Provider Handbook
2018

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Section 1: INTRODUCTION

1.1 Welcome to Umpqua Health Alliance

Umpqua Health Alliance (often called "UHA") is owned and operated by Umpqua Health, LLC and is the coordinated care organization for most of Douglas County, Oregon.

1.2 What is a Coordinated Care Organization?

A Coordinated Care Organization (CCO) is a network of providers that coordinate the physical (medical), behavioral, and dental health care services of Medicaid or Oregon Health Plan (OHP) members within their communities. The goal of CCOs is to meet the "Triple Aim" of better health, better care and lower costs for the populations they serve. CCOs are focused on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. UHA works closely with local providers, including:

- **ADAPT**, a provider of drug and alcohol treatment, primary care services and behavioral health
- **Advantage Dental**, a dental care services provider
- **ATRIO Health Plans**, a Medicare Advantage health plan
- **Mercy Medical Center**, Roseburg area's community hospital
- **Umpqua Community Health Center**, a federally qualified health center (FQHC)
- **Umpqua Health Harvard**, **LLC**, a rural health center (RHC) providing primary care services for scheduled or "walk-in" patients
- **Umpqua Health Newton Creek, LLC**, a rural health center (RHC) providing primary care services for scheduled or "walk-in" patients
- **Willamette Dental Group**, a dental care services provider

1.3 What is the Oregon Health Plan?

In Oregon, the Medicaid program is called the Oregon Health Plan (OHP). Medicaid is a health care program that is paid for by federal and state dollars, to provide eligible, low-income Oregonians' basic health care services through programs administered by the Oregon Health Authority (OHA).

OHP covers doctor visits, prescriptions, hospital stays, dental care, mental and behavioral health services, and help with addiction to tobacco, alcohol and drugs. OHP can provide hearing aids, wigs, medical equipment, home health care, and transportation to health care appointments.

Section 2: KEY CONTACTS

If you are unsure of which department to direct your call, please call UHA Provider Relations at 541.957.3094 to be directed to the appropriate department.

<table>
<tr><th colspan="2">UMPQUA HEALTH ALLIANCE</th><th colspan="2">UMPQUA HEALTH NETWORK, LLC</th></tr>
<tr><th>Member Services</th><th>Medical & Case Management</th><th>Corporate Office</th><th>Provider Enrollment & Credentialing</th></tr>
<tr>
<td>Ph: 541.229.4UHA (4842)
Fx: 541.677.6038
UHA Member Services
1813 W Harvard Ave, Suite 110
Roseburg, OR 97471
Benefit and eligibility information on your patients
PCP changes
DCO changes
Provide/replace Member ID cards</td>
<td>Ph: 541.673.1462
Fx: 541.677.5881
UHA Clinical Engagement
1813 W Harvard Ave
Suite 206
Roseburg, OR 97471
Case management
Intensive Care Coordination
Member Grievance and Appeals
Pharmacy
Utilization management
Referral and Prior Authorizations
Retroactive Prior Authorizations
Provider Reconsiderations
Medical Director
Clinical Advisory Panel</td>
<td>Ph: 541.464.4300
Fx: 541. 229.9982
1813 W Harvard Ave
Suite 110
Roseburg, OR 97471
Executive Team
Legal
Finance</td>
<td>Ph: 541.464.4470
Fx: 541.229.4782
1813 W Harvard Ave
Suite 110
Roseburg, OR 97471
Initial credentialing (new providers)
Re-credentialing
Credentialing Committee
Delegated Credentialing
Provider credentialing rights
Provider changes, updates (i.e., address, practice location, terming practice, etc.)
Change in Professional Liability Coverage</td>
</tr>
<tr><th>Claims</th><td colspan="3"></td></tr>
<tr>
<td>Ph: 541.672.1685
Fx: 541.677.6038
PO Box 5308
Salem, OR 97304
Claims inquiries or reconsideration of payment on claims already processed related to claims specific billing and/or coding questions
Claims status checks</td>
<td colspan="3"></td>
</tr>
<tr><th>Compliance</th><th>Population Health Management</th><th>Human Resources</th><th>Provider Relations & Contracting</th></tr>
<tr>
<td>Ph: 541.229.7035
Fx: 541.229.9982
1813 W Harvard Ave
Suite 110
Roseburg, OR 97471
Email:
Compliance@umpquahealth.com

Compliance & FWA Hotline (can report anonymously)
Phone: 844.348.4702
Online: www.umpquahealth.ethicspoint.com</td>
<td>Ph: 541.464.6298
Fx: 541.677.6108
1813 W Harvard Ave
Suite 110
Roseburg, OR 97471
CCO metrics
Medicare STAR rating
Quality improvement</td>
<td>Ph: 541.464.6274
Fx: 541.229.4785
1813 W Harvard Ave
Suite 427
Roseburg, OR 97471</td>
<td>Ph: 541.957.3094
Fx: 541.229.9982
1813 W Harvard Ave
Suite 110
Roseburg, OR 97471
Contracting new Providers
Contractual questions regarding terms of contract</td>
</tr>
</table>

Section 3: GLOSSARY OF TERMS

A

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

Access: Ability to obtain medical services.

ADA (Americans with Disabilities ACT): Prohibits discrimination against people with disabilities in employment, transportation, public accommodation, and communications. The ADA also establishes requirements for TTY relay services.

Adjudication: Processing a claim through a series of edits to determine proper payment.

Ancillary Services: Covered services necessary for diagnosis and treatment of Members. Includes, but is not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy, urgent or emergency care, and other covered service customarily deemed ancillary to the care furnished by primary care or specialist providers. For the OHPs, ancillary services are those medical services not identified in the definition of a condition/ treatment pair under the OHP Benefit Package, but are medically appropriate to support a service covered under the OHP Benefit Package. A list of ancillary services and limitations are identified in OAR-410-141-0520, Prioritized List of Health Services.

Appeal: A request for review of an Action that a Member disagrees with.

Assessment: The determination of a Member's need for Covered Services. It involves collection and evaluation of data pertinent to the Member's history and current problem(s) obtained through interview, observation and record review.

B

Beneficiary: A person who has health care insurance through the Medicare or Medicaid programs.

Benefit Package: Specific services covered by the OHP, OAR 410-141-0480 and OAR 410-120-1210 including diagnostic services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.

C

Call Share: The Providers on whom a Practitioner relies for backup coverage during times he/she is unavailable.

Case Management Services: Specialized coordination of care services provided by UHA and its Providers for severe or complex health care problems or for care not available locally.

CCO (Coordinated Care Organization): A local health plan that manages your health services. All CCOs have a network of health care providers, such as doctors, nurses, counselors and more.

Chemical Dependency: The addictive relationship with a drug or alcohol characterized by either a physical and/or psychological relationship that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. For purposes of this definition, chemical dependency does not include addiction to or dependency of tobacco, tobacco products, or foods.

Claim: A request for payment that you submit to Medicare or other health insurance plan when you get items and services that you think are covered.

Clinical Advisory Panel (CAP): A committee comprised of physical, behavioral and oral health providers charged with assuring best clinical practices and conducting quality improvement activities for UHA.

CMS 1500 Form: A federal agency with the Department of Health & Human Services (DHS) responsible for Medicare and Medicaid programs.

COB (Coordination of Benefits): A method of determining who has primary responsibility when there is more than one payer available to pay benefits for the same medical claim.

Complaint/Appeal: A Member or Provider's expression of dissatisfaction and identified as a complaint to be addressed by UHA. Complaints must address

issues that are part of UHA's contractual responsibility.

Condition/Treatment Pair: Conditions described in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (ICD-10-CM) and treatments described in the Current Procedural Terminology (CPT®) which, when paired by the HERC, constitute the line items in the Prioritized List of Health Services. Condition / Treatment Pairs may contain many diagnoses and treatments. The Condition / Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

Credentialing: A process of screening, selecting and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status, and judgment.

D

Denied Claims: A denied claim is a claim that has been received and processed. An explanation of benefits (EOB) is sent to the provider indicating the reason for denial.

Department of Human Services (DHS): Oregon's principal agency for helping Oregonians achieve wellbeing and independence through state funded assistance programs.

Diagnostic Services: Those services required to diagnose a condition, including but not limited to, radiology, ultrasound, other diagnostic imaging, EKGs, laboratory, pathology, examinations, and physician or other professional diagnostic/ evaluative services.

Disenrollment: The formal leaving of a managed care plan or other health coverage program; the termination of a Member or group's membership in a health plan.

DME (Durable Medical Equipment): Crutches, wheelchairs, hospital beds, or other therapeutic equipment which stand repeated use, are medically necessary and are not merely for comfort or convenience of the Member or provider. The equipment must be related to the covered medical condition of the Member.

E

Enrollment: The process of enrolling Members in a health plan.

EOB (Explanation of Benefits): A form included with a reimbursement check from UHA that explains benefits paid and/or charges that were denied.

F

Fee-for-Service: A reimbursement system in which a provider bills UHA for each service after the service has been provided.

Formulary: List of approved prescription medications. Also called a drug list.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

G

Global Fee: A single fee that is billed and paid for all necessary services normally furnished by the Provider before, during and after a procedure.

Grievance: A written complaint submitted by, or on behalf of, a Member regarding any matter other than an Action, such as: the availability, delivery, or quality of healthcare services; utilization review decisions; claims payment, handling or reimbursement for health care services; or the contractual relationship between a Member and an insurer.

H

HERC (Health Evidence Review Commission): Reviews clinical evidence in order to guide the Oregon Health Authority in making benefit-related decisions for its health plans. Its main products are the Prioritized List of Health Services, used by the legislature to guide funding decisions for the Oregon Health Plan.

HIPAA (Health Insurance Portability and Accountability Act): The "Standard for Privacy of Individually Identifiable Health Information (also called the "Privacy Rule")" of HIPPA assures your health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Hospice: A healthcare service that provides supportive care for the terminally ill. Hospice care involves a team-oriented approach that addresses the coordinated care of the Member.

Hospice also provides support to the Member's family or caregiver.

I

In-network: Providers, including hospitals, pharmacies that have agreed to provide Members of certain insurance plan with services or supplies at a contracted rate. In some insurance places, Member care is only covered if it is received from an in-network Provider.

L

Living Will: A written, legal document, also called a "medical" or "advance directive" that shows what type of treatment a Member wants in case they can't speak for themselves. This document usually only comes into effect if they're unconscious.

M

Managed Care: A system of care where a company contracts with the Oregon Health Authority to provide care under guidelines for Members assigned to manage the cost, quality, and access of care. It is characterized by a contracted panel of physicians and/or providers; use of a primary care practitioner; limitations on benefits provided by non-contracted physicians and/or providers; and a referral authorization system for obtaining care from someone other than the primary care practitioner.

Medicaid: The joint federal and state program for some U.S. citizens with low-income and limited resources.

Medically Appropriate: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare: A federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Member: A person entitled to receive benefits under a policy or contract issued, arranged, or administered by UHA.

N

Non-Covered Services: Health care services or items for which Members are not entitled to receive from UHA according to the Plan Benefit as outlined in the Oregon Health Plan (OHP) Benefit Contract. Services may be covered under OHA, but not covered under OHP. Non-covered services for the OHP are identified in OAR 410-120-1200 (excluded services and limitations), or in the individual OHA Provider Guides.

Non-Participating Provider: A Provider who has not signed a contract with UHA.

O

Open Card / FFS Member: A person found eligible by DHS division to receive services under the OHP. The individual may or may not be enrolled with UHA.

Oregon Health Authority (OHA): A division of the Department of Human Resources responsible for the administration for the Federal/State Medicaid Program and the Oregon Health Plan Medicaid Demonstration Project (OHP).

Oregon Health Plan (OHP): The Medicaid demonstration project which expands Medicaid eligibility to low income residents and to children and pregnant women up to 185% of the federal poverty level. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

Out-of-Area: Any area that is outside the UHA - Douglas County service area.

Out-of-Network Provider: A Provider who is not contracted with UHA as a part of the panel.

P

Participating Provider: A Provider who has signed a contract with UHA.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests (e.g., PAP tests) and immunizations.

Preventive Services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (e.g., pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP): A Provider selected by a Member who shall have the responsibility of providing initial and primary care and for referring, supervising, and coordinating the provision of all other covered services to the Member. A PCP may be a family provider, general practitioner, internist, pediatrician, or other practitioner or nurse practitioner who has otherwise limited their practice of medicine to general practice or a specialist who has agreed to be designated as a primary care practitioner. Managed care plans require that

each enrollee be assigned to a PCP who functions as a gatekeeper.

Primary Hospital: The hospital who has signed a contract with UHA to provide covered hospital services for its Member. Capitation payment may be the method of reimbursement for the hospital.

Prior Authorization (PA): An approval process prior to the provision of services, usually requested by the Provider for procedures, admissions or services before the services are provided. Factors determining authorization may be eligibility, benefits of a specific plan, or setting of care.

Provider Panel: Participating Providers contracted with a Plan to provide services or supplies to Members.

Q

Quality Assurance Program: A program and process that is carried out by UHA and contracted physicians and providers to monitor maintain and improve the quality of services provided to Members.

Quality Improvement (QI): A continuous process that identifies problems in healthcare delivery, tests solutions to those problems, and monitors the solutions for improvement. A process that assures that health care received by Members meets accepted community standards of care.

R

Referral: A written order from a Provider to see a Specialist or get certain medical supplies or services. If a referral is not acquired, the health insurance plan may not pay for the service.

Representative: A person who can make OHP related decisions for OHP Members who are not able to make such decisions themselves. A representative may, in the following order of priority, be a person who is designated as the OHP Client's health care representative, a court appointed guardian, a spouse or other family member designated by the OHP Member. The Individual Service Plan Team (for develop behaviorally disabled Members), or a DHS case manager designated by the OHP client.

Risk: A possibility that revenues of the insurer will not sufficiently cover expenditures incurred in the delivery of contractual services.

S

Service Area: The geographic area covered by the health insurance plan where direct services are provided (Douglas County). A Plan may disenroll Member if they move out of the health insurance plan's service area.

Subcontractor: Any Participating Provider or any other individual, entity, facility, or organization that has entered into a subcontract with the Umpqua Health or with any Subcontractor for any portion of the work under Umpqua Health's CCO contract with the Oregon Health Authority.

Supplier: Any company, person, or agency that gives you a medical item or service, except when the Member is in a hospital or skilled nursing facility.

T

Third Party Administrator (TPA): An independent person or corporate entity that administers group benefits, claims, and administration for a self-insured group or insurance company. A TPA does not underwrite risk.

Third Party Resource (TPR): A medical or financial resource that under law is available and applicable to pay for medical services and items for a medical assistance client.

Triage: The classification of sick or injured persons, according to severity, in order to direct care and ensure efficient use of medical and nursing staff and facilities.

TTY (TeleTYpewriter): A special device which connects to a standard telephone used for people who are deaf, hard of hearing, or have speech loss to communicate with a hearing person.

U

Urgent: Any injury or illness that does not immediately threaten life or limbs but must be treated as soon as reasonably possible within 16 to 24 hours.

Urgent Care Services: Covered services required in order to prevent a serious deterioration of a Member's health that results from an unforeseen illness, injury, or covered dental service required to alleviate severe pain. Services that can be foreseen are not considered urgent services.

Utilization: The extent to which the Members of a covered group use a program over a stated time, specifically measured as a percentage determined by dividing the number of covered individuals who submitted one or more claims by the total number of procedures of a particular healthcare benefit plan.

Utilization Review: The critical examination (by a Provider or Nurse) of health care services provided to Members especially of the purpose of controlling costs (as by identifying unnecessary medical procedures) and monitoring the quality of care.

Utilization Management: A set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on accepted dental practices.

W

Waste: Overutilization or inappropriate utilization of services and misuse of resources, and typically is not criminal or intentional.

Section 4: PROVIDER SERVICES

4.1 Credentialing

Umpqua Health Alliance (UHA) is committed to continuously improving the quality of patient care and serving the community in an efficient and cost-effective manner. In order to promote and ensure high quality and cost-effective care, expert credentialing and re-credentialing process that utilizes the National Committee for Quality Assurance (NCQA) standards and guidelines are necessary as a reference for credentialing. Providers are credentialed and re-credentialed according to Umpqua Health Network's Credentialing Policies and Procedures. Re-credentialing shall take place at least every three (3) years. Completion for the credentialing process and approval by the Credentialing Committee is required prior to providing care for UHA Members. Temporary participation as a Provider may be granted on a case-by-case basis by the Chairman of the Credentialing Committee or Designee. The credentialing process must be completed for all eligible Providers. Temporary participation will not exceed 90 days. The Provider will be reviewed at the next Credentialing Committee meeting.

UHA requires the following to be submitted and verified as part of the credentialing process:

- Current version of the Oregon Practitioner Credentialing Application (OPCA) (for initial/new credentialing) and the Oregon Practitioner Recredentialing Application (OPRA) (for re-credentialing) approved by the Advisory Committee on Physician Credentialing Information (ACPCI). The application must be complete in order for the credentialing process to begin, this includes the completed Attestation questions, Authorization and Release of Information form and required additional documents
- All state licenses – Oregon license must be current and unrestricted
- Hospitals admitting privileges or hospital admit plan if you do not have admitting privileges at a participating hospital
- 24 Hour Provider Call Coverage
- Professional Liability Insurance with minimum limits of $1 million/$3 million
- Malpractice Claims History
- Education, Professional degree(s) and training program(s) completion, including ECFMG
- Board Certification (not required for participation)
- DEA certificate with current practice location
- Work History
- National Practitioners Data Bank (NPDB) Report
- Peer References
- Excluded Provider Search
- Additional information may be requested during the credentialing process

4.2 Locum Tenens

A Locum Tenens arrangement is made when a participating Provider must leave their practice temporarily due to illness, vacation, leave of absence, or any other reasons. Locum Tenens is a temporary replacement for that Provider, usually for a specified amount of time. Locum Tenens should possess the same professional credentials, certifications, and privileges as the practitioner he or she is replacing.

When a participating Provider requires coverage by a Locum Tenens Provider, the practice should notify Provider Services of the arrangements. If the Locum Tenens Provider will be covering for more than 60 days, the Locum Tenens Provider is required to be credentialed and your office should email Provider Services at UHNProviderServices@umpquahealth.com.

4.2.1 Locum Tenens Provider Agreement

Locum Tenens Providers shall agree to accept UHA payments for participating Providers and not bill the Member for balances other than co-payments:

- Use participating Providers and contracted facilities when available
- Follow UHA's referral and PA procedures

4.3 Taxpayer Identification Numbers (TIN)

If you have a change in your tax identification number (TIN), you are required to notify Provider Services immediately. To ensure accurate IRS reporting, your tax ID number must match the business name you report to the federal government.

When you notify us of a change to your tax identification number, please follow these steps:

- If you do not have a current version of the IRS W9 form, you may download directly from the IRS website at http://www.irs.gov/pub/irs-pdf/fw9.pdf or Click here.
- Complete and sign the W9 form, following instructions exactly as outlined on the form. Include an effective date
- On a separate sheet of paper, tell us the date you want the new number to become effective (when UHA should begin using the new number).
- Send the completed form with the effective date by fax to 541.229.9982, email UHNProviderServices@umpquahealth.com or mail:

Umpqua Health Network
Provider Services
1813 W Harvard Ave, Ste 110
Roseburg, OR 97471

4.4 Call Share

Participating Providers will establish call share arrangements with other participating Providers when they are unavailable. In such situations, the call share Provider may bill the health insurance plans for the services provided to the Member. If changes are made in call share arrangements, please notify the Provider Enrollment and Credentialing Coordinator at 541.464.4470.

Answering service messages must include:
- Name and telephone number of the on-call Provider along with instructions on how to contact that Provider.
- A disclaimer that if the Member presents to the emergency room without contacting the on-call Provider, payment by the health insurance plan may be denied.

Answering service messages should contain:
- Office hours
- When the office is closed (e.g., vacation, holiday) and when it will re-open
- When and how often the office checks their messages
- The telephone number to call the PCP, call-share Provider or answering service
- Different contact and/or phone number(s) for after-hours and weekends

IMPORTANT NOTE: A tape-recorded telephone message instructing Members to present to or call a hospital emergency room is not sufficient for 24-hour coverage.

4.4.1 Call Share with Non-Participating Providers

In some cases, it is necessary for a participating Provider to call share with a non-participating Provider. It is the responsibility of the participating Provider to provide the following information to all non-participating Providers. Non-participating call-share Providers shall be fully credentialed by UHA prior to seeing UHA Members. UHA reserves the right to deny non-participating call share status to any Provider whose credentials do not meet UHA's requirements. Non-participating call share Providers shall agree to accept UHA payment for participating Providers as payment in full and agree not to bill the Member for balances other than co-payment.

Non-participating call share Providers shall agree to use only participating hospitals and facilities for UHA Members unless services are not available. Non-participating call share Providers shall agree to follow UHA's referral and PA requirements.

4.5 Primary Care Providers (PCP)

4.5.1 Responsibilities

When a Provider chooses to be designated as a Primary Care Provider (PCP) under the OHP, they agree to provide and coordinate health care services for UHA Members. The PCP will provide, or facilitate referrals to specialists to provide for the complete healthcare needs of the Member. PCPs are expected to abide by UHA's health plan policy MS1 – Member Assignment and Reassignment Policy. PCP responsibilities include:

- Being the Manager of the Member's Care.
- Providing all primary preventive healthcare services except for a yearly gynecological exam for which the Member may choose to seek services from a participating women's healthcare specialist.
- When specialized care is medically necessary, facilitating a referral to a Specialist or specialty facility.
- Contacting UHA to obtain a referral or PA to a specialist.
- Monitoring the Member's condition and arrange appropriate care when notified of an out-of-area emergency that will require follow-up or has resulted in an in-patient admission.
- Coordinating care and share appropriate medical information with UHA as well as with a Specialist to whom they refer their Members.
- Documenting in a prominent place in their Member's records whether or not an individual has executed an Advance Directive.
- Filling out and attaching the Sterilization and Hysterectomy Consent Form to the claim when submitting claims for their UHA Members.
- Per HIPAA Privacy rule – Providers are responsible for safeguarding their Members' personal health information (PHI). Disclosure of any PHI is limited to the minimum necessary and a disclosure form is required prior to any release of PHI.

Second Opinion

UHA provides for members to obtain a second opinion at no cost. If a Member wants a second opinion about their treatment options, they can ask their PCP to refer them for another opinion. If the Member wants to see a Provider outside UHA's network, they or their Provider can contact UHA Clinical Engagement to request a prior authorization.

4.5.2 Referral to Specialist

In cases where referrals to specialists are required to adequately address the medical needs of the Member, the PCP will refer the Member's care to the specialist when appropriate. Out-of-network Specialists will require Plan authorization. In-network Specialists do not.

In order for those services to be eligible for reimbursement by UHA, the PCP must complete a Prior Authorization (PA). The Specialist should verify that an authorization has been approved. It is not the responsibility of the Member to obtain an authorization number from their PCP before receiving services from a Specialist. The Specialist and PCP together are responsible for completion of the authorization process.

Contracted Specialists have the responsibility to:

- Treat Members within the scope of their practice
- Coordinate and share appropriate medical information with the Member, the Member's PCP, and UHA

4.5.3 Specialists as PCPs

A Specialist may consider being a PCP for an established Member if the Specialist is willing to assume all of the responsibilities of a PCP for that Member. Examples of this include an OB becoming the PCP for their pregnant Member and an Oncologist becoming the PCP for their Member during the Member's cancer treatment program.

4.5.4 PCP Selection Process

Members may choose their Primary Care Provider (PCP) based on the past history with the Provider, or from the listing of available PCPs in their area. Members must select a PCP at the time of enrollment in UHA. PCPs are listed in the Provider Directory that also lists participating providers who specialize in internal medicine, family practice, and pediatrics. Each individual family member may choose the same family PCP or a different PCP. Members may select a PCP from the following Providers:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Specialists as approved by UHA

PCPs receive a monthly report of all Members who have selected them as their PCP. PCPs can also generate a list of their eligible Members at any given time.

4.6 Availability

Participating Providers agree to accept new Members unless their practice has closed to new Members of any health plan. Providers must not close their practices to only Members of health plans they deem undesirable. Please notify Provider Services by email at UHNProviderServices@umpquahealth.com when your practice is closed to new Members and when it re-opens.

Participating Providers agree to provide 24 hours a day, 7 days a week coverage for UHA Members in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The Provider or their designated covering Provider will be available on a 24-hour basis to provide care personally or to direct Members to getting the most appropriate action for treatment. All telephone contact with Members shall be recorded and entered into the Member's medical record.

4.7 Missed Appointments

If the Provider should experience any problems with Members who fail to show for appointments, this information should be relayed to UHA Member Services. UHA will assist in educating the Member about the need to cancel or reschedule appointments prior to the time of the appointment. The Member's medical record must contain documentation regarding missed appointments and all recall efforts made by the Provider's office, either by mail or telephone. This information shall be clearly documented in the medical record.

Provider's offices shall have written policies on the minimum number of missed appointments prior to requesting that a Member choose or be reassigned to another PCP. OHP Members cannot be billed for missed appointments. A monthly report shall be submitted to UHA by the Provider's office, listing all Members failing to keep an appointment.

4.8 Member Transfer

At the occurrence of any one of the following events, UHA Member Engagement will reach out to the Member and/or family and offer a PCP or new PCP:

- Member newly assigned to UHA.
- Member newly re-enrolled to UHA.
- Member requests change in existing PCP.
- Provider leaves town, retires or passes away.
- Provider chooses to relinquish all of their UHA assigned Members.

Assignment of Members can be requested at either the provider or clinic level.

UHA's Chief Medical Officer has the authority to recommend reassigning any individual Members or an entire family under the following circumstances:

- One or more Member access to care issues with current PCP have been identified.
- One or more Member access to Medically Appropriate care issues have been identified.
- Provider or clinic utilizes Member applications or screening processes.

UHA will notify the PCP in writing of a reported concern of one or more of the circumstances above. Providers will have 30 days upon notification by UHA to remedy the situation prior to member reassignment.

Providers requesting Member disenrollment must abide by the health plan policy MS1 – Member Assignment and Reassignment Policy.

4.9 Termination of Provider's Panel Participation

A participating Provider who chooses to terminate their Umpqua Health Network Provider Services Agreement without cause, is required to provide an effective date at least ninety (90) days after a written Notice of Termination is given to Umpqua Health Network.

4.10 Billing Members

Participating providers are expected to seek compensation solely from Umpqua Health, and not Umpqua Health's members, including situations where Umpqua Health denies a claim. This includes complying with requirements established by OAR-141-3395. Furthermore, participating providers are prohibited from billing a member, sending a member's bill to a collection agency, or maintaining civil actions against a member to collect money owed by Umpqua Health for which the member is not liable for (OAR 410-141-3395(5)). This provision does not prohibit the participating providers from collecting deductibles, copayments, coinsurance, or for health services not covered by Umpqua Health as long as a valid DMAP 3165 form is signed by the member, prior to the service, as required by OAR 410-141-3395(6), OAR 410-120-1280, OAR 410-141-0420.

Section 5: MEDICAL MANAGEMENT

5.1 Utilization Management (Prior Authorization)

A request for services is required in order to determine, prior to delivery of care, if the requested service is part of the benefit plan and it meets the OHP coverage criteria. Prior Authorization (PA) requests will be addressed in a timely manner. Routine requests should be received by Umpqua Health Alliance (UHA) at least two (2) weeks before a planned service is scheduled. This allows time for UHA to process the PA and review pertinent medical information critical to the decision making process. A copy of the Member's chart notes, lab and/or x-ray tests, and any other pertinent facts should accompany the original request.

To submit PA requests electronically, you will need to contact UHNProviderServices@umpquahealth.com to request a CIM Access Request Form. Once you've received a login and password from PH Tech, you can login to CIM at https://cim1.phtech.com/mcrweb/.

PA forms also are available for download on the UHA website at www.umpquahealth.com or Click here. Supporting documentation is required and PA forms are to be completely filled out. Submitting an accurate form will expedite the PA process.

General PA requests and referrals will be reviewed by the Medical Review Committee and the Provider will be notified. The Standard timeline is fourteen (14) days, Rush timeline is seventy-two (72) hours. If a general PA request is "Rush" (e.g., Members' loss of life or limb without prompt treatment), the Provider will be notified of the Medical Review Committee's decision within seventy-two (72) hours.

Medication requests will be reviewed by the Medical Review Committee and the Provider will be notified within three (3) calendar days. If your request is "Rush" (e.g., Members' loss of life or limb without prompt treatment), the Provider will be notified of the Medical Review Committee's decision within 24 hours. **The Provider should document "Rush" on the request form.**

Prior Authorization Success Tips
• Complete information submitted with the prior authorizations (PA) request; upload chart notes in CIM or include with the faxed request. • Avoid phone calls to UHA Clinical Engagement inquiring about the determination prior to the 7 days. • Use "Rush" status only in the appropriate situations (i.e., loss of life or limb without prompt treatment.) • Avoid scheduling tests prior to receiving the PA approval from UHA. • Avoid sending a request for reconsideration that does not include new information.

A PA does not guarantee benefits. The actual claim may be rejected for reasons such as the care provided differs from the care that was pre-authorized. Payment for care that has been pre-authorized will not be denied on the basis of medical necessity unless critical information was not given at the time of authorization (i.e., Member was given an experimental or investigational treatment that was not clearly stated in the authorization process.) If the Member has lost eligibility, the claim will not be paid regardless of PA.

Prior Authorization Grid
UHA medication and procedure guidelines are approved by the Clinical Advisory Panel (CAP). Providers can view the most updated UHA Prior Authorization Grid in more detail by visiting the UHA website at www.umpquahealth.com or Click here.

5.2 Case Management

A small but significant portion of the population serviced will require a greater than usual amount of available resources. Case Management services are offered as a resource to Providers by our Nurse Case Managers under the guidance of

the Medical Director, to assist in managing the care of the Members that have presented as having complex medical and social needs, thereby requiring intensive care coordination. Early identification of these Members can significantly impact the cost associated with their care without sacrificing quality or Member satisfaction. Under the OHP, these services are referred to as ICM or "Intensive Care Management".

5.2.1 Intensive Care Management (ICM)

CCOs and medical plans have special staff to assist Members who have complex medical or special needs. CCOs refer to these staff as "intensive care managers". These staff help coordinate health care services for Members with disabilities, complex medical issues or special needs. Members who have special medical supply or equipment needs, or who will require support services in obtaining care, may ask for help from an ICM by calling UHA Clinical Engagement at 541.673.1462 or UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

Identification of Members in need of ICM service will occur through surveillance of:

- Referral and PA requests
- Facility discharge reports
- Provider referrals
- Member requests
- DHS referrals

UHA has an ICM available to assist Members Monday through Friday, 8:00 a.m. to 5:00 p.m.

5.3 Quality Assurance Program

UHA's Quality Assurance Program, administered by the UHA Health Plan leadership team, provides a mechanism for systematic, coordinated, and continuous monitoring. The goal is to improve Member health and the quality of the service provided by UHA.

5.3.1 All participating Providers will cooperate with the requests and requirements of quality review organizations, when such activities pertain to the provision of services for our Members.

5.3.2 All participating Providers are required to comply with UHA practice guidelines, medical policies, QI program, and Medical Management program, as developed by UHA Board of Directors, UHA Clinical Advisory Panel (CAP) and UHA Community Advisory Council (CAC). Providers are required to participate in the State's external quality review of UHA, if requested.

5.4 Waivers for Non-Covered Services

OAR 410-120-1280, Billing, outlines the waiver requirements for the OHP. OHA, and therefore UHA requires that Members receive advanced written notification that a specific service is not covered. Members may not be asked to sign waivers on a routine basis. OHA and UHA require that the following be included in the waiver:

- The specific service being provided
- An estimated cost of the service
- A statement indicating that the Member or Member's family is or may be financially responsible for payment for specific services

In addition, a Member cannot be billed a "cancellation fee" for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the Member or UHA as outlined in OAR 410-120-1280 (1)(a), Billing.

***NOTE*:** Services that are not supported by a diagnosis or established coding guideline (i.e., unbundling) may be denied as a Provider responsibility even though a waiver may be on file.

5.5 Interpreter Services

UHA will assure that all UHA Member Handbooks and all other printed information intended for widespread distribution to Members**,** including Member satisfaction surveys and grievance and appeals information, is available in the primary language of each substantial population of non-English speaking Members.

- Substantial is defined as 35 non-English speaking households that share the same primary language.
- UHA's online Provider Directory lists all PCP offices with bilingual capability and the language(s) spoken and can be located at https://www.physicianehs.com/?nav=providerSearch or Click here.
- During business hours, UHA Member Services can make arrangements to provide qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking Members. The interpreters shall be capable of communication in English, the primary language of the Member, and translate medical information effectively.
- There is no fee to the Provider or Member for translation services.
- When given prior notice, PCPs and other participating Providers, such as specialists and hospitals, shall be prepared to meet the special needs of visually and/or hearing impaired Members.
- PCP offices shall have signs in the primary language of each substantial population of non-English speaking Members in their practices.

5.6 Hospital Services

Provided Locally (Mercy Medical Center)

- Cardiac/pulmonary rehabilitation services (outpatient)
- Electroencephalogram (EEG) services (outpatient)
- Electrocardiogram (EKG) services (outpatient)
- Emergency department services including all emergent and urgent medical treatments
- Home health care services
- Hospice care services
- Imaging services (outpatient); CT and MRI
- Inpatient hospital services (all)
- Nutritional diabetic education
- Occupational therapy (outpatient) at Mercy Institute of Rehabilitation
- Other therapeutic services
- Other diagnostic services
- Physical therapy (outpatient) at Mercy Institute of Rehabilitation
- Pulmonary function services (outpatient)
- Sleep studies
- Speech/language pathology (outpatient) at Mercy Institute of Rehabilitation
- Treatment room services **except** when delivered as a component of outpatient treatment

5.7 Not Available Locally

Not all medically necessary services are available at Mercy Medical Center. UHA requires a PA for **all** requested services to be performed in other participating and non-participating facilities. Members and their Providers are encouraged to utilize Mercy Medical Center for all services available, however, under certain circumstances UHA may grant authorization for services to be performed at other facilities.

5.8 Urgent Care

Urgent problems are things like severe infections, sprains, and strong pain. Members are instructed to call their PCP office first regarding any health problems. PCPs should be available to Members day and night, weekends, and holidays to schedule an appointment, give medical advice or send them to the right place to get care.

5.9 Emergency Care Services

UHA defines a medical emergency as a sudden and unexpected onset of a condition requiring medical or surgical care immediately after the onset, or as soon as it can be made available. Care received later than 24 hours after the onset of the condition is not considered emergent. Chest pains, poisoning, loss of consciousness, convulsions, severe bleeding, broken bones, and accidental injuries are some examples of medical emergencies. Some conditions should **not** be treated in an emergency setting. Please do not refer Members to the emergency department for routine care. Routine care provided in a hospital emergency department is **not** a covered benefit. When a Member requires emergency services from a hospital other than Mercy Medical Center and necessary services are provided, UHA may pay for the services upon retrospective review.

In communities where after hours coverage is provided by the emergency room, a Provider must be available for telephone consultation and triage. Answering messages and services may not direct a Member to present to the emergency room as the only option after hours.

PAs are not necessary in cases of emergency room visits. UHA emergency room claims may be reviewed for medical necessity.

5.9.1 Out-of-Area Emergencies

Members are instructed to receive emergency care at their primary hospital if possible. Coverage of out-of-area emergencies are provided only for true emergency situations. UHA will cover out-of-area emergency expenses.

5.9.2 After Hours/Emergency Pharmacy Overrides

UHA's Pharmacy Benefit Manager (PBM) MedImpact Healthcare Systems Inc. may authorize a limited supply of medication when there is an emergency after business hours or on a holiday. MedImpact will forward override requests to its Internal Help Desk for review. The Internal Help Desk may use their discretion and authorize up to a five (5) day supply of the medication, by entering a PA after review of the situation. If the medication cannot be broken down due to packaging, the Internal Help Desk may use their discretion and allow the entire quantity of the medication to be filled. During business hours, please contact UHA Clinical Engagement at 541.673.1462.

If a concern is raised regarding a Member's drug use, please contact UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

5.10 Behavioral Health Services

UHA contracts with ADAPT and individually licensed behavioral health providers for outpatient behavioral health services.

Inpatient behavioral health services require prior authorization. PA/Referral forms can be downloaded online at http://www.umpquahealth.com/for-providers/ or by contacting:

UHA Clinical Engagement
1813 W Harvard Ave, Ste 206
Roseburg, OR 97471
541.673.1462

5.11 Chemical Dependency / Substance Use

Outpatient chemical dependency services for alcohol and drug treatment are part of the OHP benefit package for all OHP Members. These services include outpatient treatment and intensive outpatient detoxification. Members do not need a referral for outpatient chemical dependency services in Douglas County. Substance abuse services are provided in multiple service locations within the county.

UHA has contracted with ADAPT for provisions of outpatient chemical dependency services for OHP Members in Douglas County for the following services:

- Outpatient treatment services
- Opiate substitution services
- Intensive outpatient treatment services

ADAPT is also contracted with UHA to coordinate referral and follow-up to residential treatment services, community detoxification and/or basic core services which include child care, elder care, housing, transportation, employment, vocational training, educational services, behavioral health services, financial and legal services.

5.11.1 A & D Residential Services

Residential treatment services are available through ADAPT. A prior authorization is required for any out-of-county or out-of-network facility.

ADAPT
548 SE Jackson St
Roseburg, OR 97470
541.672.2691
Website: www.adaptoregon.org or Click here

Section 6: FILING CLAIMS

6.1 Billing & Claims

All Providers and facilities should submit their claims in HIPAA 837P, 837I, CMS 1500, or UB-04 format. It is recommended that claims be submitted within thirty (30) days of the date-of-service to facilitate collection of encounter data and provide effective utilization management.

Contracted Provider claims will be denied if received more than ninety (90) days from the date of service. Non-contracted Provider claims will be denied if received more than one hundred twenty (120) days from the date of service. Exceptions to these time guidelines for claims submissions are pregnancy related diagnoses, when Umpqua Health Alliance (UHA) is secondary to Medicare or another third party resource and eligibility issues. Payment for all claims is subject to UHA's referral and prior authorization (PA) requirements.

Payment for all services is subject to confirmation that the beneficiary is eligible to receive the services as a covered benefit, the applicability of other sources for payment, UHA's Medical Management and other policies and procedures, the terms of its contract with the State of Oregon, and all applicable laws, each as in effect or determined at the time each service is performed. If you are a participating Provider, payment is made at the rate and on the terms set out in your Provider contract. If you are a non-participating Provider, payment is made at the rate and on the terms set out in the rules and regulations related to the Oregon Health Plan (OHP) and UHA's contract with the State of Oregon to provide services to OHP Members, which requires UHA to follow the regulations related to the payment of non-participating Providers.

Common reasons for returned or denied claims:

- Print is too light
- Member cannot be identified as a UHA Member
- More than one Provider or supplier is billing on one claim
- Incomplete or inaccurate coding
- Claims not submitted on proper CMS 1500 claim form

If a claim is not approved and you believe it is in error, simply resubmit the claim and an explanation for reconsideration. We will review the case to determine whether the claim is eligible for repayment under the terms of UHA.

6.2 Paper Claims

UHA follows requirements set forth by Medicare and OHA for processing of paper CMS 1500 or UB 04 claims. The paper claims are converted to electronic image by scanning. The scanned claims then go through an optical character recognition (OCR) process. The following is required in order to properly identify each claim's data:

- CMS 1500 or UB 04 claim forms with red ink that can be scanned should be used. The claim is to be machine printed with dark black ink. Photocopies, faxes, or handwritten claims cannot be used. Light ink or dot matrix printed claims may not have characters that are recognized correctly.
- Align the claim form so all information is contained within the appropriate fields. Each piece of data must have a space between it and the next piece of data. For example: the procedure code must have a space between it and any modifier (88305 26 rather than 8830526).
- When multiple claim forms are sent, they should each be accompanied by their own EOB, chart notes, and other attachments as needed. **DO NOT** send multiple claim forms with only one EOB or attachment.
- Each EOB or attachment must be on standard 8.5 x 11 white paper with black print. Half sheets or strips of paper will rip or become separated from the claim in the scanning process. Attachments should not be stapled to the claim.
- Additional comments can be made on a standard white sheet of paper and submitted with the claim. Handwriting on the claim will not be picked up during the OCR process.

- Highlighting is not necessary and cannot be seen once the claim is scanned. Use only a yellow highlighter if highlighting is necessary; other colors will scan as black and will not be seen as highlighted material.

Failure to follow these requirements may result in claims being returned to the Provider unprocessed. For detailed information on how to complete a claim form, refer to the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov or Click here.

When you have important information about a claim, it is best to submit a paper claim with explanations attached.

Send paper claims to: **UHA Claims Processing Center**
PO Box 5308
Salem, OR 97304

6.3 Electronic Claims

HIPAA 837P or 837I claims may be submitted to UHA. These are UHA primary and do not contain prior payer information or electronic attachments. EDI claims processing is faster and more cost effective than paper billing. The online software program will pre-process the claim file checking for common billing errors that require immediate attention before the file can be accepted.

A printable receipt is produced when the claim upload is successful. There is also a 997 functional acknowledgement file available for download when each EDI file is submitted.

Most requirements for paper claims also apply to EDI claims.

If you wish to be setup to send EDI claims online, you may contact the PH Tech EDI Support at 503.584.2169, opt 1 or email EDI.Support@phtech.com.

For information on 837P and 837I guidelines, refer to the CMS website at http://www.cms.gov or Click here.

6.4 Pharmacy Claims

Pharmacy services are provided by MedImpact Healthcare Systems, Inc. Local pharmacies can contract with MedImpact if they wish to provide services to UHA Members. Pharmacy billings are done electronically.

About MedImpact
MedImpact HealthCare Systems, Inc. has used information technology and human capital to improve the practice of managed care pharmacy since 1989. Questions for MedImpact's procedures can be answered by the Help Desk at 800.788.2949. Business hours are 24 hours a day, 7 days a week including holidays.

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

6.5 Place of Service Codes for Professional Claims

Place of service codes and descriptions can be referenced online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website_POS_database.pdf or Click here. These codes should be used on professional claims to specify the entity where services were rendered. Check with individual payers (e.g., Medicare, Medicaid, and other private insurance) for reimbursement policies regarding these codes.

6.6 Member Identification

UHA Members will be issued a medical ID card once a Member becomes eligible for coverage under the OHP Medicaid Demonstration Project and is enrolled with UHA**.**

- This ID card tells you that the Member is enrolled with UHA, however, the Provider office is responsible for checking eligibility.
- The ID card tells you the Member's name, ID number, PCP name, PCP phone number, the DCO that the Member is assigned to and the issue date.

6.7 Eligibility Verification

Providers have access to an electronic eligibility verification system 24 hours a day which allows you to view a single Member's eligibility and if you are a PCP, to generate a list of eligible Members assigned to you. If you do not have an established user name and password, email EDI.Support@phtech.com or call 503.284.2169, opt 1. For ease of Member identification, these lists include the following information:

- Member name
- Member ID number
- Birth date
- Sex
- Effective date of eligibility

The steps for generating these reports are outlined below:

- To get access to PH Tech's CIM provider portal
- Go to the CIM website at https://cim1.phtech.com

Other eligibility verification sources:

- Online with MMIS system at https://www.or-medicaid.gov/ProdPortal/Default.aspx or by calling 866.692.3864 to access the Automated Voice Response system
- By calling UHA Member Services at 541.229.4UHA (4842) or 866.672.1551

UHA recommends that you make a copy of the Member's ID card and keep it in the Member's chart. Have the Member bring their medical ID card with them to their appointments. To avoid denied claims, it is strongly suggested that the PCP office verify that they are the listed PCP for the Member on the date of service prior to rendering services. Providers are required to verify before rendering services that the Member is eligible on the date of service and that the service to be rendered is covered under the OHP Benefit Package.

The Provider is also required to ascertain, prior to rendering the service that the Member is enrolled with UHA and seek any necessary PA. Finally, Providers must inform the Member of any charges for non-covered services prior to the services being delivered and must have them complete and sign an OHP Client Agreement to Pay for Health Services, if the Member is to be held financially responsible for non-covered services.

6.8 Provider Claim Appeal

Providers may appeal claims decision, where the Provider is being held financially responsible for charges, on the basis of the following issues:

- Provider payment methodology
- Medical necessity denial (if no PA was required)
- Contract/benefit plan limitation

(Providers may also assist Members who appeal a claims denial of a service, in which the Member is being held financially responsible. However, that process is addressed in a separate policy.)

PLEASE NOTE: All claim appeals submitted by a Provider must include additional information which the Provider believes was not previously known or considered by UHA in its decision to deny the claim.

If the Provider has submitted a request for reimbursement, and a clean claim has been denied on its merits, the Provider may appeal that non-payment. Claims denied due to lack of information, improper coding or some other administrative error can be resubmitted using the Claims Reconsideration Process.

Provider may file an appeal request to UHA within thirty (30) calendar days from the date of UHA's final decision on a clean claim by using the following process:

- Inform the UHA Claims Processing Center in writing of the intent to appeal the determination. A representative will work with the Provider in obtaining a formal letter of appeal and identifying the concern. All appeal requests should include the following:
  - Claim Form
  - Member name and ID number
  - Claim number assigned by UHA to the claim at issue
  - Provider name
  - Service denied
  - Issue or reason for the appeal
  - Any pertinent clinical information or related documentation that would be of assistance in reviewing the request, to support the reasons for the reversal of the adverse organization determination.

If a treatment has been denied on the basis that it is experimental or investigational, the request for reconsideration must be accompanied by peer-reviewed literature supporting the effectiveness of the procedure or treatment at issue. The written appeal should be submitted to the following address:

UHA Claims Processing Center
PO Box 5308
Salem, OR 97304

The UHA staff member who received the appeal request will complete a "Case Determination" form, which includes the following information pertinent to the service at issue, in addition to the above-required elements:

- CPT Code(s)
- ICD-10 Code(s)
- Requested service(s)
- Reason for denial
- Reason for appeal
- Any additional comments or requests for information

The appeal will be reviewed within thirty (30) calendar days of receipt by UHA or as required by law. The appeal request will be reviewed by the Grievance and Appeals Coordinator with assistance from UHA Clinical Engagement as appropriate to the issue presented. If UHA reverses their previous decision, in whole or in part on any claims denial, the claim shall be paid as soon as possible, not to exceed thirty (30) days from the date that UHA received all the information necessary to render a decision. That response will include an explanation of the denial/issue, and if the initial determination is upheld, instructions on additional appeal options. The result of this first appeal shall be forwarded to the Grievance and Appeals Coordinator for tracking purposes. If the denial is upheld, the Provider may file for a review with OHA, per OAR 410-120-1580, Provider Appeals – Administrative Review.

6.9 Claims Analysis

UHA will engage in various kinds of analysis of claims made by Providers, including reviewing claims after they are processed and paid. When reviewing a claim, UHA looks for the following:

- Inappropriate provision of healthcare services, prescriptions, or products
- An inappropriate level of care
- Unreasonable or excessive charges for healthcare services
- Over-utilization of services
- Any indicators of potential fraud, waste, or abuse

UHA will refer complex and high-cost claims to an outside claims review service. That claims review service identifies billing errors, such as the use of billing codes that are not supported by the medical record or the separate pricing of medical supplies and services that are routinely priced together.

Section 7: BENEFITS & SERVICES

7.1 Oregon Health Plan Benefits

Umpqua Health Alliance (UHA) has contracted to provide benefits to eligible Oregon Health Plan (OHP) Members. The medical, dental or behavioral health services OHP covers for each Member is called a "benefit package." UHA defines a benefit package using a priority process emphasizing primary care, preventive care, managed care, reduced cost-shifting, and monitoring the purchase and use of expensive medical technology. Each Member receives a benefit package based on certain things, such as age or healthcare condition. Members of their household may receive different benefit packages. Benefits covered under OHP and plan specific guidelines are located on the Umpqua Health Alliance website at: http://www.umpquahealth.com or Click here and listed online at: http://www.oregon.gov/oha/healthplan/Pages/benefits.aspx or Click here.

If you have any questions regarding the OHP Benefit Package (covered vs not covered services), please contact the UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

7.2 Prioritized List of Health Services

OHP does not cover all health care services. OHP Members receive services based on where health care conditions and treatments are placed on the Prioritized List of Health Services, as contained in OAR 410-141-0520. The Prioritized List of Health Services is a list of health care conditions and their treatments. The List helps determine what services the OHP covers. The Prioritized List contains 665 line items consisting of condition-treatment pairs, of which the services on lines 1-475 are covered services for OHP Members. The diseases and conditions below line 475 on the Prioritized List are usually not covered by OHP. Something that is "below the line" could be covered if you have an "above the line" condition that could get better if your "below the line" condition gets treated.

- "**Above the Line**" items – Diagnoses which range within lines 1-475. These are "above the line" diagnoses, and are payable services, assuming all other applicable requirements, such as Member eligibility, medical appropriateness, and PA approvals, are met.

- "**Below the Line**" items – Diagnoses which range within lines 476-665. These are "below the line" diagnoses, and are not covered by OHP.

- "**Non-Ranking**" items – Diagnoses which are not listed in the Prioritized List. These conditions are usually symptom codes, and are not covered by OHP without a more specific diagnoses code.

The list uses ICD-10 CM diagnosis codes and CPT and HCPCS procedure codes to define the condition-treatment pairs that make up each of the 665 lines and will eventually be converted to ICD-10. The methodology used to prioritize health services places a high emphasis on preventative services and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crisis stages of disease. The Oregon Health Evidence Review Commission (HERC) ranked all health care services to reflect the best unbiased information on clinical effectiveness and cost-effectiveness available. Co-morbid conditions factor in to decision making of line ranking.

The Prioritized List is amended from time to time according to the available budget and the approval of CMS. The most current Prioritized List can be viewed online at: http://www.oregon.gov/oha/healthplan/Pages/priorlist.aspx or requested by contacting:

Oregon Health Authority
HSB - 3rd Floor 500 Summer St NE
Salem, OR 97310-1097
503.945.6738

If you have questions about how to authorize or bill for services to UHA Members, contact UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

7.2.1 Non-Funded Treatment Pairs

Understanding the complete implication for the treatment pairs that fall below the funded line is important. These principles need to be kept in mind:

- Condition/treatment pairs are defined by specific CPT and ICD-10-CM diagnosis codes.
- All claims must have accurate CPT and ICD-10-CM coding in order to be a covered treatment pair. ICD-10-CM codes should be coded to the greatest degree of specificity (4^{th} or 5^{th} digit).
- Diagnostic services may be covered until a diagnosis is reached.

7.3 Coordination of Benefits

Current federal regulations require Medicaid to pay for health care only after the Member's other health resources have been exhausted. In other words, Medicaid is viewed as the payer of last resort. The requirement that third parties pay first is called Medicaid "third party liability" (TPL).

In guidelines issued by the CMS, TPLs are defined as individuals, entities, insurers, or programs that may be liable to pay all or part of the expenditures for medical assistance provided under a state Medicaid plan.

Third parties include private health insurance (e.g., commercial insurers, self-funded plans, or profit or non-profit pre-paid plans), Medicare, Champus, Champva, automobile insurance, state worker's compensation, and other Federal programs.

Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services or Tribal Health Facilities operating under a section 638 agreement are payers of last resort and are not considered an alternate resource or third party resource (TPR).

If you encounter any of the following or have any questions regarding third party liability, please contact the TPR Department at 541.464.4175.

- Member has other insurance which is not noted by UHA
- Member is pursuing a settlement for an injury or illness
- Member is in police custody at the time treatment is rendered

Visit the Oregon Health Authority website at http://www.oregon.gov/oha/Pages/contact_us.aspx or Click here.

7.4 Umpqua Health Alliance Summary of Benefits

UHA utilizes the OHP Prioritized List of Health Services to determine whether a diagnosis and/or service is considered to be part of the OHP Benefit Package. The Oregon Health Services Commission designed and maintains the prioritized list under the direction of the Oregon Legislature. The Legislature then determines to what line the program will be funded on a bi-annual basis. Diagnoses and/or treatments that are considered to be "below the line" are not funded by the available budget, and are not part of the OHP Benefit Package.

Covered Medical Services include:

- 24-hour emergency care
- Diagnostic testing to find out what is wrong, whether the treatment or condition is covered or not
- Chemical dependency (alcohol and drug) treatment
- Diabetic supplies and education
- Emergency ambulance
- Eye health care services

- Family planning and related services
- Hospice
- Labor, delivery and newborn care
- Durable medical equipment and supplies
- Behavioral health services
- Most prescription drugs
- Preventive services
- Treatment for most major diseases
- Smoking cessation programs
- Some surgeries
- Specialty care and referrals

7.5 Prenatal/Maternity Benefits & Case Management Fees

- Maternity care should be billed globally, to include prenatal care, delivery and postnatal care. Office visits for related OB care and routine lab handling fees are included in the global charges (with the exception of venipuncture charges, which may be billed separately).
- An exception to global billing is a situation in which the PCP or OB/Gyn has not provided all phases of care. In such a situation the charges must be broken out (using the appropriate CPT codes), and submitted by each Provider for reimbursement.
- Routine lab tests provided outside the Provider's office (e.g., hospital or independent laboratory) will be reimbursed in addition to the global fee.

7.6 Preventive Covered Services

Well Baby/Child Checks: From birth through 36 months, UHA reimburses well child checks at the current recommended intervals from the Centers for Disease Control and the American Academy of Pediatrics or as recommended by the PCP.

- Guidelines for immunizations are based on the Childhood Immunization Schedules located online at Advisory Committee on Immunization Practices (ACIP) website at http://www.cdc.gov/vaccines/acip/index.html or Click here.

Well Child/Teen Checks: From 37 months through 18 years, UHA reimburses routine well child checks at the current recommended intervals from the Centers for Disease Control and the American Academy of Pediatrics or as recommended by the PCP.

- Guidelines for immunizations are based on the Childhood Immunization Schedules located online at Advisory Committee on Immunization Practices (ACIP) website at http://www.cdc.gov/vaccines/acip/index.html or Click here.

7.7 Vaccinations

- Effective April 1, 1996, as a result of the Vaccinations for Children (VFC) Program, UHA reimburses Providers for the immunization administration fee only (with the exception of Varicella and adult vaccinations), when billed with the CPT code for the specific immunization. If a Provider does not participate the Member must be sent to another contracted Provider who participates with VFC.
- VFC is an Oregon Public Health program, in which vaccines for immunizing eligible children in public and private practices can be obtained **without charge** by Providers who service Medicaid, OHP, uninsured or American Indian/Alaskan Native patients through age 18.

Umpqua Community Health Center
150 NE Kenneth Ford Dr.
Roseburg, OR 97470
Phone: 541.672.9596 or 541.440.3512
TTY: 877.874.7662
http://www.umpquachc.org/ or Click here.

- Flu Vaccination Policy
  - Vaccinations are available annually to all Members
  - Members may get the vaccine at either a contracted pharmacy, Provider's office or Umpqua Community Health Center.

- Pneumococcal Vaccination/Revaccination Policy
  - Vaccinations are available at Umpqua Community Health Center.
  - All recommendations for clinical preventive services can be found online at the U.S. Preventive Services Task Force website: http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations or Click here.

- Adults may receive Hepatitis B immunizations without a PA.

7.8 Women's Health Services

Routine breast, pelvic exams and mammograms are based upon the recommended guidelines of The American Congress of Obstetricians and Gynecologists and can be located online at: http://www.acog.org/ or Click here.

- Routine breast and pelvic exams may be performed by the Member's PCP, or may be performed by a participating OB/GYN, without requiring a specialty referral.
- Under age 40, a PA is required for routine mammograms.

7.9 Family Planning Benefits

Services not requiring a referral and/or PA:

- UHA Members may be seen by their PCP, a panel OB/GYN, or a panel Urologist (vasectomies only), county health department, or family planning clinic for family planning services, without a referral.
- These claims must be billed with a "Family Planning" or "Contraceptive Management" diagnosis code in order to identify these claims as excluded from the standard referral procedures.
- UHA reimburses for formulary oral birth control medication, diaphragms, Depo-Provera injections and IUDs without requiring a PA. The removal of Norplant implants or similar devices is reimbursable, as long as the removal is performed by a participating panel Provider and is medically necessary.
- OHA covers abortion services, without a PA.

7.10 Sterilization

Voluntary Sterilization

Sterilizations and hysterectomies are a covered service only when they meet the federally mandated criteria in 42 CFR 441.250 to 441.259 and the requirements of OHA established in OAR 410-130-0580, Hysterectomies and Sterilization. The Provider performing the sterilization procedure (tubal ligation and vasectomy) is responsible for obtaining a completed and signed *Ages 15-20 Consent to Sterilization* or *Consent to Sterilization* form for Members age 21 and over. Parent/guardian signature for a child less than 15 years of age is required. Documentation must be received at least thirty (30) days, but not more than one hundred eighty (180) days prior to the date of the sterilization except:

- In the case when the sterilization was performed less than thirty (30) days but more than seventy-two (72) hours after the date of the Member's signature on the Consent form because of the following circumstances:
  - Premature delivery
  - Emergency abdominal surgery

- The performing Provider must sign the Consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

- The Consent form must be signed and dated by the person obtaining the consent after the Member has signed, but before the date of the sterilization. If an interpreter assists the Member in completing the form, the interpreter must also sign the consent.

When an UHA Member signs a *Consent to Sterilization* form, it must be an informed choice and they must be legally competent to give informed consent. The Consent is not valid if it is signed when the Member is:

- In labor
- Seeking or obtaining an abortion
- Under the influence of alcohol or drugs
- Signed less than 30 days prior to procedure

Consent to Sterilization form can be obtained by contacting:

OHA, Provider Forms Distribution
PO Box 14090
Salem, OR 97309-4090

Access the OHA form online at: https://apps.state.or.us/Forms/Served/oe0742a.pdf or Click here.

7.10.1 Hysterectomy

- **In cases where a woman is capable of bearing children** prior to the surgery, the person securing authorization must inform the woman and her representative that the hysterectomy will render her permanently incapable of reproducing. The woman must sign the consent acknowledging that she has received the information.
- **In cases where a woman is sterile prior to the hysterectomy** the Provider who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of sterility.
- **In cases where the hysterectomy is required because of a life-threatening emergency situation** the Provider performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which it was determined that prior acknowledgment was not possible. The nature of the emergency must also be described.
- Please download the *Hysterectomy Consent Form* at https://apps.state.or.us/Forms/Served/oe0741.pdf, complete, attach and send with the claim to:

UHA Claims Processing Center
PO Box 5308
Salem, OR 97304

7.11 Tobacco Cessation

Tobacco cessation products are covered by the health plan. Nicotine replacement therapies including Nicotine Gum and Nicotine Patches are available without Prior Authorization (PA) for up to two quit attempts per year. Chantix and Zyban (bupropion) are also available without PA for up to two quit attempts per year. Please contact UHA Member Services at 541.229.4UHA (4842) or 866.672.1551 for any questions regarding coverage details.

Quit for Life Program
Phone: 866.QUIT.4.LIFE (866.784.8454)
TTY: 877.777.6534
https://www.quitnow.net/oregon/ or Click here

7.12 Vision

All UHA members have a routine vision benefit. Plan specific guidelines are located on the Umpqua Health Alliance website at: http://www.umpquahealth.com/ or Click here.

Members who are younger than 21 years of age qualify once every 12 months. This includes a vision exam, lenses, frame and fitting. Pregnant women (21 or older) can have an eye exam and new glasses (lenses and frames) every 24 months.

Medical eye exams are unlimited, if medically necessary.

Reimbursement
• Per OHA guidelines, when a complete eye exam is done, CPT code 92015 will not be accepted as reimbursable when billed with CPT code(s) 92002, 92004, 92012, 92014. • Add-ons and buy ups for hardware are considered non-covered services, and as such the entire pair of glasses would be considered non-covered. • UHA reimburses the basic rates for standard hardware (lenses and frames). • Hardware may be ordered through a UHA participating Provider who will coordinate services.

If a Member wants to buy more expensive glasses, which are not included in the OHP Benefit Package, or wants to add options such as blended bifocals or trifocals, the Member is responsible for the entire cost of the glasses. The State of Oregon prohibits Plan coverage, in whole or in part, of a “buy-up” benefit.

Post Cataract Care, Members are covered for one lens change per eye post cataract surgery, Provider needs to bill with a medical condition.

7.13 Hearing

Hearing services are a covered benefit for UHA Members. Providers must request a PA in accordance to OAR 410-129-0080, Prior Authorization. UHA utilizes the most current OHA guidelines for hearing aid reimbursement and PA requirements as outlined in OAR 410-129-0070, Limitations (2), Audiology and hearing aid services.

7.14 Durable Medical Equipment (DME) & Supplies

DME and supplies can be described as equipment that can stand repeated use and is primarily used to serve a medical purpose. Examples include wheelchairs, walkers, concentrators, and orthopedic braces. Disposable medical supplies would include diapers, gauze, syringes, and tubing.

The UHA Policy and Procedures for DME and medical supplies are to be used in conjunction with the Medicare DMERC Supplier Manual and the OHA DME guide. DME coverage for eligible Members is based on these rules which govern the provision and reimbursement for DME and Medical Supplies and can be found online at http://www.oregon.gov/oha/healthplan/Pages/dme.aspx or Click here.

UHA has a process for managing the capped rental process for DME for Medicaid beneficiaries. In accordance with the Deficit Reduction Act of 2005, UHA has adopted the Medicaid/Medicare DME capped rental policy, whereby after 10 to 13 months of rental, the beneficiary owns the capped rental DME item. After that time, UHA will pay for reasonable and necessary maintenance and servicing (i.e., parts and labor not covered by suppliers or manufacturer’s warranty) of the

item. Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price. Please note oxygen rental terms vary from above. Please see the CMS website for details.

Rental fees include:
- Delivery
- Training in the use of the equipment
- Pick-up
- Routine service, maintenance and repair

Purchases include:
- Assessment
- Assembly
- Delivery
- Adjustment (reasonable follow-up)
- Training in the use of the equipment

Repairs include:
- A prescription is only required for the initial repair request for an item purchased by a different payer.
- Pick-up & delivery (travel time, phone time or ordering time is not to be billed), charges may only be for the time actually spent repairing the equipment).
- Miscellaneous codes are to be avoided if an appropriate code exists. If not, clearly identify item, its manufacturer, its rental price, and the price charged. All miscellaneous coded items are reviewed to verify if they are medically appropriate.
- Modifiers must be used when billing for DME.
- Rented DME: DME will rent until the combined rental equals the purchase price or the fee schedule maximum allowable, whichever comes first.
- Regular DME: If an item is part of the Medicaid capped rental program, continue to bill Medicaid for the maintenance per their schedule.

If a Member wishes to purchase a non-covered portion or service, they must purchase the entire service. If the Member accepts financial responsibility for a “buy up” service, payment is a matter between the Provider and the Member. The DME Provider is expected to maintain documentation of a signed OHA approved waiver should this occur, and is required to provide this information to UHA.

Wigs:
Members with hair loss related to chemotherapy or radiation therapy will be eligible for a wig benefit of at least $150 per year. If you have any questions, please contact the UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

7.15 Emergency and Non-Emergency Medical Transport

Requirements/Guidelines	Reimbursement
• Authorization is not required for emergent transport services. • The transport must be medically necessary. • Condition of the individual is such that use of any other means of transportation would endanger health. • Transport must be from a lower level of care to a higher level of care. • Medical transport for an inpatient or outpatient Member who is transported for the sole purpose of diagnostic or other short-term services (in which the Member is returned within the first 24 hour period) will be DENIED, per OHA rules. • Medical transport notes are required along with the submission of an ambulance claim. • Ambulance claims must be submitted on a CMS 1500 form.	**Base Rate includes:** • Any procedure/services performed. • Non-reusable supplies and/or oxygen used. • All direct or indirect costs including general operating costs. • Personnel costs including neonatal intensive care teams employed by the ambulance Provider. • The first 10 miles of transport. • Use of reusable equipment. • Miscellaneous medical items or special handling that may be required in the course of transport. **Deceased Members:** • When death occurs prior to the arrival of the transport Provider, the medical transport is not eligible for reimbursement. • When death occurs during the course of the medical transport, UHA reimburses for base rate and mileage. • A cardiac arrest victim is considered to be alive until such a time as medical interventions are curtailed.

Non-Emergency Medical Transportation (NEMT)

Bay Cities Brokerage arranges non-emergency medical transportation services (NEMT) for UHA Members. Their call center is available for Members or the provider's office to contact Monday through Friday between 8:00 a.m. and 5:00 p.m. Rides should always be scheduled at least two business days in advance and no less than 24 hours, if possible. Bay Cities Brokerage will arrange the best transportation for the Member's needs.

As medically appropriate, members may receive reimbursement for driving themselves or having a friend or family drive them to a medical appointment. A copy of the "Rider's Guide" can be downloaded online or requested by calling Bay Cities Brokerage.

Bay Cities Brokerage
1290 NE Cedar St
Roseburg, OR 97471
Phone: 877.324.8109 or 541.672.5661
Toll Free TTY: 711
http://www.bca-ride.com/ or Click here

If you have questions regarding this covered service contact UHA Member Services at 541.229.4UHA (4842) or 866.672.1551.

7.16 Dental Services

Certain dental services are a part of UHA's benefits. These services are handled through the Member's assignment to a Dental Care Organization (DCO). The DCO assigns them to a dentist and coordinates their dental care. The Member's ID card will reflect which DCO they have been assigned to.

Members should contact UHA Member Services or the Dental Care Organization (DCO) listed on their Member ID card. Provider information or Member coverage may also be obtained by calling Advantage Dental at 866.268.9631 or Willamette Dental at 855.433.6825.

7.17 Community Health Care Services

UHA affirms the value of cooperation between publicly supported programs such as community health clinics.

7.17.1 Benefits at Community Health Clinics

Any participating community health clinic may provide the following services, without requiring a referral from the Member's PCP:

- Family Planning Services: Birth control pills, Depo-Provera injections, IUD placement, condoms (with a copy of the prescription attached to the claim).
- Women's Health: Pregnancy tests, and annual women's health exams (with PAP smear). In cases in which a Member exhibits symptoms suspicious for UTI, appropriate diagnostic screening may be performed. However, claims for reimbursement must indicate the suspected UTI in order to be eligible for reimbursement. With a referral from the Member's PCP, county health departments may perform cryotherapy, colposcopies, and cervical biopsies.
- Immunizations: Administrative fees under the UHA Standard Immunization schedule.
- Prescriptions: Pre-natal vitamins, children's multi-vitamins and anti-lice medication.
- Screening and /or Diagnosis: Sexually Transmitted Diseases (including treatment), and HIV. Dual screening for UTI may also be performed as outlined above under "Women's Health".
- Tuberculosis Screening and some treatment – home visits by nurses require a PA.

7.17.2 Public Health Network

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck for Children and Teens) are covered for individuals under 21 years of age and can be provided by the Public Health Network**.**
- Public Health Networks may provide home visits by county health nurses for enforcement of tuberculosis treatment.

Contact information for our local community health clinic is:

Umpqua Community Health Center
150 NE Kenneth Ford Dr.
Roseburg, OR 97470
Phone: 541.672.9596 or 541.440.3512
TTY: 877.874.7662
http://www.umpquachc.org/ or Click here.

7.18 Internal Review Procedures

UHA's Medical Director reviews all complaints/appeals as they are received. They are then taken to the Clinical Advisory Panel (CAP), which meets quarterly. This Committee can overturn denials or determine if any corrective action needs to be taken. Issues involving Providers are referred to the CAP as the appointed PEER Review Committee.

7.19 Provider Reconsideration

The reconsideration process is offered as a courtesy to Providers and other professionals for UHA. Reconsiderations will not be reviewed if received more than forty-five (45) days after the initial denial, at which point a new PA will need to be submitted.

This reconsideration process affords the Provider an opportunity to submit new, not previously reviewed clinical information.

***NOTE*:** All reconsiderations of Clinical Engagement decisions submitted by a Provider must include new chart notes or labs from a visit with the requesting Provider or other Provider. Additional information which the Provider believed was not previously known by UHA in its decision to deny a requested service. A letter from the Provider requesting a reconsideration and reason for the request.

7.20 Retroactive Review

Should services for routinely prior authorized services be required to be performed outside of normal business hours (e.g., skilled nursing facility admission, DME), retro-active authorization requests will be reviewed following the initiation (such as, an inpatient hospital stay), or provision of the service(s) in cases in which the Member's condition is emergent and/or services were provided outside of UHA's available health care service hours (Monday – Friday, 8:00 am – 5:00 pm).

For the purpose of retroactive authorization, UHA defines "emergent" as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Serious jeopardy to the health of the individual or if pregnant, to the health of the woman or child; or
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

In order to be considered for approval:

- The request must be determined to be medically necessary and appropriate.
- Supporting documentation of medical necessity and emergent nature is provided with the retroactive PA request.

7.21 Refund Requests

On occasion, UHA will issue "refund requests" to Providers. Typically, these requests are generated because a Member is covered by other insurance or for claim adjustment purposes. It is UHA's policy that Providers forward the requested reimbursement within thirty (30) days of receiving the request. Reimbursement not received within thirty (30) days may result in a deduction from the Providers' future claim payments for the requested amount.

Section 8: MEMBERS

8.1 Member Responsibilities

- To choose your Provider or clinic once enrolled
- To treat all Umpqua Health Alliance (UHA) Providers and personnel with respect
- To be on time for appointments made with Providers
- To call in advance if you are going to be late or have to cancel your appointment with a Provider
- To seek periodic health exams, check-ups, and preventive service from your (PCP) or clinic
- To use your PCP or clinic for diagnostic and other care, except in an emergency
- To obtain a referral to a Specialist from your PCP or clinic before seeking care from a Specialist
- To use urgent and emergency care appropriately and notify UHA Member Services or PCP within 72 hours of an emergency
- To give accurate information for inclusion in the clinical record
- To help the Provider or clinic obtain clinical records from other Providers. This may include signing a Release of Information form
- To ask questions about conditions, treatment, and other issues related to your care that is not understood
- To use information to make informed decisions about treatment before it is given
- To help in the creation of a treatment plan with the Provider
- To follow prescribe agreed-upon treatment plans
- To tell the Provider that your health care is covered under the OHP before services are received and to show the Provider the Medical ID card when requested
- To tell the DHS Case Worker if someone in the family becomes pregnant and to notify the DHS case worker of the birth of a child
- To tell the DHS Case Worker if any family member moves in or out of the household
- To tell the DHS Case Worker if there is any other insurance available and report any changes in insurance in a timely manner
- To pay for received non-covered services
- To pay the monthly OHP premium on time, if required
- To assist the health insurance plan in pursuing any third party insurance to which you are entitled and to pay the health insurance plan the amount of benefits you received as a result of an accident or injury
- To bring issues, complaints, or grievances to the attention of UHA Clinical Engagement
- To sign a release so that DHS and UHA can get information that is pertinent and needed to respond to an "Administrative Hearing" request in an effective and efficient manner
- Contact UHA Fraud, Waste and Abuse at 541.229.7035 immediately if you suspect any fraud or abuse

8.2 Member Rights

- To be treated with dignity and respect
- To be treated by Providers the same as other people seeking health care benefits to which you are entitled
- To select or change your PCP
- To obtain behavioral health, chemical dependency, or family planning services without referral
- To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- To be actively involved in the development of your treatment plan
- To receive information about your condition and covered and non-covered services, and to allow an informed decision about proposed treatment(s)
- To consent to treatment or refuse services and be told the consequences of that decision, except for court-ordered services
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- To receive written materials explained in a manner which is understandable
- To receive necessary and reasonable services to diagnose the presenting condition

- To receive covered services under the OHP which meet generally accepted standards of practice and are medically appropriate
- To obtain covered preventive services
- To have access to care when you need it, 24 hours a day, 7 days a week
- To have access to your own medical records, unless restricted by statute
- To request changes to be made to your medical records
- To transfer a copy of your medical records to another Provider
- To make a statement of wishes for treatment (Advance Directive) and obtain a Power of Attorney for health care
- To know how to make a complaint, grievance or appeal and receive a response
- To receive written notice before a denial, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations
- To request an "Administrative Hearing" with the DHS
- To receive a notice of an appointment cancellation in a timely manner
- To receive adequate OHA Notice of Privacy Practices (MSC 2090 (2/2014))
- For problems that have not been resolved through OHP Client Services or other means, call the OHA Ombudsperson at 877.642.0450, TTY 711

8.3 Member Materials

Members receive the following materials from Umpqua Health Alliance:

- **UHA Member Handbook** – At minimum, the UHA Member Handbook will contain the following elements:
  - Phone numbers to call for more information
  - Choice and use of primary care provider
  - How to get a second opinion
  - Use of a referral system
  - Use of urgent and emergent services
  - How to change their medical records
  - General benefits (including preventative and family planning) available, and non-covered services
  - Information about UHA's grievance and appeals process
  - Information about Advance Directives and Declaration for Mental Health Treatment
  - How to access the UHA Provider Directory
  - Health Risk Survey

- **Member ID Card**
  - Member's full name
  - OHA identification number
  - Primary Care Provider (PCP)
  - Dental Care Organization (DCO)
  - How to access emergency services

If Members have questions regarding materials sent to them by UHA, they should be referred back to UHA Member Services at 541.229.4UHA (4842) or 866.672.1551, TTY 541.440.6304.

8.4 Access for Special Needs Members

UHA shall ensure that both the information and services provided are accessible to the Members.

- Providers are required by contract to comply with provisions of the American Disabilities Act (ADA). Providers shall provide for physical access to their offices. UHA staff may conduct an annual site review to determine the accessibility of each of the participating Provider's office. As a Provider, you must ensure the following provisions;

street level access or accessible ramp into the facility, wheelchair access to the lavatory, corridor railings, and elevators operable from a wheelchair when appropriate.

- In addition, facilities and personnel shall be prepared to meet the special needs for Members who are visually and/or hearing impaired. Providers shall request sign interpreter services to be arranged.
- In the event that a PCP is unable to meet the unique needs of the UHA Member because of a specific disability, the PCP shall notify the ICM of the Member's physical limitations and services that may be required. The ICM shall secure the appropriate medical services or assist the Member in selecting a different participating Provider or secure services from a non-participating Provider.
- Policies pertinent to the processing of referrals shall apply. The Member's PCP shall be notified of any necessary changes. Efforts to locate a Provider shall be documented in the Member's file.

8.5 Access to Care Standards

UHA recommends the following office visit access standards for Members seeking medical services from participating Providers.

Non-urgent, routine care	Must be seen, treated or referred within four weeks
Urgent care	Must be seen within two business days
Emergent care	Must be seen within one business day or referred to an emergency department depending on the Member's condition
Wait time in office for scheduled appointment	Not to exceed 45 minutes without an explanation
Wait time in office for walk-in appointment **if these are offered by the clinic**	2 hours
Access to advice nurse on the telephone	2 hours
Return telephone calls from Provider's office	Routine by close of business day Urgent within 4 hours

The Member shall be informed when the Provider is not able to see the Member at the scheduled appointment time due to an emergency. The Member shall be offered an opportunity to reschedule the appointment at another time.

Providers are expected to abide by UHA's health plan policies N7- Network Adequacy Policy, N8- Monitoring Network Availability Policy and N9- Monitoring Network Access Policy.

8.6 Patient Advocacy

Provider may, without any constraint from UHA, advocate on behalf of a Member who is their patient, for the following:

- The Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
- Any information the Member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Such contract provisions would not be allowed unless UHA has cited a moral or religious objection to counseling for a particular service or services and has provided written information to the State Medicaid agency.

8.7 Member Grievances & Appeals

UHA has two different procedures to deal with two different kinds of complaints from Members. The first is a Grievance procedure. A Grievance is a complaint from a Member that is not related to an action of UHA.

The second is an Appeal procedure. An Appeal is a complaint related to an Action of UHA. An Action is a denial or limited authorization of a requested covered service; reduction, suspension or termination of a previously authorized service;

denial of payment for service; failure to provide service in a timely manner; failure of the Health Plan to act within timeframes; denial of request to obtain services outside of the Health Plan's participating Provider panel. All Actions result in a written "Notice of Action" from UHA to the Member. Therefore, the easiest way to tell the difference between a Grievance and an Appeal is that an Appeal is related to a Notice of Action and a Grievance is not.

If a Member expresses any sort of complaint or dissatisfaction with you or to you about some aspect of their care in the UHA plan that is NOT related to a Notice of Action, you should:

- Advise the Member to contact UHA's Grievance and Appeals Coordinator in writing or by phone at 541.229.4842.
- Keep the Member's complaint confidential. If the Member wants to pursue their complaint, they can do so by following the UHA Grievance procedure.

If the complaint is something you can help with, please do not hesitate to address their concerns. For instance, if a Member complains about a long wait for an appointment, you can apologize for the wait. We encourage you to deal with Member complaints promptly and sensitively. In no event should you discourage a Member from making a complaint to the Grievance Coordinator, but that does not mean that you cannot address a Member's complaint and allow the Member to decide whether to follow up with UHA or not.

If a Member expresses a complaint related to a Notice of Action (this will usually be about some sort of denied service) you should do this:

- Advise the Member to contact UHA's Grievance and Appeals Coordinator in writing or by phone at 541.229.4842 to begin the appeal process.
- Keep the Member's complaint confidential. If the Member wants to pursue their complaint, they can do so by following the UHA Appeals procedure.
- If you feel it is appropriate, you can offer to support the Member in their Appeal of the Notice of Action. For example, if UHA has denied a service that you feel is important to the Member's health, you may support the Member's Appeal of that decision without any risk that UHA will penalize you for that. UHA encourages Providers to be advocates for their UHA Members.

8.8 Applicability of Federal Laws

As a federal contractor, UHA receives federal funds to provide services to UHA Members. As a participating Provider providing services to these Members, you are subject to laws applicable to individuals and entities receiving federal funds. Participating Providers who treat UHA Members are required to comply with applicable state and federal laws and regulations regarding Medicaid and Medicare.

8.9 Restraint & Seclusion in Delivery of Health Care

UHA Providers will ensure that Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with state and federal regulations on the use of Restraints and Seclusion.

Contractor's shall comply with all state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act (ADA) of 1990, and all amendments to those acts and all regulation promulgated there under. Contractors shall also comply with all applicable requirements of state civil rights and rehabilitation statues and rules. CFR 438.100, Enrollee Rights.

Section 9: DOCUMENTATION

9.1 Medical Record Documentation Policies

Participating Providers are required to safeguard Member-identifying information and to maintain the records in an accurate and timely manner consistent with state and federal laws. Compliance with medical record policies will be monitored by Umpqua Health Alliance (UHA). By agreeing to participate, Providers agree to cooperate in random medical record reviews that are conducted by UHA. If evidence of substandard medical record keeping is identified by random chart note review, the Provider will be educated regarding this policy and further monitoring done as deemed necessary. Participating Providers may be required to submit corrective action plans for non-compliant processes if continued evidence of substandard medical record keeping is identified by random chart note review.

Each Provider shall maintain the confidentiality of the medical record information, assuring that the contents of the medical record shall be released to authorized personnel only. This includes UHA's designee or persons, as authorized by the Member in the Release of Information form. The Provider shall cooperate with UHA and their representatives for the purposes of audits and the inspection and examination of medical records. Medical record information can be released to UHA by the Provider without a HIPAA Authorization form signed by the Member, according to HIPAA regulations, if the disclosure is for treatment, payment, and healthcare operations.

The PCP is responsible for maintenance of each Member's integrated medical record that documents all types of services delivered, both during and after office hours.

Participating Providers shall include the following in the medical record for all UHA Members' medical records:

- Preventive visits according to established protocols, basis of the diagnostic impression, Member's primary complaint sufficient to justify any further diagnostic procedures and treatment or recommendations for return visits and referrals.
- The medical record shall be complete and legible. Each entry shall be dated, have a legible signature/initial and all pages identified with the Member's name. A complete record includes chart notes, nurses' notes, vital signs, medications, immunizations, and telephone message entries. This excludes problems on the problem list, prominent allergy notations and biographical or business information.
- Medical records shall be organized, uniform, detailed, current, and contain the securely attached record of one Member in each chart.

9.2 Declaration for Mental Health Treatment

"A Guide to Oregon's Declaration for Mental Health Treatment" was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736. It was created to allow the Member to protect themselves when they are unable to make their own mental health treatment decisions. The Declaration for Mental Health Treatment form tells what kind of care the Member wants or does not want if they ever need that kind of care but are unable to make their wishes known. The Member can choose an adult to represent them. The Representative must agree to do so. The Representative keeps a copy of the Declaration and a copy is provided to the Member's PCP or mental health provider. The Declaration is only good for three (3) years and must be renewed. If the Member is incapable of making mental health treatment decisions during the 3 years, the Declaration will remain until the time-whenever that may be-that the Member regains capacity to make their own decisions. The Member can change or cancel the Declaration as long as they are still capable of understanding the information provided. A revised copy must be provided to the PCP, dental or mental health provider. Only a court and two doctors can decide if the Member is not able to make decisions about their mental health treatment.

For more information on the Declaration for Mental Health Treatment, go to the State of Oregon's website at: http://www.oregon.gov/OHA/HSD/AMH/forms/declaration.pdf

If your Provider does not follow your wishes in your Declaration for Mental Health Treatment, you can file a complaint. A form for this is at:

http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/HEALTHCAREHEALTHCAREREGULATIONQUALITYIMPROVEMENT/Pages/complaint.aspx. Send your complaint to:

Health Care Regulation and Quality Improvement Program
800 NE Oregon St, #465
Portland, OR 97232
Email: Mailbox.hcls@state.or.us
Fax: 971-673-0556
Phone: 971-673-0540; TTY: 711

9.3 Advance Directives (Living Wills)

An Advance Directive, also called a Living Will, explains the specific medical decisions the Member wants if they have a terminal illness or injury and are incapable of making decisions about their own care, including refusing treatment. Most hospitals, nursing homes, home health agencies and HMOs routinely provide information on advance directives at the time of admission. In order to comply with the Federal Patient Self Determination Act (PSDA) 1990 42 U.S.C. 1395 cc (a) Subpart E, UHA requires that PCPs, dental and mental health providers ask Members if they have executed an Advance Directive or mental health treatment declaration. The provider must document that fact in the Member's medical record, make a copy of the document and include it as part of their medical record.

To download a copy of an Advance Directive form, go to:
http://www.oregon.gov/DCBS/insurance/shiba/Documents/advance_directive_form.pdf or Click here

In Oregon, the Health Care Decisions Act (ORS 127.505 - 127.660 and ORS 127.995) allows the Member to preauthorize a health care representative(s) or health care power of attorney, at least 18 years of age, to allow the natural dying process if he or she is medically confirmed to be in one of the conditions described in his or her health care instructions. UHA encourages PCPs, as part of the Member education and registration process, to annually ask if the Member has executed an Advance Directive. If so, a copy should be put in the medical record.

9.4 Notice of Privacy Practices and HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects your protected health information (PHI) and keeps it private. All participating Providers are required to comply with HIPAA Privacy and Security rules and regulations.

9.5 Change of Information

Please notify Provider Services of any changes to your practice including:

- Billing address
- Closing practice date
- Mailing address
- Member/patient limits and restrictions
- Physical office address
- Status of your membership with Umpqua Health Alliance (UHA)
- Tax ID and NPI number
- Telephone number

Submit any changes by email to UHNProviderServices@umpquahealth.com or in writing:

Umpqua Health Network - Provider Services
1813 W Harvard Ave, Ste 110
Roseburg, OR 97471

Section 10: COMPLIANCE

Umpqua Health is dedicated to operating in accordance with its CCO Contract with the Oregon Health Authority, along with State, Federal and Local regulations. Furthermore, Umpqua Health expects its provider panel, also referred to in this section as "subcontractor," to operate with a high level of integrity to ensure compliance with regulations. Participating providers are seen as subcontractors under Umpqua Health's CCO Contract, (CCO Contract, Exhibit A, Section 3(hhhh)), and therefore are required to comply with certain requirements bestowed upon Umpqua Health.

Umpqua Health will not tolerate deceitful, wasteful, abusive, or other similarly inappropriate activities among any of those individuals or entities whom we employ, serve, or otherwise do business with. More importantly, Umpqua Health takes the health and welfare of our patients, members, and others we serve very seriously.

Many of Umpqua Health's Compliance Program documents may be accessed on UHA's website. Additionally, Umpqua Health's Compliance Office can be reached, at the contact information listed below, if there are questions or concerns regarding requirements.

10.1 Code of Conduct and Ethics

Subcontractors for Umpqua Health are required to comply with Umpqua Health's Code of Conduct and Ethics Program. This document provides a solid basis for providers to understand the fundamental core values we hold ourselves to, as well as providing guidance in conducting business with or on behalf of UHA. To that end, Umpqua Health will provide a copy of its Code of Conduct and Ethics document to subcontractors during the credentialing and contracting process, and expect subcontractors to attest that they have read and understood this document.

10.2 Compliance Plan and Policies and Procedures

Umpqua Health's Compliance Plan, along with its policies and procedures, govern the operational elements of its Compliance Program. Accordingly, subcontractors are expected to fully comply and follow the requirements established in the Compliance Plan as well as its policies and procedures. These documents can be viewed on UHA's website.

10.3 Fraud, Waste and Abuse

Subcontractors of Umpqua Health are required to comply with Umpqua Health' Fraud, Waste, and Abuse policy, along with Federal and State Fraud and Abuse laws. Below, Umpqua Health provides a brief description of some of the key Fraud and Abuse laws subcontractors should be aware of:

<u>Federal False Claims Act (FCA) (31 U.S.C. § § 3729-3733 & 18 U.S.C. § 287)</u>

The Federal FCA prohibits an individual or entity from submitting claims for payments to Medicare or Medicaid that are false or fraudulent. It is designed to ensure the Federal Government is not being overcharged or sold substandard goods or services. For civil penalties, no specific intent is needed for the FCA to be enforced. An example would include submitting a claim to Medicare or Medicaid for services that never occurred, or billing for services at a higher level than what was actually performed and documented.

Civil penalties for violating the Federal FCA include:

- Fines up to three times of the programs' loss.
- Civil monetary penalties of $5,500 to $11,000 per claim.
- Exclusion from Federal Healthcare participation.

Criminal penalties may also be administered in the event intent is proven, which could result in imprisonment and additional fines and/or penalties.

The Federal FCA also has the "Qui Tam," provision, commonly referred to as the "Whistleblower Provision." This provision allows an individual to file a lawsuit on behalf of the Federal Government, towards individuals or entities engaging in activities violating the FCA. In the event the whistleblower is the prevailing party, the whistleblower is entitled to part of the recovery proceeds (typically 15-25%). Lastly, whistleblowers are also granted certain levels of protection under the law, specifically regarding non-retaliation. Therefore, Umpqua Health takes a strong stance in prohibiting any form of retaliation against anyone who brings an issue forward in good faith.

Oregon False Claims Act (ORS 180.750)

Similar to the Federal FCA, the State of Oregon also has a FCA, which pertains to submitting a fake or fraudulent claim to the State of Oregon for payment.

Penalties include:

- Repayment of funds received.
- Penalty equal to the grater of $10,000 for each violation, or an amount equal to twice the amount of damages incurred for each violation.

Anti-Kickback Statute (AKS) (42 U.S.C. § 1320a-7b(b))

AKS is a criminal statute that prohibits one from knowingly and willfully giving payments, or remuneration, to induce or reward referrals for services paid by Federal healthcare programs. Both the giving individual and the receiving individual can be implicated with the AKS Statute if the arrangement does not fit within a designated safe harbor. Remunerations can take many forms including cash, reduced rent, lavish vacations, medical directorships, pricey goods, etc. An example of an AKS scenario is a lab compensating a physician $50 for each referral the physician sends to the lab. The AKS is an intent driven statute, meaning the compensation given or received was meant to drive up referrals. Lastly, the AKS Statute can also apply to the patient population. Routine waiver of copayments, excessive gifting to patients, free/discounted services, can also implicate AKS, as these remunerations may encourage patients to seek excessive services.

Violations for AKS include:

- $50,000 penalty per kickback.
- $25,000 criminal fine.
- Three times the amount of the remuneration.
- Five years in prison.
- Exclusion from Federal Healthcare participation.
- FCA violations.

Physician Self-Referral aka Stark Law (42 U.S.C. § 1395nn)

The Stark Law prohibits a physician from referring patients who are to receive "designated health services," payable by Medicare or Medicaid, to an entity in which the physician (or immediate family member) has a financial relationship. The Stark Law does not require intent for it to be enforced, and is strictly a liability statute. An example of a potential Stark Law violation would occur if a physician refers a patient to an imaging center that the physician has some form of ownership, and the arrangement did not fit within an exception under the Stark Law.

Penalties for Stark violations include:

- Penalties of $15,000 per claim submitted.
- $100,000 penalty per scheme.
- FCA violations.

Exclusion Statute (42 U.S.C. § 1320a-7)

Outside of fines and imprisonment, one of the Federal Government's best tool for combatting Fraud and Abuse is the use of the Exclusion Statute. Certain healthcare related offenses can result in the Health and Human Services' Office of Inspector General (HHS-OIG) seeking exclusion for individuals and entities. Excluded individuals or entities are prohibited from billing Medicare and Medicaid for treating patients, nor may their services be billed indirectly through a group or an employer.

Civil Monetary Penalties Law (CMPL) (42 U.S.C. § 1320a-7a)

The CMPL is a resource the Federal Government may use to sanction individual or entities for engaging in certain conduct. Such prohibited activities under the CMPL include:

- Offering inducements for services to Medicare and Medicaid patients.
- Offering inducements to physicians to limit services.
- Contracting or employing an individual who is excluded.
- Failing to report an overpayment.

Penalties for violating the CMPL vary depending on the situation, but may include:

- Fines up to $50,000.
- Denial of payment.
- Repayment of the amount paid.
- Exclusion authority.
- FCA violation.

Criminal Health Care Fraud Statute 18 U.S.C. Section 1347

A criminal statute, which makes it a criminal offense for knowingly and willfully engaging in a scheme to defraud healthcare programs.

Penalties include:

- 10 years in prison.
- Up to $250,000 fine.

10.4 Training

As a condition of contracting, subcontractors are required to complete certain trainings in order for Umpqua Health to meet contractual and regulatory requirements. These trainings should be conducted on an annual basis and cover the following:

- Fraud, waste, and abuse.
- HIPAA.
- Compliance training.

Subcontractors may elect to utilize their own trainings or request trainings from Umpqua Health. If subcontractors intend to develop and utilize its own training, the subcontractor must ensure it aligns with the materials presented in:

- CMS Medicare Learning Network (http://www.cms.gov/MLNProducts).
- Umpqua Health Alliance's CCO contract with the Oregon Health Authority (Exhibit B, Part 8, Section 14).

Umpqua Health reserves the right to require its subcontractor attest and/or provide documentation that the subcontractor and its workforce has received the required trainings. In the event that a subcontractor cannot demonstrate training was provided, Umpqua Health may ask the subcontractor to complete a corrective action plan to address the deficiency.

10.5 Prohibition of Excluded Individuals

Umpqua Health is prohibited from engaging in any form of contractual relationship with individuals or entities who are actively excluded/debarred from participation in State and Federal healthcare programs. This requirement trickles down to its subcontractors, therefore, subcontractors are expected to comply with this requirement by ensuring they are not contracting or employing any individual who is actively excluded/debarred from State and Federal healthcare participation.

Commonly referred to as exclusion monitoring, subcontractors shall review monthly that none of their employees or contractors are actively listed on the following databases:

- HHS-OIG's List of Excluded Individuals (LEIE).
- Excluded Parties List System (EPLS), also known as System for Award Management (SAM).

In the event a subcontractor identifies an individual who is actively excluded/debarred, the subcontractor shall notify Umpqua Health's Compliance Department within one business day.

10.6 Cooperation with Compliance Activities

Umpqua Health engages in a variety of activities to support its Compliance Program. As subcontractors for Umpqua Health, providers and their staff are expected to fully cooperate with all of Umpqua Health's Compliance activities. Such activities include but are not limited to:

- External audits
- Provider audits
- FWA audits
- Subcontractor audits
- Investigations
- Trainings

In the event Umpqua Health identifies deficiencies associated with a subcontractor's performance, Umpqua Health will engage in a corrective action plan process with the subcontractor. Subcontractors are expected to participate and take appropriate actions to mitigate any of the deficiencies in a timely manner.

10.7 Reporting Concerns

Individuals and subcontractors who suspect fraud, waste, or abuse or other suspicious activities, are required to report these concerns to Umpqua Health's Compliance Department. Furthermore, Umpqua Health expects its provider panel and subcontractors to comply with its Non-Retaliation Policy for individuals who report matters in good faith. Reports can be made to:

Umpqua Health
Attn: Compliance Department
1813 W. Harvard, Suite 110
Roseburg, OR 97471
Phone: (541) 229-7035
Email: Compliance@umpquahealth.com

Umpqua Health also provides an anonymous hotline for individuals seeking anonymity. It can be access by:

Compliance & FWA Hotline (Can report anonymously)
Phone: (844) 348-4702
Online: www.umpquahealth.ethicspoint.com

Lastly, reports can be made to State and Federal Regulators through the following channels:

Medicaid Fraud Control Unit (MFCU)
1515 SW 5th Avenue, Suite 410
Portland, OR 97201
Phone: (971) 673-1880
Fax: (971) 673-1890

OHA/DHS Provider Audit Unit (Provider FWA Allegations)
P.O. Box 141522
3406 Cherry Ave NE
Salem, OR 97309-9965
Phone: (888) 372-8301

OHA/DHS Fraud Investigation (Member FWA Allegation)
P.O. Box 14150
Salem, Oregon 97309-5027
Phone: 1-888-FRAUD01 (888-372-8301)
Fax: (503) 373-1525 ATTN: Hotline

US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
Fax: 1-800-223-8164
Web: https://oig.hhs.gov/fraud/report-fraud/index.asp