UTILIZATION REVIEW AND SERVICE AUTHORIZATION HANDBOOK

ADVANCED HEALTH CCO

2026-2027

A collection of utilization management policies, procedures, and criteria for covered services to ensure consistent application of review criteria for authorization decisions. Participating Providers and Subcontractors must adhere to the policies and procedures set forth in this Service Authorization Handbook.

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Utilization Review and Service Authorization Handbook

Utilization Management and Service Authorization

Overview

This Utilization Management (UM) and Service Authorization Handbook sets forth Advanced Health's utilization management policies, procedures, and criteria for covered services that comply with state and federal requirements (42 CFR §438.210 and OAR 410-141-3835) to ensure consistent application of review criteria for authorization decisions.

Advanced Health (AH) provides medically appropriate, cost-effective health services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the Coordinated Care Organization (CCO) Contract and Oregon Administrative Rules (OAR) 410-141-3820 and 410-141-3835.

Advanced Health maintains a specialized provider network that includes primary care, medical, dental, behavioral health providers and specialists, and Durable Medical Equipment (DME) vendors.

Some services may require prior authorization (PA). A prior authorization request allows a clinical review of requested services to ensure medical necessity. Clinical review requirements have been defined with procedures for the review of requested treatments, surgeries, and other health related items, that follow Oregon Health Authority (OHA) rules and guidelines, the Prioritized List of Health Services and any applicable state and federal laws, as part of the Oregon Health Plan (OHP) member's benefit package. Please refer to the most current Prioritized List at: http://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

Prior 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 a member has Medicare or a Medicare HMO primary and services are *covered* by Medicare, no prior authorization is required. If Medicare does not cover the service or denies the service, a prior authorization from Advanced Health is required.

If prior authorization is required, but was not obtained prior to services being rendered, the service may be denied. A retroactive service request authorization may be submitted and are subject to all applicable retroactive Oregon Administrative Rules. Please refer to Advanced Health's *Prior Authorization Grid* for details regarding services that do not require prior authorization. The grid is updated at least annually and is located within **Provider Forms and Resources** on our website, www.advancedhealth.com.

DEFINITIONS

Covered Services – (OAR 410-120-0000) means medically necessary and appropriate health services and items described in ORS chapter 414 and applicable administrative rules. Covered services include:

(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature;

(b) Ancillary Services OAR 410-120-0000;

(c) Diagnostic Services OAR 410-120-0000;

(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and

(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 division 151.

Medically Appropriate OAR 410-120-0000 means health services, items, or medical supplies that are

(a) Means health services, items, or medical supplies that are:
(A) Recommended by a licensed health provider practicing within the scope of their license; and
(B) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and
(C) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and
(D) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.
(b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.
(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.

Medically Necessary OAR 410-120-0000 health services that are required to address one or more of the following:

(a) Health services and items that are required to address one or more of the following:
(A) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or

(B) The client's or member's ability to achieve age-appropriate growth and development; or

(C) The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(D) The client's or member's ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice, when they are receiving Long Term Services or Supports (as defined in these rules);

(b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.

UTLIZATION MANAGEMENT PROGRAM OVERVIEW

Utilization Management (UM) is integrated within the Medical Service teams. The Directors of Medical Services, Pharmacy and Behavioral Health oversee the program operations under the supervision of the Chief Medical Officer and Chief Operating Officer. Advanced Health (AH) provides utilization review in accordance with the policies, procedures, and criteria for covered services that comply with state and federal requirements (42 CFR §438.210 and OAR 410-141-3835) to ensure consistent application of review criteria for authorization decisions. Such reviews ensure medically appropriate, cost-effective health services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the Coordinated Care Organization (CCO) Contract and Oregon Administrative Rules (OAR) 410-141-3820 and 410-141-3835.

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

A request for services is required to determine, prior to delivery of care, if the requested service is part of the benefit plan and it meets the OHP coverage criteria. Prior Authorization (PA) requests are addressed in accordance with timeframe to decision requirements per OAR 410-141-3835. Routine requests should be received by Advanced Health at least two 7 days before a service is scheduled. This allows time for AH to process the PA and review pertinent medical information critical to the decision-making process. A copy of the Member's chart notes, lab and/or x-ray tests, and any other pertinent facts should accompany the original request.

AH ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.

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

AH constitutes medically necessary covered services and administers the services in a manner that:

- Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative limits (as indicated in other State policies, procedures, and administrative rules).
- Considers and addresses the following:
    - The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.
    - The ability for a member to achieve age-appropriate growth and development.
    - The ability for a member to attain, maintain, or regain functional capacity.

- The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Prior Authorization Request

Forms are located on our Advanced Health website, www.advancedhealth.com: Hover Navigate to the Provider tab, select the Provider Forms and Resources button, select the corresponding form. Service requests should be faxed to (541-269-7174) or emailed to authorizations@advancedhealth.com . Provider and staff can utilize the **VisibilEDI portal** for a variety of reasons including ensuring requests are received, checking status, obtaining corresponding authorization number, or to reprint an authorization. You may also call **Medical Management at 541-269-7400**. To gain access to the VisibilEDI portal, apply by visiting https://visibiledi.com/advancedhealth/Home/Login.

Required Information for Authorization

The following information is required for authorizations:

- Patient Name, Date of Birth, Member ID#
- Name of Primary Care Physician
- Name of Referred Provider
- Primary Diagnosis Code(s)
- Date(s) of Service
- Procedure Code(s)
- Chart Notes including but not limited to
    - Imaging reports
    - PCP notes
    - Specialist notes
    - Lab reports

Hospital Notification of Admit or Observation

The following information is required for inpatient hospital and mental hospital stays:

- Name of the member/potential member
- Name of the member's physician
- Date of admission
- If applying for Medicaid benefits after admission, the dates of application for the authorization of benefits
- The plan of care
- Date of operating room reservation, if applicable
- * for non-mental hospitals only
- Justification of emergency admission, if applicable
- * for non-mental hospitals only
-
- Reasons and plan for continued stay if attending physician believes continued stay is necessary
- Initial and subsequent continued stay review dates
- Other supporting material that the utilization review committee believe appropriate to be included in the record

Other Requirements Related to Authorization Requests:

• The Primary Care Provider (PCP), or Primary Care Dentist (PCD) when appropriate, is accountable to submit prior authorizations, with the exception of Behavioral Health. Direct access to a specialist, at no cost to the member, is appropriate when PCP or PCD believes member's condition and identified needs require such a referral; or when Advanced Health Care Coordination has designated a member as having special healthcare needs (SHCN). A prior authorization is not required for office visits with in-network providers

• An out of network specialist/provider with a valid authorization, requested by PCP, another specialist when an initial referral is on file or created by Advanced Health in appropriate circumstances, may request additional follow-up services from Advanced Health with proper documentation showing the need for follow-up. Specialists with approved authorizations on file

may provide diagnostic services without prior authorization, except those diagnostics listed as requiring authorization on the authorization grid. **For billing purposes, specialists will need to submit a service request for the diagnostic services being performed, along with the initial approved referral.

• Providers can email , mail, or fax the Advanced Health service request forms to Advanced Health at (fax) 541-269-7147, (email) authorizations@advancedhealth.com , (mail) Advanced Health, Attn: Medical Management, 289 La Clair Street, Coos Bay, OR 97420.

- Upon completion of the authorization review, approved services are issued an authorization number. This number *must* be included on the claim when submitted.

- When a prior authorization is requested by PCP or PCD they are responsible for relaying the outcome of the authorization decision and the authorization number to the requested provider or facility.
- Subsequent authorization details are available on VisibilEDI PORTAL at: https://visibiledi.com/advancedhealth/Home/Login.

Utilization Review

The mission of Utilization Review (UR) is to enhance member health and ensure quality, cost-effective health care services through collaboration with members, providers, and the community. The program's scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities, home health care services, outpatient care, and office visits.

Advanced Health, as an organization, promotes effective, understandable, and respectful quality care and services that advance health equity through the delivery of culturally and linguistically appropriate services (CLAS). Health disparities are the indicators used to track progress toward achieving health equity. Obtaining health equity means pursuing the highest possible standard of health for all people while giving attention to those at greatest risk of poor health, based on health disparities.

The UR team reviews the benefits available to the member under the appropriate rules. The focus is on determining whether a service constitutes a covered benefit, whether criteria for coverage has been satisfied, and whether the service is the most cost-effective option among those available. Clinical specialists with appropriate licenses or certifications perform this function under the direct supervision of the Chief Medical Officer, Behavioral Health Director, Director of Medical Services, and Director of Pharmacy

Utilization review determinations are reviewed using relevant Oregon Administrative Rules, the Prioritized List of Health Services, HERC Coverage Guidance and Guideline Notes, Center of Medicare & Medicaid National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria guidelines, and published national evidence-based guidelines such as those from Agency for Healthcare Research and Quality (AHRQ), Milliman Care Guidelines, World Professional Association for Transgender Health (WPATH), the American College of Radiology's Appropriateness Criteria. Commercial based evidence-based resources, such as *Hayes Review, Up-to-Date,* NCCN, JCCN, Open Evidence may also utilized.

In some cases, direct review of recently published medical literature is performed to identify best

practices in areas of medicine and behavioral health that are rapidly changing. Advanced Health's goal is to identify current standards of care and criteria for establishing medical necessity to ensure that all members receive the best possible high-quality care.

At a minimum, members will be provided those Covered Services that are medically appropriate and described as a funded condition with treatment that pairs on the Prioritized List of Health Services, including Ancillary Services. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, dental or long-term services and supports needs.

If the prior authorization is approved, Advanced Health will fax a notification to the requesting provider. If the prior authorization is denied or when a requested service or previously approved service is reduced in an amount, duration, or scope that is less than requested, Advanced Health will provide a written notice to the requesting provider and the enrollee informing both of the determination to deny a service authorization request. Denial decisions are made by the level of clinical expertise appropriate to provide services to the member in compliance with "OAR 410-141-3835." Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease."

Authorizations are valid for 90 days from the date of authorization, unless an extension to the standard authorization period has been requested/granted. When network adequacy is relevant as in the case of CDRC services, the authorization may not be valid for up to 18 months. An authorization is not 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 Department of Human Services Department (DHS) as applicable.

Advanced Health accepts requests to update approved authorizations for situations where member appointments, provider and facility changes are necessary to deliver care. You may submit a request to update approved authorizations for date range, provider update, and facility updates that do not change the level of service previously authorized by visiting https://advancedhealth.com/providers/resources/ and completing the "Authorization change request form" and faxing to (541)269-7147.

Covered Service Types:

considering Prioritized List of Health Services, Oregon Administrative Rules (OARs) and Guideline Notes, and Medicare Coverage Guidelines, as appropriate:

Covered Service Types	
Acupuncture	Case Management/Care Coordination
Chiropractic	Dental
Diagnostic studies	Durable Medical Equipment (DME)
Emergency Services	Family Planning
Hearing aids and exams	HIV/AIDS testing and prevention services
Home Health	Hospice
Hospital services (Inpatient/Outpatient)	Immunizations
Inpatient rehabilitation	Intensive Care Coordination
Interpreter Services	Labor and Delivery
Medical/Non-Medical Transportation	Behavioral Health Services/SUD
Naturopathy	OB Care
Pain management	Physical Therapy/Occupational Therapy/Speech Therapy
Podiatry	Prescription drugs, pharmacy services, and medication-related supplies, subject to the member's benefit package, formulary requirements, OHA carve-outs, and applicable coverage limitations
Preventative Services	Primary Care Provider Visits
Radiological Services	Skilled Nursing Facility (SNF)
Specialty Visits	Telehealth Services
Traditional Health Worker	Transgender Health
Vision Care *limited	Women's health exams

Time Frame to a Decision of PA Requests

All authorization requests will be determined valid or non-valid within 24 hours of receipt on business days or within 24 hours immediately following a non-business day. Medication and pharmacy prior authorization requests follow the pharmacy-specific timeframes stated in the Pharmacy Authorizations section below. Advanced Health reviewers make expedited authorization decisions and provide notice

as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request. For standard authorization requests for services not previously authorized, Advanced Health provides notice as expeditiously as the member's condition requires and no later than 7 days following receipt of the request for service OR within 21 days if an extension was granted. Extension criteria include:

- The member, the member's representative, or provider requests an extension; or
- The MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

Reviewers make determinations on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to care required while in a skilled nursing facility.

All service requests to deny or reduce services are escalated to MD Review to ensure that the reviewer has appropriate expertise in treating the member's medical, behavioral health, oral health, or long-term services and support needs.

Advanced Health shall process **Standard** authorization requests, for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 7 days following receipt of the request for service, or within 21 days if an extension was granted.

For cases in which a provider indicates, or Advanced Health determines, that following the Standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Advanced Health must make an **Expedited** decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. Advanced Health may extend the 72-hour time, by up to 14 calendar days, if an extension is determined necessary and is in the member's best interest. Requests for complex rehab technology (CRT) are processed as expedited requests and are not subject to extension of timeframe to review.

If at any time during the review process it is deemed that additional information is necessary to provide a complete review, written, telephonic, or electronic requests for more information will be made following the 3 attempts/2 methods rule. A reviewer may also consult with the requesting provider at any time during the review period. If a peer to peer prior to determination may result in an approval versus a denial, a peer to peer will be sent to the CMO. If after a service request has been escalated to MD review and that MD indicates that more information may assist in a complete and thorough review, requests for more information are following the 3 attempts/2 method rule. If information requested is not received, the request may be denied for insufficient information.

If it is necessary to extend the standard timeframe to allow for a complete and accurate review Advanced Health will notify the member in writing. For expedited timeframe, if it is necessary to extend the expedited timeframe Advanced Health will notify the member in writing. CRT requests are not subject to extensions.

Authorization to a Specialty Provider

Direct access to specialists:

For members with **Special Health Care Needs (SHCN)**, as determined by care coordination through a

comprehensive assessment. Advanced Health will allow direct access to a specialist, at no cost to the member. Prior Authorization is not required. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist. The referring provider should also notify Advanced Health of the referral by submitting the Prior Authorization Service Request, found on our website, marking the **SHCN Box** at the top of the form and providing the name and contact information of the specialist. This will allow the creation of an authorization number to be provided to the specialist which is need for billing purposes. This authorization will include pre-approved visits (i.e. 6 visits in 6 months) allowing the member to establish with specialist and receive care.

Prior Authorizations are not required for services related to family planning, immunizations, women's health exams, HIV/AIDS testing and prevention services. 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. For a full list of services that do not require prior authorization, refer to the Authorization Grid.

Please refer to Advanced Health's Authorization Grid to determine what services require a prior authorization. The grid is updated at least annually and is located within **Provider Forms and Resources on the Advanced Health website** at https://advancedhealth.com/providers/resources/, then select "Authorization Grid".

Second Opinions

A Second Opinion may be requested by a provider without prior authorization. For billing purposes, the requesting provider should notify Advanced Health by completing a service authorization request and marking "Second Opinion". If a qualified In-Network Provider cannot be arranged by the referring provider then an out of network provider can be requested. The authorization will be preapproved with visits (i.e.6 visits in 6 months) allowing the member to establish with specialist and receive care, at no cost to the Member.

Pharmacy Authorizations

The Advanced Health Formulary is not intended to be a substitute for the knowledge, expertise, skill, and judgment of the medical provider in his/her choice of prescription drugs. The medications on the

Advanced Health administers pharmacy benefits in accordance with the member's benefit package, applicable federal and Oregon law, the CCO Contract, Oregon Administrative Rules, and current Advanced Health pharmacy policies and clinical criteria. The formulary supports safe, effective, clinically appropriate, and cost-effective medication use but does not replace the prescribing provider's professional judgment. A provider may request authorization or an exception when a preferred treatment is ineffective, contraindicated, not clinically appropriate, or otherwise does not meet the member's medical needs.

The current Advanced Health formulary identifies covered medications and applicable preferred status, prior authorization, step therapy, quantity limits, age limits, and other coverage conditions. Requirements may change during the year. Refer to the online formulary and drug-specific criteria for the most current information. Advanced Health reviews and updates its formulary and criteria as required by clinical evidence, safety information, drug availability, regulatory requirements, OHA

direction, Pharmacy and Therapeutics Committee actions, and benefit changes. Current resources are available at www.advancedhealth.com.

The Oregon Health Authority directly reimburses designated behavioral-health medications and high-cost drugs or biological products through the Oregon Health Plan fee-for-service program when those products are identified on current OHA carve-out lists. Providers and pharmacies must verify the current payer, authorization requirements, and billing process before dispensing or administering a potentially carved-out medication. Injectable, infused, and provider-administered medications may be covered under the pharmacy benefit, medical benefit, or an OHA carve-out arrangement depending on the product, administration setting, dispensing method, billing code, and current policy. Compounded, experimental, investigational, cosmetic, and lifestyle medications are generally excluded or limited.

Generic Medications**:** Advanced Health requires use of therapeutically equivalent generic medication when clinically appropriate. A brand-name or non-preferred medication may be considered on a case-by-case basis depending on the member presentation and clinical judgement.

Non-Formulary Medications**:** Prior authorization or a formulary exception is generally required for a medication not listed on the formulary. A medication listed on the formulary may still be subject to prior authorization, step therapy, quantity limits, age limits, specialty-pharmacy requirements, or other conditions. Prior authorization requests should include the diagnosis, relevant clinical history, requested dose and duration, prior therapies and outcomes, contraindications or adverse effects, and other information required by the applicable criteria.

Discharge Medications**:** Please refer to Advanced Health's formulary when prescribing discharge medications. Medications not listed on the formulary must be authorized, and some drugs that are listed on the formulary will require a prior authorization or step therapy as well. If an authorization cannot be obtained at discharge, then a five-day supply should be provided so that a prior authorization can be requested from the provider. You can also contact the MedImpact Pharmacy Help Desk at 1-800-788-2949 or the Advanced Health Pharmacy team at 541-269-7400.

Pharmacy Point-Of-Sale Overrides: A point-of-sale override may be available for eligible discharge medications, vacation supplies, lost, stolen, or destroyed medications, dose changes, drug changes, refill-too-soon situations, emergency supplies, and other circumstances recognized by current policy. The pharmacy should review the claim-rejection message and contact the MedImpact Help Desk. A clinical prior authorization remains necessary when the rejection concerns medical necessity, step therapy, non-formulary status, or another requirement that cannot be resolved through a claim-level override.

Specialty Medications**:** Specialty medications may require prior authorization, a designated specialty pharmacy, clinical monitoring, special handling, or coordination under the medical benefit. Providers must consult the current formulary and drug-specific policy. Specialty medications, such as injectable medications, are dispensed through MedImpact Direct Specialty Pharmacy. They can be reached at 877-391-1103.

Help Desk**:** MedImpact is Advanced Health's pharmacy benefit manager. Its designated functions may include pharmacy claims processing, drug-utilization review, point-of-sale support, and medication authorization support. Contact the MedImpact Pharmacy Help Desk at 1-800-788-2949 for claim

rejections, pharmacy-system eligibility, covered alternatives, point-of-sale overrides, and processing questions. Direct clinical requests requiring Advanced Health review to the Advanced Health Pharmacy Department at 541-269-7400.

When requesting authorization for medications, please use the medication prior 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.

Pharmacy Authorization Timeframes

Advanced Health will make medication coverage decisions as quickly as the member's condition requires. For prior authorization requests that include all required information, Advanced Health generally makes a decision within 24 hours when physician review is not needed. If physician review or more information from the requesting provider is required, a decision may take up to 72 hours after Advanced Health receives the request.

Retroactive Authorization Guidelines

To be considered for approval, the retroactive authorization request 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 90 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;

- Hospital services are only granted retro authorization for specific circumstances following OAR 410-125-0124.

- Retroactive authorizations will not be granted for pharmacy benefits without a justified reason. Pharmacy authorization should be obtained before dispensing. A retrospective pharmacy request may be considered only when the request is received within 90 days of the date of dispensing/date of administration and when the provider or pharmacy documents why prospective authorization was not reasonably possible. The submission must identify the dispensing date, rejection or claim information, reason for delay, relevant clinical information, and supporting documentation, and remains subject to eligibility, coverage, timely filing, medical necessity, and applicable policy.

Denials and Appeals

A denial is a decision to reduce or deny authorization of a requested service or item. Whenever a decision is made to reduce or deny a requested service or item, the requesting provider and the

member will receive a notice in writing.

Any request that is denied can be appealed by a member, or their authorized representative. A clinically appropriate, impartial reviewer, who was not involved in the initial denial, makes the redetermination decision.

All service authorization appeals submitted by a provider must include the members signature, consenting to the appeal. Providers cannot request an appeal on behalf of members without their written consent on the attached form: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3302.pdf. The member may also call the CCO directly to start the appeal process requesting outreach to specific providers for medical records.

If new information, not previously submitted in the initial review, is available, a new authorization request may be submitted. If there is no new information and the appeal is within 60 days of the initial determination, an appeal may be submitted. The member's signature is required.

If treatment has been denied on the basis that it is experimental or investigational, the request for appeal must be accompanied by peer-reviewed professional literature supporting the effectiveness of the procedure or treatment at issue. A provider claim reconsideration will be reviewed by the Advanced Health Claims department. These can be submitted to Claim.Appeals@AdvancedHealth.com .

Medical Management Policies and Procedures

The Utilization Management Handbook sets forth written policies and procedures that comply with 42 CFR § 438.210 and OAR 410-141-3835 to ensure consistent application of review criteria for authorization decisions.

1) Prior Authorization (PA) Request Policy
2) Utilization Review Policy
3) Inter Rater Reliability

Health Related Social Needs HRSN

Health-Related Social Needs (HRSN) benefits are covered services available through the Oregon Health Plan (OHP) to eligible members experiencing certain life transitions or social circumstances that may impact their health and well-being. These benefits are intended to address social and economic barriers to health by providing support related to housing stability, nutrition, extreme weather, and connecting members to needed resources and services.

OHA has established four primary HRSN benefit categories:

1. Home Changes for Health

Provides medically appropriate equipment and home modifications to help members maintain a safe and healthy living environment, particularly during extreme weather events. Covered supports may include:

- Air conditioners and heaters.
- Air filtration devices and replacement filters.
- Portable power supplies.
- Mini refrigerators for medication storage.
- Installation and related equipment support.
- Certain medically necessary home modifications and remediations.

2. Housing Supports

Provides assistance to eligible members who are experiencing homelessness or are at risk of becoming homeless. Services may include:

- Rent and utility assistance.
- Utility setup fees and past-due utility payments.
- Tenancy support services to help members maintain stable housing.
- Storage fee assistance.
- Medically necessary home modifications for accessibility and safety.
- Temporary hotel or motel stays when necessary to complete approved home modifications.

3. Nutrition Supports

Provides nutrition-related services to help members access healthy food and address health conditions affected by nutrition. Benefits may include:

- Pantry stocking to help members access essential food items.
- Fruits and vegetables to support healthy eating.
- Medically tailored meals for members with qualifying health conditions.
- Nutrition education and support.

4. Outreach and Engagement (O&E)

Provides assistance to help eligible members connect with HRSN benefits and other available community resources. Services may include:

- Identifying and addressing unmet social needs.
- Helping members understand and access available benefits.
- Connecting members with housing, nutrition, healthcare, and community resources.
- Assisting with applications, referrals, and coordination of services.
- Supporting members through transitions and barriers to accessing care.

Eligibility and Authorization:

HRSN benefits are not automatically available to all OHP members. Eligibility is determined by OHA-established criteria, including qualifying life transitions, clinical risk factors, and social risk factors, depending on the specific benefit requested. Each service is subject to applicable coverage requirements, authorization guidelines, and available provider networks.

HRSN services are intended to complement, rather than replace, existing community resources and other available benefits. All services must meet applicable OHA guidelines and be authorized in accordance with Advanced Health policies and procedures.

How to apply:

Visit the Advanced Health website https://advancedhealth.com/providers/provider-health-related-social-needs/#tab-id-3 or call customer service at 541-269-7400.

Resources Sponsored by Advanced Health

Access Nurse: The contractually arranged telephone services of a registered nurse are made available 24 hours per day, seven days per week, by calling 1-888-647-3627. This service is available to members to assist in clarifying whether the members' needs are emergent or urgent or can be addressed by the primary care provider the following business day.

Provider Portal: Advanced Health's provider portal is available at https://visibiledi.com/advancedhealth/Home/Login. You can register at this site for access to the provider portal.

Advanced Health's Website, www.advancedhealth.com, offers easily accessible information for both members and providers, including: pharmacy information, forms, calendar of events, link to the Oregon Health Authority's (OHA's) *prioritized list,* contract information, and information regarding the Oregon Health Plan (which is Oregon's Medicaid benefit).

Community Resources: Advanced Health works closely with a variety of community partners to provide health-related educational opportunities. Please visit the website for a full list of available programs.

Interpretation Services: Advanced Health provides Spanish-language medical interpreter services through directly employed personnel who can be deployed to provider offices for face-to-face interpretation services. In addition, Advanced Health contracts for medical interpretation services for a wide array of foreign languages; these services are available telephonically. To arrange for interpretation services, please contact Member (Customer) Services at least 48 hours prior to the scheduled appointment date. For urgent needs of less than 24 hours, please contact Member Services. Providers may choose to coordinate interpretation services; however, the cost will not be reimbursed unless arrangements have been made through Member Services.

Tribal Liaison Services: Advanced Health is required to retain the services of a Tribal Liaison to assist Native Americans in accessing health-related services. If assistance is needed on behalf of any Tribal

member, please contact Member Services.

Traditional Health Workers: Every Medicaid member assigned to Advanced Health is entitled, upon request, to receive the services of a Traditional Health Worker (i.e., community health worker; peer support specialist; peer wellness specialist; patient navigator; birth doula). At Advanced Health, most Traditional Health Workers are embedded in case management or care coordination teams. Providers are encouraged to recommend traditional health worker services to members as needed. For assistance in linking any member with a Traditional Health Worker, please contact Advanced Health Case Management Coordinator.

Non-Emergency Medical Transportation (NEMT): NEMT is among the benefits available to Oregon Health Plan members, and includes transportation assistance for regularly scheduled medical, pharmacy, dental, and behavioral health appointments. Members may contact Bay Cities Transportation Brokerage directly at 1-877-324-8109 to schedule transportation. Scheduling must occur at least 2 days prior to the assigned appointment time. Please contact Member Services for any issues or questions that might arise regarding the transportation benefit.

Resources Sponsored by the Oregon Health Authority

Oregon Health Evidence Review Commission (HERC): The HERC reviews medical evidence to prioritize health spending for the Oregon Health Plan (OHP) and to promote evidence-based medical practice on a statewide basis through comparative effectiveness reports, including coverage guidance and multisector interventions, health technology assessments, and evidence-based practice guidelines. The Commission uses a transparent public process to ensure its decisions are made in the best interest of patients and taxpayers, while considering input from providers, beneficiaries, and the public, including those affected by the conditions discussed. http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/index.aspx

Prioritized List of Health Services: The HERC ranks health care conditions and treatment pairs in order of clinical effectiveness and cost effectiveness. The *Prioritized List of Health Services* emphasizes prevention and patient education. In general: treatments that help prevent illness are ranked higher than services that treat illness after it occurs; and, the Oregon Health Plan covers treatments that are ranked above a covered *Prioritized List* line for the patient's reported medical condition. To learn more about the *Prioritized List:* http://www.oregon.gov/OHA/HPA/CSI-HERC/Pages/Searchable-List/aspx

Oregon Health Plan Dental Services: The Oregon Health Plan has a list of covered and non-covered dental services, similar to the *Prioritized List of Health Services*. To learn more about dental services, view OHP's Dental Services Program at http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx

Reporting Non-Compliance and Fraud, Waste, and Abuse: Advanced Health takes its fraud, waste, and abuse monitoring and reporting responsibilities very seriously, and a discussion of these issues appears later in the Manual. In the event that a provider believes Advanced Health has engaged in fraud, waste, or abuse, and the provider elects not to report these concerns directly to Advanced Health through its established communication channels, the provider is obligated to report such concerns to both the Medicaid Fraud Control Unit of the Oregon Department of Justice and to the Oregon Health Authority's Fraud Investigation Unit. http:www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

Oregon Health Plan Policies, Rules, and Guidelines may be accessed at http://www.oregon.gov/DHS/POLICIES/Pages/dhs-oha-policies-guidelines.aspx

The Oregon Health Plan Fee Schedule may be accessed at
http://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx

The State of Oregon Advance Directive Form may be accessed at
https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.aspx

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Advanced Health continues to ensure that it conducts 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 Advanced Health is fully committed to the protection of Personal Health Information (PHI). Advanced Health has adopted policies, procedures, tools, and handbooks to aid in the practice, monitoring, and safekeeping of protected health information. While these documents are too extensive to include as Exhibits to this handbook, they are available for inspection and review by providers and members.

Advanced Health recognizes that under HIPAA privacy regulations, 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. Advanced Health's 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 on request. For any questions, please contact Member/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.

Although not contractually required, Advanced Health strongly encourages its providers to assure that all members of the office staff are annually trained in the protection of confidential, individually identifiable, health information.

References:

- Centers for Medicare & Medicaid Services (CMS)
- Code of Federal Regulations (CFR)
- Oregon Health Authority (OHA)