criteria • Medical literature COA <p><u>CareOregon Advantage (Medicare)</u></p> <ul style="list-style-type: none"> • Member eligibility • National and Local Coverage Determinations – Parts B and A (NCD/LCD) http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd https://www.noridianmedicare.com/p-medb/ https://www.noridianmedicare.com/p-meda/ • Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals • InterQual[®] criteria • CareOregon authorization policies http://www.careoregon.org/providers/support/policies-and-forms |
| <p><u>Pharmacy</u></p> <p>Prior Authorization</p> <p>Retrospective</p> <p>Review (Retroactive Authorizations)</p> | <p><u>OHP (Medicaid)</u></p> <ul style="list-style-type: none"> • Member eligibility • OHP benefits (Prioritized List and Provider Guides) http://www.oregon.gov/oha/healthplan/Pages/pharmacy-policy.aspx • CareOregon Medicaid Guidelines for OHP <p><u>CareOregon Advantage (Medicare)</u></p> <ul style="list-style-type: none"> • Member eligibility • National and Local Coverage Determinations – Parts B and A (NCD/LCD) http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd https://www.noridianmedicare.com/p-medb/ https://www.noridianmedicare.com/p-meda/ • Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals • Medicare Prescription Drug Benefit Manual • CareOregon Advantage PA Guidelines for COA |

Requirements

Some specialty care, procedures, DME, and services provided by non-contracted providers may require an authorization. To determine which services require authorization and to access the appropriate form, see the CareOregon website at the following link: <http://www.careoregon.org/providers/support/policies-and-forms>

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

Responsibilities

The PCP is responsible for obtaining an authorization for the initial specialty or ancillary visit that requires 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 subsequent services require 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 Health Services Operations 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 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.

Authorization Determinations

Timely authorization determinations will be made when the prior authorization requests that are submitted have complete information, including correct coding and with relevant chart notes attached. Medicare and the Oregon Health Plan allow up to 14 calendar days to make prior authorization determinations. Additional time may be allowed to make a determination if it is in the best interest of the member.

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. Authorization time frames and number of visits approved differ based on the type of service being authorized and any benefit limits that may exist.

Retroactive Authorization Requests

CareOregon accepts retroactive authorization requests for medical services. Since the service has already been provided, it may take CareOregon up to 45 days from the date of the request to make a decision.

Providers will receive written notification if the request is denied or approved. If a denial determination is issued for Oregon Health Plan members, the provider cannot bill the member. Therefore it is recommended that providers submit authorization requests prior to the service being provided whenever possible.

Denials

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

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

CareOregon does not reward staff for denying authorization requests and CareOregon do not use financial incentives to reward underutilization.

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

Appeals

Denial letters indicate to members that they may contact CareOregon to request an appeal. Appeals must be requested within 45 days of the date of the denial letter. Providers may appeal on behalf of the member.

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 of the decision.

Members who want to appeal directly to the Oregon Health Authority 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 OHA, it is processed by CareOregon; however, the final decision is made by an administrative law judge contracted by OHA to hear appeals.

Pharmacy Program

CareOregon Formularies

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.

The CareOregon Medicaid Formulary does not contain Mental Health drugs which are covered directly by DMAP.

The **CareOregon Medicare Advantage** 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).

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:

- The pharmacy benefit is limited to generics when Food and Drug Administration (FDA) – rated generic equivalents 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
- 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
- Drugs used for the symptomatic relief of cough and colds
- Drugs when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose, i.e. morbid obesity)
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride, and fluoride preparations (Medicaid)
- Prescription vitamins and minerals, except prenatal vitamins and fluoride (Medicare)
- Other drugs specifically excluded from coverage under Medicaid and/or Medicare, such as drugs not approved by the FDA

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 the **“Contracted Pharmacies”** section.

The drugs listed in the CareOregon Medicaid Formulary do not have copays. The drugs listed in the CareOregon Advantage Formularies might have copays which may change from year to year. For more information, see the [CareOregon Advantage Plus](#) or [CareOregon Advantage 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 QL, 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 has not demonstrated failure of or contraindication to the prerequisite drug(s).
- 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 Request form if member does not meet age criteria (Medicaid only).
- Drugs labeled **QL or Quantity Limit** are restricted to specific quantities. If a provider or member wants to exceed the limit, a Formulary Exception request must be submitted and approved.

The formularies and formulary updates for Medicaid are on the CareOregon web site at: <http://www.careoregon.org/providers/support/pharmacy-help-desk/formulary-list-and-updates>

The formularies and formulary updates for Medicare are on the CareOregon Advantage web site at: <https://www.careoregonadvantage.org/providers/rx-and-drug-information>

PLEASE NOTE: formulary updates are posted by the first of each month for Medicare and every other month for Medicaid.

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.

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
- Brand drugs with generic equivalents are considered non-formulary and can be requested through the Formulary Exception Process
- Drugs listed in the formulary or formulary updates with “AR” restrictions prescribed to members who do not meet age criteria (Medicaid only)
- 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

For Medicaid (OHP), the prior authorization guidelines are available on the website at <http://www.careoregon.org/providers/support/policies-and-forms> for Medicaid or

For Medicare, prior authorization guidelines can be found at:
<http://www.careoregonadvantage.org/providers/rx-and-drug-information> .

To obtain prior authorization or request a formulary exception, fax a completed Prior Authorization and Formulary Exception Request form to 503-416-8109. You can find the form at <http://www.careoregon.org/providers/support/policies-and-forms>

Providers must provide information to support a formulary exception request including a statement of medical necessity on why the covered alternatives are not appropriate.

The pharmacy benefit is limited to generics when Food and Drug Administration (FDA) rated generic equivalents are available. Brand drugs with generic equivalents are considered non-formulary and can be requested through the Formulary Exception Process.

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 Customer Service.

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 “Injectables/Medications Administered Under the Medical Benefit” at <http://www.careoregon.org/providers/support/policies-and-forms>

To request prior authorization for a Medical Benefit Injectable:

1. Complete the appropriate “Injectable Authorization Form” available at <http://www.careoregon.org/providers/support/policies-and-forms>
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 503-416-4722.

Contracted Pharmacies

Search for CareOregon contracted participating pharmacies by city or county in the Provider Type field at <http://coapps.careoregon.org>

Search for CareOregon Advantage contracted pharmacies in the COA Pharmacy Directory at <http://www.careoregonadvantage.org/member-resources/find-a-pharmacy>

Contracted pharmacies are also listed in the pharmacy directory that CareOregon Advantage members receive when they enroll.

Pharmacy providers who have questions related to pharmacy claims processing should call CareOregon Customer Service at 503-416-4100 or 800-224-4840.

Drug Denials and Appeals

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

The prior authorization guidelines are available on the website at <http://www.careoregon.org/providers/support/policies-and-forms> for Medicaid or <https://www.careoregonadvantage.org/providers/rx-and-drug-information> for Medicare. Upon request, CareOregon can also provide the benefit provisions, guidelines or criteria on which the denial decision was based. This information can be provided by mail, fax, email or orally. Please call CareOregon Customer Service.

To appeal a denied pharmacy prior authorization, check the denial letter for instructions on the appeals process. Appeals for medications prescribed to Medicaid members should be submitted to us by mail or fax, but for our Medicare members, appeals can also be started by phone if you contact the Pharmacy Services department of CareOregon Advantage at 503-416-4279.

Discharge and Disenrollment of Members

- **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.

Requirements

Although there are general Oregon Health Authority (OHA) guidelines for discharging a member from a PCP, CareOregon is responsible for establishing specific discharge policies and procedures. CareOregon must follow the guidelines established by the OHA regarding disenrolling members from the plan.

CareOregon's 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.

For guidelines for disenrolling or discharging a member for specific scenarios, please review the procedures in [Appendix A](#).

If clinic management decides to discharge the member, a letter must be sent 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 and additional actions may be required.

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

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 OHA 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 OHA/DHS Fraud Investigations Unit as appropriate. Call the Fraud Hotline at 1-888-FRAUD01 (1-888-372-8301).

When a Member *Cannot* Be Discharged

According to OHA 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

Key Factors 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.

Medicare Advantage Terms and Conditions

CareOregon operates Medicare health plans called Care-Oregon Advantage (COA) Star HMO plan and Care-Oregon 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.

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 the following link:

www.careoregonadvantage.org.

Medicare Advantage Requirements (Policies and Procedures)

- 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])
- 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])
- COA will cover renal dialysis services provided while the member is temporarily outside the COA service area. (42CFR 422.100[b])
- Medicare Advantage allows members to directly access (through self-referral) mammography screening and influenza vaccinations. (42CFR 422.100[h])
- COA and participating providers may not impose cost-sharing for influenza vaccine and pneumococcal vaccine for COA members. (42CFR 422.100[h])
- 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))
- 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))
- 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)
- COA and participating providers may not distribute any marketing materials or election forms without prior approval from CMS. (42CFR 422.80)
- 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))
- 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)
- Participating providers will provide covered services in a manner consistent with professionally recognized standards of health care. (42CFR 422.502(a))

- 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)
- Participating provider payments from COA are, in whole or in part, from federal funds. (42CFR 422.502(h))
- 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))
- 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)
- 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))
- 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)
- Participating providers agree to adhere to the requirements of the quality improvement program (see the ["Quality Assurance Program"](#) section). 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])
- 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))
- 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)

- 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)
- COA and participating providers agree to adhere to member appeal and grievance procedures. (42CFR 422.562[a])
- 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])

Terms And Conditions For Payment

CareOregon offers CareOregon Advantage (COA) Star HMO 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 or COA Plus HMO-POS SNP for benefits not covered under Original Medicare.

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

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

- The provider is aware, in advance of furnishing health care services, that the patient is a member of COA Star HMO or COA Plus HMO-POS SNP. All COA members receive a member ID card that clearly identifies them as POS members. The provider may verify eligibility by calling CareOregon Customer Service or on CareOregon Connect which can be found at the following link:
<http://www.careoregon.org/providers/provider-portal>
- 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 via our provider manual (this document). The Terms and Conditions may also be obtained by calling CareOregon Customer Service. The provider furnishes covered services to a COA Star HMO or COA Plus HMO-POS SNP member.

If all these conditions are met, the provider is deemed to have agreed to COA Star HMO 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 or COA Plus HMO-POS SNP member. A decision to treat one plan member does not obligate you to treat other COA Star HMO or COA Plus HMO-POS SNP members.

Providers not willing to accept these Terms and Conditions of payment should only furnish emergency services to a COA Star HMO or COA Plus HMO-POS SNP member. Nonetheless, providers furnishing non-emergency services will be subject to these Terms and Conditions whether explicitly agreed to or not.

Provider qualifications and requirements

In order to be paid by CareOregon for services provided to members, a provider must:

- Have a National Provider Identifier in order to submit electronic transactions to CareOregon, in accordance to HIPAA requirements.
- Be licensed or certified by the state and furnish services to a COA Star HMO or COA Plus HMO-POS SNP member within the scope of 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 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 or COA Plus HMO-POS SNP members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by CareOregon, 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.

Filing a claim for payment

Claims must be submitted to CareOregon for covered services within the same time frame required by Original Medicare. Failure to submit timely claims may result in non-payment.

Claims must be submitted using an industry standard claim form (CMS-1500, UB-04), or the appropriate electronic filing format and using 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 or COA Plus HMO-POS SNP plans Terms and Conditions of payment, contact CareOregon Customer Service.

Summary of Covered Services

Please review these documents for detailed information about covered services.

- [CareOregon Advantage Star Summary of Benefits](#)
- [CareOregon Advantage Plus Summary of Benefits](#)

Medicare Referrals and Authorizations

For Medicare members who are enrolled with CareOregon Medicare Advantage Plus or Star, see the **"Referrals and Authorizations"** section for detailed information on authorization requirements.

Member Rights and Responsibilities

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 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

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 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
- Tell us if you move outside or within our plan service area

Appendix A

Discharging a Member

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

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.

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.

Process For Discharging A Member

CareOregon Care Coordinator

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

DRUG-SEEKING BEHAVIOR

RESPONSIBILITY
PCP or PCP Staff

ACTION

CareOregon Pharmacy Staff

PCP or PCP Staff

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

2. At the PCP's request, restrict the member to one or more designated pharmacies and/or one or more designated prescribers.

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

CareOregon Care Coordinator

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

Process For Discharging A Member

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

| RESPONSIBILITY | ACTION |
|------------------------------------|--|
| PCP or PCP staff | <ol style="list-style-type: none"> 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. <p>A member may be discharged in the following situations:</p> <ul style="list-style-type: none"> • 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 | <p>At Care Coordinator’s discretion, contact DMAP Coordinator by phone to request disenrollment of member.</p> <ol style="list-style-type: none"> 1. Fax written documentation to DMAP. 2. Inform PCP of DMAP decision regarding disenrollment. <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Notify the CareOregon Care Coordinator.</p> <p>IMPORTANT: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.</p> |

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

ACTION

PCP or PCP staff

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 process 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.

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.

VERBAL ABUSE – VULGAR LANGUAGE

RESPONSIBILITY

ACTION

PCP or PCP staff

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.

Process For Discharging A Member

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| <p>CareOregon Care Coordinator</p> <p>PCP or PCP staff</p> | <ol style="list-style-type: none"> 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. <p>IMPORTANT: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.</p> |
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**DISCHARGE FROM PCP BY MUTUAL AGREEMENT
 BETWEEN THE MEMBER AND THE PROVIDER**

| RESPONSIBILITY | ACTION |
|---|--|
| <p>PCP or PCP staff</p> | <ol style="list-style-type: none"> 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. <p>IMPORTANT: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.</p> |
| <p>CareOregon Care Coordinator</p> | <ol style="list-style-type: none"> 5. Work with CareOregon Customer Service to assign the member to a new PCP. |

Process For Discharging A Member

PROVIDER AND CAREOREGON AGREE THAT ADEQUATE, SAFE, EFFECTIVE CARE CAN NO LONGER BE PROVIDED FOR A MEMBER

| RESPONSIBILITY | ACTION |
|------------------------------------|--|
| PCP or PCP staff | <ol style="list-style-type: none">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. |
| CareOregon Care Coordinator | <ol style="list-style-type: none">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.5. Work with CareOregon Customer Service to assign the member to a new PCP. |