Provider Handbook
2021

Version 2.2021

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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. This helps reduce unnecessary hospitalizations, emergency room visits and, and diagnostic testing and gives people support to be healthy. UHA works closely with local Providers to achieve these goals.

1.3 What is the Oregon Health Plan?

The Oregon Health Plan or OHP is the Medicaid program in Oregon. 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 medically necessary and appropriate including but not limited to: 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.

- Doctor visits
- Primary care
- Lab and x-ray
- Prescription drugs
- Pregnancy care
- Hospital visits
- Medical equipment
- Dental cleanings
- Mental health care
- Some vision services

Additional services such as assistance with transportation and non-billable services and supplies may also be covered by UHA in some circumstances.

Section 2: KEY CONTACTS

If you are unsure of which department to direct your call, please call UHA at 541.229.4UHA (4842) 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>Customer Care</th><th>Medical & Case Management</th><th>Corporate Office</th><th>Provider Network; Provider Relations & Credentialing</th></tr>
<tr>
<td>Ph: 541.229.4842
Fx: 541.677.6038
UHA Customer Care
500 SE Cass Ave, Ste 101
Roseburg, OR 97470

• Benefit and eligibility information on your patients
• PCP changes
• DCO changes
• Provide/replace Member ID cards</td>
<td>Ph: 541.229.4842
Fx: 541.677.5881
UHA Clinical Engagement
500 SE Cass Ave, Ste 101
Roseburg, OR 97470

• Case management
• Intensive Care Coordination
• Member Grievance and Appeals
• Pharmacy
• Utilization management
• Referral and Prior Authorizations
• Clinical Advisory Panel</td>
<td>Ph: 541.464.4300
Fx: 541. 440.6306
3031 NE Stephens St
Roseburg, OR 97470

• Executive Team
• Legal
• Finance</td>
<td>Ph: 541.464.6299
Secure Fax: 541.229.4782
3031 NE Stephens St
Roseburg, OR 97470

• Initial credentialing (new Providers) and 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: 541.229.4842
Fx: 541.677.6038
Ph Tech
Attn: UHA Claims
PO Box 5308
Salem, OR 97304
UHAClaims@umpquahealth.com
• Claims inquiries, First level payment reconsiderations, billing issues, payment methodology inquiries</td>
<td colspan="3"></td>
</tr>
<tr><th>Compliance</th><th>Quality Improvement</th><th>Human Resources</th><th>Provider Network; Contracting</th></tr>
<tr>
<td>Ph: 541.229.7035
Fx: 541.229.9982
3031 NE Stephens St
Roseburg, OR 97470
Email:
Compliance@umpquahealth.com

Compliance & FWA Hotline (can report anonymously)
• Phone: 844.348.4702
• Online: www.umpquahealth.ethicspoint.com</td>
<td>Ph: 541.464.6270
Fx: 541.440.6306
3031 NE Stephens St
Roseburg, OR 97470

• CCO quality metrics
• Medicare STAR rating
• Quality improvement</td>
<td>Ph: 541.464.6274
Fx: 541.229.4785
3031 NE Stephens St
Roseburg, OR 97470</td>
<td>Ph: 541.229.7019
Fx: 541.440.6306
3031 NE Stephens St
Roseburg, OR 97470
• Contractual questions regarding terms of contract
Ph: 541.957.3094
• Contracting new Providers
• Out of state DMAP enrollment</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.

Americans with Disabilities Act (ADA): 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 **adverse benefit determination (ABD)** that a Member disagrees with.

Adverse Benefit Determination (ABD): The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

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®) and Healthcare Common Procedure Coding System (HCPCS) 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

Emergent/Emergency: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
(a) Placing their health or the health of an unborn child in serious jeopardy;
(b) Serious impairment of bodily functions; or
(c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which could not be delayed by 24 hours.

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 (FFS): 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 ABD, 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 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 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 individual, entity, facility, or organization, other than a participating Provider, that has entered into a Subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.

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: A medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

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 review of health care services for medical necessity, efficacy, quality of care, and cost-effectiveness.

Utilization Management: A set of techniques used 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. Providers are initially credentialed and subsequently re-credentialed according to Umpqua Health Network's Credentialing Policies and Procedures, which utilize the National Committee for Quality Assurance (NCQA) standards and guidelines. 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. Additionally, per UHA's policy, CR3 that is recognized by the State, the following is also a process that must meet approval prior to any contracts executed: High Risk: Medicare and Medicaid designates a "high" risk category according to section 42 CFR §424.518(c)(l) when a Provider is newly enrolling. A Provider designated "high" risk must meet limited and moderate risk screening requirements. Criminal background check must be conducted, and submission of fingerprint set required based on risk of Fraud, Waste, and Abuse in accordance with 42 CFR §455.434. A Provider who has received suspension, sanction, or exclusion from a State or Federal program within the previous 10 years. Should a Provider not obtain the proper background verifications based on the below requirements of the credentialing UHA will not honor their contract.
  - DMAP Medicaid number
  - CMS Medicare number
  - Electronic Medical Records (EMR)

  Attest to annual training requirements:
    - Cultural Competency Training
    - Americans with Disabilities Act (ADA)
- 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
- Proof of background checks
- Seclusion and Restraint attestation form
- 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 https://www.irs.gov/forms-pubs/about-form-w-9 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 541.440.6306, email UHNProviderServices@umpquahealth.com or mail:

Umpqua Health Network
Provider Services
3031 NE Stephens St
Roseburg, OR 97470

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 Credentialing Specialist at 541.464.6299.

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 (if required).
- 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.
- Follow the MS1 – Member Assignment and Reassignment Policy when terminating a member from care. UHA expects providers to consider, on an individual basis, whether termination would be appropriate for the member. If possible and safe to do so, providers should attempt to mitigate any behavior in order to maintain the relationship. When a dismissal is necessary, please fax a copy of the letter to UHA Customer Care at 541-677-6038. This will ensure that we take the appropriate steps needed to provide our members with continued care while at the same time honoring the provider's request of dismissal.

4.5.2 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.

4.5.3 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 (except as noted in the Prior Authorization grid published on UHA website).

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

4.5.4 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.

4.5.5 PCP Selection Process

All UHA members are assigned to an Open PCP upon becoming eligible with UHA. Initial assignments are made within the first week of enrollment for all members and follow the assignment algorithm described in the MS1– Member Assignment and Reassignment Policy.

Members may also 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 may change their PCP to another in-network PCP at any time and the change is effective immediately. 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.

PCPs receive a weekly report of all Members who have been assigned to 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.

4.6.1 Provider Availability Requirements

UHA's Providers shall meet the following availability standards for appointment wait times (OAR 410-141-3515):

I. Primary Care Providers ("PCPs") are required to meet the following availability standards (OAR 410-141-3515(11)(a)):
   i. Timeframe for Urgent Appointments – Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840.
   ii. Timeframe for Routine Appointments – Within four weeks, or as otherwise required by applicable care coordination rules, including OARs 410-141-3860,410-141-65, 410-141-3870.
   iii. Timeframe for referring for Emergency Care – Immediately or referred to an emergency department depending on the member's condition.

II. Specialists are required to meet the following availability standards (OAR 410-141-3515(11)(a)).
   i. Timeframe for Urgent Appointments – Within 72 hours
   ii. Timeframe for Routine Appointments – Within four weeks

III. Dental Care Providers are required to meet the following availability standards (OAR 410-141-3515(11)(b)):
   i. Timeframe for Emergent Oral Care – Seen or treated within 24 hours
   ii. Timeframe for Urgent Oral Care – Within one week or as indicated in the initial screening in accordance with OAR 410-123-1060;
   Timeframe for Routine Oral Care – Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

IV. Behavioral Health Providers are required to meet the following availability standard (OAR 410-141-3515(11)(c)):
   i. Routine behavioral health care – for non-priority populations: assessment within seven days of the request, with a second appointment occurring as clinically appropriate.
   ii. Specialty behavioral health care for priority populations –
      a. In accordance with the timeframes listed below for assessment and entry, terms are defined in OAR 309-019-1015, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;
      b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;
      c. IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;
      d. Opioid use disorder: Assessment and entry within 72 hours;
      e. Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;
      f. Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.
   iii. Urgent behavioral health care for all populations – Within 24 hours

4.6.2 Provider Access Requirements

UHA shall ensure that its network is meeting the following time and distance access standards.

a. UHA's in-network PCPs are required to meet the following time and distance standards for at least 90% of UHA's

Members.

i. Travel time for Member to PCP: 30 minutes urban/60 minutes rural (OAR 410-141-3220(4)(a)); or
ii. Distance for Member to PCP: 30 miles urban/60 miles rural (OAR 410-141-3220(4)(b)).

b. UHA's in-network Specialists are required to meet the following time and distance standards, which are based on the proposed specialties and standards for Qualified Health Plans in Oregon in 2018.
   i. Dental – within 60 minutes or 60 miles of Member.
   ii. Endocrinology – within 60 minutes or 60 miles of Member.
   iii. Gynecology (OB/GYN) – within 60 minutes or 60 miles of Member.
   iv. Infectious Diseases – within 60 minutes or 60 miles of Member.
   v. Oncology (Medical/Surgical) – within 60 minutes or 60 miles of Member.
   vi. Oncology (Radiation/Radiology) – within 60 minutes or 60 miles of Member.
   vii. Mental Health – within 60 minutes or 60 miles of Member.
   viii. Pediatrics – within 60 minutes or 60 miles of Member.
   ix. Cardiology – within 60 minutes or 60 miles of Member.
   x. Rheumatology – within 60 minutes or 60 miles of Member.
   xi. Hospitals - within 60 minutes or 60 miles of Member.
   xii. Outpatient Dialysis – within 60 minutes or 60 miles of Member.
   xiii. Inpatient Psychiatric Facility Services – within 60 minutes or 60 miles of Member.

4.6.3 Access and Cultural Considerations

UHA promotes delivery of health equity for all its Members ensuring they reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. UHA requires its Providers to uphold delivery of services in a culturally competent manner to all Members (diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity), including those with limited English proficiency. UHA requires its Providers to complete annual cultural responsiveness and implicit bias training and education by providing trainings consisting of, but not limited to: the use of culturally and linguistically appropriate services (CLAS) standards, implicit bias training addressing structural barriers and systemic structures of oppression, language access, adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma, the use of REAL+D to advance health equity, universal access and accessibility in addition to compliance with the American Disabilities ACT (ADA), and health literacy (PN6 – Provider Orientation and Training).

4.7 Missed Appointments

Providers requesting Member disenrollment due to Members missing their appointments, must abide by the health plan policy MS1 – Member Assignment and Reassignment Policy. If the Provider should experience any problems with Members who fail to show for appointments, this information should be relayed to UHA Customer Care. UHA will authorize a request for reassignment for frequent missed appointment only if the following has occurred:

a. Member was given a copy of the Provider's policy at intake.
b. The policy allows no less than four missed appointments over a six-month period.
c. The Provider has made documented attempts to remind the Member of upcoming appointments.
d. The Provider has attempted to reduce barriers (e.g., transportation needs).
e. The Provider has previously reached out to UHA's Customer Care Department regarding the Member, requesting a care coordination referral to assist with Member engagement.

Upon receipt of the request, UHA's Customer Care Department will render a decision within five business days on whether the request has been approved. Customer Care will also inform the Contracting Department of any potential reassignment requests that do not align with this policy. The Contracting Department will then contact the Provider for remediation strategies. OHP Members cannot be billed for missed appointments.

Coordination of Reassignment

- Once a request for reassignment has been approved, Providers are expected to assist in the coordination of care process.
- Upon approval of reassignment, the Provider office must inform the Member by mail of the reassignment within two business days of approval.
- Content of the letter to the Member should include:
    a. Reason for reassignment, if appropriate.
    b. Timeline for reassignment.
        i. If possible and safe to do so, Providers should attempt to provide a 30-day or more transition period.
            1. In certain situations, a longer transition may be warranted if it is feasible and safe to do so.
            2. Shorter transitions may be necessary specifically in situations where safety is a concern (e.g., immediate reassignment).
        ii. Provider availability during the transition, such as being willing to see the Member during the transition timeframe for routine and/or urgent appointments.
    c. Prescriptions.
        i. If Member is currently using prescription prescribed by the Provider, a dialogue of future refills (if applicable) is needed during the transition.
    d. Referrals, labs, and/or imaging studies follow up.
        i. If Member currently has open referrals, labs, imaging studies, etc. that were referred by the Provider, the letter must discuss the process for follow up of these services during the transition period.
    e. Name, address, and phone number for new Provider (if known).
    f. Language that Member's medical records will be available for ten years.

If there are any barriers during the transition process, Providers should contact UHA's Customer Care and/or Care Coordination team for assistance.

4.8 Member Transfer

At the occurrence of any one of the following events, UHA Customer Care 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.

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-410-3635. 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 410-141-3565(7)). 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 410-141-3565(5) and OAR 410-120-1280.

Section 5: MEDICAL MANAGEMENT

5.1 Coverage and Authorization of Services (Prior Authorizations)

UHA has processes in place to provide covered services outlined in the contract that are no less than the amount, duration, and scope of the same services to beneficiaries under Fee-For-Service (FFS) Medicaid, and for members under the age of 21. UHA ensures that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. UHA does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

UHA places appropriate limits on a service on the basis of criteria applied under the state plan, such as medical necessity for the purpose of utilization control, provided that:

- The services furnished can reasonably achieve their purpose.
- The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.
- Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with contractual requirements.

UHA furnishes medically necessary services in a manner that is no more restrictive than that used in the Fee-For-Service Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures UHA also addresses:

  - The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;
  - The ability for a member to achieve age-appropriate growth and development.
  - The ability for a member to attain, maintain, or regain functional capacity.

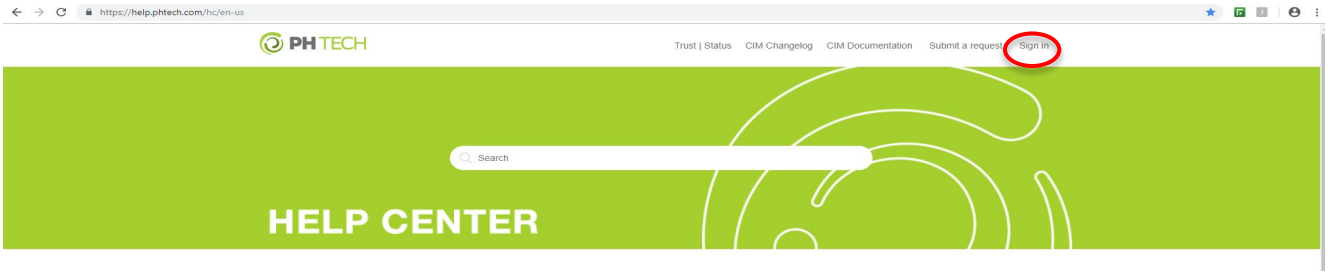
UHA does not incentivize providers, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member.

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.

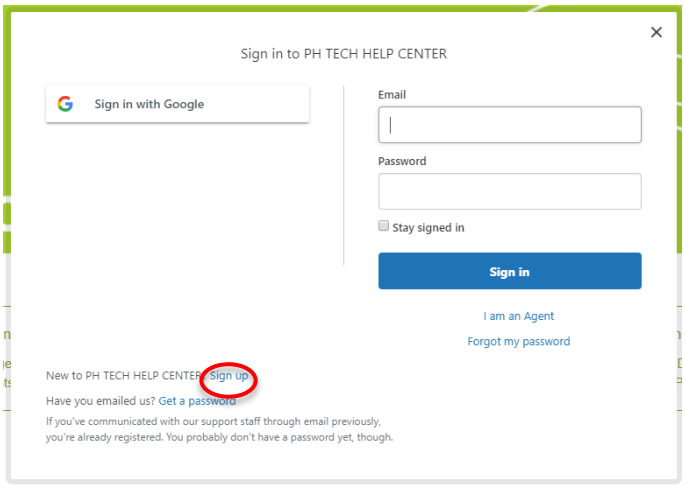
Submit a Prior Authorization Electronically

Umpqua Health Alliance offers providers the ability to submit, check the status, and manage your prior authorization (PA) requests online. By signing up for access to our Community Integration Manager (CIM), you can eliminate paperwork and fax associated with the authorization process. You will also have direct email access to our Customer Care, Prior Authorization, and Claims teams that can assist you with questions of member eligibility and monitoring PA and claims status'. UHA requires all participating providers to submit their PA requests electronically. PA forms also are available for download on the UHA website at www.umpquahealth.com or Click here. *Each office staff member from the provider's office will need a separate log in.

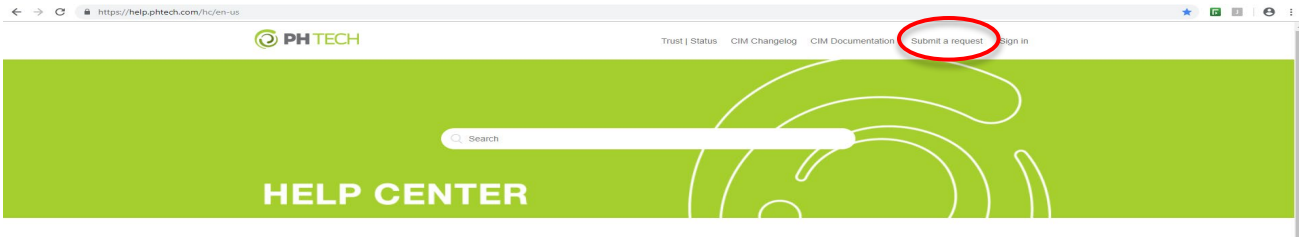
To sign up for this feature, please visit https://help.phtech.com. Select the "Sign in" link in the top-right header.



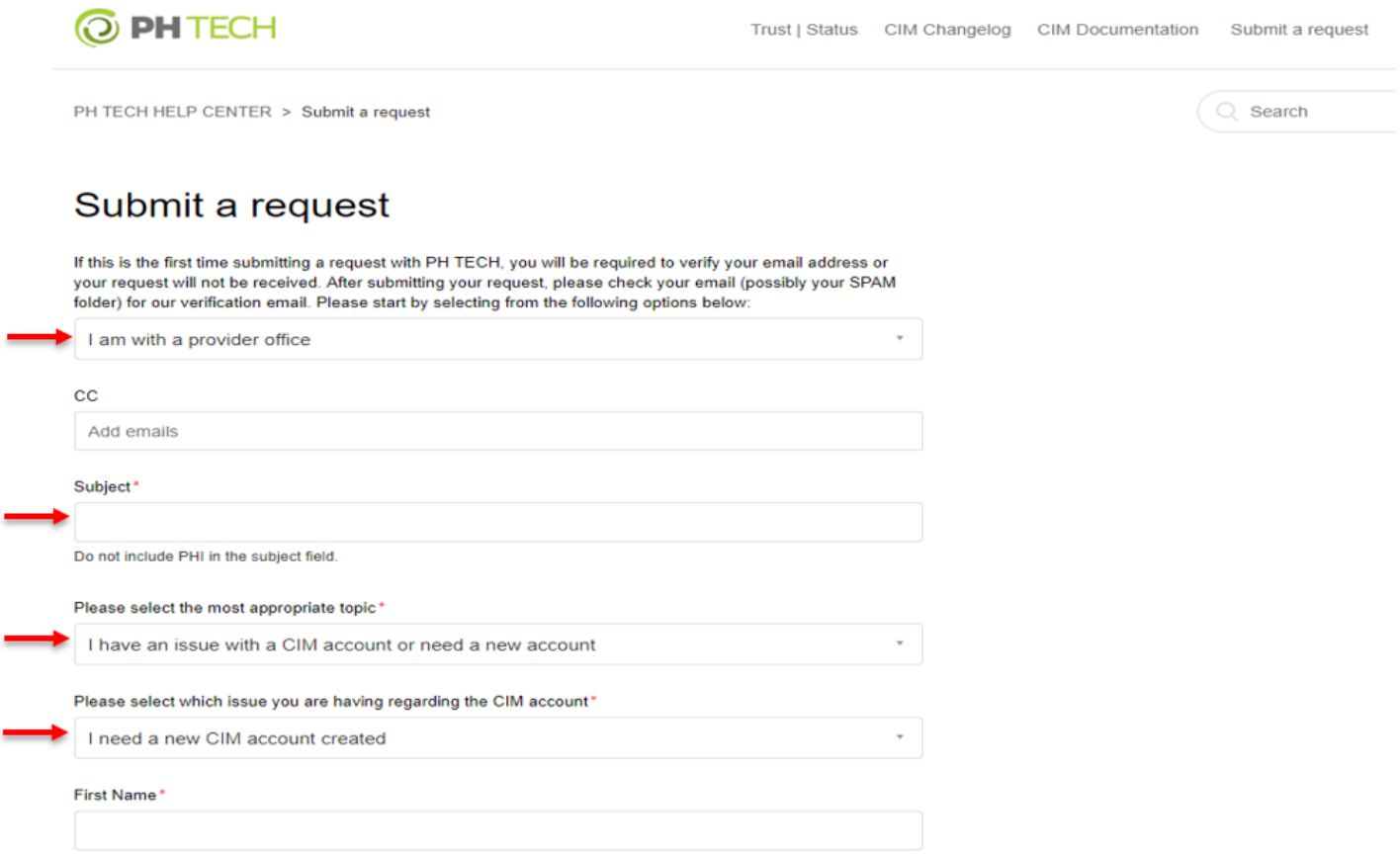
When the new window appears, select the “Sign up” link in the bottom left corner.



After you have signed up. Sign into the help center by following the steps first step. Then select “Submit a request” in the top header.



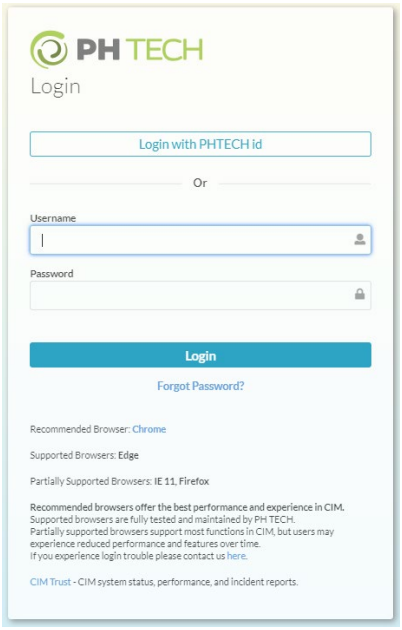
To submit a ticket directly to PH Tech for access, select “I am a provider office” in the first dropdown. Include a subject line “New CIM Account”. Next, select the topic drop down. “I have an issue with a CIM account or need a new Account”. Then select the issue drop down “I need a new CIM account created”.



Continue to fill in the form with the * required fields. PH Tech will grant access within 1-7 business days. If you need further assistance, please email support@phtech.com or call 503-584-2169 option 2. You can get further information by contacting PriorAuthorizations@umpquahealth.com or by calling UHA at 541-673-1462.

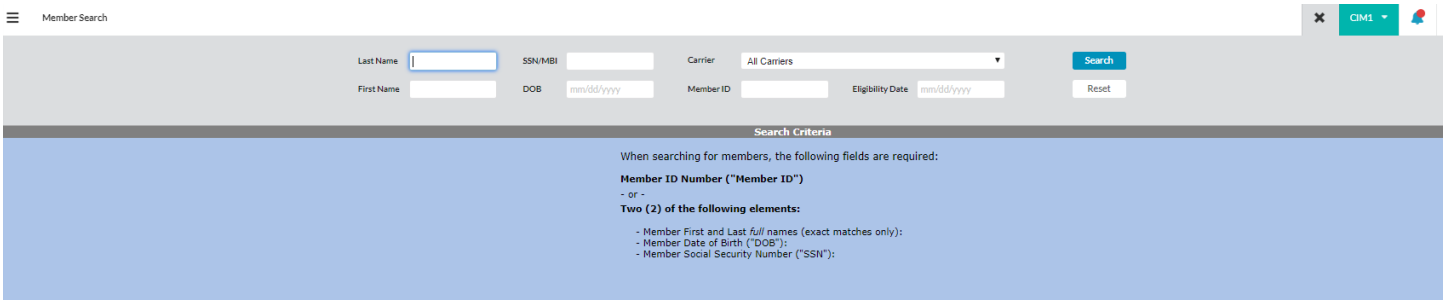
Sign In

To access CIM, visit https://cim1.phtech.com/ in your Chrome internet browser. Enter the username and password that you received via email. Then select “Login”.

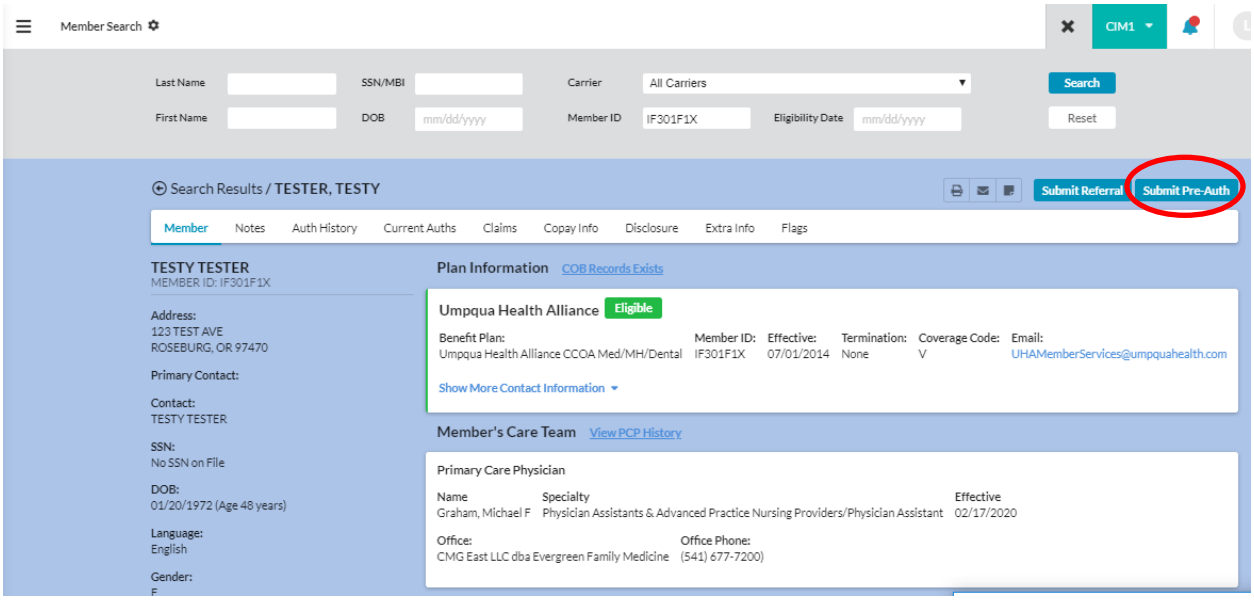


Entering CIM Prior Authorizations

Using *Member Search*, Enter the members First and last name and DOB.



Verify the member's eligibility and demographic information. For proper claims payment, please pay special attention to the benefit plan type, termination date, and other coverages.



Submit Pre-Auth Notification

To start the prior authorization UHA notification process, select the "Submit Pre-Auth" button. ***NOTE:** "Submit Referral" is only used for referring a member to Case Management services. Be sure the "Pre-Authorization" radio button has been selected.

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 7 days. • Use "Expedited" status only in the appropriate situations (i.e., loss of life or limb without prompt treatment.) • Avoid scheduling appointments, tests, or procedures 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.

5.2 Medical Prior Authorization Review

Prior authorization (PA) requests that require review by a Utilization Review Coordinator (URC), also referred to as clinical staff, are assessed for medical appropriateness and necessity by using the following resources:

- The Prioritized List of Health Services - all practice guidelines including ancillary and diagnostic service notes;
- Health Evidence Review Commission (HERC) guidelines;
- Oregon Administrative Rules (OAR);
- InterQual® Care Guidelines
- UHA Clinical Practice Guidelines adopted by Clinical Advisory Panel
- Up to Date - Wolters Kluwer; and
- Utilization Management Can Do (UMCD). This is direct guidelines for our clinical staff to approve services without a Medical Director review.

All PA decisions for medical, pharmacy, dental, and behavioral health services are conducted by qualified healthcare professionals that have the necessary training and expertise to make authorization decisions.

Determinations that would deny or limit the requested services or fall outside of the guidance provided by the list above will be reviewed by the Chief Medical Officer for the final determination.

- Any decisions to deny, reduce, or authorize a service in an amount, duration, or scope less than what was requested are made by a health care professional with appropriate clinical expertise.
  - Determination to deny or reduce the amount, duration, or scope of a required service will not be arbitrarily made solely because of diagnosis, type of illness, or condition of the member.
  - UHA does not incentivize providers, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member.
- UHA will not deny or reduce the amount, duration, or scope of a Covered Service solely because of diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.
- UHA will not apply more stringent utilization or prior authorization standards to out-of-network services, than standards that are applied to medical/surgical benefits.
- UHA may limit services:
  - Based on criteria applied under the State plan, such as medical necessity, or for the purpose of utilization control, provided that:
    - The services furnished can reasonably achieve their purpose;
    - The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and
    - Family planning services are provided in a manner that protects and enable the member's freedom to choose the method of family planning to be used.
- For all services that are determined to be medically appropriate covered services, UHA will provide such services in a manner that is:
  - In an amount, duration and scope that is no less restrictive than the amount, duration and scope for the same services provided to Clients under Fee-for-Service as set forth in 42 CFR 438.210, and for members under the age of 21, as set forth in 42 CFR 441 subpart B, and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-141-3835 (5), 410-120-1160, 410-120-1210, and 410-141-3830; and
  - Sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are provided and include:
    - The prevention, diagnosis, and treatment of a disease, condition, or disorder that results in health impairments or disability;
    - The ability to achieve age-appropriate growth and development; and
    - The ability to attain, maintain or regain functional capacity.

Emergent care does not require prior authorization. Applicable retro requests for these services relevant to OAR 410-141-0140 follow the same review process listed above.

- Continuing authorization requests follow the same process for review as initial requests, however, documentation supporting continued medical necessity is also required.
    - For an appeal or hearing, a member is entitled to continuing benefits while the case is pending consistent with OAR 410-141-3250.
    - Please reference UHA policy CE22 – Payment and Authorization for Hospital Admission for information on concurrent review.
- Clinical and support staff will consult with the requesting provider, as needed, based on member's current needs assessment and consistent with person-centered service plan.

Dissemination of Guidelines

- UHA distributes a Provider Newsletter to providers and any staff that subscribe. Information may also be found on the UHA public website. Content may include best practices, guidelines, or other updates as determined by the organization.
- UHA facilitates training/events, such as the Provider Services Forum, to share information on guidelines and practices.
- Providers may also request a peer-to-peer or inquire on the guidelines applied to a determination.

5.3 Medical Prior Authorization Requirements

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.

Emergent care does not require prior authorization (PA). UHA will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. UHA does not require PA for or restrict freedom of choice to providers of family planning services as referenced in UHA's Member Handbook. Additionally, members are permitted to self-refer to any provider for the provision of family planning services, including those not within UHA's Provider Network. UHA will ensure the provision of sexual abuse exams without a PA.

UHA permits its Indian members to obtain covered services from non-participating Indian Health Care Providers (IHCP) from whom the Indian members are otherwise eligible to receive services and non-participating IHCPs to refer Indian members to participating providers for covered services.

When UHA is the secondary insurance (payer) a PA is not required if the primary insurance authorization guidelines are met, except when a pharmacy claim exceeds fifty dollars. All pharmacy claims exceeding fifty dollars will be reviewed by a pharmacist.

All PA decisions for medical, pharmacy, dental, and behavioral health services are conducted by qualified healthcare professionals that have the necessary training and expertise to make authorization decisions for more information refer to UHA policy CE05 - Medical and Pharmacy Review.

UHA does not incentivize providers, employees, or other utilization reviewers to inappropriately deny, limit, or discontinue medically appropriate services to any member. UHA may not authorize services under the following circumstances:

- The request received by UHA was not complete;
    - A PA with missing or inaccurate diagnosis and procedure codes, referring or delivering provider, or in-valid requests will be dismissed within two (2) business days and will require a corrected resubmission.
- The provider did not hold the appropriate license, certificate, or credential at the time services were requested;
- The recipient was not eligible for Medicaid at the time services were requested;

- The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to UHA;
    - Prior authorization requests will be pended for no more than 10 days from initial request of additional supporting documentation. Once the additional information is received, a determination will be made no more than three (3) days after receipt.
- The services requested are not in compliance with OAR 410-120-1260 through 410-120-1860.

Prior Authorization Timelines	
Standard Requests	14 days
Expedite Requests	72 hours
Skilled Nursing Facility	2 business days
Behavioral Health SUD Services	2 business days
Behavioral Health Inpatient and Residential	72 hours
Pharmacy	24 hours

5.4 Pharmacy Formulary and Utilization Management

The UHA Formulary is a list of covered drugs selected by the UHA Pharmacy and Therapeutics (P&T) Committee to treat medical conditions that are covered by the Oregon Health Plan. Formulary decisions are based on critical review of the available scientific evidence for efficacy, safety, outcomes, cost-effectiveness, value, the OHP Prioritized List of Health. The UHA Formulary does not contain Mental Health drugs which are covered directly by OHA. The UHA Formulary can be on the UHA website at www.umpquahealth.com. Starting no later than January 1, 2020, Prior Authorization criteria will also be posted to the UHA website. The UHA formulary and prior authorization criteria are updated periodically throughout the year, and formulary updates are posted to the website prior to the effective date.

In general, the following are not covered:

- Brand medications when a generic equivalent exists, except select “narrow therapeutic index” drugs;
- Drugs not listed in the formulary (non-formulary exceptions may be granted through the prior authorization process);
- Drugs used for non-medically accepted indications;
- Drugs when used to treat conditions that are not covered by the OHP, such as fibromyalgia, allergic rhinitis, fungal infections of the skin and nails and chronic pain (see section 7.2, “Prioritized List of Health Services”);
- Drugs used to promote fertility or to treat sexual dysfunction;
- Drugs used for cosmetic purposes or hair growth;
- Drugs used for the symptomatic relief of cough and colds;
- Drugs when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose, i.e. morbid obesity);
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride, and fluoride preparations; and
- Other drugs specifically excluded from coverage under Medicaid, such as drugs not approved by the FDA.

The formulary applies only to drugs provided by a pharmacy and do not apply to drugs used in inpatient settings or furnished by a Provider. For more information on coverage of drugs furnished by a Provider and administered in a clinic or facility, see the “Medical Prior Authorization Grid” section.

The drugs listed in the Formulary do not have copays. Drugs that require prior authorization, step therapy, or age restriction or have quantity limits are designated as PA, ST, AR, and QL, respectively. Prior authorization (PA) is required for the following:

- Drugs listed in the formulary as “PA” (prior authorization required);
- Drugs listed in the formulary as “ST” (step therapy) if the Member does not have claims history of the
- prerequisite drug(s);
- Non-formulary drugs (drugs not listed in the formulary);

- Brand drugs with generic equivalents;
- Drugs listed in the formulary with "AR" (age restriction) when prescribed to Members who do not meet age
- criteria;
- Drugs listed in the formulary with QL (quantity limit) when prescribed in quantities greater than allowed; and
- Select drugs administered incident-to-a physician's service in a clinic or facility.

To obtain a prior authorization or request a formulary exception for medications obtained at the pharmacy, submit a "Pharmacy Drugs" PA through CIM or fax the "Pharmacy medication prior authorization form", available on the website, to the fax number listed on the form. To obtain a prior authorization for medications furnished by a Provider and administered in a clinic or facility, submit a "Injectable/Infusion Drugs" PA through CIM or fax the "J-code prior authorization form", available on the website, to the fax number listed on the form. Medication requests will be reviewed by a Member of the Clinical Pharmacy Services team, and the Provider will be notified of the coverage decision within 24 hours of receipt.

5.4.1 Medication Therapy Management (MTM) Program

The MTM program at UHA includes a range of services offered by the UHA Clinical Pharmacy team that help our members achieve maximum benefit from their medications. The goals of MTM include identifying, preventing, and resolving medication-related problems. MTM services is be offered via phone or mail to certain members. Providers, case managers or other members of the care team can refer members as needed.

Reasons for member referral to MTM may include:

- A high risk of developing medication-related problems
- An identified medication-related problem
- Medication adherence issues
- Polypharmacy related to the member having two or more chronic conditions and eight or more maintenance medications.

Provider Referral Process:

To refer a member to the MTM Program complete the MTM Referral Form and submit the form:

- via fax to (541) 677-5881,
- via email to UHPharmacyServices@UmpquaHealth.com.

Alternatively, you can submit a referral using the Community Integration Manager (CIM) platform by choosing the Medication Therapy Management referral type and selecting the specific services requested under the diagnosis section.

5.5 Notice of Adverse Benefit Determination (NOABD)

UHA issues a written notification approved by OHA for an Adverse Benefit Determination (ABD) or denial letter/notice, for any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of UHA to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- For a resident of a rural area with only one managed care organization, the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The ABD notifies the member and requesting provider in writing of the determination. The notice complies with the

OHA's formatting and readability, including, without limitation, translating a notice of adverse benefit determination (ABD) for those members who speak prevalent non-English language and is written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal. The ABD also indicates the following:

- Date of the notice;
- UHA's name, address, and telephone number;
- Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
- Member's name, address, and member ID number;
- Service requested or previously provided, and the ABD UHA made or intends to make, including whether UHA is denying, terminating, suspending, or reducing a service or denial of payment;
- Date of the service or date service was requested by the provider or member;
- Name of the provider who performed or requested the service;
- Effective date of the ABD if different from the date of the notice;
- Whether UHA considered other conditions such as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services; statement of intent governing the use and application of the Prioritized List to requests for health care services, and other coverage for services addressed in the State's 1115(a) Waiver;
- Clear and thorough explanation of the specific reasons for the adverse benefit rules including specific sections of the statues and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:
    - The item requiring prior authorization but not authorized;
    - The services or treatment requested not meeting medically necessary or medically appropriate criteria;
    - The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;
    - The service or item received in an emergency care setting that does not qualify as an emergency service;
    - The person is not a member at the time of the service or not a member at the time of the requested service;
    - Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;
    - Prior approval not obtained; or
    - UHA's denial of member's disenrollment request and findings that there is no good cause for the request.
- Language clarifying that oral interpretation is available for all languages and how to access it.

The ABD includes Non-Discrimination Notice, Language Taglines for the need to get notices translated or in an alternative format, and the Appeal and Hearing Request Form (OHP 3302). The Appeal and Hearing Request Form (OHP 3302) also explains the following to the member:

- The member's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- Circumstances under which an appeal process can be expedited and how to request it.
- The member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services.
- The member's right to have benefits continue pending the resolution of the appeal [to be entitled to continuing benefits, the member shall complete a UHA appeal request or an Authority contested case hearing request for continuing benefits no later than:
    - The tenth day following the date of the notice of ABD or the notice of appeal resolution (NOAR); and
    - The effective date of the ABD proposed in the notice, if applicable.

- The member's right to request an appeal within 60 days from the date of notice on the ABD.
- The member's right to request a hearing within 120 days from the date of notice on the NOAR.

UHA provides notice of an ABD expeditiously as the member's condition requires within state-established timeframes for authorization requests consistent with OAR 410-141-3835:

- For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and **no later than 14 days** following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:
    - The member, the member's representative, or provider requests an extension; or
    - UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via administrative notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
- For notice of ABDs that affect services previously authorized, UHA shall mail the notice at least ten days before the date the ABD takes effect:
    - UHA shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and **no later than 72 hours** after receipt of the request for service;
    - UHA may extend the 72-hour time period up to 14 days if the member requests an extension or if UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
- If UHA extends the ABD timeframe for standard or expedited authorization decisions that deny or limit services, it must:
    - Give the member written notice and make reasonable effort to give oral notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision.
    - Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- UHA mails the notice of ABD by the date of the action when any of the following occur:
    - The recipient has died.
    - The member submits a signed written statement requesting service termination.
    - The member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
    - The member has been admitted to an institution where he or she is ineligible under the plan for further services.
    - The member's whereabouts unknown based on returned mail with no forwarding address and OHA has no other address.
    - The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
    - A change in the level of medical care is prescribed by the member's PCP, PCD, or behavioral health professional.
        - The notice involves an adverse determination with regard to preadmission screening requirements for LTPC admissions.
    - The transfer or discharge from a facility will occur in an expedited fashion.
    - The denial of payment.
    - Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an ABD. A notice of ABD shall be issued on the date the timeframe expires.
    - For ABDs for long term psychiatric care (LTPC) transfers, the safety or health of individuals in the facility would be endangered, the member's health improved sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the LTPC for 30 days.
- UHA mails the notice of ABD at least 10 days before the date of ABD, when the ABD is a termination, suspension, or reduction of previously authorized Medicaid-covered services. UHA may mail the ABD as few as five (5) days prior to the date of ABD if the agency has facts indicating that ABD should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources.

UHA will give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

Denial Notice Tips

- Authorization Denials
  - Be sure you submit a valid PA and attached all required supporting documentation
  - Check the Prioritized List, OAR's, and associated guideline/criteria to meet the requirements
  - Retro requests more than 30 days past the date of service need to follow the provider appeal process as outlined in Section 6.11 Denials and Provider Claims Appeals or on our website at https://www.umpquahealth.com/claims/.
- Claims (Payment) Denials
  - Check your Explanation of Benefits (EOD) to verify the notice was not due to a provider claim submission error.
  - If you disagree, you can also follow the provider appeal process as outlined in Section 6.11 Denials and Provider Claims Appeals or on our website at https://www.umpquahealth.com/claims/.
- Assist the member with the Member Appeal process as outlined in Section 8.7 Member Appeals

SAMPLE NOTICE

UMPQUA HEALTH ALLIANCE
500 SE CASS AVENUE, SUITE 200
ROSEBURG, OR 97470

Date of Claim Denial:	(YOUR EOB DATE)
Date of Notice:	12/18/20
Effective Date of Action:	12/18/20 7:40am

TEST TESTER
123 TEST LANE
TEST CITY, OR 97470

OHP ID Number: Member ID
Date of Birth: Member DOB
PCP/PCD/BH Professional: Assigned PCP

Notice of Action
Benefit Denial
(SAMPLE LETTER)
THIS IS NOT A BILL

Dear TEST TESTER,

On Date of Service, Delivering Provider listed on claim asked us to cover description (CPT) for claim number Claim Number. The Oregon Health Plan does not cover all services and supplies. After careful review of this request, we denied payment under the Oregon Health Plan because Denial Reason.

We based our decision on denial OARs.

If you get a bill for this service, contact our Customer Care team at 541-229-4842 or TTY

5.6 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.

5.7 Member Communication and Language Services

Members or potential Members who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English are called limited English proficient or LEP. Anyone who is LEP is entitled to language assistance for healthcare services/encounters or benefits.

The following are provided to the Provider or Member at no cost:

- Sign language interpreters
- Spoken language interpreters for other languages
- Written materials in other languages
- Braille
- Large print
- Audio
- Auxiliary Aids and other formats (i.e., tablets)

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/searchProvider.cfm or Click here.
- During business hours, UHA Customer Care can make arrangements to provide qualified interpreters and certified health care interpreters who can interpret in the primary language of non-English speaking Members, during their office visits. The interpreters shall be capable of communication in English, the primary language of the Member, and translate medical information effectively.
- All contracted providers shall be prepared to meet the special needs of visually and/or hearing-impaired Members in accordance with Section 1557 of the Affordable Care Act and other applicable laws. Please see UHA's Language Access Plan for more information which can be founder at language-access-plan.9.2.20.pdf (umpquahealth.com) or by clicking here.
- All contracted providers are required to report on language access and interpreter services to UHA Customer Care, who in turn is required to report on these services to OHA.
- PCP offices shall have signs in the primary language of each substantial population of non-English speaking Members in their practices.

5.8 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); Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)
- Inpatient hospital services (all)
- 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 (both home and facility based)
- Speech/language pathology (outpatient) at Mercy Institute of Rehabilitation
- Treatment room services **except** when delivered as a component of outpatient treatment

Elective Admissions

Scheduled, non-emergent, elective admission for inpatient services require appropriate prior authorization (PA).

- Provider of services will submit request no less than 7 days before admission. To include:
    - Patient demographics;
    - Medical justification for services;
    - Supporting documentation and applicable medical records;
    - Planned date of service;
    - Expected length of stay; and
    - Diagnoses.

Unplanned or Emergency Admission

The hospital must provide notification to UHA of admission as soon as practical, but no more than 48 hours after the admission, for all unplanned admissions, including admissions from the emergency department or observation unit:

- All hospital admission request must include:
    - Member identification and patient demographics;
    - Admitting and attending physician name;
    - Date of admission;
    - Plan of care (as required under 42 CFR 456.80);
    - Initial and subsequent continued stay review dates (described under 42 CFR 456.128 and 456.133);
    - Reasons and plan for continued stay if applicable; and
    - Medical records supporting need for admission and continue stay.

Extended Stay and Concurrent Review

If a hospital anticipates that a patient will remain hospitalized or otherwise need services beyond those authorized, it shall provide the following information to Umpqua Health Alliance as soon as practical, but no later than 48 hours after learning of the need to exceed any authorization:

- A request for additional authorization clearly stating the scope of the requested authorization;
- UHA authorization reference number or numbers for all prior authorizations relevant to the request, preferably on the cover sheet or first page;
- The member's health plan number;
- The relevant diagnoses code or codes; and
- All new relevant medical records.

Authorization

UHA shall consider all requests for authorization and either approve, partially approve, or deny the request within the time frames set. With the exception to in-network facilities, UHA requires a prior authorization to be submitted for all inpatient hospitalizations.

Re-Admissions

Members who are readmitted for inpatient services within thirty (30) days of original inpatient discharge for the same or related condition for which they were treated during the original admission may be reviewed. If it is determined that the member is being treated for the same or a related condition as the original admission, the readmission can be retracted.

Notification of Admission

Fax Medical Requests and supporting documentation to UHA by fax at (541) 677-5881 or by mail to the attention of its Medical Management Department at 500 SE Cass Ave. Suite 101, Roseburg, OR, 97471.

5.9 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.

5.10 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. There are currently 3 Urgent Care clinics in Roseburg that accept OHP Members.

Canyonville Health & Urgent Care
115 S Pine St
Canyonville, OR 97417
541.839.4211

Evergreen Urgent Care
2570 NW Edenbower Blvd, Ste 100
Roseburg, OR 97471
541.957.1111

Umpqua Health Newton Creek – Urgent Care
3031 NE Stephens St
Roseburg, OR 97470
541.229.7038

5.11 Emergency Care Services

UHA defines a medical emergency health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility. 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 health services. UHA emergency room claims may be reviewed for medical necessity.

UHA does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The member will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. UHA will not refuse to cover emergency services based on the emergency room

provider, hospital, or fiscal agent not notifying the member's primary care provider, of the member's screening and treatment within 10 days of presentation for emergency services.

5.11.1 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.

5.11.2 After Hours/Emergency Pharmacy Overrides

UHA handles all Member and Provider calls as well as Prior Authorizations. UHA's pharmacy staff reviews all medication prior authorizations within 24 hours of receipt, 365 days a year. UHA's Pharmacy Benefit Manager (PBM) MedImpact handles pharmacy calls 24/7 but does not handle any Member or Provider calls during or after business hours. For Emergencies, MedImpact will enter a five-day override, only after the plan's business hours, if the pharmacy states that it is for an emergency. During hours, MedImpact will refer the caller to UHA at 541.229.4842 for emergency situations.

Specific to Natural Disasters, MedImpact will enter a one-time refill-too-soon override, per medication, if the pharmacy states the Member has had to evacuate due to a disaster. The override may include quantity restrictions, as long as there is no lifetime or yearly limit on the medication and the quantity does not exceed the limit allowed per month as defined in the Member's benefit.

5.11.3 Dental Emergency/Urgent Services

UHA contracts with Advantage Dental to provide dental emergency services. During normal working hours, members can call their primary care dentist (PCD) for services. If the PCD cannot be reached, the member can call the DCO's Customer Service Department, the number will be answered twenty-four hours, seven (7) days a week by a customer service representative. In the event of a dental concern when the PCD cannot be reached, the customer service representative will contact the on-call dentist if it meets the emergency or urgency guidelines.

It is the on-call provider's responsibility to provide emergency dental services to members during their scheduled on-call time. The on-call provider is required to respond to all emergency calls received by the DCO's Customer Service Department within one hour. The on-call provider then has twenty- four hours to address the member's dental emergency (relieve the member's emergency). This is for true emergencies (bleeding, swelling, infection, trauma and severe pain). An avulsed tooth needs to be re-implanted within 30 minutes. The on-call provider will determine, based upon the needs of the member, whether services are provided in an ambulatory setting or a hospital setting. These providers do not provide medical emergency services, enrollees needing medical emergency services will be referred to call 911 or to go to the nearest facility that provide medical emergency services.

5.12 Behavioral Health Services

UHA contracts with Adapt dba Compass Behavioral Health, the designated County Mental Health Provider (CMHP), as the main provider of behavioral health services for UHA Members.

- **Outpatient Services**; 24-hour crisis evaluation and care, comprehensive assessment and diagnosis, counseling for children, adolescents and adults, individual, group and family counseling, psychiatric medical services for children and adults, forensic mental health programs for individuals involved in the criminal justice system
- **Community Support Services**;
    - Assertive Community Treatment (ACT); https://www.adaptoregon.org/mental-health/community-support-services/assertive-community-treatment/
        - 24-hour crisis counseling
        - Individual assessment and treatment planning

        - Nursing services, including care coordination, education, consultation and support
        - Treatment for co-occurring substance use disorders
        - Psychiatric services
        - Supportive mental health therapy
        - Skills-training to support and sustain stability
        - Vocational services, such as job interest assessment, education, follow-along supports
        - Case management to assist Members in accessing benefits, housing and other support services
        - Education, support and consultation for families and other supports
        - Referrals and coordination of hospital admissions and discharges
    - Early Assessment & Support Alliance (EASA); https://www.adaptoregon.org/mental-health/community-support-services/early-assessment-support-easa/
      EASA is committed to providing rapid identification, support, assessment and treatment for teenagers and young adults who are experiencing the early signs of psychosis. EASA provides up to two years of treatment and support for Douglas County young people ages 15 to 25 who have experienced a first episode of psychosis or who have experienced risk symptoms within the last year that are not caused by a medical condition or substance abuse.
        - Rapid access to psychiatric and counseling services
        - Education about causes, treatment and management of psychosis
        - Coaching on rights to employment, school, housing and additional resources
        - Family psycho-education and support groups
        - Employment education and independent living supports
        - Access to local teams including psychiatrists, social workers, psychologists and occupational therapists
        - Referral to community services
    - Individual Placement and Supported Employment (IPS); https://www.adaptoregon.org/mental-health/community-support-services/ips-supported-employment/
        - No-cost placement services to help local employers match applicants to business needs
        - On-the-job support, including initial placement and stabilization in the workplace
        - Ongoing support, skill building and job coaching to meet individual needs and preferences
        - Benefits counseling and financial planning
        - Referral to community agencies, such as Vocational Rehabilitation
        - Peer support, including recovery and integration role-modeling
        - Links to natural community resources to reduce barriers to school or work, such as transportation, housing, training and social supports
    - Peer Support Services; https://www.adaptoregon.org/mental-health/community-support-services/peer-support-services/
        - Support to make connections in the community
        - Help to develop community navigation and integration skills
        - Connections to help transition to independent living and self-sufficiency
        - Assist in identifying barriers and solutions for needed resources and services
        - Assistance with group and class attendance
        - Provide individual and group activities in the community to help develop and maintain social networks and natural supports
        - Education and support to help individuals move forward with their goals
    - Mental Health Court; https://www.adaptoregon.org/mental-health/community-support-services/mental-health-court/
        - Assessment & diagnosis
        - Treatment planning
        - Individual & group counseling
        - Coordinate mental health, drug and alcohol treatment services
        - Work in coordination with court staff to support compliance with Mental Health Court
        - Referral and coordination of community supports and resources

- **Crisis Services**; mental health evaluation and intervention, treatment determination, referral to mental health services and other community resources, client protective service investigations, pre-commitment investigation.
- **Adult Mental Health Services**; offers comprehensive psychiatric and behavioral health care for adults struggling with a variety of mental health symptoms, focusing on restoring well-being and preventing the relapse of symptoms. Services include psychiatric assessment and diagnosis, medication services, individual and group therapy, crisis intervention, rehabilitation services, forensic services and clinical case management.
  Adapt works in close collaboration with Compass Behavioral Health Community Support Programs to assist individuals in obtaining employment, assessing medical care, securing safe and supportive housing and accessing other social services to support recovery, resilience and independence
    - **Adult Outpatient**; comprehensive assessment and treatment planning, short-term psychotherapy, individual, group and family services, Choice Model Partnership to ensure the availability and quality of treatment services and supports, skill-building training, comprehensive case management to assist individuals in gaining access to needed services and supports
    - **Clinical Case Management**; assessment and coordination of services to meet individuals and family needs, assistance with the transition to independent living, individual and group skill-building, information and assistance in gaining access to needed medical, behavioral health, housing, employment, benefits, social, education and other essential services
        - Clinical Case Management services are available by referral from a Compass Behavioral Health treatment provider
    - **Forensic Services**;
        - *Jail Diversion Program* (JDP) is designed to provide appropriate treatment for individuals with a serious mental illness that is thought to be contributing to low level criminal behavior. The goal of JDP is to provide treatment to help avoid or reduce incarceration through appropriate community-based services, such as mental health and/or substance abuse treatment.
        - *.370 Project* (also known as Aid and Assist)
          The .370 Project is designed to aid individuals with a mental illness who are involved with the criminal justice system to achieve stabilization and a level of understanding of the charges against them so that they can participate in their own defense. For more information, contact our office or visit Oregon Aid and Assist.
        - *Psychiatric Security Review Board* (PSRB)
          Compass works in cooperation with the Oregon PSRB to ensure that individuals diagnosed with a mental illness who have committed serious crime receive the necessary services and support to reduce the risk of future criminal behavior. We use recognized principles of risk assessment, victims' interest and person-centered care. For more information, visit Oregon PSRB.
- **Youth & Family Mental Health**; comprehensive assessment and treatment planning, individual, group and family services, skills-training to support and sustain stability, psychiatric day treatment for students in kindergarten to 8th grade, school-based therapeutic services, care coordination, referrals and transition planning with community services, hospitalization, residential care and other treatment Providers
    - **Wraparound Program**; a referral-based planning process that follows a series of steps to help children, young adults, and their families accomplish their family vision
- **Mental Health Support Services**; such as Assertive Community Treatment (ACT), Clinical Case Management, Early Assessment & Support Alliance, Individual Placement Support Supported Employment, Peer Support Services, and Mental Health Court

Adapt dba Compass Behavioral Health
Adult, Medical and Crisis Services
621 W Madrone St
Roseburg, OR 97470
Mon – Fri 8:00 a.m. to 5:00 p.m. 541.440.3532
24-hour Crisis Line: 800.866.9780
Website: www.adaptoregon.org or Click here

5.12.1 Behavioral Health Services (Prior Authorizations)

UHA will not apply more stringent utilization or prior authorization standards to behavioral health services than standards that are applied to medical/surgical benefits.

- UHA will permit members to obtain medication-assisted treatment for SUD, including opioid and opiate use disorders, for up to 30 days without first obtaining PA for payment. In the event a member is unable to receive timely access to care as required under the CCO Contract, the affect member shall have the right to receive the same treatment from a non-participating provider outside of or within UHA's service area.
- Members are not required to obtain a referral from their primary care provider for behavioral health assessment and evaluation services.
- Members may refer themselves to any available behavioral health services with in UHA's provider network.
- Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.
- UHA does not require PAs for outpatient behavioral health services or behavioral health peer delivered services.
- PAs and reauthorizations for services pertaining to drugs, alcohol, or drug services will be completed within two (2) working days.
- PAs are required for non-emergent behavioral health hospitalizations and residential services and will be completed within three (3) days of the time the PA was received.

In addition, UHA has individually licensed behavioral health Providers for outpatient behavioral health services.

All 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 Customer Care at 541.229.4842.

5.13 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 and Serenity Lane 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 childcare, elder care, housing, transportation, employment, vocational training, educational services, behavioral health services, financial and legal services.

5.13.1 A & D Residential Services

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

Adapt
621 W Madrone St
Roseburg, OR 97470
541.672.2691
Website: www.adaptoregon.org or Click here

Serenity Lane
91150 Coburg Industrial Way

Coburg, OR 97408
800.543.9905 or 541.687.1110
Website: https://serenitylane.org/ or Click here

5.14 Case Management

All UHA members are eligible for Care Coordination through Medical Management. Care Coordination services are offered as a resource to Providers by our team of Care Coordinators under the guidance of the Chief Medical Officer, to assist in managing the care of the Members that have medical and/or social needs. Early identification and intervention with these members can significantly reduce the cost associated with their care without sacrificing quality healthcare or member satisfaction.

5.14.1 Intensive Care Coordination (ICC)

UHA has specialized staff to assist Members who have been identified as having complex medical conditions, or special healthcare needs. Staff coordinating care for this member population are referred to as "Intensive Care Coordinators (ICC)". The designated staff will assist with coordinating health care services for Members with disabilities, complex medical issues, mental health issues, substance abuse disorder or special healthcare needs. Members who require special medical supplies/equipment, or who need assistance navigating the healthcare system, or who may require assistance having their health and social needs met, may request help from an ICC by calling UHA Customer Care at 541.229.4UHA (4842) or 866.672.1551. Providers can refer members for Care Coordination services by completing the referral form found on the UHA website at https://www.umpquahealth.com/wp-content/uploads/2018/08/case-manager-referral.fillable.pdf and faxing completed form to 541-677-5881.

Identification of Members in need of ICC services occurs through surveillance of:

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

Care Coordination staff are available to assist Members Monday through Friday, 8:00 a.m. to 5:00 p.m.

5.15 Traditional Health Workers (THWs)

THWs help individuals in their communities, providing physical and behavioral health services. THW is a blanket term for public health workers who work in the community under the direction of a licensed medical provider. There are five traditional health worker types:

- **DOULA**: A (Birth) Doula is a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience. (From original version of the THW rules, 410-180-0300).
- **PSS**: A Peer Support Specialist is any [range of] individuals who provide supportive services to a current or former consumer of mental health or addiction treatment. (From ORS 414.025).
- **PWS**: A Peer Wellness Specialist is an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- **PHN**: A Personal Health Navigator is an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.

- **CHW:** A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. (APHA CHW Section).

UHA's THW Liaison is the single point of contact for communicating with members, the community, THWs, and stakeholders regarding THW services. The Liaison is responsible for increasing recruitment and retention of THWs in UHA's network and for addressing barriers to integration and utilization of THWs and their services.

Information about THW services, resources and THW availability can be found on the UHA Case Management page https://www.umpquahealth.com/case-management/ and Provider Page https://www.umpquahealth.com/providers/. The UHA Provider Directory lists our current contracted THWs.

5.16 Quality Assurance Program

UHA's Quality Assurance Program, 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.

5.16.1 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.

5.16.2 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.

Section 6: FILING CLAIMS

6.1 Billing & Claims

UHA accepts paper and electronic claim submissions and these should be submitted in HIPAA 837P, 837I, CMS 1500, or UB-04 format. In order to be paid for services rendered to a UHA member, provider and or/facility **MUST** be enrolled with the state of Oregon and have an active DMAP number for the date(s) of service. If you are an out of area provider needing to be enrolled with DMAP, please contact the Contract Department by phone or by email at UHNProviderServices@umpquahealth.com.

Facility Type	Claim Form	Billing Rules
Hospital	UB-04	DMAP/Medicare
Physician	CMS 1500	DMAP/Medicare
Federally Qualified Health Clinic (FQHC)	CMS 1500	DMAP/Medicare
All other claim types; DME, lab, radiology, transport services, ancillary services *pharmacy excluded*	CMS 1500	DMAP/Medicare

UHA strives to adjudicate claims in an accurate and timely manner to aid in quality service to our members and providers. Claims are typically processed within 60 days of receipt of a clean claim. Non-clean claims typically result in a longer adjudication window and/or denials.

Claim Submission Methods		
Electronic Vendor Clearinghouse	**Payor ID**	**Paper (via mail)**
Allscripts/PayerPath (via forwarding)	77502	**Use Exact Address as Listed**
Availity	77503	PH Tech Attn: UHA Claims
Cortex EDI	CIM11	

Emdeon/Change Healthcare	77502	PO Box 5308 Salem, OR 97304
GE Healthcare/Athena	77500	
Gateway EDI/Trizetto	77504	PH Tech Attn: UHA Appeals PO Box 5308 Salem, OR 97304
Office Ally	77501	
Relay Health PCS (Professional)	77505-CPID 1291	
Relay Health PCS (Institutional)	77505-CPID 6551	

******Please note that UHA must be present in mailing address or claim may be rejected and returned******

- UHA **requires** that all hysterectomy or sterilization claims be submitted with Informed Consents attached to confirm the validity of the consent. Claims that do not include these attachments may be denied and/or any claims processed with missing or invalid consents will be recouped.
- UHA does not pay claims for provider-preventable conditions. UHA expects providers to comply with reporting requirements.

UHA contracted providers must sign up for access to Community Integration Manager (CIM) where you can check the status of your claims, access member eligibility and prior authorizations, and correspond with UHA's Customer Care, Prior Authorizations, and Claims teams via secure email. If you are needing any assistance with CIM access, please contact PH Tech at 503.584.2169 option 2 or by email at support@phtech.com.

UHA has a Claims Support team available by phone Monday-Friday 8 a.m. - 5p.m. (PST) at 541.229.4842 option 2 or can be reached by email at UHAClaims@umpquahealth.com. If sending any PHI through email, please ensure that it is sent via secure email.

Please visit our website https://www.umpquahealth.com/claims/ for more helpful information about UHA. Here, you can also navigate other department pages to find our prior authorization forms, case management referral forms, provider newsletters, and various other information pertaining to care for our members.

6.2 Timely Filing Guidelines

Timely Filing Guidelines are as follows:

- 120 days from the date of service (DOS) (unless it is an inpatient stay, then date of discharge)
- 1 year (365 days) from DOS for corrections, appeals, and secondary/tertiary billing (primary EOB/documentation must be included with original claim submission)

Providers are encouraged to submit claims within thirty (30) days of the date of service to facilitate collection of encounter data and provide effective utilization management. Exceptions to the above guidelines for claims submissions are:

- Pregnancy related diagnoses
- When UHA is secondary to Medicare or another third-party resource
- Inpatient stays
- Eligibility issues
- Provider system and/or claim submission errors/issues
- If you are experiencing any system issues with claim submissions or any instances that will delay timely billing, UHA MUST be notified as soon as issue is identified
- Please contact UHA Claim Support by phone at 541.229.4842 option 2 or by email UHAClaims@umpquahealth.com
- **Please note that DMAP enrollment is not a valid reason for untimely claims submission. Once provider/facility becomes enrolled claims are automatically reprocessed and original submission must be within the timely guidelines above.**

You may submit a request for reconsideration on a timely filing denial. Please see section 6.11 Denials & Claims Appeal for more details on what to include.

6.3 Paper Claims

UHA follows requirements set forth by Medicare and OHA for processing of paper CMS 1500 or UB-04 claims. Paper claims must be submitted on either a current standard CMS-1500 form or a UB-04 claim form. When you have important information about a claim, it is best to submit a paper claim with explanations attached. The paper claims and/or documents 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 outline that can be scanned should be used. The claim is to be machine printed with dark black ink. Photocopies, faxes, or handwritten claims will not be accepted. 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 for text only. If the attachment is a screen shot or copy, it must be submitted in color. The images darken upon scanning and may not be readable upon claim review. 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.
- Any EOB attachments must not contain any other patients PHI. Any PHI other than the members should be blacked out. All information included must be for the member the claim is submitted for.

Failure to follow these requirements may result in claims being returned to the Provider unprocessed. In the event that this happens, PH Tech will mail a letter with the rejected claim and information on how to correct the issue. If you receive one of these letters with your rejected claim, please contact PH Tech at the number listed on the letter. This letter also serves as your timely filing and **MUST** be submitted with your corrected claim as proof.

Common reasons for returned or denied claims:

- Unreadable or handwritten information
- Missing, incomplete, or invalid member information
- Missing, incomplete, or invalid provider information
- Date of service does not precede the claim receipt date
- Missing, incomplete, or invalid procedures codes or diagnosis codes
- Incorrect managed care entity referenced on claim (i.e., OHP, DMAP, etc.) UHA must be in address title to ensure PH Tech is processing claim for the proper Managed Care program

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.

Documents such as chart notes, timely filing proof, and EOBs from primary insurance can be uploaded electronically to the claim via CIM if they are missed upon the scanning of the claim. Please contact UHA's claims support team at 541.229.4842 for assistance on attaching documents.

Paper (via mail)
* Use Exact Address as Listed *
PH Tech

Attn: UHA Claims
PO Box 5308
Salem, OR 97304

6.4 Electronic Claims

HIPAA 837P or 837I claims may be submitted to UHA. 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. Most requirements for paper claims also apply to EDI claims. For information on 837P and 837I guidelines, refer to the CMS website at http://www.cms.gov or Click here.

UHA utilizes the clearinghouses below:

Electronic Vendor Clearinghouse	Payor ID
Allscripts/PayerPath (via forwarding)	77502
Availity	77503
Cortex EDI	CIM11
Emdeon/Change Healthcare	77502
GE Healthcare/Athena	77500
Gateway EDI/Trizetto	77504
Office Ally	77501
Relay Health PCS (Professional)	77505-CPID 1291
Relay Health PCS (Institutional)	77505-CPID 6551

If you wish to be setup to send EDI claims online or are having trouble with direct claim submissions, you may contact the PH Tech EDI Support at 503.584.2169, option 1 or email EDI.Support@phtech.com. You can become a direct submitter to PH Tech, or you can use your clearinghouse. If you do not see your clearinghouse on the below list, please reach out to PH Tech EDI Support Line above.

6.5 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 claims adjudicate electronically in real-time. If you are having any issues filling a prescription for a UHA member, please reach out to Customer Care by phone at 541.229.4842 or by email at UHAMemberServices@umpquahealth.com.

6.6 Dental Claims

Please note that UHA (PH Tech) does not process dental claims. Please refer to members assigned Dental Coverage Organization (DCO) for dental billing. If you need information for the members assigned DCO you can contact Customer Care by phone at 541.229.4842 or email UHAMemberServices@umpquahealth.com.

6.7 Place of Service Codes

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.

6.8 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.

Per OAR 410-120-1280(8)(a-e), it is the Provider's responsibility to obtain any third-party liability (TPL) information from the member. The Provider must make reasonable efforts to obtain payment from other sources as UHA is always payor of last resort.

Third Party payors include:

- Private health insurance (e.g., commercial insurers, self-funded plans, or profit or non-profit pre-paid plans)
- Medicare and MedAdvantage Plans
- Champus and Champva
- Motor Vehicle Accidents (MVA), Workers Comp (WC), 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).

With the exception of tribal/Indian Healthcare, the primary coverage should **ALWAYS** be billed first. Upon receipt of payment or denial from the primary carrier, charges should then be submitted to UHA, accompanied by the primary carrier's explanations of benefits (EOB).

If you encounter any of the following or have any questions regarding third party liability, please contact the TPR Department by phone at 541.464.4175 or by email at UHTPR@umpquahealth.com

- 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
- If it is not available in the CIM portal, please reach out to UHA using contact information above

Per OAR 410-120-1280(5)(e) If a member has Medicare primary (this also includes ATRIO), these claims are automatically crossed over after the primary adjudicates the claim. In order to complete this process effectively, the provider **MUST** submit the Medicare (or ATRIO) claim with all applicable Medicaid information for all full benefit dual eligible (FBDE) clients. Providers are encouraged NOT to submit secondary claims to UHA for FBDE members since this process is in place. In the event that your crossover claim is not located or denied, please contact UHA claims support team **PRIOR** to submitting a new claim to UHA. UHA is responsible for claims payment including deductible/co-insurance/co-payments up to the allowed amount. If the primary carrier's payment is equal to or exceeds UHA's allowed reimbursement, the remaining balance **cannot** be billed to the member. Please see 42 CFR § 447.15 and OAR 410-120-1280 for further details on billing Medicaid members.

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.

6.9 Eligibility Verification

All UHA members are issued an ID card upon becoming active with UHA. It contains the members name, ID #, assigned PCP clinic, DCO, and issue date. Providers are encouraged to keep an updated copy in the member's chart. It is the Provider's responsibility to confirm member's eligibility at the time of service, as well as, confirming PA requirements with UHA for that service. Providers must inform the Member of any charges for non-covered services **prior** to the services being delivered. If the Member is to be held financially responsible for non-covered services, the Provider must have them complete and sign the OHP Client Agreement to Pay for Health Services form (OHP 3165). Claims payment is dependent on may factors including member eligibility on the date(s) of service.

Providers have access to an electronic eligibility verification system, CIM1, 24 hours a day which allows you to view a single Member's eligibility. If you are an UHA contracted PCP, CIM1 can also be used to generate a list of eligible Members assigned to you. For ease of Member identification, these lists include member identifiers (name, ID#, DOB), sex, and effective date of UHA eligibility.

If you do not have an established user name and password, email EDI.Support@phtech.com or call 503.284.2169, opt 1. You can also reach out to UHA at 541.229.4842 to request the CIM Access Request Form to send to PH Tech.

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 Customer Care Monday-Friday 8 a.m. – 5 p.m. at 541.229.4842 or 866.672.1551

6.10 Claims Payment and Refund Requests

Claims payment is subject to UHA's referral and prior authorization (PA) requirements, OARs specific to the service, member eligibility, active DMAP enrollment, proper billing, etc.

- *Participating* providers are issued payment at the rate and terms agreed upon and set out in your Provider contract with UHA.
- *Non-participating providers* are issued payment typically at the current DMAP rates, based on 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. This requires UHA to follow the regulations related to the payment of non-participating Providers. Please see OAR 410-120-1295 for more information.

Payment can be issued electronically or by paper check. If you are unsure how your payments are being issued, please reach out to UHA claims support team. Typically, if you use a clearinghouse, are a participating provider, or direct submitter payment is done electronically. This can be dependent on the billing information, so verification on provider's side may be required. Paper checks are mailed to the billing provider address located on the claim form and are typically accompanied by an EOB. If you feel that you have not received a paper check or EOB, please contact UHA claims support team at 541.229.4842 option 2 or by email at UHAClaims@umpquahealth.com

UHA occasionally must request funds back from a provider due to other coverage found, incorrect payment issued, billing errors, etc. Once the need for a refund is identified, PH Tech will send the provider a refund request notice. There are two ways you may receive a refund request notice.

1. If a claim is put into refund request either by plan direction or due to TPA error, a refund request voucher will be sent out to the provider. It looks very similar to an EOB, however, it is titled "Refund Voucher Statement". Much like the EOBs it will have an Explanation of Benefits Summary with the CARC definitions or reason for the refund request. **It is important to note that this does not mean that PH Tech has recouped the funds. There is a "remit payment to" section following the Explanation of Benefits Summary and these funds are due back to the plan.**
2. If a claim is identified by our Third-Party Liability (TPR) department, the provider will receive a letter titled "refund request" with all the claim identifiers and explanation for refund request. These letters come directly from UHA's TPR department, and the funds should be remitted within 30 days from the letters date. Please remit any TPR related refunds with letter to:

Umpqua Health Alliance
Attn: Third Party Recovery
500 SE Cass, Suite 101
Roseburg, OR 97471

For both instances noted above, if there is no refund check or corrected claim sent, PH Tech will look to recoup the balance owed in the upcoming check runs. If there are funds available, PH Tech will automatically recoup the balance and the claim information will be included on the EOB for that check run. The claim will show as negated indicating that funds for that claim have been taken back. Providers are encouraged to remit Refunds within 30 days of receiving the refund request.

6.11 Denials and Provider Claim Appeals

Claim denial information is provided in the EOB (Explanation of Benefits) that is sent to providers. There will be an "Explanation of Benefits Summary" section on the last page of the EOB following all claim information. These codes will correspond with the "EOB Code" column on the EOB, which is the reason for claim denial/partial payment. This information can be useful in creating a corrected claim or identifying other claim submission issues. If you have received a claim denial and have questions, please reach out to UHA claims support team at 541.229.4842 option 2 or by email at UHAClaims@umpquahealth.com. We will review the claim with the provider to determine what options are available. If there is an issue on UHA side, *typically*, corrected claims are not required, and UHA will have claim reprocessed. ***Please note that our UHA Claim Support team does not advise on how to bill, rather provides information that may be helpful in correcting the issue.***

Common reasons for denied claims:

- Member cannot be identified as a UHA Member (usually DOB/Name/member ID mismatch)
- Timely filing, duplicate billing, missing documentation
- Provider and/or facility is not enrolled with DMAP
- More than one Provider or supplier is billing on one claim
- Incomplete or inaccurate coding
- Claims not submitted on proper CMS 1500 or UB-04 claim form
- Missing, incomplete, or invalid unit of measure on codes that require an NDC
- Incorrect provider information
- Discarded drugs not billed properly

Provider Claim Appeals: Timely filing for appeals or corrections is 1 year (365 days) from the date of service as long as the initial claim submission was within the original timely filing guidelines. There are two levels of claims appeals if you receive a claim denial or partial payment that you do not agree with. A provider can submit a Level II appeal by mail or electronically. Please see below for the options.

- **Level I** claim dispute:
  - It is a communication from a provider about a disagreement with the manner in which a claim was processed.
  - This communication can be done verbally by phone/via UHA provider representative or in writing via email/letter.
  - When a Level I claim dispute is reviewed, UHA will advise providers on the additional options based on the findings.
  - The Provider Request for Reconsideration and Claim Dispute Form is not required.
  - These are worked as time allows and *may* exceed 60 days.
  - Typically consists of an addition to a claim such as an EOB, proof of timely filing, consent form, itemized statement, or invoice attached in CIM/mailed in to add to claim that will potentially change the claim decision
  - These do not require a formal denial letter if the original decision is upheld after review by either PH Tech or UHA
  - If original claim decision is upheld, claim note/email will be added by assessor to the claim in CIM as "public" visibility with a subject of "Claim Note: Reconsideration Upheld"
  - If UHA is unable to complete review, inquiry will be sent through the claim titled "Level I" to the UHAclaims@phtech.com email. *Notification must be titled this way, by UHA and providers alike.*

- **Level II** claim dispute

- Is a formal request for review when the provider has received an unsatisfactory response on an *original claim decision* or to a Level I appeal? You *do not* need to complete a Level I appeal to request a Level II, but if a Level II appeal is denied, you cannot for a Level I on the same claim.
- These inquires come from the providers directly via CIM or mailed appeal. You only have one opportunity for a Level II appeal per claim.
- Provider Request for Reconsideration and Claim Dispute form is REQUIRED and must be filled out completely and correctly. The form can be found here: https://www.umpquahealth.com/wp-content/uploads/2020/04/claims-appeal-reconsideration-form-updated.pdf
- The Provider's Level II appeal will be reviewed within sixty (60) calendar days of receipt of a clean claim by UHA or as required by law. If the claim is not clean, the 60 days does not start until all the required information is received.
- The appeal request will be reviewed by the appropriate department depending on the reason for appeal. If UHA reverses their previous decision, in whole or in part on any claims denial, the claim shall be reprocessed and paid as soon as possible. If original claim decision is upheld, claim note will be added to the claim in CIM as "public" under note subject "Claim note: Provider Dispute" advising of reasoning by PH Tech or UHA staff member that reviewed. An official denial letter will be sent to the provider with the reasoning for the appeal denial. If the Level II claim dispute denial is upheld, the Provider may file for a review with OHA, per OAR 410-120-1580, Provider Appeals – Administrative Review.
- **Level II Claim Disputes must include the following**:
  - Provider Request for Reconsideration and Claim Dispute Form completely filled out (one per claim)
  - A UHA EOB with claim number in question clearly circled
  - 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. This includes but is not limited to chart notes, EOB's, contract snips, and claims submission logs
  - If including screen shots or print outs, they must be sent in color or attached via CIM directly to the claim. These images darken upon scanning and often cannot be read when in black and white.
  - 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.

If the above requirements are not included, *the appeal will be considered an invalid submission* and will not be reviewed.

*****Please note that if at any time you receive notification of and *invalid appeal submission,* this does not count as the appeal opportunity. In order to exhaust appeal attempts, there must be a formal decision by plan or TPA.*****

Written appeals should be submitted to the following address:

Paper (via mail)
*** Use Exact Address as Listed ***
PH Tech **Attn: UHA Appeals** PO Box 5308 Salem, OR 97304

Providers that have CIM1 access can also utilize the provider portal to upload a Level I or Level II appeal to the claim in question directly. If this is the route that is chosen, please note:

- Appeal **MUST** be followed up with a CIM email to PH Tech
  - Level I Appeal must be titled as such and sent to the general PH Tech Claims address, UHAClaimAppeal@phtech.com
  - Level II Appeal must be titled as such and be sent to UHAClaimAppeal@phtech.com

This will notify PH Tech of the addition to the claim and they can review and route to the correct department. If this step is not completed, the appeal will be considered an invalid submission and will not be reviewed. You can find a tutorial on

How To Upload Documentation here, https://www.umpquahealth.com/wp-content/uploads/2020/04/how-to-upload-additional-documentation-pdf.pdf.

If you need assistance with uploading, please reach out to the UHA claims support team at 541.229.4842 option 2 or by email at UHAClaims@umpquahealth.com.

6.12 Claims Analysis

UHA reserves the right to do retrospective review of claims paid. 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

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 Customer Care 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 410-141-3830. 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 662 line items consisting of condition-treatment pairs, of which the services on lines 1-471 are covered services for OHP Members. The diseases and conditions below line 471 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 1-471. These are "above the line" diagnoses, and if paired, 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 472-665. 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 662 lines. 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) ranks all health care services to reflect the best unbiased information on clinical effectiveness and cost-effectiveness available. Co-morbid conditions factor into 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: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.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 Customer Care 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

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.

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

- Pneumococcal Vaccination/Revaccination Policy
  - Vaccinations are available at Aviva Health.
  - 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 College 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://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Pages/resources-medical.aspx#consent 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://www.oregon.gov/OHA/HSD/OHP/Pages/Forms.aspx?wp2131=se:%22sterilization%22, 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 Customer Care 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
• 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 Customer Care 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. If calling after hours, there is a 24-hour hotline available. Medical trips are covered and provided 24 hours a day, 365 days a year. In accordance with OAR 410-141-3920:

- Same day for NEMT Services
- Up to 90 days in advance

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 Customer Care 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 Customer Care 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.

7.17 Community Health Care Services

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

7.17.1 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 dba Aviva Health
150 NE Kenneth Ford Dr.
Roseburg, OR 97470
Phone: 541.672.9596 or 541.440.3512
TTY: 877.874.7662
http://aviva.health/ or Click here.

7.18 Internal Review Procedures

Member appeals and grievances data is present to the Clinical Advisory Panel (CAP), which meets quarterly. This Committee may determine if a corrective action needs to be taken.

7.19 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.

7.20 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 Customer Care 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 Department or Authority Worker if someone in the family becomes pregnant and to notify the DHS case worker of the birth of a child.
- To tell the Department or Authority if any family Member moves in or out of the household.
- To tell the Department or Authority 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 or the State (OHA).
- 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 Member is entitled and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs.
- To select or change a PCP or service site and to change those choices as permitted in the MCE's administrative policies.
- Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider.
- To have a friend, family member, member representative or advocate present during appointments and at other times as needed within clinical guidelines.
- To be actively involved in the development of a treatment plan.
- To receive information about their 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 the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.
- Receive culturally and linguistically appropriate services and supports in locations as geographically close to where members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.
- Receive oversight, care coordination and transition and planning management from their CCO within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.
- To receive necessary and reasonable services to diagnose the presenting condition.
- Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.
- To obtain covered preventive services.
- To have access to care when it is needed, 24 hours a day, 7 days a week without prior authorization.
- Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in UHA's referral policy.
- To have access to their medical records, unless restricted by statute.
- To request changes to be made to their medical records.
- To transfer a copy of their medical records to another Provider.
- To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.
- 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.
- Receive certified or qualified health care interpreter services
- To receive a notice of an appointment cancellation in a timely manner.
- To receive adequate OHA Notice of Privacy Practices (MSC 2090 (2/2014)).
- The right to file an appeal within sixty (60) days from the date on an ABD.
- The right to file a grievance with UHA and/or OHA for any matter other than an ABD.
- The right to request a contested case hearing with either UHA or OHA within one hundred and twenty (120) days from the date on the Notice of Appeal Resolution (NOAR), when the ABD is upheld, or the date that OHA deems that the member has exhausted the appeals process, or except where UHA fails to adhere to the notice or timing requirements. In which case member is deemed to have exhausted the grievance and appeals system process and the member may request a contested case hearing.
- The right to have an attorney or member representative present at the contested case hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1.800.520.5292, TTY 711.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- The right to continuation of benefits pending an appeal or contested case hearing.
- 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 OHP Coverage
  - Care Coordination
  - Language Assistance
  - Member Rights and Responsibilities
  - Fraud, Waste, and Abuse
  - 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
  - Transition of Care

- **Member ID Card**
  - Member's full name
  - OHA identification number
  - Primary Care Provider (PCP)
  - Dental Care Organization (DCO)
  - Pharmacy Bin & Group number
  - How to access emergency services
  - Phone number for Non-Emergent Medical Transportation
  - Phone number for the 24-hour Crisis Line

If Members have questions regarding materials sent to them by UHA, they should be referred back to UHA Customer Care 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 PCP Providers.

Non-urgent, routine care	Must be seen, treated or referred within four weeks
Urgent care	Must be seen within 72 hours
Timeframe for follow-up visits following an ER visit or post hospital discharge	Must be seen within 72 hours
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 PN7- Network Adequacy Policy, PN8- Monitoring Network Availability Policy and PN9- Monitoring Network Access Policy. Policies are covered in the UHA Provider Orientation Slide Deck and available on the UHA Website at the following link: https://www.umpquahealth.com/provider-trainings/

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 Grievance, Appeals and Hearings

8.7.1 Grievance and Appeal System Overview

UHA, participating providers and subcontractors are to comply with UHA's Grievance and Appeal System requirements as outlined policies, the CCO Contract, OAR 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860 and 42 CFR §438.400 through §438.424.

Any time a member expresses dissatisfaction or concern they are informed of their right to file a grievance or if applicable an appeal. UHA, its subcontractors, and its participating providers may not:

- Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal;
- Encourage the withdrawal of a grievance, appeal, or hearing request already filed;
- Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment;

- Member grievance and appeals resolution process will protect the anonymity of complaints and protect callers from retaliation.

A member grievance or appeal may be received orally or in writing. With written consent, a provider or an authorized representative can file on the member's behalf, either to UHA or to the State.

UHA will provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:

- Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
- Providing auxiliary aids and Certified or Qualified Health Care Interpreter services upon request, at no charge, including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
- Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

A grievance or appeal can be completed by going to the Customer Care office, in writing by mail or email, calling the standard phone number, or by using the TTY or TTY toll free phone number.

- Contact information is posted on UHA's website, in the Member Handbook, Provider Handbook and is on the Member ID card.
- Grievance and appeal applicable forms are located on UHA's and OHA's website and accessible to Members in the all administrative offices.
- Additionally, the Appeal and Hearing Request form (OHP 3302) is provided to the member at the time of the ABD and can be mailed to the member again upon request.

Parties of the grievance, appeal and/or hearing include:

- The member;
- The member's representative;
- A provider acting on behalf of a member, with written consent from the member; or
- The legal representative of a deceased member's estate; and
- UHA.

UHA will ensure all staff who have contact with members or potential members are fully informed of UHA's appeal and grievance policy.

- UHA staff and consulting experts, or any individuals who make decisions on appeals, are not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member;
- Not involved in any previous level of review or decision making nor a subordinate of such individual with respect to the grievance or appeal;
- Are health care professionals with appropriate clinical expertise in treating the member's condition or disease, when deciding any of the following:
    - An appeal of a denial that is based on lack of medical necessity;
    - A grievance regarding denial of expedited resolution for a grievance or service authorization appeal; and/or
    - A grievance or appeal that involves clinical issues.

When UHA receives the grievance or appeal, they will attempt to obtain documentation of all relevant facts concerning the issues. UHA will ensure that:

- Decision makers will take into account all comments, documents, records, and other information submitted by the member or their representative, regardless to whether such information was previously submitted or, for appeals, were considered in the initial ABD;

- For cases in which a provider indicates, or UHA determines, that following the standard appeal timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, UHA will investigate, resolves, and provide notice as expeditiously as the member's health condition requires and within the standard or expedited appeal timeframes.
- Members are provided reasonable opportunity, by phone, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Inform the member of the limited amount of time available to present evidence and argument sufficiently in advance of the resolution timeframe for both standard and expedited appeals.

Upon request, members are provided with a copy of their case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the ABD. This information is provided free of charge and sufficiently in advance of the resolution timeframes.

UHA will ensure a member's grievance or appeal will be kept confidential.

- UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance or appeal, have a right to use this information for purposes of UHA resolving the grievance or appeal, for purposes of maintaining the appropriate logs, and for health oversight purposes by OHP, without a signed release from the member.
- If UHA must release any information related to the grievance or appeal to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. UHA's investigation may be restricted and information will not be released without a signed authorization.

8.7.2 Member Rights

The Adverse Benefit Determination (ABD) notices and Appeal and Hearing Request form (OHP 3302) provides information on member's rights and the process for appealing. These rights include, but are not limited to following:

- The right to file an appeal within sixty (60) days from the date on the ABD;
- The right to file a grievance with UHA and/or OHA for any matter other than an ABD;
- The right to request a contested case hearing with either UHA or OHA within one hundred and twenty (120) days from the date on the Notice of Appeal Resolution (NOAR), when the ABD is upheld, or the date that OHA deems that the member has exhausted the appeals process, or except where UHA fails to adhere to the notice or timing requirements in 42 CFR §438.408. In which case member is deemed to have exhausted the grievance and appeals system process and the member may request a contested case hearing;
- The right to have an attorney or member representative present at the contested case hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1.800.520.5292, TTY 711; and
- The right to continuation of benefits pending an appeal or contested case hearing as stated below.

8.7.3 Grievances

A member grievance may be received orally or in writing. With written consent, a provider or an authorized representative with written consent, file on the member's behalf, either to UHA or to the OHA.

Any time a member expresses dissatisfaction or concern they are informed of their right to file a grievance and how to do so. This must be for a matter other than an ABD.

- If the member files a grievance with OHA, OHA will then forward promptly to UHA for handling.

Upon receipt of a grievance, UHA obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.

Each grievance is investigated and resolved as expeditiously as the member's health condition requires and within the following timeframes:

- **Acknowledgment**: Within five (5) working days;
- **Standard:** Within five (5) working days from the date of receipt, UHA will make a decision and notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or
- **Extension:** Within five (5) working days notify the member in writing that a delay of up to 30 calendar days from the date of receipt is necessary to resolve the grievance.
    - If a delay is needed to resolve the grievance, UHA shall specify the reasons the additional time is necessary.
    - An extension up to 30 calendar days may also occur at the member's request.
- If UHA's failure to meet a required timeframe for review precipitated the grievance, UHA will work with the member and provider(s) to coordinate care and address the original request as appropriate.
- If a grievance is related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO, UHA shall log the grievance and work with the receiving or sending CCO to ensure continuity of care during the transition.

The grievance resolution may be given to the member by phone, but a written response will be given despite how the grievance was received. This notice of grievance resolution shall:

- Address each aspect of the member's grievance and the reason for UHA's decision;
- Comply with OHA's formatting and readability standards and provide written notice in the preferred language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.
- Advise all affected members that they have the right to present their grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by telephone. Such telephone numbers shall be included in the notice of grievance resolution and are as follows:
    - For CSU: 800-273-0557;
    - For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450.
        - UHA shall promptly cooperate and cause its subcontractor to promptly cooperate with any investigations and resolution of a grievance by either or both DHS' Client Services Unit and OHA's Ombudsperson as expeditiously as the affected member's health condition requires, and within timeframes set forth in or required by the CCO contract.

8.7.4 Appeals

UHA has only one level of appeal for members. Members are required to complete the appeals process before requesting a contested case hearing. **The member must file the appeal with UHA no later than 60 days from the date of notice on the ABD.**

- A request for a contested case hearing made without previous use of the appeal procedures may be forwarded to UHA to review as an appeal prior to the hearing.

A member, their representative, legal representative of a deceased member's estate, a subcontractor, or a provider with the member's written consent, may file an appeal orally or in writing with UHA to:

- Express disagreement with an ABD; or
- Contest the failure of UHA to act within the timeframes provided regarding the standard resolution of grievances and appeals.

Oral Appeals

The date of an oral appeal request will establish the filing (received) date as the date of the oral request. **The member must follow an oral filing with a written, signed, and dated appeal unless the individual filing the appeal requests expedited resolution**. If after filing an oral appeal, a member or the provider on the member's behalf does not submit a

written appeal request within the appeal timeframe, the appeal shall expire. No notification will be provided to the member when this occurs.

Appeal Timeframes

- **Acknowledgement of receipt**:
  - **Standard**: In writing within five (5) business days;
  - **Expedited**: Orally and in writing within one (1) business day.
- **Resolutions:**
  - **Standard:** UHA will resolve and provide written notice of the disposition, as expeditiously as a member's health condition requires and no later than sixteen (16) days from the received date of the appeal.
  - **Expedited:** UHA will complete the review as expeditiously as the health condition requires or in a timeframe that is no longer than seventy-two (72) hours.
    - UHA will make reasonable efforts to call the member and the provider to tell them of the resolution within seventy-two (72) hours after receiving the request; and
    - Mail written confirmation (Notice of Appeal Resolution (NOAR)) of the determination to the member within three (3) days.
- **Extensions**:
  - The timeframe for standard and expedited appeals may be extended by up to fourteen (14) days if:
    - The member requests the extension; or
    - UHA shows to the satisfaction of the OHA, upon its request, that there is need for additional information and how the delay is in the member's interest.
  - If UHA extends the timeframes, but not at the request of the member, it shall:
    - Give the member a written notice and make reasonable effort to give the member oral notice of the reason for the delay.
    - Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.
    - Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
    - All appeals that are granted extensions are resolved no later than the expiration date of the extension.

Expedited (fast) Appeals

When the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, they can ask for an expedited review.

If UHA denies a request for an expedited appeal, the appeal will transfer to the timeframe for standard resolution. UHA will:

- Resolve the appeal no later than sixteen (16) days from the received date with a possible fourteen (14) day extension.
- Make reasonable efforts to give the member prompt oral notice of the denial.
- Follow-up with a written notice within two (2) days.
  - The written notice will include the member's right to file a grievance if they disagree with the decision.

If UHA approves a request for expedited appeal but denies the services or items requested in the expedited appeal, UHA will:

- Make reasonable effort to provide oral notice; and
- Inform the member of their right to request an expedited contested case hearing and will send the member a Notice of Appeal Resolution (NOAR), Hearing Request and Information forms.

If UHA fails to adhere to any of the notice and timing requirements, the member is considered to have exhausted UHA's appeals process. In this case, the member may initiate a contested case hearing.

Appeal Resolutions

UHA will make reasonable effort to provide the member with oral notice of the resolution.
The member will also be notified in writing of the resolution of the appeal by means of the Notice of Appeal Resolution (NOAR). The NOAR will include the process for requesting a hearing if applicable. It will also inform the member of the rules to govern representation and their right to have an attorney or member representative present, the availability of free legal help through Legal Aid Services and Oregon Law Center, and he telephone number of the Public Benefits Hotline 1.800.520.5292, TTY711.

If a portion of the request was overturned, UHA would indicate in the NOAR details of those services that had a favorable outcome.

For appeals not resolved in favor of the member (wholly or partially), the NOAR will include:

- Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the NOAR relied upon to deny the appeal.
- The right of the member to request a standard or expedited contested case hearing with OHA within one hundred and twenty (120) days from the date of the NOAR and how to do so, which includes sending the Appeal and Hearing Request (OHP 3302).
- The right to continue to receive benefits pending a contested case hearing and how to do so;
- Information explaining that if the ABD is upheld in a contested case hearing, the member may be liable for the cost of any continued benefits (see Continuation of Benefits below).

If the original ABD is overturned, UHA will issue a notice of appeal resolution within the required timeframes and must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than (72) hours from the date of notice reversing the determination. UHA must promptly correct the ABD taken up to the limit of the original request or authorization.

8.7.5 Contested Case Hearings

A member may request a contested case hearing with OHA only after receiving notice that UHA notice of ABD is upheld or, in the case of UHA failing to adhere to the notice and timing requirements, in which case the member is deemed to have exhausted the grievance and appeals system process and may request a contested case hearing.

Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms. If a participating provider filed an appeal on behalf of the member, the participating provider is allowed to request a contested case hearing on behalf of member.

If the member files a request for an appeal or hearing with the OHA prior to the member filing with UHA, the OHA shall transfer the request to UHA and provide notice of the transfer to the member. UHA will review the appeal request immediately and respond within 16 days with a NOAR.

OHA must receive the member's hearing request within 120 days of the date shown on the NOAR.

If a member sends the contested case hearing request to UHA after the initial plan appeal, or upon receipt of a request for a contested case hearing from OHA, UHA will immediately transmit the request to OHA with the required documentation within two (2) days. Information regarding the member used for administrative hearings is handled in confidence.

OHA, the member, their representative or the legal representative of a deceased member's estate, UHA, and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the administrative hearing have a right to use this information for purposes of resolving the administrative hearing without a signed release from the member.

- OHA may also use this information for health oversight purposes and for other purposes authorized or required by law.
- The information may also be disclosed to the Office of Administrative Hearings and the administrative law judge assigned to the administrative hearing and to the Court of Appeals if the UHA member seeks judicial review of the final order.
- OHA will ask the member to authorize a release of information regarding the administrative hearing to any other individual.

The hearing will be scheduled through the Office of Administrative Hearings. If a member or provider believes that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function may request an expedited contested case hearing.

OHA will resolve a contested case hearing ordinarily within ninety (90) days from the date UHA receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing request. The final order is the final decision of OHA.

If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal or contested case hearing was pending, UHA will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date UHA receives the decision reversing the ABD.

8.7.6 Continuation of Benefits

A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount as previously authorized while an appeal or contested case hearing is pending.

To be entitled to continuing benefits complete an appeal request or an OHA contested case hearing request form and check the box requesting continuing benefits by timely filing, on or before the later of the following:

- Within ten (10) days after the date of the NOABD; or
- The intended effective date of the action proposed in the NOABD.

UHA will continue COB to the member's benefits if:

- The member or member's representative timely files the appeal or contested case hearing request;
- The appeal or contested case hearing request involves the termination, suspension, or reduction of previously authorized services;
- An authorized provider ordered the services; and
- The member timely files for continuation of benefits.

If at the member's request, UHA continues or reinstates the member's benefits while the appeal or contested case hearing is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal; or
- UHA issues an NOAR;
- Unless the member requests a contested case hearing with continuing benefits, no later than ten (10) days following the date of the NOAR, a final appeal resolution resolves the appeal;
- The member withdraws their request for contested case hearing; or
- A final contested case hearing decision is upheld.

If the final resolution of the appeal or contested case hearing upholds the ABD, UHA will recover from the member the cost of the services furnished to the member while the appeal or hearing was pending, to the extent that they were furnished.

If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services furnished, and the member received the disputed services while the appeal was pending, UHA or the state shall pay for those services in accordance with the OHA policy and regulations.

Should the administrative hearing decision uphold UHA's ABD, UHA may recover the cost of service furnished to the member while the hearing is pending to the extent that they were furnished.

8.7.7 Peer-to-Peer Consultation

UHA allows providers to have a consultation with the Medical Director when a prior authorization is denied. This can be done by calling our main line at 541.229.4842, option 1, and requesting to schedule a peer-to-peer. Peer-to-peer can occur at the same time a member is in the process of appealing an ABD.

8.8 Applicability of State and Federal Laws

As a State contractor, UHA receives State 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 state and 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 Risk Response 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.

UHA Case Management is available to assist Members with completing Advance Directives by contacting Customer Care at 541.229.4842.

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
3031 NE Stephens St
Roseburg, OR 97470

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 to operate with a high level of integrity to ensure compliance with regulations.
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, or upon request. 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

Providers 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 Providers during the credentialing and contracting process and expect Providers to attest that they have read and understood this document.

10.2 Compliance Program and Fraud, Waste, and Abuse Prevention Plan Handbook and Policies and Procedures

Umpqua Health's Compliance Program and Fraud, Waste, and Abuse Prevention Plan Handbook and all applicable policies and procedures, govern the operational elements of its Compliance Program and Fraud, Waste, and Abuse (FWA) Plan. Accordingly, Providers are expected to fully comply and follow the requirements established in the Compliance Program and FWA Prevention Plan Handbook as well as its policies and procedures. These documents can be viewed on UHA's website.

10.3 Fraud, Waste and Abuse

Providers of Umpqua Health are required to comply with Umpqua Health's Fraud, Waste, and Abuse policies, 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 Providers should be aware of:

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

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 an 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, Providers 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 (Compliance Program and FWA Prevention Plan Handbook and Code of Conduct and Ethics).
- False Claims Act and Whistleblower Protection.
- Excluded Provider Requirements and Provider Screening/Enrollment Requirements- Subcontractors and Credentialing Staff only

Umpqua Health shall require and provide training or ensure training is provided on implicit bias for all of the Provider network. Cultural Responsiveness and Implicit Bias training for the Provider network, at a minimum, includes:

- Implicit bias/addressing structural barriers and systemic oppression;
- Language access and use of health care interpreters;
- Culturally and Linguistically Appropriate Services (CLAS) Standards;
- Adverse childhood experiences/trauma informed care;
- Uses of data to advance health equity; and
- Universal access or accessibility in addition to ADA.

Providers may elect to utilize their own trainings or request trainings from Umpqua Health. If Providers intend to develop and utilize its own training, the Provider 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 K, Part 10, Section d).

Umpqua Health reserves the right to require its Providers attest and/or provide documentation that the Provider and its workforce has received the required trainings. In the event that a Provider cannot demonstrate training was provided, Umpqua Health may ask the Provider to complete a Risk Response Plan to address the deficiency.

All training requirements and policies referenced in the UHA Provider Handbook are covered in the UHA Provider Orientation Slide Deck and available on the UHA Website at the following link: https://www.umpquahealth.com/provider-trainings/ .

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 Providers, therefore, Providers 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, Providers 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 Provider identifies an individual who is actively excluded/debarred, the Provider 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. 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 Provider's performance, Umpqua Health will engage in a Risk Response Plan process with the Provider. Providers are expected to participate and take appropriate actions to mitigate any of the deficiencies in a timely manner.

10.7 Reporting Concerns

Individuals and Providers who suspect fraud, waste, or abuse or other suspicious activities, are required to report these concerns to Umpqua Health's Compliance Department. If identification of Overpayment was the result of self-reporting to Contractor by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR § 401.305, such Overpayment to Contractor within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment.

Furthermore, Umpqua Health expects its Provider panel 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
3031 NE Stephens St
Roseburg, OR 97470
Phone: 541.229.7043
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) (Provider FWA Referrals)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971.673.1880
Fax: 971.673.1890

OHA Office of Program Integrity (OPI) (Provider FWA Referrals)
3406 Cherry Ave NE
Salem, OR 97303-4924
Phone: 888.372.8301
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

DHS Fraud Investigation (Member FWA Referrals)
P.O. Box 14150
Salem, Oregon 97309-5027
Phone: 888.FRAUD01 (888.372.8301)
Fax: 503.373.1525 ATTN: Hotline
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

US Department of Health and Human Services

Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026
Phone: 800.HHS.TIPS (800.447.8477)
Fax: 800.223.8164
Web: https://oig.hhs.gov/fraud/report-fraud/index.asp

Section 11: UHA Contact List

- **Contact Provider Relations at** UHNProviderServices@umpquahealth.com
  - For DMAP enrollment/inquiries, contracting, or provider network questions

- **UHA Claims Support Team** at (541) 229-4842 option 2 or via secure email to UHAClaims@umpquahealth.com
  - For general claim support including denials and payment questions, notification of system issues

- **Contact Customer Care** at (541) 229-4842 option 1 or by secure email UHAMemberServices@umpquahealth.com
  - For member eligibility, PCP changes, coverage questions, or any other UHA member issues

- **PhTech EDI Support** at (503) 584-2169 or support@phtech.com
  - For EDI, direct claim submission, or CIM issues

- **TPR** at (541) 464-4175 or UHTPR@umpquahealth.com
  - To report third party liability, secondary payment questions, or TPR refund requests

- **Care Coordination Department** by email at casemanagement@umpquahealth.com
  - For Care Coordination assistance

- **Appeals and Grievance Department** by email at UHAGrievance@umpquahealth.com
  - For member appeal or complaint assistance

Please visit the updated provider section of our website at
https://www.umpquahealth.com/providers/