Provider Manual

Advanced Health

Coordinated Care Organization

289 Laclair Street, Coos Bay, Oregon 97420

Phone: 541-269-7400 ∞ Toll Free: 800-264-0014

TTY 877-769-7400 ∞ Fax: 541-269-2052

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Contact Information

Office Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.

Office Location – Coos Bay

289 Laclair Street
Coos Bay, OR 97420
Phone 541-269-7400
TTY for Hearing Impaired 877-769-7400

Office Location – Gold Beach

29692 Ellensburg Avenue
Gold Beach, OR 97444
Phone 541-551-0126

Fax Numbers

- Administration Office: 541-269-7789
- Claims Department: 541-266-0141
- Credentialing/Contracting: 541-266-0141
- Customer Service Dept: 541-269-2052
- Medical Mgmt/Auths: 541-269-7147

Claims

Mailing Address: PO Box 705
Elk Grove Village, IL 60009
Physical Address: 289 Laclair Street
Coos Bay, OR 97420
Phone 541-269-0567
Fax 541-266-0141

- Claim Submission Filing Limits
- Claim Status
- Claim Reconsideration Requests
- Claim Specific Billing Questions
- Third Party Recovery (TPR)

Customer & Provider Services

289 Laclair Street
Coos Bay, OR 97420
Phone 541-269-7400
TTY for Hearing Impaired 877-769-7400
Fax 541-269-2052

- Member Benefits/Eligibility
- Plan Policies and Procedures
- Interpreter Services
- Patient/Provider Complaints & Appeals
- Pharmacy Benefit Questions
- Transportation

Office Location – Gold Beach

29692 Ellensburg Avenue
Gold Beach, OR 97444
Phone 541-551-0126

Medical Management
289 Laclair Street
Coos Bay, OR 97420
Phone......................................541-269-7400
Fax...541-269-7147

- Authorization Status
- Prioritized List Questions
- Authorization Requests
- Emergency Room Utilization
- Durable Medical Equipment (DME)
- Pharmacy Questions

Contact Information (continued)

Care Management
289 Laclair Street
Coos Bay, OR 97420
Phone...541-269-4559
Fax..541-269-7147

- Substance Use Disorder Treatment
- Disease Management,
- Maternity Care Management
- Challenging Member Issues
- Care Coordination

Advanced Health's Access Nurse
Phone..................................... 1-888-647-3627

24 Hours a day, 7 days a week

Members can call Advanced Health 's Access Nurse for advice on health concerns. A registered nurse will speak with members for issues related to:

- Whether they should go to the emergency room if a medical provider is unavailable.
- If they feel their health issues may be urgent or emergent and are unsure if they should wait for their next appointment or seek emergency help.

Resources

Provider Portal: www.docshp.com

The provider portal may be used as your resource for:

- PCP Assignment
- Eligibility, Verification/History
- Authorization Status

To register for access to the provider portal, please visit our website at www.advancedhealth.com, click on For Providers →Policies and Forms→Online User Registration. Follow the directions located on the form and submit for approval.

Advanced Health's Website: www.advancedhealth.com

Our new website offers easily accessible information for both members and providers, including:

- Pharmacy Information
- Advanced Health Policies & Forms
- Calendar of Events
- Link to the Prioritized List
- Contact Information
- OHP Information

Community Resources

Advanced Health works closely with our community partners to provide educational opportunities related to health and well-being for providers and health plan members. Please visit our website for a full list of available opportunities.

Providers:

- Patient Care Conferences
- Provider Orientation Sessions
- Health Plan Education

Members:

- Care Management
- Health Plan Education
- Diabetic Education

Interpretation Services

- Advanced Health covers and coordinates interpretation services for our members medical appointments.
- To arrange for interpretation services, please contact Advanced Health Customer Service at 1-800-264-0014, at least 48 hours prior to the appointment date.
- A Customer Service Representative will call back to confirm that arrangements for an interpreter have been made.
- For urgent needs (less than 48-hour notice), please contact Customer Service.
- Providers may choose to coordinate interpretation services; however, the cost will not be reimbursed unless arrangements have been made through our Customer Service Department.

Non-Emergent Medical Transportation for Covered Medical Services (Bay Cities Brokerage Transportation)

Members have a benefit that includes non-emergent medical transportation (medical, pharmacy, dental, behavioral health). Members can call Bay Cities Brokerage Transportation directly at 1-877-324-81090 to schedule a ride to a medical appointment. Please contact Customer Service for questions regarding transportation benefit coverage at 541-269-7400.

Member Eligibility

Identification Cards

Advanced Health sends member identification cards to the member when they are enrolled onto the health plan. Providers should always verify member eligibility by logging onto the State's website at www.or-medicaid.gov.

It is the responsibility of the treating provider to verify a member's eligibility on the date of service and that the service is covered under the OHP Benefit Package prior to rendering services. The provider is also required to verify that the patient is enrolled in Advanced Health and seek any necessary authorization required. Providers must also inform the member in-advance of any non-covered items prior to delivering services. This must be in the form of a written DMAP waiver and must specify the reason for non-coverage, estimated cost, and the specific service that is not covered. The member must also be provided with a copy of the waiver for their records. Please reference Oregon Administrative Rule (OAR) 410-120-1280 for further details.

Online Eligibility

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

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

Basic Benefit Packages

The Health Services Division (HSD), formerly known as Medical Assistance Programs (MAP), is responsible for determining patient eligibility for the Oregon Health Plan (OHP). Below is a quick reference chart that illustrates the medical, dental or behavioral health services OHP covers for each benefit package. Please refer to the member's HSD Medical Care ID card to determine which

benefit package the member has.

Covered Services	OHP Plus Children/Individuals (Ages 0-20)	OHP with Limited Drug* OHP Plus Non-Pregnant Adults (Ages 21 and Older)
Acupuncture	Covered	Covered
Substance Use Disorder	Covered	Covered
Dental (Basic services including cleaning, fillings and extractions. Urgent immediate treatment. Other services are limited*	Covered	Covered
Durable Medical Equipment and Supplies (DME)	Covered	Covered
Hearing Aids & Exams	Covered	Covered
Home Health	Covered	Covered
Hospice Care	Covered	Covered
Hospital Care (Inpatient/Outpatient)	Covered	Covered
Immunizations	Covered	Covered
Labor & Delivery	Covered	Covered
Laboratory & X-Ray	Covered	Covered
Medical Transportation	Covered	Covered
Mental Health Services	Covered	Covered
Naturopathy	Covered	Covered
Physical, Occupational & Speech Therapy	Covered	Covered
Physician Services	Covered	Covered
Podiatry	Covered	Covered
Prescription Drugs	Covered	Limited*
Private Duty Nursing	Covered	Covered
Vision Care	Covered	Limited*

Additional Benefit Information

Mental Health Services

Mental Health services are a covered benefit through Advanced Health. We contract with various agencies throughout Oregon for administration and panel providers for mental health services. Locally, we work with Coos Health & Wellness (CHW) and Curry Community Health (CCH).

Advanced Health members who need inpatient, residential, or outpatient treatment for mental health diagnoses, or mental health assessment may self-refer to CHW, or CCH.

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

Addiction Treatment

Advanced Health has contracted with ADAPT and CCH for provision of outpatient addiction treatment in Coos and Curry Counties. Advanced Health members who need *inpatient* or residential level substance abuse treatment can ask their Primary Care Physician (PCP) to contact ADAPT or CCH to set up a patient assessment prior to contacting ADAPT or CCH directly to create a treatment plan. Advanced Health members who need *outpatient* addiction treatment should contact ADAPT or CCH for assistance. Members can self-refer to ADAPT for chemical dependency treatment without seeking an authorization from their PCP.

Pharmacy Benefits

Oregon Health Plan members currently have drug benefits as part of their benefit package. Coverage of medications is dependent upon whether the drug is included on Advanced Health's Drug Formulary. Diagnosis must be covered and are subject to exclusions and limitations. It is mandatory that generic medications be substituted whenever possible. Medications not listed on the formulary must be authorized in advance. Please use the Medication Authorization Form located at the back of this Manual. For our most current Drug Formulary please visit our website: www.advancedhealth.com.

Dental Services

Dental Services are a covered benefit for Advanced Health members. This includes anesthesia, hospital or ambulatory surgical services for patients with severe medical needs. Authorization is required for some services prior to services being rendered.

Advantage Dental provides all dental services for Advanced Health members. Advantage Dental has various locations throughout Coos and Curry Counties, including: Bandon, Brookings, Coos Bay and North Bend. Each location can be contacted by calling 1-866-268-9631 or TTY 711.

Participating Provider Agreement

Your rights and responsibilities as a participating provider are defined in your service agreement. As a participating provider, you are responsible for:

1) Submitting claims for Advanced Health patient members:

This includes claims for inpatient, outpatient and office services. To ensure prompt and accurate payment, it is important that you provide all patient information on the CMS-1500 claim form (or the UB-04 claim form for certain allied providers) including appropriate Physicians' Current Procedural Terminology (CPT®) codes, ICD-10-CM and ICD-10-CM diagnosis codes. Remember to include your HSD provider number, and your National Practitioner Identification (NPI). The Claims Submission section of this manual gives specific information about completing the claim form as well as coding information. The Allied Health Providers section gives specific information about completing the UB-04 claim form.

*CPT ® is a registered trademark of the American Medical Association.

2) Accepting Advanced Health payments as payment in full for covered services:

Advanced Health's payment for covered services is not to exceed the allowable charges. Advanced Health's Explanation of Benefits (EOB) summarizes each claim and itemizes the amount billed, the allowed amount; withhold adjustment, and net payment.

3) Not billing for non-covered services or services that are not medically necessary:

Unless the provider has notified the Advanced Health Member in advance and in writing that certain non-covered or not medically services will be the member's responsibility. Generic or all-encompassing notifications will not meet the specific notification requirements. Providers may have a member sign a waiver in which the member acknowledged their financial responsibility in the case of a non-covered or non-medically necessary service. The waiver must be specific and

indicate the date of service, the specific non-covered/not medically necessary service to be rendered, the estimated cost of the service and the reason why the service will not be covered by Advanced Health. Please see the section titled "Waiver of Non-Covered Services" for more detailed information.

Provider Responsibilities

Credentialing Program

Only licensed practitioners who are professionally competent and continuously meet the credentials, standards and requirements established by Advanced Health shall be approved to provide health care services to Advanced Health members.

Please notify Advanced Health Credentialing Services at (541) 269-7400 as soon as possible if you are a new provider and wish to become a participating provider so that we may begin the credentialing process.

Participating providers are expected to cooperate with quality of care policies and procedures. An integral component of quality of care is the credentialing of participating providers. This process consists of two parts: credentialing and re-credentialing.

Credentialing consists of an initial full review of a provider's credentials at the time of application to our organization.

If a provider applies for participation in our network, they must be credentialed before being approved for participation. A pre-application will be sent to the provider to complete. The pre-application acts as a primary intake of basic information about the provider. Once the completed pre-application is received, it will be reviewed by Advanced Health's Medical Director. If approved by the Medical Director, Advanced Health will send an Oregon Standardized Credentialing Application (OSCA) to the provider to complete. Advanced Health will then gather and verify all the information provided on the application. Once the complete application is verified, it will then be submitted for final review and approval by the Advanced Health Board.

The Advanced Health Medical Director will review the provider's credentials to ascertain compliance with the following credentials criteria:

- Unrestricted license to practice medicine in Oregon as required by state law;
- Agreement to complete regular credentialing and re-credentialing forms;

- Agreement to participate in Advanced Health quality of care and utilization review programs;
- Agreement to maintain a comprehensive outpatient medical record on each Advanced Health Member;
- Professional liability insurance that meets required amounts;
- Malpractice claims history that is not suggestive or a significant quality of care problem;
- Appropriate coverage/access provided when unavailable on holidays, nights and weekends;
- Absence or patterns of behavior to suggest quality of care concerns;
- Utilization review pattern consistent with peers and congruent with needs of managed care;
- No sanctions by either Medicaid or Medicare;
- No disciplinary actions either pending or imposed;
- No felony or serious misdemeanor convictions; and
- No current drug or alcohol abuse.

All participating providers must maintain these criteria on an ongoing basis.

Based upon compliance with credentialing criteria, Advanced Health's Medical Director will make a recommendation to the Credentialing Committee that a provider be approved or denied participation in our network. The Credentialing Committee, comprised of IPA members, will make the final decision related to the provider's participation with the Southwest Oregon IPA.

Confidentiality in Credentialing

Advanced Health maintains confidentiality of all information obtained through the credentialing and re-credentialing process as required by law. Advanced Health has implemented procedures and safeguards to ensure that the confidentiality of all practitioner credentialing and re-credentialing information and files are maintained. Only Advanced Health Credentialing Dept., Medical Director, CEO and other authorized persons shall have access to such information. Advanced Health will not disclose confidential information to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Re-Credentialing

After a provider has completed the initial credentialing process, he/she will undergo re-credentialing approximately every three years thereafter. A re-credentialing application will be sent to the

practitioner for completion. The re-credentialing application will request the practitioner update the information on the initial credentialing application.

Failure to Complete Credentialing Process

The credentialing application must be completed in full and returned to Advanced Health within 30 days of receipt of the application. Failure to return the requested information within the established timeframe may result in termination of the Participating Provider Agreement.

Change of Address/Status Changes/Adverse Information

Providers are required to report changes to their credentialing criteria to Advanced Health within 15 days from the date of occurrence. This includes any adverse, legally discoverable information, e.g., license restriction, professional liability history, board-certification decisions, health issues, illegal or unethical conduct, monitored programs, termination or exclusion from Medicare or Medicaid programs, etc. Failure to do so may result in immediate termination from Advanced Health's participating provider panel. Please contact Credentialing Services at 541-269-7400 to report changes.

Practitioners Rights Regarding Credentialing Information

Practitioners reserve the right to review the information submitted in support of their credentialing applications. Practitioners will be notified of any information obtained during the credentialing process that varies substantially from the information provided to Advanced Health by the practitioner. The practitioner has the right to, and will be given the opportunity to, correct erroneous information submitted in support of their credentialing application or submitted by another source.

For more information regarding Advanced Health's credentialing and re-credentialing policies and procedures you may contact Credentialing Services at 541-269-7400.

Provider Reporting of Quality of Care Concerns

Providers are encouraged to report quality of care issues or concerns. You may call Advanced Health's Medical Director at 541-269-7400, or put your concerns in writing and mail them to us at: **Advanced Health, Attention: Medical Director, 289 Laclair Street, Coos Bay, OR 97420**

Provider Availability Standards

Advanced Health is committed to providing high quality health care to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. The information below is used as a general availability standard, but timeframes may be adjusted based upon community standards.

Type	Access Standard	Examples
Emergency		
Medical situations in which a member would reasonably believe his/her life to be in danger, or that permanent disability might result if the condition is not treated.	Immediate Access, Refer or Treat, 24 Hours a Day, 7 Days a Week.	➢ Loss of Consciousness ➢ Seizures ➢ Chest Pain ➢ Severe Bleeding ➢ Trauma
Urgent		
Medical conditions that could result in serious injury or disability if medical attention is not received.	48 Hours or Less.	➢ Severe or Acute Pain ➢ High Fever in Relation to Age and Condition.
Non-Urgent/Acute		
Medical conditions that are symptomatic in nature but would not typically result in serious injury or disability.	Within 7 Calendar Days.	➢ Colds/Flu
Routine Primary Care		
Problems for chronic or ongoing medical problems.	Within 10 Working Days.	➢ Backache ➢ Suspicious Mole
Preventative Care		
Routine Exams.	Within 4 Weeks.	➢ Routine Health Assessment ➢ Well Baby Exam ➢ Annual Pap Smear

Additional Standards

- Participating providers are responsible for assuring access to services 7 days a week, 24 hours a day, 365 days a year other than in an emergency room for non-emergent conditions. This includes arrangements to assure patient awareness after hours to another participating provider. Coverage shall be provided in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care personally or to direct members to the setting most appropriate for treatment.
- The average wait times should be no more than 45 minutes for patients who arrive on time for a scheduled appointment.
- If a provider must cancel an appointment, the provider must make a good-faith effort to contact the member and reschedule for a later time.
- The provider's office should return a patient's call within 4-6 hours for an urgent/acute medical question and within 24 hours for a non-urgent issue.
- The provider shall notify the Customer Service Department if an Advanced Health member has repeatedly failed to keep scheduled appointments so that Advanced Health may determine if outreach services are appropriate.
- Participating providers agree to accept new patients unless his/her practice has closed to new patients from all health plans. Please notify Advanced Health in writing when your practice is closed to new patients and then again if the practice re-opens.
- Provider's offices and medical facilities must be equipped and maintained in accordance with the Federal Americans with Disabilities Act (ADA) of 1990. Site reviews will be conducted by Advanced Health to verify compliance with the ADA requirements, Federal and State laws and guidelines.

Participating providers will establish call-share arrangements with other participating providers when they are unavailable. In such situations, the call-share provider may bill Advanced Health for the services provided to the patient. If changes are made in call-share arrangements, please notify Credentialing Services at 541-269-7400. If you prefer to leave a voicemail, please include the name of the on-call provider and their direct contact information. NOTE: If the member presents to the emergency room without contacting the on-call physician, payment by insurer may be denied.

Important:

A tape-recorded telephone message instructing members to call a hospital emergency room is not sufficient for 24-hour coverage.

Closing Practice Policy

A PCP must not close their practice to Advanced Health members unless the PCP is closing their practice to all patients, regardless of insurance source.

PCP's who wish to close prior to meeting the assigned Advanced Health member volumes should forward a written request to the Customer Service Department explaining their reason(s) for closing at less than the standard member load.

- Following receipt of written notification of closing, Advanced Health will contact the PCP's office to verify receipt and the closure will be made internally within five (5) working days.

Locum Tenens Arrangements

Advanced Health requires written notification when a provider takes a leave of absence from their practice. Please contact Credentialing Services to discuss the details. If the provider is absent less than 90 days, then the locum may bill under the absent provider's name and with the correct billing modifier (-Q6) attached to the CPT code(s) as needed. If the provider is absent for more than 90 days, Advanced Health must be notified, as the locum is then required to go through the credentialing process.

Termination of Provider's Panel Participation

When a participating provider leaves SWOIPA, we are required to demonstrate a good-faith effort by notifying all Advanced Health members who were seen by the departing provider within 15 days of his/her termination notice. Advanced Health requests that participating provider provide as much notice of termination as possible as set forth in their contract.

If a participating provider terminates his/her contract with SWOIPA without cause, we require not less than a 30 days prior written notice.

Change of Information

Please notify Advanced Health if any of the following changes occur within your practice:

- Telephone Number
- Physical/Billing Address
- Tax ID Number
- Status of Advanced Health Membership

- Closing Practice
- Billing ID Changes

Applicability of Federal Laws

As a federal contractor, Advanced Health receives federal funds to provide services to our members. As a participating provider providing services to Advanced Health members, you are subject to laws applicable to individuals and entities receiving federal funds. Participating providers who treat our members are required to comply with all applicable state and federal laws and regulations regarding Medicare and Medicaid.

Medical Record Documentation Policies

Participating providers are required to safeguard patient-identifying information and to maintain records in manner consistent with State and Federal laws. If evidence of substandard medical record keeping is identified by random chart audit, the provider will be educated regarding the policy and further monitoring done as deemed necessary. Participating Providers are required to submit corrective action plans for non-compliant processes.

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

- All pages contain patient name;
- Address is contained in biographical/personal data;
- Telephone number is contained in biographical/personal data;
- Work telephone number is contained in biographical/personal data;
- Employer is contained in biographical/personal data;
- Marital status is contained in biographical/personal data;
- All entries contain author identification;
- All entries are dated. Every entry must contain complete date (mm/dd/yy);
- The record is legible;
- There is a complete medical condition list, which states significant illnesses, etc., single sheet prominently displayed;
- Medication allergies and adverse reactions to medications, or the lack of them (NKDA/NKA) is prominently displayed;

- There is an appropriate past medical history in the chart, which includes serious illness, surgeries, accidents, family history, and mental health history. This applies to patients seen three times or more and must be easily found within the record;
- If OB patient, there is an Oregon uniform prenatal record or its equivalent in the record. The form must be complete to current date;
- There is documentation of smoking habits and history of alcohol use and substance abuse. This applies to records of patients age 14 and older who have been seen three or more times, or who have been seen before the third visit for an annual health exam;
- There is pertinent history with subjective and objective reasons for presenting problem;
- There is a pertinent physical exam for presenting problem;
- Lab and other studies are ordered as appropriate;
- Working diagnosis is consistent with findings. Diagnosis is specific and clearly identified;
- Plans of action/treatment are consistent with diagnosis. Includes tests, medications, patient education, and ancillary services;
- The encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. (Includes hospital discharge planning when patient is hospitalized.);
- Unresolved problems from previous visits are addressed;
- There is evidence of appropriate use of consultants;
- If a consultation is requested, there is a note from the consultant in the record. All consultation, lab, and imaging reports filed in the chart or initialed by the primary care physician. (Includes hospital and ER records.);
- Consultation and abnormal lab and imaging study results have an explicit notation in the chart regarding follow up plans when appropriate;
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem. Includes tests, medications, and authorizations to consultants, treatments, preventive care, and follow-up;
- An immunization record has been initiated for children (10) ten years old and under or any appropriate history has been made in the medical record for adults;

- Preventive services are appropriately used;
- Medical records are organized, permitting effective patient care and quality review;
- All documents in medical record are securely attached in the chart;
- There is no more than one patient in each chart;
- There is documentation of patient education;
- If medications are prescribed, they are recorded on a medication sheet that is easily found and is current in the record or all current medications are listed in each chart note;
- All entries must be dated and legible, and must include author identification;
- All signatures must be full and legible and must include the title of the writer. The use of a rubber stamp to identify the signature of the practitioner is acceptable, if the provider has signed a statement saying they are the only one person who will use the stamp to sign a document. The statement must be kept on file in the provider's administrative office;
- A clinical entry must be made for every patient-provider contact;
- Should it be necessary to correct an entry in the medical record, the error should be crossed through one time with ink. The cross-through must be initialed and dated by the corrector. Do not write "error";
- A medical record shall not be permanently filed until it is reviewed and completed by a responsible practitioner; and
- Records may be removed from the care provider's jurisdiction and safety only in accordance with a court order, subpoena, or statute. All records are the property of the participating provider and shall not be taken away without the permission of the clinical site. Unauthorized removal of records by providers or the provider's staff is prohibited.

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

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

Records Retention

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

Submitting Encounter Data

Participating providers are required to submit to Advanced Health all data, including medical records, necessary to comply with CMS and MAP Encounter Data requirements. CMS also requires that Advanced Health and our contracted providers certify the completeness and truthfulness of their encounter data.

For questions regarding our encounter data requirements, please contact our Information Technology Department at 541-269-7400.

Regulatory Access to Books and Records

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

Participating Provider Site Review Criteria

Participating providers agree to participate in a site review, if requested by Advanced Health, and to abide by the recommendations given to them after the review. Below is a sampling of items that may be reviewed:

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

Quality Review and Compliance with Advanced Health's Practice Standards

All participating providers must cooperate with the requests and requirements of quality review organizations, such as Health Insight when such activities pertain to services for our members. Participating providers must also comply with Advanced Health practice guidelines, medical policies, Quality Assurance (QA) programs and medical management program. Advanced Health's policies also require that providers exchange appropriate information for coordinating care of members identified with special healthcare needs.

Primary Care Provider (PCP)

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

The PCP's responsibilities as the manager of the member's care are as follows:

- The PCP provides all primary preventative healthcare services except for an annual gynecological exam, should the member choose to seek this service from a participating women's health specialist or Obstetrician/Gynecologist;
- When specialized care is medically necessary, the PCP will facilitate an authorization to a specialist or specialty facility;
- The PCP must contact the Plan to obtain authorization to specialty providers, except in cases when an Advanced Health member has original Medicare as their primary insurance;
- The PCP will coordinate care and share appropriate medical information with the plan as well as with specialty providers to whom they refer their patients;
- The PCP will refer members for a second opinion at the member's request. Referrals to non-contracted providers require prior authorization from Advanced Health;
- The PCP will forward copies of the completed advance directive forms for their patients to the Customer Service Department and document in their patient's medical record whether or not an individual has executed an advance directive;
- The PCP will forward copies of the sterilization and hysterectomy form to the Advanced Health's Medical Management Department; and

- The PCP will adhere to the medical record standards that were developed and approved by the Ambulatory Record Certification Program of the Oregon Medical Association.

Discharging Patients from Your Practice

Definitions

- Discharge occurs when a member is removed from the care of their assigned PCP.
- Disenrollment is when a member is removed from their health plan.

Requirements

- Advanced Health must follow the guidelines established by the Department of Human Services (DHS) regarding dis-enrolling members from the plan.

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

- Advanced Health's philosophy is to encourage members and their providers to resolve complaints, problems, and concerns at the clinic level.
- Prior to discharging a member from a PCP, or prior to requesting that a member be dis-enrolled from Advanced Health, the PCP must request Advanced Health's assistance in resolving the issue.

Key Points When Considering Discharging a Member

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

1. Timely, early communication and collaboration with Advanced Health Customer Service staff and/or Advanced Health's Exceptional Needs Care Coordinator (ENCC) to problem solve.
2. Thorough documentation of events, problems and behaviors.
3. A plan generated by the PCP to attempt to address the problem or concerns.
4. Advanced Health strongly encourages the use of contracts and case conferences to address problems and concerns. Please call Customer Service for sample contracts and assistance.
5. Mental health diagnoses should be considered whenever discharging or dis-enrolling a member is being considered.

When a Member May be Discharged

A member may be discharged from a PCP only with just cause. The list of just causes, identified by DHS, include but are not limited to:

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

Note: The provider, or provider's staff must report any illegal act(s) to law enforcement authorities, or to MAP's Fraud and Abuse Unit as appropriate.

When a Member May Not be Discharged

According to HSD Administrative Rule 410-141-0080, members shall not be discharged from a PCP or dis-enrolled from Advanced Health solely because;

- The member has a physical or mental disability;
- There is an adverse change in the member's health;
- The PCP or Advanced Health believes the member's utilization of services is either excessive or lacking;
- The member has been diagnosed with End State Renal Disease (ESRD);
- The member requests a hearing;
- The member exercises their option to make decisions regarding his/her medical care, with which the provider or the plan disagrees; or

- The member displays uncooperative or disruptive behavior resulting from special needs (except when continued enrollment seriously impairs Advanced Health's ability to furnish services to its members.)

Reasonable Notice

When a physician discharges a member who is in need of continuing care at that time, the physician must take the following steps:

- Give reasonable notice of the intent to withdraw; and
- Provide the member with a reasonable time to find alternative care, and
- Continue to be available during this time to treat the member until the date indicated in the notice.

In most cases thirty (30) days' notice would be considered reasonable. If the basis for discharge of a member from your practice is for disruptive behavior or danger to other patients or staff, the period may be shortened to as little as one (1) day, depending upon the seriousness of the threat and our ability to either terminate the member from our plan, or to locate another panel provider willing to accept the member within the range of one (1) to thirty (30) days, considering both the severity of the patient's condition, and the availability of other care in the community within the time period selected. It is not necessary to indicate to the member why the relationship is being terminated.

NOTE: Please notify our Customer Service Department of the discharge at the same time the member is notified. A copy of the dismissal letter must be submitted to Advanced Health. Dismissal letters must include the reason for dismissal and notification to the member that the dismissing provider will provide urgent/emergent care for 30 days following notification to the member.

Process for Discharging a Member

Please follow the procedures/guidelines in this section to discharge a member from a PCP, or to request dis-enrollment of a member from Advanced Health.

PROCESS FOR DISCHARGING A MEMBER

Reason	Action
Missed Appointments	1. If a member misses an appointment, consider writing a letter to the member expressing the importance and expectations of keeping appointments and advanced notice of cancellation. 2. If member misses 2 appointments in a row after the initial office visit, or three appointments over a 6 month period, write a letter informing the patient that they must contact the clinic manager or designated staff person before further care is provided. 3. A meeting with the member should be held and a specific contract with clear expectations should be signed. A copy of this contract should also be faxed to the member's caseworker. 4. If the PCP decides to discharge the member, a letter should be sent to the member informing them of the discharge. PCP's are asked to provide urgent care for the discharged member for 30 days following member notification. The PCP must send a copy of the notification to Advanced Health Customer Service. 5. Relevant documentation, including chart notes, copies of letter(s) sent to the member, and signed contracts should be sent to Advanced Health. 6. Customer Service staff will work with the member to establish a new PCP.
Reason	Action
Drug Seeking Behavior	1. PCP meets with the member to develop a plan to address possible drug seeking behavior and documents the meeting. Substance abuse treatment may be considered at this time. 2. If behavior persists after the initial meeting, a medication contract should be established with the member. Sample contracts can be obtained from Advanced Health 's Customer Service Department. 3. Advanced Health Customer Service staff will coordinate a member care conference between all necessary parties. 4. PCP should document any contract violation in member's medical record. PCP should also notify Advanced Health Customer Service of the contract violation. 5. If the PCP feels that they are unable to manage the member's care, they must send a letter to the member informing them of their discharge. PCP's must provide urgent care for 30 days following notification to the member. A copy of the notification must be sent to Advanced Health Customer Service. 6. Advanced Health Customer Service will work with the member to establish a new PCP. 7. PCP should set expectation of tapering opioids for chronic pain patients by suggesting and prescribing non-opioid pain management modalities.

PROCESS FOR DISCHARGING A MEMBER

Reason	Action
Threats, Acts of Physical Violence and/or Fraudulent or Illegal Acts	1. Immediately contact the police to file an official report. 2. Contact Advanced Health Customer Service to describe the incident. Fax chart notes and police report when available to Advanced Health Customer Service at 541-269-2052. - If a member commits acts of violence to staff, property or other patients, member may be discharged; - If a member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation, member may be discharged. This includes, but is not limited to acts of theft, vandalism or forgery. 3. Advanced Health Customer Service may contact the HSD PHP Coordinator in writing to request disenrollment of a member. Documentation will be faxed to MAP. 4. Advanced Health Customer Service will inform the PCP of HSD's decision regarding the disenrollment request. 5. If HSD decides against disenrollment of the member, Customer Service will work with the PCP to plan for appropriate discharge process and establish the member with a new PCP. 6. If the PCP decides to discharge the member, a letter must be sent to the member informing them of the discharge. PCP must provide urgent care for the discharged member for 30 days following member notification. A copy of the notification must be sent to Advanced Health Customer Service.

Reason	Action
Verbal Abuse Justifying Discharge (including vulgar language and menacing tones)	1. Document incident(s). 2. At PCP's discretion, contact police to file an official report. 3. Contact Advanced Health Customer Service to describe incident. 4. Fax chart notes and police report to Advanced Health Customer Service. 5. Advanced Health Customer Service will contact PHP Coordinator to request disenrollment and fax documentation to HSD. 6. Advanced Health Customer Service will inform the PCP of HSD's decision. 7. If HSD decides against disenrollment of the member, Customer Service will work with the PCP to plan for appropriate discharge process and establish the member with a new PCP. 8. If the PCP decides to discharge the member, a letter must be sent to the member informing them of the discharge. PCP must provide urgent care for the discharged member for 30 days following member notification. A copy of the notification must be sent to Advanced Health Customer Service.

PROCESS FOR DISCHARGING A MEMBER

Reason	Action
Mutual Agreement Discharge	1. PCP documents the date and reason for mutual decision. 2. PCP faxes documentation to Advanced Health Customer Service describing the facts of the decision. 3. If discharge is mutually agreed upon, Advanced Health Customer Service works with PCP to plan for appropriate discharge process and establishing a new PCP. 4. If the PCP decides to discharge the member, a letter must be sent to the member informing them of the discharge. PCP must provide urgent care for the discharged member for 30 days following member notification. A copy of the notification must be sent to Advanced Health Customer Service.
Reason	Action
Mutual Agreement that Adequate, Safe and Effective Care Can No Longer be Provided	1. PCP documents the date and reason for mutual decision. 2. If the PCP decides to discharge the member, a letter must be sent to the member informing them of the discharge. PCP must provide urgent care for the discharged member for 30 days following member notification. A copy of the notification must be sent to Advanced Health Customer Service. 3. Advanced Health Customer Service will work with the member to establish new PCP.

Wavier for Non-Covered Services

HSD requires providers to use the 3165-waiver form to use before they treat and bill a member for a service not covered by Advanced Health. The waiver, which will be completed/signed by the provider and signed by the member, gives the member information about the service they will be receiving and paying for, including:

- The condition being treated;
- The estimated charges; and
- The expected date of service;
- Other kinds of potential charges, such as lab costs, x-rays, and other care

A copy of the waiver is provided at the back of this manual. Services that are not supported by a diagnosis or established coding guidelines, or services that require authorization, or are submitted untimely may be denied as provider responsibility.

Advance Directive

An Advance Directive is a document that allows adult patients to express and control their healthcare needs at a time when they are unable to make decisions.

The Advance Directive is a legal document that has two parts. The first part is called "Health Care Instructions" and lets the patient control the medical treatment they may receive and under what specific circumstances they receive them. The second part is called "Appointment of Health Care Representative" and allows the patient to select another adult as their decision-making representative.

Adult Advanced Health members receive Advance Directive forms upon enrollment and are advised to review it with their PCP and to complete the form if they find it pertinent to their medical situation or possible future medical situation. Copies of the Advance Directive can be obtained on our website at www.advancedhealth.com or by calling Customer Service at 541-269-7400.

Voluntary Sterilization (Form Number: OHP 742A or 742B)

Voluntary sterilization is a covered service for Advanced Health members. In accordance with MAP rules, Advanced Health requires the completion of a "Consent to Sterilization" form (HSD 742) for all sterilizations. The provider performing the sterilization procedure is responsible for the following:

Obtaining a signed HSD Consent to Sterilization from members ages 15 and over (parent or legal guardian must sign for a child that is less than 15 years old). This must be done at least 30 days, but no more than 180 days prior to the date of sterilization except as outlined below:

- In the case of premature delivery by vaginal or cesarean section, the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement.

- In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before sterilization was performed.

The consent form must be signed and dated by the person obtaining the consent after the patient

has signed, but before the date of the sterilization. If an interpreter assists the patient in completing the form, the interpreter must also sign the consent form where indicated.

When an Advanced Health member signs a HSD "Consent to Sterilization" form (HSD 742) it must be an informed choice and the patient must be legally competent to give informed consent. The consent is invalid if it is signed when the patient is in labor, seeking or obtaining an abortion, under the influence of alcohol or drugs, or if the form was signed less than 30 days prior to the procedure.

The physician performing the procedure must complete the physician statement in its entirety. The physician must sign and date the consent form on the date of the procedure or following the procedure. Completed consent forms may be submitted to Advanced Health prior to billing or along with the claim.

Consent to Sterilization forms can be found by visiting the Oregon Health Authority's (OHA) website at: http://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx?2131=%7B%22filter%22%3A%22741%22%7D

Hysterectomy Consent Form (Form Number: OHP 741)

Advanced Health requires physicians to obtain a signed HSD hysterectomy consent form prior to surgery. There is no required waiting period between signing the hysterectomy consent form and surgery. The method for completing the consent form will vary based on the following criteria:

- Woman is Capable of Bearing Children: Physician must obtain informed consent from the member prior to the surgery. Member must sign and date the consent form prior to the date of surgery.
- Woman is Sterile Prior to Hysterectomy: Physician performing the hysterectomy must clarify in writing that the woman was sterile prior to hysterectomy. Reason for hysterectomy must also be clarified.
- Life Threatening Emergency in which Prior Acknowledgement is Not Possible: Physician performing the hysterectomy must clarify in writing their determination that prior acknowledgement was not possible and that the hysterectomy was performed under a life threatening, emergent situation. Completed consent form may be submitted to Advanced Health prior to billing or along with the claim.

Consent to Hysterectomy forms can be found by visiting the Oregon Health Authority's (OHA) website at: http://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx?2131=%7B%22filter%22%3A%22741%22%7D

Authorizations

Overview of Authorization Process

Medical services that have been identified as high cost or highly utilized require authorization from Advanced Health prior to the service being rendered. Some services may require review for medical necessity prior to approval. To assist providers with this determination, authorization and clinical review requirements have been defined that clearly define procedures, treatments, surgeries and other health related items that require further review. Please refer to Advanced Health's authorization grid for more detail.

An authorization may be required if Advanced Health is secondary to primary health coverage. Advanced Health is a payer of last resort unless the member also has Indian Health coverage. If a member has Indian Health, Advanced Health will become primary coverage. If an authorization is required, but was not obtained prior to services being rendered, the service may be denied. Pease refer to the Advanced Health authorization grid for more details.

Reimbursement may be considered for non-covered services under the primary carrier's benefit plan, if the service is a covered benefit under OHP and has a linking covered diagnosis.

Providers must remember that services and diagnoses must be paired and identified as covered or "above the line" per the current Prioritized List to be considered for payment. Please refer to the most current Prioritized List at: http://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

Emergency Room Usage

Please refer to Advanced Health's authorization grid for further information. Emergency care is covered 24 hours a day, 7 days a week. Emergency medical conditions must have symptoms that are severe or life threatening. Members should not utilize the emergency room for care that could take place in the provider's office. Routine care for sore throats, colds, flu, back pain and tension headaches are not considered an emergency.

Observation Utilization

Authorization is required for observation room stays, except for Obstetrics.

- Observation: A stay in a hospital facility for less than 48 hours not resulting in an inpatient admission, in which documentation of the patient's condition clearly establishes the need for high level observation and monitoring by medical personnel. An outpatient observation which exceeds 48 hours must be billed as inpatient.

Required Information for Authorization

The following information is required for authorizations:

- Patient Name
- Name of Referred Provider
- Primary Diagnosis Codes
- Chart Notes Attached
- Primary Care Physician
- Date(s) of Service
- Procedure Code(s)
- Length of Stay (Inpatient Authorizations)

If the requested procedure, treatment, or surgery requires clinical review, the information received will be forwarded for clinical review by Advanced Health's Medical Director. The requesting provider may be asked to provide additional documentation that will support the need for the service(s) requested.

Authorization Process

Providers may advise members of treatment options. Members have the right to participate in decisions regarding their health, which includes the right to refuse treatment.

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

Authorization is not a guarantee of payment. Payment depends upon member eligibility on the date of service, contract terms and compliance with rules, regulations and policies of Advanced Health and HSD as applicable.

Requirements:

- The Primary Care Provider (PCP) is accountable for all authorizations. Although Advanced Health will accept clinical data from any source, the PCP must still approve the authorization.
- A specialist provider with a valid authorization from the member's PCP may request additional follow-up services from Advanced Health with proper documentation showing the need for follow-up.
- A specialist provider may see a member without an authorization if the member was seen in the ER within the past seven days and referred for specialty care. If the specialist sees the member outside of that time frame, an authorization is required.
- The PCP or specialist office may choose to complete and fax the Advanced Health Physician

Authorization Request to Advanced Health at 541-269-7147, or the form can be mailed to Advanced Health, Attn: Medical Management, 289 Laclair Street, Coos Bay, OR 97420.

- Upon completion of the authorization, approved services will be given an authorization number. This number must be included on the claim when submitted.
- The PCP is responsible for relaying the outcome of the authorization and authorization number to the requested provider or facility.
- Authorization numbers can be located on our provider portal at: www.docshp.com.

Authorization to a Specialty Provider

In cases where an authorization to a specialist is required, the PCP will refer the member's care to the specialist. Routine specialty services are eligible for reimbursement only with an approved authorization from Advanced Health. Authorizations for services related to OB care, family planning, immunizations, women's health exams, HIV/AIDS testing and prevention do not require an authorization. In addition, no authorization is required for physician services or surgical services provided by a participating provider in Oregon if the primary diagnosis is HIV/AIDS.

The PCP must complete an authorization as outlined in Advanced Health's authorization grid. The specialist should verify than an authorization has been approved. It is not the responsibility of the member to obtain an authorization number from their PCP prior to receiving services from a specialist to which they have been referred. The specialist and PCP are responsible for completion of the authorization process.

A provider may contact Advanced Health to verify authorization status. Please contact Advanced Health at 541-269-7400 to check the status of the authorization request. Contracted specialty providers have the responsibility to treat members within the scope of their practice, ensure that the authorization is in place prior to treating the member and coordinate care between the member, PCP and Advanced Health.

Specialist as PCP

A specialist may consider becoming the PCP for an established patient if the specialist is willing to assume all the responsibilities of a PCP for the member. If you would like to become a PCP, please contact Advanced Health's Customer Service Department at 541-269-7400 to request PCP status for an individual member.

Pharmacy Authorizations

Medications that are listed on Advanced Health's drug formulary and/or for which the member has a covered diagnosis are covered. Some medications may have step edits, age or quantity restrictions that may apply. Advanced Health updates the formulary on an annual basis. The current formulary and pharmacy authorization form can be found on our website at www.advancedhealth.com.

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

- Generic Medications: Advanced Health has a mandatory generic medication plan. Generic medications should always be substituted by the pharmacist if one is available for a name brand.
- Non-Formulary Medications: An authorization request is required for medications that are not listed on Advanced Health's formulary. If a prescription for a non-formulary medication is written after hours or on the weekend, pharmacies are instructed to provide a three-day supply and are to submit an authorization on the next business day. Pharmacies are encouraged to call the MedImpact Help Desk at 1-800-788-2949 for assistance at any time.
- Discharge Medications: Please refer to Advanced Health's formulary when prescribing discharge medications. Medications not listed on the formulary must be authorized. If an authorization cannot be obtained, then a five-day supply should be provided so that a prior authorization can be obtained from the physician. You can also contact our Pharmacy Help Desk at 800-788-2949.
- Specialty Medications: Specialty medications, such as injectable medications are dispensed through Bioscrip Pharmacy. You may contact US Bioservices at 1-888-518-7246.
- Help Desk: MedImpact is Advanced Health's Pharmacy Benefits Management (PBM) company. They help us monitor our drug utilization and process pharmacy requests for medication. Please feel free to contact the Help Desk with any questions: 1-800-788-2949.

When requesting authorization for medications, please to use the medication authorization form which can be found on our website at www.advancedhealth.com. The form can be faxed to our Pharmacy Department at 541-269-7147.

Retroactive Authorization Guidelines

In order to be considered for approval, the authorization must be determined to be medically

necessary and appropriate. Retroactive requests will be reviewed for approval under the following conditions:

- The request must be received within 30 days of the date of provision of the service. Providers must provide the reason that the authorization was not requested in a timely manner;
- The member is eligible on the date of service;
- The service and diagnosis are paired and considered above the line in accordance with the Prioritized List and are covered under the member's OHP benefit package; and
- Retroactive authorizations will not be granted for pharmacy benefits without a justified reason.

If your office has billed and received an EOB from Advanced Health denying payment for a claim, or an acknowledgement of denial of pharmacy benefits, then you may ask for a provider appeal if you do not agree with the decision. Provider appeal request forms are located in the back of this manual. Please forward appeals to: Advanced Health, Attn: Provider Appeals, 289 Laclair Street, Coos Bay, OR 97420. You may also fax an appeal with any supporting documentation to 541-269-7147.

Care Management

Overview of Care Management Program

A small but significant portion of the population served by Advanced Health will require a greater than normal amount of available resources. Care Management services are offered as a resource to providers by Advanced Health Care Managers who can assist in managing the care of members with complex medical and social needs. Early identification of these members can significantly impact the cost associated with their care, increasing quality of care and member satisfaction. Under the Oregon Health Plan, these services are referred to as Exceptional Needs Care Coordination (ENCC), or Intensive Care Management (ICM).

Care Management services include maternity care management, disease management, care coordination and substance use disorder treatment. Our Care Managers ensure that the member receives the appropriate services within a timely manner.

Identifying Members in Need of Care Management

Members may be referred to Care Management through a variety of sources, including direct referrals from providers, contacting Advanced Health directly, through the clinical review process,

claims data or authorizations from inpatient and outpatient utilization review nurses. Members who may benefit from case management may include:

- Patients with a newly diagnosed chronic condition, such as diabetes mellitus;
- Patients in an acute phase of illness requiring coordination of multiple services;
- Patients with unstable chronic illness; and
- Patients identified by health risk assessments.

After a member has been referred to Care Management, the Care Management nurse conducts a thorough and objective assessment of the member's current health status. Using this data, the nurse identifies the immediate, short and long term needs of the member.

Maternity Care Management

Providers may notify Advanced Health when a member becomes pregnant and receive $10.00 for the notification. A pregnancy notification form can be faxed to Advanced Health at 541-269-7147. The form must be submitted within two weeks of the pregnancy test or office visit. The pregnancy notification form can be found on our website at www.advancedhealth.com. Women who are uninsured must sign a release of information. Members can call local contracted OB providers to make an appointment and call our Customer Service Department to be assigned at 541-269-4552. Members are sent a brochure encouraging them to obtain prenatal care, along with a list of available support services.

Role of Care Manager

- Monitor all aspects of care
- Evaluate alternatives to care
- Develop a problem list
- Coordinate care
- Document care information and actions taken
- Coordinate care with community resources

Member education is provided on a variety of topics and may include general information about disease processes, an analysis of medication usage for compliance, or plan specific information on routine preventative health screening as well as screening for disease related complications. Member education may occur in a variety of settings using various resources depending on the member's individual needs:

- Whenever possible, members will be apprised of disease specific, community based educational opportunities. This information will be made available to members on Advanced Health's website, through mailings and other resources.

- Disease prevention and disease specific information will be included in member newsletters and on Advanced Health's website.

- One on one meetings (Care Conferences) with Care Managers and any other health care providers or case workers involved in the member's health care.

Claims

General Claims Information

As a participating provider, you agree to submit claims for Advanced Health members on the CMS-1500 Health Insurance Claim Form. Facilities such as hospitals and surgery centers must bill on a UB-04. All applicable information should be completed in full, including CPT codes, ICD-10-CM diagnosis codes and applicable medical records to support the use of modifiers or unlisted codes as needed to ensure payment is made accurately and without delay. All completed claim forms should be forward to the following address for processing: Advanced Health c/o Claims Dept., PO Box 705, Elk Grove Village, IL 60009

Advanced Health will process claims in an accurate and timely manner to provide quality service to our members and providers and to effectively manage healthcare premium dollars. Advanced Health requires that claims be submitted either on an original standard CMS-1500 claims form or an UB-04 claim form. The following describes the appropriate claim form by type of provider or service:

- Hospital claims shall be billed on the UB-04 using HSD billing rules for Advanced Health;

- Physician claims shall be billed on the CMS-1500 using HSD billing rules for Advanced Health;

- All other claims (except Pharmacy) shall be billed on the CMS-1500 according to HSD rules for Advanced Health members. Advanced Health will work with providers to ensure proper billing; and

- Pharmacy claims are managed by MedImpact.

With the advent of encounter data collection by CMS and HSD, health plans doing business with the State and Federal government (such as Advanced Health) are required to report to the most specific ICD-10 digit on all CMS-1500 and UB-04 forms. Not only is coding specificity and accuracy extremely important, but placement of the information in the appropriate box on the forms has become critical.

The following is a brief overview of the coding rationale:

- Offices and hospitals will benefit if they submit claims with accurate coding. It is likely that a claim will not be rejected by Advanced Health for coding errors if coding procedures are accurately followed. This will aid in a quicker turn-around time and the need to re-bill will be minimized.
- HSD and CMS use the encounter data captured from the claims submitted on CMS-1500's and UB-04's to establish risk scores for members enrolled in the various health plans. CMS and HSD reimbursement will then be determined from risk scores. Plans with enrolled members that are documentarily proven to be "sicker" will receive high reimbursement. However, risk adjustment works only with complete and accurate data received by you, the provider.

The scores are established based on encounter data obtained from CMS-1500's and UB-04's submitted by the plans. Many plan's scores do not reflect the true risk of their enrolled members. Therefore, capitation payments will be reduced to reflect the lower scores and most of the reduction will unfortunately be passed on to the providers and hospitals in the form of reduced payments.

General Claims Information

Participating providers must submit claims to Advanced Health within 120 days from the date of service to facilitate collection of encounter data and effective utilization management. Initial claims must be submitted to Advanced Health within 120 days from the date of service, except under the following circumstances:

- Global maternity care may be billed within 120 days from date of delivery;
- When Advanced Health is secondary, the 120-day time frame starts from the date printed on the primary insurance carrier's Explanation of Benefits (EOB) provided such claim was submitted in a timely manner to the carrier and the carrier has not rejected the claim for untimely submission;
- Billing is delayed due to eligibility issues (retroactive eligibility initiated by the State);
- Cases involving Third Party Recovery; and
- Other circumstances in which there are reasonable grounds for delay (which does not include a provider's failure to verify the member's HSD eligibility).

Advanced Health is always the payer of last resort, except for Indian Health Services. If the member has other healthcare coverage, bill the primary carrier prior to billing Advanced Health. When Advanced Health is secondary, submit the claim with a copy of the primary insurance carrier's EOB. The EOB must clearly show the printed date on the primary carrier's EOB.

Correctable claims that have been denied by Advanced Health can be resubmitted within 120 days from the date of denial. Please clearly mark the claim as "Corrected Claim" to aid in proper handling.

Billing Guidelines

Advanced Health follows HSD and Medicare guidelines for all lines of business. Below are some more common Medicare guidelines that are used in billing claims:

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

Standardized Billing

Provider claims will be accepted for processing when services are billed in a standardized format. Claims received with more than one rendering provider's services billed on the claim will be returned to the billing provider's office for correction and resubmission.

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

Standards: 1) The rendering provider's name should appear in Box 31 of the CMS-1500; 2) The HSD ID# and NPI should be shown in Box 24J; 3) The vendor's name, address and phone number must be shown in Box 33; 4) Vendor's NPI in Box 33A; and 5) Federal Tax ID in Box 25.

External Causes of Injury, Poisoning and Other Adverse Events (E-Codes)

These codes are used in addition to ICD-10 diagnosis codes when there is an environmental event, circumstances and/or conditions that are the cause of injury, poisoning and other adverse events.

Modifiers

A modifier indicates that a service or procedure has been altered by some specific circumstance but does not change in its definition or code. To ensure you receive the most accurate payment for services rendered, Advanced Health recommends using modifiers when claims are filed. Modifiers should always be used, when applicable by placing the valid CPT or HCPCS modifier(s) in Block 24D of the CMS-1500 claim form. A complete list of valid modifiers is listed in the most current CPT or HCPCS code book. Please ensure that your office is using the current edition of the code book reflective of the date of service of the claim. If necessary, please submit medical records with your claim to support the use of a modifier.

Modifier Guidelines

The table below lists many of the modifiers that Advanced Health accepts. If you have any questions about billing modifiers, please call the Claims Department for further details.

CPT/HCPCS Modifiers	Description	Advanced Health Use
24	Unrelated evaluation and management service by the same physician during a postoperative session	Pays separate allowable.
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	Pay separate allowable.
26	Professional component	Pays professional component of the allowable charge when billing separately for the professional component of a service.
50	Bilateral procedure	Payment based on 150% of allowable charge for applicable codes.
51	Multiple procedure	Generally pays primary or highest allowable at 100% of allowable charge, 2nd and 3rd procedure at 50% of allowable charge and the rest at 25% of allowable charge.
52	Reduced services	Pays only the portion that was actually performed (i.e. preoperative, intra-operative, or post-operative care Medicare factor) or a combination thereof.
55	Post-operative management only	Allowable charge will be adjusted based on the current allowable charge and the pre-operative Medicare factor.
56	Pre-operative management only	Allowable charge will be adjusted based on the current allowable charge and the pre-operative Medicare factor.
57	Decision for surgery	Pays separate allowable charge.
62	Two Surgeons	If allowed, pays 62.50% of allowable to both surgeons.
78	Return to the operating room for a related procedure during the post-operative period.	Allowable charge will be adjusted based on the current allowable charge and the intra-operative Medicare factor.
80	Assistant Surgeon	Pays 16% of allowable charge for applicable codes.

CPT/HCPCS Modifiers	Description	Advanced Health Use
81	Minimum assistant surgeon	Pays 16% of allowable charge for applicable codes
82	Assistant surgeon (when qualified resident surgeon is unavailable)	Pays 16% of allowable charge for applicable codes
AL	Nurse practitioner, non-rural, team member	Pays 85% of allowable charge.
AN	PA services for other than assistant-at-surgery, non-team member	Pays 85% of allowable charge
AS	Physician assistant, or nurse practitioner assist at surgery	Pays 85% of the assistant surgeon allowable charge (which equals 13.60% of the allowable charge for applicable surgical codes)
NU	New equipment	Payment based on purchase allowable charge
RR	Rental	Payment based on rental allowable charge up to purchase allowable charge
S	Stat laboratory test	Pays 100% of allowable charge
Q6	Locum tenens provider	Pays 100% of allowable charge
TC	Technical component	Pays the technical portion of the allowable charge when billed separately for the technical component of a service
W	Waived test	Pays 100% of allowable charge

Billing Modifiers -24, -25 and -52

When using modifiers -24 (unrelated evaluation and management service by the same physician during the post-operative sessions), -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), or -52 (reduced services), please attach a medical or operative report and an explanation of why the modifier is being submitted or copies of applicable medical records. Without this information, the modifier will not be recognized, and the standard allowable charge will be applied without review or consideration of the modifier.

Radiology, Pathology and Laboratory

Modifiers are used to report both the professional and technical components for radiology, pathology and laboratory services. Professional component only, or technical component only codes do not

require modifiers -26 or –TC.
Modifier rules:

- Use modifier -26 when billing separately for the professional component of a service;
- Use modifier –TC when billing separately for the technical component of a service;
- Total component (global) billing does not require a modifier;
- To ensure prompt and correct payment for your services, always use the appropriate modifier.

When billing for diagnostic and therapeutic hospital-based physician services, you should only bill the professional component on the CMS-1500 claim form. Advanced Health will not reimburse technical components associated with hospital inpatient and outpatient services.

The technical and/or professional components for all radiology and other imaging services may be billed by the physician only if they render the service. The physician may not bill Advanced Health for the technical and/or professional component of any diagnostic test or procedure, including but not limited to, X-rays, ultrasound, or other imaging services, computerized axial tomography, or magnetic resonance imaging by utilizing another entity's provider number. The referring provider may not receive compensation, directly or indirectly, from the provider who rendered the service.

Equipment, Devices and Supplies

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

Code Editing: Billing Practices Subject to Reduction

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

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

Co-surgery is defined as two surgeons of different specialties operating together to perform a single surgery, expressed under one CPT® code. Advanced Health allows 125 percent of the allowable

charge, which is divided equally. Additional surgical assistants are not covered.

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

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

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

Claim Form (CMS-1500) Instructions for Completion

1. Type of Health Insurance: Indicate coverage applicable to this claim by checking the appropriate block: a) Insured Members ID Number – Enter the member's HSD identification number exactly as it appears on the HSD medical identification.
2. Patient's Name: Enter the full name of the individual treated.
3. Patient's Date of Birth: Indicate the month, day and year. Sex –X in the appropriate field.
4. Insured Person's Name: Enter the name from the identification card, except when the insured and the patient are the same individual; then the word "same" may be entered.
5. Patient's Address: Enter the patient's current mailing address and phone number.
6. Patient's Relationship to Insured: Place an X in the appropriate field. *Self* – Patient is the subscriber. *Spouse* – Patient is the subscriber's spouse. *Child* – Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes step-children). *Other* – Patient is subscriber's grandchild, adult-sponsored dependent, or is a dependent of a relationship which was not previously covered.
7. Insured's Address: Enter the complete address, street, city, state and zip code of the policy

holder. If the patient's and insured's addresses are the same, enter "same in the field.

8. Patient Status: Check the appropriate box for the patient's marital status and whether employed or a student (single, married, other, employed, full-time student, part-time student).
9. Other Health Insurance Coverage: If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).
10. Is the Patient's Condition Related to: a) Employment (current or previous); b) Auto Accident; or c) Other Accident. Check the appropriate box where applicable.
11. Not Required.
12. Patient's or Authorized Person's Signature: Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or "signature on file" and date required. "Signature on file" indicates that the signature of the patient is contained in the provider's records.
13. Insured's or Authorized Person's Signature: Payment for covered services is made directly to providers. Acceptable language for this field includes: A) Signature in block; B) Signature on file; C) On file; D) Benefits assigned; E) Assigned; F) Pay provider.
14. Date of Current: Enter the date of the first illness, injury or pregnancy.
15. Same or Similar Illness or Injury: Indicate appropriate date(s).
16. Date of Disability: Enter dates, if applicable.
17. Name of Referring Physician: Enter the referring physician's complete name, if applicable. A) Enter the referring physician's Medicare UPIN or HSD ID number.
18. Services Related to Hospitalization: Enter admission and discharge dates to/from hospital.
19. Reserved for Local Use: This block is available to billing providers to supply additional information (i.e., drug NDC numbers, special requests, etc.)
20. Laboratory Work Performed: Enter if applicable.
21. Diagnosis or Nature of Illness or Injury: Enter the ICD-10-CM code and/or description of the diagnosis.
22. Not required.
23. Authorization Number: Enter the authorization number obtained from Advanced Health, if

applicable.

24. A) Dates of Service: Enter the "from" and "to" date(s) for services rendered.
    B) Place of Service: Enter the appropriate place of service code. Place of service codes include: ASC =24, Inpatient =21, Office =11, Outpatient =22.
    C) Type of Service: Enter the type of service code that represents the services rendered
    D) Procedures, Services or Supplies: Enter the appropriate CPT or HCPCS code. *Please ensure your office is using the most current CPT and HCPCS codes. Append modifiers to the CPT and HCPCS codes when appropriate.
    E) Diagnosis Code: Enter the numeric code that corresponds with the diagnosis code in block 21 when more than one diagnosis is given. Refer to the procedure for diagnosis codes guidelines section for more information.
    F) Charges: Enter the total charge for each service rendered. You should bill your usual charge to Advanced Health regardless of our allowable charges.
    G) Days or Units: Indicate the number of times the procedure was performed, unless the code description accounts for multiple visits, or the number of visits the line item charge represents.
    H) Not required.
    I) NPI –ID Qualifier: (1D = HSD ID Qualifier) NPI = NPI Qualifier.
    J) Upper Area: MAP ID Required. Lower Area: NPI Number Required.

25. Federal Tax ID Number: Enter the provider's clinic's federal tax identification number to which payment should be reported to the Internal Revenue Service.

26. Patient's Account Number: Enter the patient's account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Explanation of Benefits (EOB) only if it is indicated on the claim form.

27. Accept Assignment: Not applicable.

28. Total Charge: Total of all charges in Item F.

29. Amount Paid: Not required unless there is primary insurance that has paid. If so, indicate the total amount paid by the primary carrier.

30. Balance Due: Enter the total amount due.

31. Signature of Provider: Provider's signature required, including degrees and credentials.

32. Name and Address of Facility: Required, if services were provided at a facility other than the

physician's office. a) Facilities' NPI number.

33. Physicians, Suppliers Billing Name, Address, Zip Code and Phone Number: Enter complete name, address, telephone number and HSD provider ID. If the provider is a solo practitioner, enter the NPI provider ID number in the "a" area. If the provider is part of a practice, also enter the practice's NPI number in the "b" area.

Coordination of Benefits (COB)

Other health insurance coverage information is important in the Coordination of Benefits (COB) process. COB occurs when a member is covered by two or more insurance plans. Providers can assist in the COB process by asking the Advanced Health member if they have other coverage. This information can be indicated in block 9 of the CMS-1500 claim form.

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

Claims must be received no later than 120 days from the primary carrier's EOB date. Upon receipt of payment, any balance remaining should be submitted to Advanced Health, accompanied by the primary carrier's EOB. In accordance with HSD rules for COB, Advanced Health will calculate benefit reimbursement by using the Advanced Health allowed amount or the primary carrier's allowed amount (whichever is less) minus the primary carrier's payment. In some instances, the primary carrier's payment exceeds the allowed amount or the primary carrier's payment is 100% of allowable. When this happens, the balance will appear on your Advanced Health remittance as a provider write-off. The patient cannot be billed for this amount.

Third Party Resources/Third Party Recovery (TPR)

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

- Private Health Insurance
- Medical Support from Absent Parents
- Medicare
- Court Judgements or settlements from a liability insurer.
- Employment Related Health Insurance
- Workers' Compensation
- Auto Insurance
- Federal Programs, unless excluded by statute.

Under OAR 410-120-1280, Section 14, Third Party Resources, Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Department of Medical Assistance Programs will be the payer of last resort. Therefore, Advanced Health is the payer of last resort when there is other insurance or Medicare is in effect for its members. Advanced Health is required by HSD to pursue recovery of Third Party Resources when it is found that an Advanced Health member has other coverage. If Advanced Health has paid claims for a member, and then upon further investigation finds that the member has other healthcare coverage at the time of service, Advanced Health will recoup the monies paid to the provider that furnished the service.

NOTE: For Workers Compensation cases that have been paid by Advanced Health, regardless if the WC carrier has paid for services or not, Advanced Health will recoup monies from all providers that have submitted claims and were paid. Providers may bill Advanced Health with an itemized claim with a copy of the "Medical Bill Analysis" from the workers compensation carrier, or after a final denial/determination from the WC carrier has been issued. The documentation date must match the date of service on the CMS-1500 form or UB-04.

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

Anesthesia Billing Guidelines

Anesthesia services billed by anesthesiologists or CRNA's must be filed using the appropriate anesthesia CPT code (beginning with "o"). One of the following modifiers must be submitted with each anesthesia service billed. The modifier billed will not affect the allowable, it will only be used for data analysis purposes; however, failure to submit one of the modifiers may result in a returned claim. Clinical editing is applicable to all anesthesia services. Advanced Health processes claims based on CPT and time units from the RVU Guide for Anesthesia.

Anesthesia Modifier Description

- AA Billed by physician when personally providing the anesthesia service.

- AD Medical supervision by a physician; more than four concurrent anesthesia procedures.

- QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- QX Billed by CRNA when providing the anesthesia service while being supervised by physician.
- QY Billed by physician when supervising a CRNA providing the anesthesia service.
- QZ Billed by CRNA when providing unsupervised anesthesia services.

To ensure proper reimbursement when billing for anesthesia services, anesthesiologists and CRNA's must include:

1. Number of minutes of administration;
2. CPT anesthesia (00100-01999) codes with one of the above required modifiers, plus any additional modifiers as appropriate;
3. ASA modifier codes(s) for physical status and qualifying circumstances, if appropriate.

Definitions

Base Units: The base unit is the value assigned to each CPT code and includes all usual services, except the time actually spent in anesthesia care and the qualifying factors. This usually includes pre-op and post-op visits. When multiple anesthesia services are performed, only the anesthesia service with the highest base unit value should be filed with total time for all services reported on the highest base unit value code.

Time Units: Anesthesia time must be reported in ASA Relative Value Units with a remark stating total case time. Per the ASA's Relative Value Guide, "anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision." No additional time units are payable for add-on codes; therefore, total time must be reported on the primary procedure code. In the case where multiple procedures are performed, time for lower base unit value codes should be reported on the highest base unit value code.

The number of time units is calculated using the following table:

1 minutes	-	15 minutes	=	1 unit
16 minutes	-	30 minutes	=	2 units
31 minutes	-	45 minutes	=	3 units

46 minutes	-	60 minutes	=	4 units
61 minutes	-	75 minutes	=	5 units

Nerve Blocks: All nerve blocks require authorization prior to the services being rendered with the exception of CPT codes 64415, 64447 and 64450. These codes do not require authorization when performed in conjunction with the orthopedic CPT codes listed below:

23120	Claviculectomy; partial
23130	Acromioplasty or acromionectomy, partial
23412	Repair of ruptured rotator cuff; acute
23455	Capsulerrhaphy, anterior with labral repair (Bankart procedure)
23700	Manipulation of shoulder joint under anesthesia
27447	Arthroplasty, total knee
29822	Arthroscopy, shoulder, debridement, limited
29826	Arthroscopy, shoulder, decompression of subacromial space
29877	Arthroscopy, knee, diagnostic, with chondroplasty
29881	Arthroscopy, knee, diagnostic, with meniscectomy
29888	Arthroscopically aided anterior cruciate ligament repair

Post-Operative Pain Management

Post-operative pain management services require authorization. The use of epidurals for post-operative pain management (including, but not limited to: CPT codes 62318, 62319 and 01996) will be covered without authorization, when the following criteria is met:

1) Major intra-abdominal, retroperitoneal, intrathoracic, hip or lower extremity surgery (major surgery is defined as surgery that is not laparoscopic surgery and involves a large incision);
2) The member has a confirmed oncology diagnosis; and/or
3) The member falls under the category of ASA physical status codes: P3, P4 or P5.

Management of epidural or subarachnoid drug administration (CPT 01996) is separately payable on dates of service subsequent to surgery, but not the date of surgery. If the only service provided is management of epidural/subarachnoid drug administration, then an evaluation and management service is not allowed in addition to CPT code 01996. Payment for management of epidural/subarachnoid administration is limited to one per day, up to four days, with authorization.

Other Covered Services

If the authorized surgical procedure being performed is on the list of approved CPT codes for nerve blocks and further post-operative pain management services (CPT 01996) are also being performed, no authorization is required for the epidural or subarachnoid drug administration.

Reimbursement

Allowable Charges

Advanced Health reimburses participating providers based on allowable charges. The allowable charge is the lesser of the submitted charge or the amount established by Advanced Health as the maximum amount allowed for provider services covered under the terms of the OHP benefit package(s) when linked with a covered diagnosis.

Claims Reimbursement Timeframe

In accordance with Advanced Health's contract with the Oregon Health Authority, Advanced Health processes claims as follows:

Claim Validity: Determination of claim validity will be performed by Advanced Health within 45 days of receipt (all claims are date stamped upon receipt). If there is insufficient information to process the claim, the claim can be pended up to 15 days to obtain additional information.

Claim Processing: Claims shall be paid or denied within 60 days of receipt.

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

Claim Review Guidelines

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

Electronic Billing Guidelines

Advanced Health receives both professional and institutional claims electronically. Submitting your claims electronically is more cost-effective and reimbursement turn-around time is approximately 30% faster than submitting paper claims.

Health Information Portability and Accountability Act of 1996 (HIPAA): Transactions and code sets standards mandate that electronic healthcare claims submitted from a provider to a payer must be in a standard 837-4010 format. Advanced Health is currently accepting 837-4010 HIPAA compliant claim transactions directly from provider offices.

Technical Requirements: To submit your HIPAA compliant claim transactions directly to us, you must be able to create an 837-4010 professional or institutional claim transaction. You must have an internet connection and a secure FTP (SFTP) client capable of using SSH2. You also need a printer attached to your system or available through your office network in order to generate your receipts. Advanced Health's Information Technology (IT) Department can assist you with questions you may have regarding electronic billing. This applies to both paper and electronic submissions.

Request for Claim Reconsideration

Many claims are denied due to lack of pertinent information, improper coding or other administrative errors. Claims can be submitted for reconsideration if done within 120 days from the original denial date. You may send your claims via fax, mail or by contacting the Claims Department. If you need to appeal a denied claim for other reasons, please refer to the provider appeals section of this manual for further information regarding submission.

Claim Payment Refunds

Provider Refunds: If a payment error is identified, please refund the full amount promptly. Enclose a copy of the EOB highlighting or marking the claim. Please provide a brief explanation or reason for the refund. If the claim requires reprocessing, Advanced Health will handle it promptly.

Member Has Other Coverage: If the member has coverage that Advanced Health was not aware of at the initial processing, please provide a copy of the primary carrier's EOB. This includes motor vehicle, workers' compensation, Medicare, or other commercial insurance coverage.

Advanced Health Requests Refund: Advanced Health may request provider refunds up to one year from the date of service if refund is due for an administrative reason. For refund requests generated due to the member having other medical coverage, Advanced Health may request a refund if the provider may bill the other coverage based on the primary carrier's timely filing limit. Refunds are

due within 30 days from the date of the request letter. If payment is not received within that time frame, a "punch credit" may be taken from your next claims payment and will be reflected on the EOB provided by Advanced Health.

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

Member Satisfaction

Member Complaint & Appeal Process

Advanced Health is responsible for providing a meaningful process for timely resolution of all member complaints. This includes setting a standard resolution and an expedited resolution timeframe. These grievances can be related to overall concerns about the quality of care, access to services, or appeals for denied services. This process meets all guidelines established by the Centers for Medicare and Medicaid and the Health Services Division (HSD).

All members receive information about their complaint and appeal rights in the Advanced Health Member Handbook. Members are also individually notified in writing of their complaint and appeal rights each time a service, or request for service is denied. This Notice of Action (NOA) letter informs the member of the denial and provides them with a copy of their appeal rights and other information regarding the process. Complaints and appeals can be filed by the member, their advocate or health care providers on their behalf. No punitive action will be taken against a provider who requests an expedited resolution or supports a member's appeal.

Complaints are any expression of dissatisfaction and can be filed verbally or in writing at any time. Appeals can be filed after the member has received a NOA informing them that a service has been denied, limited, or reduced. Appeals must be filed within 45 days of the NOA.

In reviewing a complaint or an appeal, it may be necessary to obtain additional information from the health care provider. If this is necessary, the Complaint & Appeals Coordinator will contact the appropriate office to request additional information.

The complaint and appeal processes are outlined in more detail in the member handbook. If a member is dissatisfied with the action of the health plan, or any of its contracted entities or providers, the member has the right to file an appeal or complaint.

A Member can file the appeal their self or can have a representative file on their behalf with written

permission from the Member. Representatives can be providers, family members, friends, legal advocates, etc. To file a complaint or appeal, please contact our Complaint & Appeals Coordinator at 541-269-7400.

Provider Complaint & Appeal Process

Providers may contact the Complaint & Appeals Coordinator at 541-269-7400 with any concerns or complaints.

Claim Reconsideration: For claims denied due to lack of information, improper coding or some other administrative error, the claim can be resubmitted as a corrected claim for reconsideration. If you believe there may be an adjudication error, please contact our Claims Department at 541-269-7400.

Appealing a Claims Denial

Providers may appeal a claims decision, where the provider is being held financially responsible for charges, on the basis of the following issues: 1) Provider payment methodology; 2) Medical necessity denial (if no authorization was required); and 3) Contract/benefit plan limitation. Providers may also assist members who appeal a claims denial of service, in which the member is being held financially responsible.

If the provider has submitted a request for reimbursement and the clean claim has been denied on its merits, the provider may appeal the non-payment after receiving a notice of denial letter from Advanced Health. The appeal must be in writing with all supporting documentation and any additional information not previously considered or known by Advanced Health. A "Provider Appeal Request" form has been included in this manual for your convenience.

Please Note: All claim appeals submitted by a provider must include additional information which the provider believes was not previously known or considered by Advanced Health in its decision to deny the claim. Appeals submitted without additional information are subject to the original denial being upheld without further consideration.

Timeframes

Claim Reconsideration: Providers may file claim reconsiderations within 120 days from the original denial letter, if the claim meets the reconsideration criteria listed above. Reconsideration requests received outside of the 45-day timeframe will be denied as submitted untimely.

Claim Appeals: If a provider disagrees with an Advanced Health determination, they may file an appeal within 45 days from the date of the EOB, which indicated the claim was denied. Appeals received outside of the 45-day timeframe will not be processed as the original denial will be upheld

and the appeal will be considered untimely.

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

Appeals will be reviewed by Advanced Health within 45 calendar days of receipt of the written appeal request, or as required by law. Appeal requests based on medical necessity denials will be reviewed by the Clinical Advisory Panel (CAP) as appropriate to the issue presented. If the CAP reverses the prior decision, in whole or in part on any claims denial, the claim shall be paid as soon as possible, not to exceed 45 days from the date that Advanced Health received all the information necessary to render a decision. The response will include an explanation of the denial/issue if the initial determination is upheld.

All appeals are reviewed by the Appeals Committee for final recommendation to the CAP for a second level review and determination. CAP may uphold the decision, overturn the decision, request additional information, or request that the provider present their appeal in person. CAP's decision will be communicated to the provider in writing and if the decision is made to overturn the first level appeal, the claim shall be paid within 45 days of receipt of all requested information. If the final decision upholds the original denial and the provider does not agree with the decision, then the provider may contact MAP to request an Administrative Review.

Appealing an Authorization Decision

Providers may appeal the following Advanced Health medical decisions:

- Authorization of procedures, hospitalizations, or medications;
- Hospital length of stay; and
- Denials of coverage based upon medical necessity of a service.

Please Note: All authorization appeals submitted by a provider must include additional information which the provider believes was not previously known or considered by Advanced Health in its decision to deny the authorization request. Appeals submitted without additional information are subject to the original denial being upheld without further consideration.

If a treatment has been denied on the basis that it is experimental or investigational, the request for reconsideration must be accompanied by peer-reviewed literature supporting the effectiveness of the

procedure or treatment at issue. The claim reconsideration will be subject to review by CAP and MAP as necessary.

Filing Information

The appeal must be in writing with all supporting documentation and any additional information note previously considered or known by Advanced Health. Provider Appeal Request forms can be found on our website at www.advancedhealth.com.

Timeframes

If a provider disagrees with an Advanced Health determination, they may file an appeal within 45 days from the date of the authorization denial. Appeals received outside of the 45-day timeframe will not be processed as the original denial will be upheld. The appeal will be considered untimely.

- Appeals will be reviewed by Advanced Health within 45 days of receipt of the written appeal, request or as required by law.
- All appeals are reviewed by the Appeals Working Committee for final recommendation to CAP for a second level review and final determination.
- Appeal requests based on medical necessity denials will be reviewed by the CAP as appropriate to the issue presented. If the CAP reverses the prior decision, in whole, or in part on any authorization denial, and if a claim has been submitted by the provider, the claim shall be reprocessed and paid as soon as possible, not to exceed 45 days from the date that Advanced Health received all of the information necessary to render a decision. The response will include an explanation of the denial if the initial determination is upheld.

The CAP may uphold the decision, overturn the decision, request additional information, or request that the provider present the appeal in person. The decision of CAP will be communicated to the provider in writing and if the decision is made to overturn the first level appeal, the claim shall be paid within 45 calendar days of receipt of all requested information. If the final decision upholds the original denial and the provider disagrees with the decision, they may contact HSD to request an Administrative Review.

Allied Health Care and Other Providers

Allied Health Care providers are licensed or certified health care providers other than a primary care physician, specialist or hospital and may include a laboratory, optometrist, chiropractor, podiatrist,

therapist, durable medical equipment supplier, ambulatory surgical center, diagnostic center and any other health care provider, organization, institution or other arrangements recognized by Advanced Health.

Ambulance Provider Billing Guidelines

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

Emergency Medical Transportation

A service will qualify for Advanced Health reimbursement as an emergency ambulance transport when a sudden, unexpected occurrence creates a medical crisis requiring immediate transportation to a site, usually a hospital, where appropriate medical care is available. When transport occurs, the patient must be transported to the nearest appropriate facility able to meet their medical needs. (OAR 410-136-0200).

Non-Emergent Transportation

All non-emergent transports must be authorized by Advanced Health and must meet medical necessity and be cost effective in order to be considered for reimbursement.

Base Rate

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

Required Documentation

All claims submitted to Advanced Health must be filed on a CMS-1500 claim form and have supporting documentation attached (i.e., Emergency Technician Report). If a non-emergent transport has been authorized, the authorization number must appear in Box 23 of the CMS-1500 or the claim may be rejected.

Durable Medical Equipment (DME) Billing Guidelines

Durable Medical Equipment (DME) are items used to serve a specific therapeutic purpose in the

treatment of an illness or injury, that can withstand repeated use, are generally not useful to a person in the absence of illness, injury or disease and appropriate for use in the patient's home.

DME and medical supplies typically require authorization unless they are non-recurring and are less than $100.

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

DME Benefits

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

Rental vs. Purchase

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

Payment Allowance

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

Therapy and Rehabilitation Services

Outpatient therapy (physical, occupational and speech) benefits are subject to member eligibility, OHP benefits and HSD guidelines. Providers are responsible for verifying eligibility and benefits prior to rendering service to Advanced Health members. Initial evaluations do not require

authorization when provided by a local provider. All other services must be authorized by Advanced Health.

Benefit Limitations:

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

Home Health Agency Billing Guidelines

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

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

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

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

- Skilled nursing services;
- Skilled nursing assessment (including OASIS assessment);

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

Vision Services Guidelines

Vision services, including routine visual exams, retinal exams for diabetics, eyeglasses and contacts do not require authorization when administered by a local provider, and in accordance with Advanced Health guidelines. Advanced Health uses MAP's visual services rules and will authorize payment for vision services for covered services that are subject to member eligibility and benefit package limitations and exclusions.

Providers are responsible for verifying member eligibility and benefit package prior to administration of vision services.

Hearing Services

Advanced Health utilizes HSD's speech-language, pathology, audiology and hearing aid service guidelines for the administration of hearing and audiology services. All benefits are subject to member eligibility and OHP benefit plan limitations and exclusion.

Routine hearing exams do not require authorization when administered by a local provider. Hearing aids and repairs must be authorized. Services must be an OHP covered service and are subject to member eligibility and benefit limitations.

Services Not Requiring Authorization:

- One basic audiology assessment per calendar year;
- One basic comprehensive audiometry per calendar year;
- One hearing aid evaluation, tests, selection per calendar year;
- One electroacoustic evaluation for hearing aid, monaural, per calendar year;
- One electroacoustic evaluation for hearing aid, binaural, per calendar year; and
- Hearing aid batteries (limited to a 3 month supply, not to exceed 15 at one time)

Services Requiring Authorization:

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

Additional Information:

- All hearing services must be performed by a licensed audiologist or hearing aid dealer;
- Reimbursement is limited to one (monaural) hearing aid every 5 years for adults who meet the following criteria: 1) Loss of 45 decibel (dB) hearing level or greater in two or more of the following frequencies 1000, 2000 and 3000 Hertz (Hz) in the better ear.
- Adults who meet the criteria above and have vision correctable to no better than 20/200 in the better eye, may be authorized for two hearing aids for safety purposes. Providers are required to submit a vision evaluation with the authorization request.
- Two (binaural) hearing aids will be reimbursed no more frequently than every three years for children who meet the following criteria: 1) Pure tone average of 25dB for the frequencies of 500 Hz, 1000Hx and 2000Hz; or 2) High frequency average of 35dB for frequencies of 3000Hz, 4000Hx and 6000Hz.
- An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear, or who cannot benefit from a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a listening situation. It is restricted to a hand-held amplifier and headphones.
- Adjustments to hearing aids are included in the fitting and dispensing fee and are not reimbursable separately.
- Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately.

Fraud & Abuse

Advanced Health has fraud and abuse policies and procedures in place that enable Advanced Health to help prevent and detect fraud and abuse activities. This includes operational policies and controls in areas such as claims, authorization, utilization management, member and provider grievances, credentialing and contracting, provider and staff education, and corrective action plans to prevent potential fraud and abuse activities.

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

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

Qui Tam Whistleblower Provisions

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

Definitions

- Abuse (of Member by Provider): Intentional infliction of physical harm and/or injury caused by negligent acts of omission, unreasonable confinement, sexual abuse or sexual assault.
- Abuse (by Provider): Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to health programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the health plan.
- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some authorized benefit to him/her, or some other person. It includes any act that constitutes fraud under applicable State or Federal law.
- Incident: A situation of possible fraud, abuse, neglect and/or exploitation which has the potential for liability to Advanced Health, State of Oregon, MAP or MAP contractors.

Examples of Potential Fraud, Abuse or Suspicious Activity

Falsifying Claims/Encounter:

Alteration of Claim

Incorrect Coding (i.e. Upcoding/Downcoding)

Double Billing

Billing for Services Not Provided

Delivery of Services:

Denying/Limiting Access to Services/Benefits

Failure to Refer for Needed Services

Underutilization

Overutilization

Misrepresentation of Service/Supplies

Substitution of Services

Unbundling/Bundling (i.e., Lab Tests)

Administrative/Financial/Broker:

Kickbacks/Start Violations

Fraudulent Credentials

Fraudulent Recoupment Practices

Embezzlement

Member Abuse:

Physical or Mental Abuse

Sexual or Emotional Abuse

Neglect, Discrimination

Providing Substandard Care

Financial Exploitation

Member Eligibility Fraud:

Eligibility Determination Issues

Resource Misrepresentation

Residency

Household Composition

Income

Citizenship Status

Prescription Alteration/Forgery

Durable Medical Equipment Theft

Misrepresentation of Medical Condition

Failure to Report Third Party Liability

Medicare Part D Fraud, Waste and Abuse:

Medicare Part D is the prescription drug benefit as part of the Medicare program. Along with the benefits that come with this program, come opportunities for potential fraud, waste and abuse. Examples of potential violations include:

- Billing for Services not Furnished and/or Drugs Not Provided;
- Billing for Non-covered Prescription as Covered Items;
- Billing for Expired Drugs;
- Dispensing Without a Prescription;
- Billing for Recycled Prescription Drugs;
- Billing for Brand when Generics are Dispensed;
- Altering Scripts or Data to Obtain a Higher Payment Amount; and
- Misrepresentation of Dates, Descriptions of Prescriptions or Services.

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

How Serious is Fraud & Abuse?

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

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

How to Report Potential Fraud, Abuse or Suspicious Activity

If you suspect insurance fraud, abuse, or suspicious activity has occurred, is occurring, or will occur, please report it immediately through any of the following ways:

Advanced Health Phone 541-269-7400
Advanced Health Fax 541-269-7789
HSD's Fraud & Abuse Hotline 1-800-372-8301
HSD's Fax 503-373-1525
HSD's Fraud Reporting Website: www.oregon.gov/dhs/abuse/pages/fraud-faq.aspx

Frequently Asked Questions

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

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

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

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

Advanced Health Members’ Rights and Responsibilities Statement

Members have the *right* to:

1. Be treated with dignity and respect;
2. Be treated by providers the same as other patients getting health care;
3. Have covered substance abuse treatment and family planning without a referral;
4. Have a friend, family member or advocate with you during appointments;
5. Be involved in making decisions about your health care and treatment plan;
6. Get information about your condition, covered and non-covered services;
7. Agree to treatment or refuse services (except for court-ordered services) and be told the consequences of that decision;
8. Get written information on your rights, responsibilities, benefits available, how to access services and what to do in an emergency;
9. Get written information that you can understand;
10. Get services to diagnose the presenting condition;
11. Receive covered services under OHP which meet generally accepted standards of practice and are medically appropriate;
12. Obtain covered preventative services;
13. Receive a referral to specialty providers for medically appropriate, covered services;
14. Have a clinical record that documents conditions, services received, and referrals made;
15. Have access to your own clinical record, unless access is restricted by law;
16. Have your medical records corrected;
17. Be able to limit who can see your medical records;
18. Ask for a copy of your clinical record to be given to another provider;
19. Make a statement of wishes for treatment (Advance Directive) and obtain a power of attorney for health care;
20. Get written notice before a denial of, or change in, a service level or benefit is made, unless such notice is not required by Federal or State regulations;
21. Know how to make a complaint, grievance, or appeal and receive a response without a negative reaction from Advanced Health or your provider;
22. Request an administrative hearing from the Department of Human Services (DHS) or Oregon Health Authority (OHA);
23. Get notified in a timely manner if your appointment is cancelled;
24. Receive adequate notice of DHS/OHA and Advanced Health privacy practices;
25. Choose your provider;

26. Have Advanced Health's written material explained in a manner that is understandable;
27. Receive care when you need it; 24 hours a day, 7 days a week;
28. Receive information about Advanced Health, its services, its providers and member rights and responsibilities; and
29. Make recommendations regarding Advanced Health's member rights and responsibilities policy.

Members have the *responsibility* to:

1. Treat all providers and personnel with respect;
2. Be on time for appointments made with providers;
3. Call ahead of time if you are going to be late or must cancel your appointment;
4. Get periodic health exams, check-ups and preventative services from your medical, dental, or mental health providers;
5. Use your Primary Care Provider (PCP) or clinic for diagnostic and other care, except in an emergency;
6. Get a referral to a specialist from the PCP or clinic before seeing a specialist, unless a self-referral is allowed;
7. Use emergency and urgent care services appropriately;
8. Give accurate information for your medical record;
9. Help the provider or clinic get clinical records from other providers;
10. Ask questions about conditions, treatments and other issues about your care;
11. Use information to make decisions about treatment before it is given;
12. Help create a treatment plan with your provider;
13. Follow prescribed, agreed upon treatment plans;
14. Tell your provider you have OHP coverage and show them your Oregon Health Plan ID;
15. Call OHP Customer Service at 1-800-699-9075 to report:
    a. A change of address or telephone number;
    b. If someone in the family becomes pregnant;
    c. The birth of a child;
    d. If any family members move in or out of the household;
    e. If there is any other insurance available and to report any changes in insurance in a timely manner;
16. Pay for non-covered services they receive;
17. Assist Medical Assistance Programs (MAP) to find any other insurance that you are entitled to and to pay MAP the amount of benefits they received because of an accident or injury;
18. Notify MAP of issues, complaints or grievances;

19. Sign a release so that DHS/OHA and Advanced Health can get information they need to respond to an Administrative Hearing Request in an effective and timely manner.

Health Insurance Portability and Accountability Act (HIPAA)

Advanced Health continues to ensure that we conduct business in a manner that safeguards member information in accordance with the privacy act pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The enacted privacy regulations have been fully implemented throughout this organization and we are fully committed to the protection of Personal Health Information (PHI).

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

Requested information may be faxed to Advanced Health. Our fax system is secure and only authorized personnel have access to the information. Email should never be used to transfer member information unless it is encrypted and secured.

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

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

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

Health information contained in medical or financial records is to be disclosed only to the patient or legal guardian, unless the patient or legal guardian authorized the disclosure to another individual or organization, or a court order has been sent to the provider. Health information may only be disclosed to those immediate family members with the verbal or written permission of the patient or the patient's legal guardian. Health information may be

disclosed to other providers involved in caring for the member without the member or member's legal representative's written or verbal permission.

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

Information may be disclosed to insurance companies or their representative for Quality and Utilization Review, payment, or medical management. Providers may release legally mandated health information to the State and County Health Divisions and to disaster relief agencies.

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

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

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

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

Appendix A – Forms and Instructions

- Please visit www.advancedhealth.com for a complete listing of all our up to date forms, information and resources.