Provider Manual

Last Revised: July 2025

CareOregon®

Contents

CareOregon Helpful Contact Information

Provider services:
503-416-4100 or 800-224-4840

CareOregon Connect (Provider Portal):
careoregon.org/providers/provider-portal

CareOregon Provider Directory:
careoregon.org/members/find-a-provider

CareOregon Advantage (COA) Provider Directory:
careoregonadvantage.org/provider-directory

Jackson Care Connect (JCC) Provider Directory:
jacksoncareconnect.org/members/find-a-provider

Columbia Pacific CCO (CPCCO) Provider Directory:
colpachealth.org/members/find-a-provider

Billing & payment details:

Electronic payer ID: #93975

CareOregon
PO Box 40328
Portland, OR 97240-0328

Welcome to CareOregon

CareOregon vision

Healthy communities for all individuals regardless of income or social circumstances.

CareOregon mission

Building individual well-being and community health through partnerships, shared learning and innovation.

CareOregon standards of service

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

Our commitment

We are equally committed to:

- Providing medically effective health care within state and federal guidelines
- Promoting the health of every member
- Providing exceptional and proactive service to our members and providers
- Treating all contacts with dignity, respect and understanding
- Working in partnership with our members, their extended health support groups and the providers that help make up their medical homes

CareOregon understands that in order to accomplish these goals we must advocate for and on behalf of our members.

Philosophy

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

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

Specifically, this means using appropriate clinical judgment in the application of approved criteria and guidelines to evaluate the member's circumstances and medical needs rather than adherence to literal standards. This is especially critical for members with complex medical or social issues, and for those who need additional support in understanding health care issues because of language or literacy barriers. In these cases, appropriately trained staff gather more information to help members make informed decisions that meet their needs within the health care benefit.

From a member and provider service perspective:

- We will be both proactive and responsive in our efforts to resolve member, provider and community concerns.
- In cases where we must decline care or services on the basis of coverage limitations or criteria not being met, we will do so in a polite and courteous manner always seeking alternative solutions in or outside of the organization to assist the member.
- Members and providers will always be informed of their right to appeal an initial decision and CareOregon will have a reasonable and expeditious process to evaluate and respond to this appeal.
- Correspondence regarding denials and appeals will be clear, respectful and informative.

Member Enrollment and Eligibility

How an individual becomes a "CareOregon member"

Individuals become members in CareOregon by joining a CareOregon-affiliated health plan. CareOregon participates in the Oregon Health Plan (OHP Plus), Oregon Health Plan Bridge (OHP Bridge), and Medicare Advantage (MA) health plans. An individual must meet eligibility criteria and successfully apply and enroll as a member of any of these plans. For matters of this manual, all members of a CareOregon-affiliated health plan, including those enrolled with a Coordinated Care Organization (CCO) and/or MA health plan, will be referenced as "CareOregon members."

Medicare Advantage and CareOregon Advantage Plus

CareOregon operates a Medicare Advantage health plan. CareOregon Advantage (COA) Plus HMO-POS D-SNP is a Special Needs Plan for dual eligible beneficiaries. These beneficiaries qualify for both Medicare and Medicaid coverage. As a Medicare Advantage Plan, CareOregon Advantage also administers Part D, which offers Medicare prescription drug coverage.

The Oregon Health Plan and coordinated care organizations (Medicaid, OHP and CCOs)

OHP Plus is the Oregon Medicaid program administered by the Oregon Health Authority (OHA). It has extended Medicaid eligibility to all state residents with incomes up to 138% of the federal poverty level (FPL), as well as children whose family income is up to 300% of the FPL.

OHP Bridge is a Medicaid-equivalent benefit package administered by the OHA, which covers adults with higher incomes than those that qualify for OHP Plus. OHP Bridge recipients must meet the following criteria:

- Be 19 to 65 years of age;
- Have an income between 139% and 200% of the FPL;
- Have an eligible citizenship or immigration status; and,
- Not have access to other affordable health insurance.

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

OHP eligibility and CCO enrollment

Applicants who meet eligibility requirements become eligible for an OHP health plan.

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

OHP Plus recipients are eligible for 24 months and must reapply at the end of each 24-month period. OHP Bridge recipients are eligible for OHP for 12 months and must reapply at the end of each 12-month period.

If recipients do not reapply before their eligibility ends, their OHP eligibility may terminate until they successfully reapply.

Applying for OHP enrollment

Application for eligibility is coordinated by Oregon Health Authority offices.

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

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

Health plan enrollment

CareOregon is a managed care entity (MCE) and participates in a variety of different coordinated care organizations (CCOs). To CCO members, the appearance is one of CareOregon being a "partner." All material they will receive is branded per their respective CCO.

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

- Columbia Pacific CCO
- Health Share of Oregon
- Jackson Care Connect

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

OHA enrolls OHP recipients shortly after they become eligible for OHP. Recipients can be enrolled with their health plan on the first day of the month or on any Monday.

Counties have either mandatory MCE or CCO enrollment, with some exceptions, or voluntary enrollment with a health plan.

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

Verifying an OHP recipient's health plan enrollment

There are four ways to verify health plan enrollment:

1. OHA sends recipients an Oregon Health ID card when they enroll. Find the member's name on their Oregon Health ID card for the current month. Follow the row across to the Managed Care/TPA column; or
2. Call the AIS (Automated Information System) at 800-522-2508. Enter your OHA provider number; or
3. Use CareOregon Connect, CareOregon's provider portal, at *careoregon.org/providers/provider-portal*. Only enrolled CareOregon members are in CareOregon Connect. OHP recipients enrolled with a CCO other than CareOregon will not be found in CareOregon Connect. Recipients also receive a Member ID card from their respective CCO that can be used to prove eligibility as a member. Please visit the link above to establish access or to view tutorials for CareOregon Connect; or
4. Visit OHA's Medicaid Management Information System (MMIS) at *or-medicaid.gov/ProdPortal/*; MMIS provides eligibility verification and health plan enrollment for all OHP enrollees. Access can be facilitated through this link.

Batch eligibility (270/271 EDI)

Our batch eligibility (270/271 EDI) service provides a batch eligibility check for providers' practice management systems to check a member's enrollment status and benefits. The service is provided by our vendor, VisibilEDI, and does not replace the individual member eligibility check service available on our CareOregon Connect online portal.

NOTE: There is no requirement for a provider to use this service. In addition, use of this service does not qualify for incentive payments.

For information on how to establish the 270/271 EDI real time batch eligibility verification process, please contact us at 800-224-4840 or *providercustomerservice@careoregon.org*, after reviewing these initial prerequisites:

- Must be a CareOregon participating/contracted provider
- Must have ability to establish an SFTP connection: Have FTP solution and provide an SFTP technical contact

Member Rights and Responsibilities

Member rights and responsibilities for CareOregon Advantage Plus

CareOregon Advantage members' rights and responsibilities are an integral part of the Evidence of Coverage (EOC), based on federally mandated model language. They appear in the EOC, Chapter 8, Your Rights and Responsibilities.

Member rights (COA Plus)

a. To be provided information in a way that works for them (in languages other than English that are spoken in the plan service area, in Braille, in large print or other alternate formats, etc.) If they are eligible for Medicare because of a disability, we are required to give them information about the plan's benefits that are accessible and appropriate for them.

b. To be treated with fairness and respect at all times.

c. To be ensured timely access to their covered services and drugs.

d. To choose a primary care provider (PCP) in the plan's network to provide and arrange for their covered services.

e. To go to a women's health specialist (such as, but not limited to, a gynecologist) for routine and preventive women's health care services without a referral. This is in addition to their primary care provider if that PCP is not a women's health specialist.

f. To family planning services and supplies without a referral, and to choose the method of family planning to be used.

g. To get their prescriptions filled or refilled at any of our network pharmacies without long delays.

h. To receive protection of the privacy of their personal health information.

i. To know how their health information has been shared with others for any purposes that are not routine.

j. To receive information about the plan, its network of providers, and their covered services.

k. To file an appeal of an organizational determination.

l. To file a grievance without fear of retaliation for concerns about COA.

m. To get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

n. To receive confidential communications from CareOregon.

o. To receive support for their right to make decisions about their care, as well as participate fully in decisions about their health care.

p. To be told about all their treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

q. To be told about any risks involved in their care.

r. To be told in advance if any proposed medical care or treatment is part of a research experiment. They always have the choice to refuse any experimental treatments.

s. To refuse any recommended treatment, or to stop taking their medication.

t. To receive an explanation from us if a provider has denied care that they believe they should receive.

u. To give instructions about what is to be done if they are not able to make medical decisions themselves.

v. To make complaints and ask us to reconsider decisions we have made.

w. To get a summary of information about the appeals and complaints that other members have filed against our plan in the past.

Member responsibilities (COA Plus)

a. Become familiar with their covered services and the rules they must follow to receive these covered services.

b. If they have any other health insurance coverage or prescription drug coverage in addition to our plan, they are required to tell us.

c. Tell their doctor and other health care providers that they are enrolled in our plan.

d. Show their plan Member ID card whenever they get their medical care or Part D prescription drugs.

e. If they receive extra help, be sure to show their state Medicaid card. Their state Medicaid program may cover some prescription drugs not normally covered on a Medicare drug plan.

f. Help their doctors and other providers help them by giving them information, asking questions and following through on their care.

g. Follow the treatment plans and instructions that they and their doctors agree upon.

h. If they have any questions, be sure to ask.

i. Be considerate.

j. Respect the rights of other patients.

k. Act in a way that helps the smooth running of their doctor's office, hospitals and other offices.

l. They must pay their plan premiums to continue being a member of our plan.

m. In order to remain eligible for our plan, they must maintain their eligibility for Medicare Part A and Part B.

n. For some of their medical services or drugs covered by the plan, they must pay their share of the cost when they get the service or drug.

o. Tell us if they move outside or within our plan service area.

p. Be considerate.

q. Respect the rights of other patients.

r. Act in a way that helps the smooth running of their doctor's office, hospitals and other offices.

s. They must pay their plan premiums to continue being a member of our plan.

t. In order to remain eligible for our plan, they must maintain their eligibility for Medicare Part A and Part B.

u. For some of their medical services or drugs covered by the plan, they must pay their share of the cost when they get the service or drug.

v. Tell us if they move outside or within our plan service area.

Member rights and responsibilities for CareOregon OHP

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

These are also available in OHP Client Handbook.

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

Participating providers are required to ensure members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.

Member rights (OHP)

CareOregon OHP members shall have the following rights, as outlined in OAR 410-120-1855(1):

a. To be treated with dignity and respect and with consideration for their privacy.

b. To be treated by providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with their care team, including providers and community resources appropriate to the member's needs.

c. To choose a primary care provider or service site and to change those choices as permitted in CareOregon's administrative policies. This includes being notified if a provider is no longer in-network.

d. To refer oneself directly to mental health, substance use disorder (including addiction to cigarettes, alcohol or drugs), or family planning services, without a referral from a primary care provider or another provider.

e. To have a friend, family member, member representative or advocate present during appointments and other times as needed within clinical guidelines.

f. To be actively involved in the development of their treatment plan.

g. To go to a women's health specialist (such as, but not limited to, a gynecologist) for routine and preventive women's health care services without a referral. This is in addition to their primary care provider if that PCP is not a women's health specialist.

h. To family planning services and supplies without a referral, and to choose the method of family planning to be used.

i. To be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatment(s), including obtaining a second opinion or referral if needed.

j. To consent to treatment or refuse services and be informed of the consequences of that decision, except for court ordered services.

k. To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency.

l. To have written materials explained in a manner that is understandable to the member, to be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

m. To receive culturally and linguistically appropriate services and supports in locations as geographically close as possible to where members reside or seek services, including choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.

n. To receive oversight, care coordination, and transition and planning management from CareOregon to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.

o. To receive necessary and reasonable services to diagnose their presenting condition.

p. To receive integrated, person-centered care and covered services designed to provide choice, independence, and dignity, and that generally accepted standards of practice are medically appropriate.

q. To have a consistent and stable relationship with a care team that is responsible for comprehensive care management.

r. To receive assistance from trained CareOregon staff in navigating the health care delivery system, accessing community and social support services and statewide resources, including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the member's care team, to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

s. To obtain covered preventive services.

t. Have access to urgent and emergency services 24 hours a day, seven days a week, without prior authorization.

u. To receive a referral to specialty providers for medically appropriate, covered, coordinated care services, per CareOregon's referral policy.

v. To have a clinical record maintained that documents conditions, services received, and referrals made.

w. To have access to one's own clinical record, including obtaining a copy of the medical record, unless restricted by statute.

x. To transfer a copy of the clinical record to another provider.

y. To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder, or mental health treatment, and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990—Self Determination Act.

z. To receive a written Notice of Adverse Benefit Determination (NOABD) before a denial, or change, of a benefit or service level is made, unless a notice is not required by federal or state regulation.

aa. To be able to make, and to receive help making, a complaint, grievance, or appeal, and to receive a written response.

bb. To request an Administrative Hearing with the Oregon Health Authority.

cc. To receive certified or qualified health care interpreting services, free of charge.

dd. To receive a notice of an appointment cancellation in a timely manner.

ee. To receive adequate notice of CareOregon privacy practices.

ff. To be free from any form of restraint (including being held down or chemically restrained) or seclusion being used as a means of coercion, discipline, convenience, retaliation, or punishment.

gg. For members who are American Indians or Alaska Natives to receive their care from a tribal wellness center, Indian Health Services (IHS) clinic, or the Native American Rehabilitation Association of the Northwest (NARA).

hh. For children and teens through age 20 to be provided health care that:

a. Includes preventive, dental, mental health, developmental, and specialty services

b. Prevents illnesses

c. Finds and treats health issues early, including treatment of issues found during screenings

ii. To file a complaint if the member feels that the orders in their advance directive are not being followed.

jj. To be free to ask the Oregon Health Authority Ombudsperson for help with problems at 503-947-2346 or toll free 877-642-0450, TTY 711.

Member responsibilities (OHP)

a. To choose, or help with assignment to, a PCP or service site

b. To treat CareOregon, provider, and clinic staff members with respect

c. To be on time for appointments made with providers, and to call in advance to cancel if unable to keep the appointment or if expected to be late

d. To seek periodic health exams and preventive services from their PCP or clinic

e. To use their PCP or clinic for diagnostic and other care, except in an emergency

f. To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist, unless self-referral to the specialist is allowed

g. Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in the CareOregon referral policy

h. Give accurate information, including name, that matches the member's ID card for inclusion in the clinical or billing record

i. To help their provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information

j. To ask questions about conditions, treatments, and other issues related to their care that is not understood

k. To use information furnished by providers or care teams to make informed decisions about treatment before it is given

l. To help in the creation of a treatment plan with their provider

m. To follow prescribed and agreed upon treatment plans and to actively engage in their health care

n. To tell their provider, prior to services being received, that their health care is covered under OHP, and, if requested, present their valid member ID card to their provider

o. To notify CareOregon customer service of any change of address or phone number

p. To notify CareOregon customer service if they become pregnant and to notify the customer service representative of the birth of the member's child.

q. To notify CareOregon customer service if any family members move in or out of the household

r. To notify providers and CareOregon customer service if there is any other insurance available, changes of insurance coverage including private health insurance according to OAR 410-120-1960 (Payment of Private Insurance Premiums), and to complete required periodic documentation of such insurance coverage in a timely manner

s. To pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280 (Excluded Services and Limitations) and 410-120-1280 (Billing)

t. To pay the monthly OHP premium on time if so required

u. To assist CareOregon in pursuing any third-party resources available and reimbursing the CCO the amount equal to what the CCO paid for an injury from any third-party recovery received from that injury

v. To bring issues, complaints, and/or grievances to CareOregon's attention

w. To sign an authorization for the release of medical information so CareOregon can obtain pertinent information necessary to respond to an Administrative Hearing request in an effective and efficient manner

x. To inform CareOregon and/or your providers of translation/interpreting needs and to request an interpreter at least two days before an appointment with a provider whenever possible

Other member rights

Member rights under HIPAA (COA Plus and OHP)

CareOregon recognizes the right of members to privacy, especially related to Protected Health Information (PHI). Under the Health Insurance Portability and Accountability Act (HIPAA), members have the right to:

a. Review or obtain a copy of their medical record and other health information

b. Request that incorrect information with their medical record be corrected and/or that information is added if something is missing or incomplete

c. Know who has reviewed their health information and to be informed of how the information is used

d. Request that their health information not be shared with certain people, groups, or companies. These types of requests may be accepted if doing so would adversely affect the care the member receives.

e. Ask to be contacted in a method the member prefers, including alternative mailing addresses, phone numbers, etc.

f. File a complaint, or grievance, if the member feels that their rights under HIPAA were not protected, including filing a complaint with CareOregon, the CCO, and/or the U.S. Department of Health and Human Services (HHS). The member will not be penalized in any way for filing a complaint.

Member rights under the Civil Rights Act and ORS Chapter 659A (COA Plus and OHP)

CareOregon recognizes our members' right to receive care and services without discrimination, including:

a. The right to receive care and services without discrimination based on race, color, national origin, primary language and proficiency of English language, sex, sex characteristics, sex stereotypes, sexual orientation, gender identity, age, religion, marital status, disability, health status, pregnancy or related conditions, or need for healthcare services.

b. The right to meaningful access to care and services, including receiving culturally and linguistically appropriate information free of charge, including interpreting or translation services. Interpreting services provided by CareOregon, and/or providers, will be certified or qualified.

c. The right of members with disabilities to equal and full access to health care and services, including the right to reasonable accommodation.

d. The right to file a complaint related to discrimination with CareOregon, the Oregon Health Authority, the Bureau of Labor and Industries (BOLI), and/or the Office for Civil Rights, without retaliation.

Restraint and seclusion

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

Restraint is:

- Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely.

  OR

- A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom or movement, which is not a standard treatment or dosage.

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

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

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

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

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

Member complaints

Resolving complaints at the provider's office

Members who have complaints about a specific provider, clinic staff or the provider site in general should contact the clinic manager for help in addressing the issue.

Mental health providers are required to address complaints consistent with Grievances and Appeals sections as required by Oregon Administrative Rules 309-019 and 309-022. If a Member remains dissatisfied with the provider's response to the complaint, the member should contact their CCO's Customer Service. Providers may contact CareOregon Customer Service for help in resolving members' complaints.

Providers may not discourage any member from using any aspect of the grievance and appeal system, nor is the following acceptable behavior from providers:

a. Encourage any member to withdraw a grievance, appeal, or contested case hearing request already filed.

b. Use the filing or resolution of a grievance, appeal, or contested case hearing request as a reason to retaliate against a member or as a basis for requesting member disenrollment.

c. Take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.

Violation of these provisions may cause corrective action taken by the plan that could ultimately result in termination of the contract.

Resolving complaints at CareOregon

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

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

OHP complaint forms

If a CareOregon OHP member is uncomfortable contacting CareOregon, they may submit a complaint to the OHA using Oregon Health Plan Complaint Form 3001 or contact OHP Client Services Unit at 800-273-0557 (TTY 711).

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

Medicare Advantage complaints (COA Plus)

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

Member appeals and grievance rights

Advance Directives (COA Plus and OHP)

Members have the right to participate in their care, including making decisions about which treatments they accept and/or refuse. This includes the right to formulate advance directives.

However, there is not a requirement that members develop an advance directive, nor is receiving care contingent in any way on the existence of an advance directive.

CareOregon does not have any institution-wide conscientious objections to advance directives. If a provider has a conscientious objection, it is the responsibility of the provider to furnish CareOregon, and members enrolled with that provider, with a clear statement that includes the range of medical conditions, procedures and/or treatments affected, identification of the State legal authority that permits the objection and (as applicable) any differences between institution-wide and an individual physician's objections.

Applicable providers (hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, home health care providers, hospice, religious non-medical health care institutions [and for purposes of Medicaid, personal care providers]) must meet 42 CFR 489.102(a) including having an advance directive policy in place.

1. Providers must provide written information to members of their right to create an advance directive.

2. Members may have their representative involved in formulating advance directives.

   i. If a member becomes incapacitated, the member's designated representative is recognized as being able to manage care or treatment decisions.

   ii. If the incapacitated member has not designated an authorized representative or the representative is unable/unwilling to make timely health care decisions, CareOregon will follow the Oregon State Law, specifically ORS 127.635 for authorized decision makers.

3. Providers must adhere to the advance directive.

4. Providers must document the existence of an advance directive in a prominent location in their medical record.

5. Members may repeal or amend advance directives.

6. Members may file a complaint with the State Health Licensing Office and/or CareOregon if they feel their advance directive was not followed.

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

Declaration for mental health treatment (COA Plus and OHP)

All CareOregon members have the right to participate in their care, including making decisions about which treatments they accept and/or refuse. This includes the right to formulate a declaration for mental health treatment.

However, there is not a requirement that CareOregon members develop a declaration for mental health treatment, nor is receiving care contingent in any way on the existence of this declaration.

Providers will ensure all capable adult members who are receiving mental health treatment receive information on their rights to make mental health treatment decisions, including the right to execute a declaration for mental health treatment.

Declarations for mental health treatment remain in effect for three years, or until revoked. If a declaration was invoked and in effect at the expiration point, the declaration remains in effect until the member is no longer incapable.

A physician, or provider, may provide treatment that is contrary to the declaration only if the conditions in ORS 127.720 are met.

Members may file a complaint with the State Health Licensing Office and/or CareOregon if they feel their declaration was not followed.

Timing

4. A member may file a grievance at any time. The CCO will notify the member, within 5 business days from the date of receipt of the grievance, of one of the following: (a) A decision on the grievance has been made and what that decision is; or (b) That there will be a delay in the contractor's decision, of up to 30 days. The written notice will specify why the additional time is necessary. Member and provider may file complaint with the CCO, or the state.

5. If the CCO denies, stops or reduces a medical service a provider has ordered, the CCO will mail the enrollee a Notice of Adverse Benefit Determination (NOABD) letter explaining why the decision was made. If the member or provider disagrees with this decision, they may file an appeal within 60 days from the date on the NOABD. The member will receive a Notice of Appeal Resolution (NOAR) letter within 16 days with the CCO's decision.
6. If the CCO fails to adhere to required time frames for processing standard/extended appeals, the member is deemed to have exhausted the CCO's appeal process and may initiate a contested case hearing.
7. If the decision is upheld, the member can file a contested case hearing request with CCO or OHA, no later than 120 days from the date of the Notice of Appeal Resolution (NOAR). Or, if the CCO fails to adhere to the notice and timing requirements, OHA may deem that the CCO appeals process is exhausted.

Filing procedures/requirements

1. A member, or their provider or member representative with written consent, may file a grievance, a CCO level appeal, and may request a contested case hearing.
2. A member may file a grievance, either orally or in writing, with OHA or the CCO.
3. A provider acting on behalf of the member, and with the member's written consent, may file an appeal, either orally or in writing.
4. If the member and their provider believe that the member has an urgent medical problem that cannot wait for a regular appeal, an expedited appeal can be requested. Members should include a statement from their provider or ask the provider to call the CCO to explain why it is urgent. If the CCO agrees that it is urgent, a decision will be made in 72 hours.
5. The CCO can provide assistance to the enrollee with filing grievances and appeals.
6. A contested case hearing can be requested by submitting Form MSC 0443. This form will be included with the NOAR or may be requested by calling the CCO or OHA.
7. Include as parties to the contested case hearing: The member and the representative, CCO and the legal representative of a deceased member's estate.
8. A member, or provider, who believes that taking the time for a standard resolution of a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function may request an expedited contested case hearing.
9. OHA's toll-free number is 800-273-0557, CPCCO's toll-free number is 855-722-8206, JCC's toll-free number is 855-722-8208.

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

Timing

Request must be made within 10 days after the date of the Notice of Adverse Benefit Determination (NOABD), or the intended effective date of the Action proposed in the notice.

The CCO shall continue the member's benefits if:

1. The member or member's representative files the appeal or administrative hearing request in a timely fashion;
2. The appeal or administrative hearing request involves the termination, suspension or reduction of a previously authorized service;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired;

   AND

5. The member files for continuation of benefits in a timely manner.

If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal is in process, the benefits must be continued until one of the following occurs:

1. The member withdraws the appeal or contested care hearing;
2. The member does not request a contested case hearing within 10 days from when the CCO mails the Notice of Appeal Resolution (NOAR) to the member's appeal;
3. A contested case hearing decision adverse to the member is made;
4. OHA issues an appeal decision adverse to the member;

   OR

5. The authorization expires or authorization service limits are met.

If the final resolution of the appeal or contested case hearing is adverse to the member (upholds the CCO's original decision), the CCO may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

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

If they are not resolved, OHP members have the right to request a hearing by OHA through its hearing process. Members may call the Customer Service of their CCO to file their complaint.

Member Benefits

Benefit guidelines

Medicare covered services

Medicare has three parts:

- **Part A** covers facility care such as inpatient hospitalization, skilled nursing care and hospice care.
- **Part B** covers outpatient care including outpatient surgery and office visits.
- **Part D** covers prescription drugs.

Most Medicare enrollees are eligible for both Part A and Part B, but some are eligible for only one part. To be a beneficiary with CareOregon Advantage, a member must have Parts A and B.

For more information about Medicare coverage and exclusions, visit the CMS website at ***cms.hhs.gov***

You can view benefit information for CareOregon Advantage Plus (HMO-POS D-SNP) in the current Summary of Benefits, Benefit Highlights Sheet or Evidence of Coverage, all available online at *careoregonadvantage.org/members/my-plan-documents*

- **Medicare Advantage maximum out-of-pocket:** CMS passed a new rule effective January 1, 2023, affecting the administration of the Medicare Advantage Part A and B calendar year maximum out-of-pocket (MOOP) benefit provision. Prior to this rule, Medicare Advantage plans were not required to apply the MOOP for services covered by Medicaid since the individual enrollee was not responsible for paying them. The new rule specifies that the Medicare Advantage plan must apply the enrollee's calculated cost-sharing to the MOOP even though that cost-sharing would not be paid by the enrollee. This results in the Medicare Advantage plan paying 100% of the fee schedule allowance for covered services when the MOOP has been met. See *Coordination of Benefits* for more information.

OHP covered services

Prioritized List of Health Services: OHP covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits.

To determine if a service is covered by CareOregon, check the prioritized list on the MMIS portal which may be found at the following link: ***or-medicaid.gov/ProdPortal/***

Diagnosis and treatment pairs that are above the line are covered by OHP and CareOregon.

Diagnosis and treatment pairs that fall below the line are not covered benefits of either OHP or CareOregon. Services below the line generally include conditions that improve by themselves, conditions for which no effective treatments are available or cosmetic treatments.

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

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

Fee-for-service (OHP) covered services

Some OHP-covered services must be billed directly to the OHA, rather than the CCO, regardless of whether the member is enrolled with CareOregon. If a claim is received by CareOregon for OHA-covered services, it will be returned.

Death with Dignity services: OHA covers physician aid in dying (death with dignity services) and claims for these services should be submitted directly to OHA. Providers should ensure they are billing according to these guidelines to avoid claim processing delays.

Elective abortion services: OHA covers elective abortion services and claims for these services should be submitted directly to OHA. CareOregon only covers services related to managing a miscarriage. Providers should ensure they are billing according to these guidelines to avoid claim processing delays.

For information on CareOregon covered abortion and miscarriage management services, please see the *Abortion and miscarriage management* section.

CareOregon covered services

- *Primary care and preventive services*
- Specialty services
- Maternity care
- Family planning
- *Abortion and miscarriage management*
- *Inpatient hospital and extended care (hospice and skilled nursing facility*)
- Prescriptions
- Laboratory and X-ray
- Durable medical equipment and supplies
- Home health
- Physical, occupational and speech therapy
- Ambulance transportation
- *Routine vision services*
- *Mental health treatment services*
- *Substance use disorder treatment services*
- *Sterilizations & hysterectomies*
- *Tobacco cessation*

Please note: *For additional details related to HealthShare/CareOregon Behavioral Health services, please refer to our metro area behavioral health providers page at careoregon.org/bhproviders*

Services not covered by OHP and CareOregon

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

Providers may freely communicate with patients about their treatment options regardless of benefit coverage limitations.

CareOregon will not pay for services that are not covered by OHP.

IMPORTANT: OHA prohibits billing Oregon Health Plan recipients for covered services. You can read more in the "*Member Billing*" section.

Sterilizations & hysterectomies

Requirements

Oregon law requires that informed consent be obtained from any individual wanting voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy.

It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. Therefore, CareOregon cannot reimburse providers for these procedures without proof of informed consent. For more information about claims for these procedures, please see the "*Claims*" section.

Voluntary sterilization

For a tubal ligation or vasectomy, the patient must sign the Consent to Sterilization form (available in both English and Spanish) at least 30 days, but not more than 180 days, prior to the sterilization procedure.

Exceptions:

- In case of premature delivery, the sterilization may be performed fewer than 30 days but more than 72 hours after the date that the member signs the consent form. The member's expected date of delivery must be entered.
- In case of emergency abdominal surgery, the sterilization may be performed fewer than 30 days but more than 72 hours after the date of the individual's signature on the consent form. The circumstances of the emergency must be described.

The person obtaining the consent must sign and date the form. The date should be the date the patient signs or after. It cannot be on the date of service or later. The person obtaining consent must provide the address of the facility where consent was obtained.

If an interpreter assists the patient in completing the form, the interpreter must also sign and date the form.

The physician must sign and date the form either on or after the date the sterilization was performed.

Fully and accurately completed consent forms, including the physician's signature, should be submitted with all sterilization claims. Incomplete forms are invalid and will be returned to the provider for correction.

Hysterectomies

Hysterectomies performed for the sole purpose of sterilization are not a covered benefit.

Patients who are not already sterile must sign the Hysterectomy Consent form (available in both English and Spanish).

Physicians must complete Part I including the portion "medical reasons for recommending a hysterectomy for this patient." CareOregon will return the form to the provider if this portion is omitted.

Patients who are already sterile are not required to sign a consent form. In these cases, the physician must complete Part II including cause and date (if known) of sterility, e.g. "tubal ligation 1992."

In cases of life-threatening emergency when consent cannot be obtained, the physician must complete Part II including the nature of the emergency that made prior acknowledgement impossible.

Abortion and miscarriage management

CareOregon covers services related to managing a miscarriage, including evaluation and management codes for non-surgical intervention, or treating complications following an abortion. Elective abortion services are not covered by CareOregon, but may be covered by OHA for OHP-enrolled members. For more details regarding elective abortion services, please see the "*Fee-for-service (OHP) covered services*" section of this manual.

Skilled nursing facility care

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

Placing a member in a nursing facility

When a CareOregon member being discharged from the hospital must be placed in a skilled nursing facility, the hospital discharge planner and the CareOregon Concurrent Review RN coordinate placement.

Skilled nursing care requires prior authorization. You will be notified when your member is admitted to a skilled nursing facility.

Managing care of members in a nursing facility

PCPs can choose whether or not to manage the care of their patients who are placed in a nursing facility.

PCPs can choose to provide medical management to these patients.

OR

PCPs can have the nursing facility's house physician provide medical management.

Members remain assigned to their existing PCP during a temporary stay in a nursing facility. The house physician is paid a fee-for-service for their office visits with these members.

The CareOregon Concurrent Review RN monitors members while they are in the facility. Arrangements for discharge to a lower level of care are coordinated by the CareOregon RN and the skilled facilities staff.

Hospice care

CareOregon covers hospice care when the member has a terminal illness and a life expectancy of six months or fewer. The goal of hospice care is comfort care only, to make the dying process as comfortable and tolerable as possible. Hospice care does not require authorization from CareOregon.

Mental health treatment services

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

Mental health treatment coverage for OHP members

Treatment provided by a mental health provider, such as psychotherapy by a professional therapist or medication management by a psychiatrist, is covered under OHP and may be administered by CareOregon or an entity which may be separate from CareOregon.

OHP recipients do not choose who manages their mental health benefits. They are assigned to an entity based on the CCO they select and the county where they live. Although CareOregon coordinates with the other entities, members should contact the entity noted below to access mental health services.

For Intensive In-home Behavioral Health Treatment (IIBHT) guidelines, please see *Appendix B* at the back of this book.

Mental health entities in CareOregon's service area:

- Multnomah, Clackamas and Washington counties: Health Share of Oregon
- Clatsop, Columbia and Tillamook counties: Columbia Pacific CCO
- Jackson County: Jackson Care Connect

Mental health services for COA Plus members

For COA members, mental health services are covered and coordinated by CareOregon.

Mental health benefits for COA members include:

- Part A coverage – inpatient care (note: inpatient care at a psychiatric specialty hospital is limited to a lifetime benefit of 190 days)
- Part B coverage – outpatient care, including laboratory and radiology
- Part D coverage – prescription care

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

Contracted providers are listed in the "Mental Health" section of the CareOregon Advantage Provider Directory, which may be found at the following link:
careoregonadvantage.org/provider-directory

Mental health in the primary care setting

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

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

Behavioral health appointment availability and standard scheduling procedures

Urgent behavioral health treatment appointments should be scheduled within 24 hours.

Routine behavioral health treatment appointments should be scheduled as follows:

- Within seven days of request, see patient for an intake assessment.
- Within 14 days, see the patient for second appointment (sooner if clinically indicated).
- Within 48 days of request, see the patient three additional times.

Appointments must be therapeutic in nature and expand beyond administrative activities.

Specialty Behavioral Health providers are to ensure patients have timely access to covered specialty behavioral health services. If providers cannot meet these time frames, the member must be placed on a wait list and provided interim services within 72 hours of being placed on a wait list.

Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance abuse disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135.

If care cannot be provided according to the time frames listed here, the provider must contact CareOregon Care Coordination services, which will help place the member in the appropriate care setting.

The following populations require immediate assessment and intake. If interim services are necessary, treatment at the appropriate level of care must start within 120 days from placement on a wait list:

- Pregnant women
- Veterans and their families
- Women with children
- Unpaid caregivers
- Families
- Children ages birth through five years
- Individuals with HIV/AIDS or tuberculosis
- Individuals at the risk of first episode psychosis
- Children with serious emotional disturbance
- I/DD population

For IV drug users, immediate assessment and intake is required. Admission must occur within 14 days of request, or if interim services are necessary, admission must commence within 120 days from placement on a wait list.

For opioid use disorder and medication assisted treatment, assessment and intake are required within 72 hours.

Substance use disorder treatment services

Substance use disorder coverage for OHP members

The Oregon Health Plan substance use disorder (SUD) benefit includes coverage for the diagnosis and treatment of substance use disorders.

Accessing substance use disorder services covered by CareOregon

IMPORTANT: Substance use disorder services do not require a referral from the PCP.

Members can self-refer to any CareOregon contracted SUD treatment provider for a SUD assessment. These providers are listed in the Online Provider Directory of each respective CCO.

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

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

Authorization of services

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

To request authorization for hospital detoxification, follow the authorization procedure in the *Requirements* section.

Dental health services

Members have dental health benefits in addition to physical and mental health benefits. Dental benefits are provided through our partner dental care plans. The dental plan is listed on the member's CCO ID card and OHP coverage letter. members can choose or change their dental plan by calling their CCO. They can choose or change their primary dental provider (PDP) by calling their dental plan, not their CCO.

CCO	CCO Phone#	Partner Dental Care Plans	DCO Phone#
health share Health Share of Oregon	888-519-3845	Advantage Dental CareOregon Dental Kaiser Permanente ODS Willamette Dental Group	866-268-9631 888-440-9912 800-813-2000 800-342-0526 855-433-6825
Columbia Pacific CCO™	855-722-8206	Advantage Dental CareOregon Dental ODS Willamette Dental Group	866-268-9631 888-440-9912 800-342-0526 855-433-6825
Jackson Care Connect™	855-722-8208	Advantage Dental Capitol Dental ODS	866-268-9631 800-525-6800 800-342-0526

Dental benefits and services

There are two levels of dental benefits:

1. OHP Supplemental for pregnant women and members under 21 years of age
2. OHP for all other adults

Some services may be limited or need prior approval.

Benefit summary	OHP Supplemental (for pregnant women and members under age 21)	OHP (for all other adults)
Emergency services		
Emergency stabilization (in or out of service area) **Examples:** • Extreme pain or infection • Bleeding or swelling • Injuries to the teeth or gum	✓	✓
Preventive services		
Exams	✓	✓
Cleaning	✓	✓
Fluoride treatment	✓	✓
X-rays	✓	✓
Sealants	Limited to age 15 and under	Not covered
Restorative and prosthodontic services		
Fillings	✓	✓
Partial dentures	✓	Limited
Complete dentures	Limited	Limited
Crowns	Limited	✓
Oral surgery and endodontics		
Extractions	✓	✓
Root canal therapy	✓	Limited

Referrals to other providers and specialists

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

Emergency and urgent dental care services

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

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

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

- A toothache
- Swollen gums
- A lost filling

Local care for emergency and urgent dental care

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

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

Out of area emergency and urgent dental care

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

Dental appointment availability and standard scheduling procedures

Oral and dental care for children and non-pregnant individuals:

- Dental emergencies should be seen or treated within 24 hours.
- Urgent dental appointments should be scheduled within two weeks.
- Routine and follow-up dental appointments should be scheduled within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

Oral and dental care for pregnant individuals:

- Dental emergencies should be seen or treated within 24 hours.
- Urgent dental appointments should be scheduled within one week.
- Routine and follow-up dental appointments should be scheduled within four weeks, unless there is a documented special clinical reason that makes a period of longer than four weeks appropriate.

Routine vision services

CareOregon has contracted with Vision Services Plan (VSP) to provide routine vision services, such as refraction and dispensing of glasses, to our members.

Coverage is only available for individuals under 21 years old and pregnant adults who have coverage on OHP. All other OHP patients are not covered unless they have a qualifying medical eye condition. **Please note:** VSP is not available in Tillamook County.

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

IMPORTANT: Do not refer members to these routine vision providers for medical eye care needs. Medical eye services are considered specialty visits. Members should be referred to a participating ophthalmologist or optometrist. To determine if services require an authorization, see the *Requirements* section.

Tobacco cessation

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

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

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

How to quit: Tobacco Information and Prevention: *cdc.gov/tobacco/how2quit.html*

National Quit Line: 800-QUIT NOW
For free personalized help with quitting, call 877-44U-QUIT (877-448-7848)
Toll-free 9 a.m. to 4:30 p.m., Monday through Friday.
American Lung Association of Oregon: *lungoregon.org/quit/index.html*
Email: *healthinfo@lungoregon.org*, or call 503-924-4094, ext. 10.

For pregnant smokers:

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

Smoking and Pregnancy, American Lung Association:
lungusa.org/stop-smoking/about-smoking/facts-figures/women-and-tobacco-use.html
Call: 800-LUNG-USA (800-586-4872)

Many treatment options are available to assist members in tobacco cessation efforts. These include medications, telephonic counseling, provider interventions and other community support.

Resources can be found at the following link:
careoregon.org/members/health-and-wellness/staying-healthy/quitting-tobacco

PCP Assignment and Selection

Assigning a PCP to CareOregon members

All CareOregon members have a primary care provider (PCP) who manages their medical needs.

CareOregon members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

PCPs are automatically assigned when the member enrolls with CareOregon. Auto assignment is based on where the member lives.

Members have 30 days from the date of enrollment to change their PCP assignment.

Changing PCPs

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

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

After their first 30 days with their CCO, members may change their PCP no more than twice in a six-month period. Exceptions will be made for members who have had a change of residence or who have been discharged from their PCP clinic.

PCP assignments become effective the day they are requested. However, newly assigned PCPs may not know about their assignments until they download their member roster.

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

Member rosters

PCP clinics can access their current clinic roster of members assigned to their clinic on CareOregon Connect at careoregon.org/providers/provider-portal

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

Member Care and Support Services

Primary care and non-primary care

Primary care is defined as comprehensive, continuous, first contact care that focuses on preventive care and care of common conditions. CareOregon's model of managed care is based on a foundation of primary care services.

Non-primary care is defined as services that are not considered primary care services. PCPs can choose to provide non-primary care services to their patients or to refer patients to specialists for provision of these services.

Provider survey

Providers will periodically receive a survey intended to validate key information to ensure the CareOregon Provider Directory publishes accurate information. Responses to this survey are required.

Primary care services

CareOregon's primary care providers are responsible for providing primary care services to their assigned patients.

General categories of primary care services:

Preventive services, health maintenance and disease screening such as:

- Well child care
- Immunizations
- Blood pressure screening
- Physical exams, including annual gynecological exams

Managing common chronic primary care problems such as:

- Diabetes
- Hypertension
- Chronic lung disease
- Asthma
- Arthritis
- Seizure disorders
- Peptic ulcer disease
- Ischemic heart disease
- Other similar conditions managed in the office

Managing common acute primary care problems such as:

- Respiratory infections
- Urinary infection
- Gastroenteritis
- Acute musculoskeletal strains, sprains and contusions
- Vaginitis
- Hemorrhoids
- Depression
- Anxiety disorders
- Other similar conditions managed in the office and minor outpatient procedures

Coordinating care including such services as:

- Referring patients for specialty care needs, communicating with specialists and managing the ongoing referral process.
- Coordinating hospital care and discharge planning, including planning done by a consultant.

Non-primary care services

PCPs are responsible for managing all of the medical care needs of their assigned CareOregon members. This means PCPs are responsible for either providing or coordinating services that are not considered primary care services.

PCPs can choose to provide non-primary care services to their patients or to refer patients to specialists for provision of these services (see "*Referrals and Authorizations*" for information on the referral and authorization process).

Examples of services considered non-primary care include, but are not limited to, the following:

- Inpatient physician care
- Obstetric care
- Prenatal care
- Non-primary laboratory including all lab tests not waived by the CLIA regulations
- Mental health treatment not provided in a primary care setting
- Radiology services including X-ray interpretation
- Consultant care
- Home and nursing home visits including hospice care
- Prescription drugs including medications dispensed from the office

Examples of non-primary care outpatient procedures include, but are not limited to, the following:

- ECG tracing and interpretation
- Spirometry
- Fracture care including casting
- Colposcopy
- Endometrial biopsy
- Sigmoidoscopy

Examples of non-primary care family planning services include, but are not limited to, the following:

- IUD insertion
- Birth control pills
- Vasectomy
- Emergency contraception

Responsibilities of the PCP

Primary care providers will provide at least the following level of service to those CareOregon members assigned to them:

- Maintain a comprehensive problem list in the member's record, which lists all medical, surgical and psycho-social problems for each patient.
- Maintain a comprehensive medication list that includes all prescription medications the member is taking and their medication allergies. This includes medications prescribed by specialists.
- Provide accessible outpatient care within four weeks for any routine visit (e.g., preventive care).
- Provide accessible outpatient care within 24 hours for any member with an urgent problem.
- Provide access to telephone advice for member questions 24 hours per day.
- Provide preventive services as recommended by the U.S. Preventive Services Task Force.
- Provide immunizations as recommended by the Centers for Disease Control.
- Arrange and authorize specialty consultation with a network consultant within four weeks for any member with a non-urgent problem needing such consultation.
- Arrange and authorize specialty consultation with a network consultant within 24 hours for any member with an urgent problem needing such consultation.
- Ensure specific written communication including initial diagnosis and procedures requested as part of each referral.
- Arrange for hospitalization in a network institution when required. Arrangements include identifying the responsible attending physician or providing the service and member's care plan to the facility within 24 hours of the initial call.
- Coordinate hospital care for every hospitalized member including participation in planning for post-discharge care.

- Coordinate nursing home care for each member in a nursing home.
- Provide interpretation services by certified or qualified interpretation staff or utilize a CareOregon-approved interpretation service for telephonic interpretation and/or onsite appointments, in accordance with CareOregon policy that anyone interpreting on behalf of members, including bilingual clinic staff, be a certified or qualified interpreter.
- Ensure that multi-lingual providers have passed an OHA-approved proficiency test before providing in-language services.
- Have a policy and/or procedure to arrange for and provide access to an appropriate back-up physician or practitioner for any leaves of absence.

Responsibilities of hospital and specialty services providers

Hospital personnel and specialty providers are responsible to participate in the transition and discharge planning process and ensure achievement of successful transitions of care. Hospital personnel and specialty providers should work collaboratively with the members' primary care provider to facilitate member transition into the most appropriate, independent and integrated community-based settings.

Access to care: primary care and non-primary care

It is the policy of CareOregon to ensure that our members have access to timely, appropriate preventive and curative health services that are delivered in a patient-friendly and culturally competent manner. CareOregon requires practitioners to have policies and procedures that prohibit discrimination in the delivery of health care services.

Physical access

All participating CareOregon provider clinics must comply with the requirements of the Americans with Disabilities Act of 1990, including but not limited to street level access or accessible ramp into the facility and wheelchair access to the lavatory.

Appointment availability and standard scheduling procedures

Routine and follow-up appointments should be scheduled to occur as medically appropriate within four weeks.

Urgent care cases should be scheduled to be seen within 72 hours, or as indicated in the initial screening, in accordance with OAR 410-141-3840.

Emergency care cases should be scheduled to be seen and treated immediately or referred immediately to an emergency department depending on the member's condition.

Appointments for initial history and physical assessment should be scheduled in longer appointment slots to allow for preventive care and health education as needed.

Providers should apply the same standards to their CareOregon members (including hours of operation) as they do to their commercially insured or private pay patients.

Additional scheduling standards for Jackson Care Connect mental health providers can be found in the Jackson Care Connect Mental Health Practice Guidelines posted on the Jackson Care Connect website.

Non-scheduled walk-ins

Provider procedures for triaging walk-ins must include the following actions:

When a member walks in without an appointment, office staff record the member's demographic information (name, address, etc.) and presenting problem and send this information to the triage nurse or provider.

1. The triage nurse or provider performs a preliminary assessment of the member's condition.
2. Members with **emergent** conditions are seen immediately and/or referred for transport to the nearest hospital.
3. Members with **urgent** conditions are seen within two hours, depending on the severity of the condition, and/or referred for transport to the nearest hospital.
4. Members who present with a **non-urgent** condition are scheduled for an appointment as medically appropriate.

Follow-up of missed appointments

To ensure optimum health services and outcomes, CareOregon participating providers should document and follow up with members who do not keep their scheduled appointments.

Providers should have a procedure for follow-up of missed appointments that includes the following features:

- Documentation on the same day in the member's medical record of the date, type of appointment and failure to keep the appointment.
- Review of the member's medical record by the triage nurse or provider.
- An assessment of the need for and type of follow-up to occur (e.g. telephone contact, attempt to reschedule, failed appointment letter) by the triage nurse or provider.
- If telephone contact is required, the provider or triage nurse should call the client. Otherwise, non-medical support staff can follow up as specified by the provider or triage nurse.

It is important to have written documentation of continually missed appointments if you wish to pursue discharging such members from your care (see *Appendices* for more information on the discharge and disenrollment process).

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

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

24-hour telephone access

CareOregon has a commitment to its members to provide 24-hour telephone access to health care.

CareOregon primary care providers must have a telephone triage system with the following features:

Access during office hours: A primary care provider (physician, nurse practitioner or physician's assistant) or registered nurse triages member calls to determine appropriate care and assists the member with advice, an appointment or a referral. Calls may be answered by, but not screened by, support staff. If calls are answered by support staff, the member should be informed of the estimated response time (not to exceed 30 minutes).

The nature of the call and intervention are documented in the member's medical record.

Interpreter services are available for telephone calls (see the *Language Access* section for more information about interpretation).

Access after hours: The Provider Services team conducts an annual after-hours survey to ensure that the following criteria are met. If you have questions, contact a Provider Relations Specialist at *careoregon.org/providers/support*.

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

Answering service:

- Urgent situations: The person who answers the phone must offer to either page the doctor on call and call the member back or transfer the member's call directly to the doctor on call.
- Emergency situations: The person who answers the phone tells the member to call 911 or go to the nearest emergency room if the member feels their situation is too emergent to wait for the doctor to call them.

Answering machine:

- Urgent situations: The message gives instructions on how to page a doctor for urgent situations or tells the member to go to the hospital emergency room or urgent care if the situation cannot wait until the next business day.
- Emergency situations: The message must provide information on accessing emergency services, i.e. call 911 or go to the nearest emergency room if the member feels the situation is emergent.

Discharge and disenrollment of members

- **Discharge**: A member is removed from the care of his or her assigned PCP.
- **Disenrollment**: A member is removed from his or her health plan.

Requirements

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

CareOregon's philosophy is to encourage members and their providers to resolve complaints, problems and concerns at the clinic level. However, before discharging a member or requesting that a member be disenrolled from CareOregon, the PCP must request CareOregon's involvement to help resolve the problem or concern.

For additional primary care discharge and disenrollment guidelines, please review the procedures in Appendix A at the back of this manual.

If clinic management decides to discharge the member, a letter must be sent to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number.

Fax a copy of the discharge letter to 503-416-8117, Attn: Enrollment Department. If any of the above information is missing, the discharge may not be processed and additional actions may be required.

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

Just causes for discharging a member

A member may be discharged from a PCP or disenrolled from CareOregon only with just cause. Just causes identified by OHA include but are not limited to:

- Missed appointments (except prenatal care patients).
- Drug-seeking behavior.
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or CareOregon staff.
- Verbal abuse: abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.
- Discharge from PCP by mutual agreement between the member and the provider.
- Agreement by the provider and CareOregon that adequate, safe and effective care can no longer be provided.
- Fraudulent or illegal acts committed by a member, such as permitting someone else to use his or her medical ID card, altering a prescription, or committing theft or another criminal act on any provider's premises.

Note: The provider or provider staff must report any illegal acts to law enforcement authorities or to the OHA/DHS Fraud Investigations Unit *as appropriate. Call the Fraud Hotline at 888-FRAUD01 (888-372-8301).*

When a member cannot be discharged

According to OHA Administrative Rule 410-141-0080, members cannot be discharged from a PCP or disenrolled from CareOregon solely because of any of the following reasons:

- The member has a physical or mental disability.
- The member has an adverse change in health.
- The PCP or CareOregon believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises their option to make decisions regarding their medical care and the provider/plan disagrees with the member's decisions.

Key factors when considering discharging a member

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

- Timely, early communication and collaboration with CareOregon Care Coordination staff to problem solve.
- Thorough documentation of events, problems and behaviors.
- A plan generated by the PCP to attempt to address the problem or concerns.
- CareOregon strongly encourages using contracts and case conferences to address problems and concerns. (Call a CareOregon Care Coordinator for sample contracts and assistance.)
- Consider mental health diagnoses as part of the discharge and disenrollment process.

Quality Assurance Program

CareOregon's Quality Program is the mechanism through which CareOregon provides structure and processes to ensure that care provided to members is accessible, cost effective and improves health outcomes. It is designed to support the achievement of clinical and operational performance goals and to ensure that CareOregon meets its regulatory and contractual deliverables to the Oregon Health Authority (OHA), the Centers for Medicare and Medicaid Services (CMS) and other relevant accrediting bodies. The Quality Program reflects the imperative of the Triple Aim to improve the member's experience of care, improve the health of populations and reduce the per capita cost of care. CareOregon pursues these aims through the implementation of programs and strategies that have the following objectives:

- Monitor the health status of our members to identify areas that most significantly impact health status and/or quality of life.
- Ensure the optimal use of health strategies known to be effective, including prevention, risk reduction and evidence-based practices.
- Develop population-based health improvement initiatives.
- Ensure quality and accountability through achievement of relevant clinical performance metrics.
- Provide enhanced support for those with special health care needs through:
  - » Proactive identification of those at risk.
  - » Case management and coordination of fragmented services.
  - » Promotion of improved chronic care practices.
- Coordinate fragmented services by supporting integrated models of mental and physical health care services.
- Participate in efforts that improve health care for all Oregonians by:
  - » Supporting community, state and national health initiatives.
  - » Building partnerships with other health care organizations.
  - » Pursuing research on new models of health care design and delivery.
- Seek collaboration within the community to identify and eliminate health care disparities.
- Create and support the capacity development of community providers to facilitate clinical change.

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

Clinical practice guidelines

CareOregon, through its Quality Committee, reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses.

Practice guidelines are posted at the following link:
careoregon.org/providers/best-practice-guidelines

Jackson Care Connect mental health practice guidelines are posted at the following link:
jacksoncareconnect.org/for-providers/policies-and-forms

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

Medical records

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

Criteria for what constitutes a complete medical record:

- Each medical record must contain information for one patient only.
- Medical records must have dated legible entries for each patient visit.
- Entries are identified by author.
- Signatures are full and legible and include the writer's title. Acceptable forms of signatures include handwritten, electronic signatures or facsimiles of original written or electronic signatures. **Stamped signatures are not acceptable.**
- A medical record is reviewed and completed by a responsible provider before it is filed.
- Records are organized and stored in a manner that allows easy retrieval and ensures confidentiality compliant with applicable privacy laws.
- Medical records are stored securely.

Each medical record should contain the following information:

- Patient's name, date of birth, sex, address, telephone number and any other identifying numbers, as applicable
- Name, address and telephone of patient's next of kin, legal guardian or other responsible party
- Advance Directives, guardianship, power of attorney or other legal health care arrangements, when applicable
- A problem list with significant illnesses and medical conditions

- A medication list, including an indication of allergies and adverse reactions to medications, and documentation if no allergies are identified as well
- History of presenting problems and a record of a physical exam for the presenting problem(s)
- Diagnoses for presenting problems
- Plans of action (treatment plan) consistent with diagnoses
- Vital signs, height, weight, etc
- Laboratory and other studies ordered, as appropriate, and initialed by the primary care provider
- Documentation of referrals to and consultations with other providers
- Documentation of appropriate follow-up
- Emergency room and other reports
- Baseline documentation of tobacco and alcohol use
- Documentation of past and present use/misuse of illegal, prescribed and over-the-counter drugs
- Documentation of behavioral health status assessments
- Copies of signed release of information forms
- Age-appropriate screenings and developmental assessments
- Copies of advance directives and/or mental health declarations

Medical records for mental health services covered by Jackson Care Connect must adhere to applicable OARs or can be viewed at the following link: *jacksoncareconnect.org/providers/provider-resources/forms-and-policies*

Medical record review

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

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

Confidentiality

Providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Act's (HIPAA) transactions must adhere to the HIPAA Privacy and Security regulations as well as 42 CFR Part 2, as applicable.

Providers must provide privacy and security training to any staff who have contact with individually identifiable health information.

All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored.

Examples of stored information include: clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disk or optical media formats.

Disclosure of health information in medical or financial records can only be to the patient or legal guardian unless the patient or legal guardian authorizes the disclosure to another person or organization, or a court order has been sent to the provider.

Health information may only be disclosed to those immediate family members with the verbal or written permission of the patient or the patient's legal guardian. Health information may be disclosed to other providers involved in caring for the member without the member or member's legal representative's written or verbal permission.

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

Information may be disclosed to insurance companies or their representatives for quality and utilization review, payment or medical management. Providers may release legally mandated health information to state and county health divisions and to disaster relief agencies.

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

Take extra care not to discuss patient information (financial and clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

Providers' employees (including physicians) must not have unapproved access to their own records or records of anyone known to them who is not under their care. CareOregon staff adheres to the HIPAA-mandated confidentiality standards.

Language access

Interpreting

All contracted CareOregon providers must make interpreting services available to CareOregon members. Interpreters may operate on-site, over the phone, or via computer screen.

In accordance with OAR 950-050-0160, providers must work with qualified or certified interpreters when arranging for or providing services to a person who has interpretation needs. Exceptions are allowed when the provider:

- Has documented proficiency in the preferred language of the person
- Has made a good faith effort to schedule a qualified or certified interpreter and has found that none are available; in this scenario they may schedule an interpreter who is not certified or qualified
- Has maintained records that the person with interpretation needs was offered interpretation services at no cost and the person declined and chose a different interpreter, which could include a family member or friend

Healthcare providers must provide personal protective equipment to healthcare interpreters providing services on-site.

In-language services

In-language services are considered any healthcare service in which a multilingual provider is performing the services in the member's preferred, non-English language. This does not apply to clinic staff or contracted interpreters who interpret on behalf of the provider and the member. CareOregon requires that providers pass an OHA-approved language proficiency test prior to providing in-language services. The Oregon Health Authority's Equity & Inclusion Division (E&I) maintains a list of OHA-approved proficiency tests on the Healthcare Interpreter Training Programs website (e.g., Language Line Solutions and Language Testing International). The provider must sufficiently pass the proficiency test with a score of:

- 2+ or higher for Interagency Language Roundtable (i.e., Language Line Solutions' proficiency test); or
- Advanced-mid level or higher for American Council on the Teaching of Foreign Language (i.e., Language Testing International)

After completing the test, the provider would receive a certificate of completion with a score. CareOregon may request a copy of that document to confirm that the provider qualifies as passing the proficiency test in the member's preferred language. The proficiency testing should be completed within the last three years.

Occurences when CareOregon covers interpreting services:

- Onsite medical, dental, behavioral or social health appointments
- Scheduling or rescheduling appointments
- Appointment reminders
- Appointment follow-ups
- Relaying test results
- Registration for procedures/admissions

Using CareOregon-approved vendors

CareOregon pays for interpreting services through our approved vendors. We have contractual arrangements with these vendors who will prioritize scheduling certified and qualified interpreters for CareOregon member appointments that we encourage providers to use.

Should a provider use a vendor other than a CareOregon-approved vendor, the provider will be responsible for coordinating and paying the interpreting services. When using CareOregon-approved interpretation vendors, the interpretation vendor will bill CareOregon directly for the appointment. Information for using each of the interpretation vendors is detailed below. You can also reference our *Vendor Intake Guide*, available on our ***Language services*** webpage.

Immigrant & Refugee Community Organization (IRCO)	
Web:	*irco.org*
Services:	On-site, VRI, and OPI

Scheduling an appointment:	• Online Scheduling Portal: When using the *online portal*, there are two options available for scheduling an appointment:
	  • Login: The requestor should select the login button if they already have an account. This will take the requestor directly the portal to schedule an appointment.
	  • Schedule: First-time users should select the "Schedule" button to go directly to IRCO's online request form, enter appointment information, and to submit their request. Once IRCO receives the initial request, if an account has not been setup, an account specialist will contact the requestor to do so and will provide more detailed instructions at that time.
	• Email: *interpretation@ircoilb.org*
	• Phone: When scheduling by phone, there are two options available:
	On-site and scheduled OPI/VRI appointments:
	  • 503-234-0068
	On-demand appointments:
	  • 971-271-6489 (CareOregon Access Code: 4840)

Linguava	
Web:	*linguava.com*
Services:	On-site, VRI, and OPI

Scheduling an appointment:	Providers who have not already signed up with Linguava, or that have a signed service agreement, must reach out to the sales department first to complete the onboarding process before submitting an interpretation request.
	• Online scheduling portal: To create a login for the *online portal*, refer to the help links section on the right side of the login page.
	• Email: *scheduling@linguava.com*
	• Phone: 503-265-8515
	  • On-site and scheduled OPI/VRI appointments: option 1
	  • On-demand services: option 2
	  • For on-demand, the provider will need to give a customer code (ask for one from Linguava, if not available)
	• Fax: 503-954-1038

National Interpreting Service (NIS)	
Web:	*nationalinterpretingservice.org* (For general information, inquiries, or quotes, not to make appointments)

National Interpreting Service (NIS)	
Specialty	American Sign Language (ASL) and other sign languages
Services:	On-site and VRI

Scheduling an appointment:	Please be aware that scheduling a sign language interpreter can take more time than scheduling for other languages. On-demand services are not always available and should not be expected.
	• Email: *schedule@nationalinterpretingservices.org*
	• Phone: 877-NIS-SIGN or 877-647-7446 (toll free)
	  • Oregon: 503-932-8460
	  • Washington: 206-337-4447
	• Fax: 866-411-9742

Oregon Certified Interpreter's Network (OCIN)	
Web:	*oregoncertified.interpretmanager.com*
Services:	On-site, VRI, and OPI

Scheduling an appointment:	The online portal is highly recommended when scheduling with OCIN.
	• Online scheduling portal: To create a login for the *online scheduling portal*, there are two options available:
	  • Send in a request online here: *https://oregoncertified.com/new-clients/*
	  • Email OCIN at *scheduler@oregoncertified.com* and ask to create an account.
	  • NOTE: Let IRCO know that they will be billing CareOregon. Once IRCO has the requestor's information, the requestor will receive an invitation to the online scheduling portal and guides. IRCO can also schedule an online training for the requestor and team members.
	• Email: *scheduler@oregoncertified.com*
	• Phone: When scheduling by phone, there are two options available:
	  • On-site and scheduled OPI/VRI appointments: 503-213-3191, option 1
	  • On-demand services: 503-461-6409
	  » *Each account has an individual PIN, which will need to be provided for on-demand calls.*
	  » *If a PIN is misplaced, the requestor may call 503-213-3191 or email scheduler@oregoncertified.com*
	• Fax: 971-228-2164

Telecommunication relay and captioned telephone services

Telecommunication relay and captioned telephone services allow individuals that are deaf, hard of hearing, deafblind, or have speech disabilities, to communicate by telephone in a manner that is functionally equivalent to telephone services. This service is offered by the federal government through FCC funding. In Oregon, this service is provided by *Hamilton/Oregon Relay.*

To access telecommunication relay and captioned telephone services, the requestor should call the toll-free number listed on the website or dial 711 and give them the phone number to dial.

Oregon Relay offers the following services:

- TTY (Text Telephone): The most common way to connect to relay – allowing a person who is deaf or hard of hearing to type their messages and read the other person's responses.
- VCO (Voice Carry Over): VCO users speak directly to the person being called and, through specialized equipment, read what is spoken by the other party.
- HCO (Hearing Carry Over): HCO users listen directly to the person called and, through specialized equipment, type their responses to the other party.
- DBS (Deafblind Service): DBS users type their messages and read the other person's responses, typed by the Communication Assistant (CA), on a braille display.
- STS (Speech-to-Speech): STS involves specially trained Communication Assistants (CA) who are familiar with the speech patterns of a wide variety of individuals who have difficulty being understood.
- CapTel (Captioned Telephone): Users speak directly to the other party and listen while reading captions of what's said to them.
- Voice: The Oregon Relay program allows standard phone users to communicate with individuals who are deaf, hard of hearing, deaf-blind or have difficulty speaking and who may use a TTY, TeleBraille or other assistive telecommunications devices.
- Spanish Relay: Spanish Relay is available for all relay calling options offered in your state. Spanish and English translations are available in select states.

Intensive Case Management (ICM)

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

ICM services include:

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

ICM referrals

Potential candidates for CareOregon ICM services include:

- Members who have difficulties with self-management skills.
- Members who have difficulty accessing providers.
- Members who have difficulty receiving medical services.

- Members with issues requiring community support.
- Members who need help with discharge planning or care coordination.
- Providers who need assistance treating members who show inappropriate, disruptive or threatening behaviors.

To make a referral:

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

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

Traditional Health Workers (THW)

A Traditional Health Worker (THW) is a person who has similar life experiences with the people they work with. They can assist members in getting services and care that support their health and wellbeing by helping with things like:

- Navigating the health system.
- Understanding benefits.
- Connecting to community resources.
- Cross-cultural communication.
- Connecting to health care providers.

Traditional Health Workers complete training and certification in five areas. The following are the five different types of THWs that members have access to:

- Doula: A birth companion who provides personal, nonmedical support to pregnant people and families throughout a person's pregnancy, childbirth and post-partum experience.
- Personal Health Navigator (PHN): A person who can provide information, assistance, tools and support to enable a patient to make the best health care decisions.
- Peer Support Specialist (PSS): An individual with shared lived experience with substance use disorders and/or mental health conditions who provides supportive services to a current or former consumer of mental health or addiction treatment.
  Peer Support Specialists receive training to specialize in one or more of the following PSS subtypes:
  - Recovery Peer: A person in addiction recovery with two years of abstinence who provides support services to people seeking recovery from addiction.
  - Mental Health Peer: A person with lived experience of mental health conditions who provides support services to other people with similar experiences.
  - Family Support Specialist: A person with experience parenting a child or youth who has experience with substance use disorders or mental health conditions, who supports other parents with children or youth experiencing substance use disorders or mental health conditions.
  - Youth Support Specialist: A youth/young adult with lived experience as a youth, themselves, with substance use disorders or mental health treatment who also had difficulty accessing education, health or wellness services.

- Peer Wellness Specialist (PWS): A PWS is an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health-home team, integrating behavioral health into primary care.
- Community Health Worker (CHW): A trusted member of the community who serves as the link between the health system, social services network and community to support, promote and advocate for improved quality and cultural competency of services for all community members.
    - Promotores: These are lay health workers who provide a variety of services to Hispanic and Latinx populations and traditional health care services.

THWs comprise a diverse workforce that can provide culturally and linguistically responsive care that is rooted in trust and shared or common lived experience that supports:

- Linkages between physical, behavioral, oral and social health.
- Decreased barriers to accessing care and treatment.
- Reduced acute care utilization.
- Engagement in preventive care and chronic condition management.
- Improved engagement and reduced no-show rates.
- Establishing connections and building relationships with members from traditionally marginalized communities.
- Improved overall health and wellness.
- Improved culturally concordant delivery of care.
- Improved coordination between health care domains and providers.
- Higher patient and provider satisfaction.

THWs can be found in community-based organizations and in clinics. They are a free benefit to members and do not require a referral or prior authorization.

Not all THWs are contracted with CCOs or provide services to Medicaid Members. To learn more about your THW network and access for CCO members you serve, contact your regional THW Liaison listed below.

The OHA Office of Equity and Inclusion has identified Best and Promising Practices & Other Resources for THWs. This information is available on the OHA-OEI THW website: *oregon.gov/oha/OEI/Pages/Information-for-Health-Systems,-Providers,-and-THW%27s.aspx*

THW Liaisons by region

To get more information on local THWs, or if you have questions about hiring THW staff in your organization, you can contact the THW Liaisons below:

- Columbia Pacific CCO THW Liaison by email at *colpacthwliaison@careoregon.org*
- Jackson Care Connect THW Liaison by email at *jccthw@careoregon.org*
- Health Share of Oregon/CareOregon by email at *metrothw@careoregon.org*

Transportation for OHP members

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

Multnomah, Clackamas and Washington counties

Ride to Care
Ride scheduling: 503-416-3955,
Toll-free: 855-321-4899, TTY 711
Website: *ridetocare.com*

Ride to Care is the non-emergent medical transportation (NEMT) program. It is a benefit through OHP members' coverage that helps them get transportation services — based on their needs — to their health care appointments including medical, behavioral health and dental appointments.

Members can contact Ride to Care to talk about transportation services. Ride to Care's phone number is 503-416-3955.

Ride to Care is available only for services covered by the Oregon Health Plan. Some appointments may require members to call or get approval before trips can be scheduled. For trips beyond the Health Share of Oregon service area, members may need prior authorization to use Ride to Care.

Trip requests can be made as many as 30 days or as few as 48 business hours in advance of the transportation need. Same-day and next-day visits may be approved if they are medically necessary and urgent.

Ride to Care offers three services:

1. The first is reimbursement for members who have access to a vehicle, can have a friend or family member drive them, or are staying out of area.
2. The second is public transportation. Members can receive bus fare to use public transit to get to their health care appointments.
3. The third service is vehicle-provided rides. This is for members who are unable to use mileage reimbursement or transit services.

Columbia, Clatsop and Tillamook counties

NW Rides
Toll-free: 888-793-0439

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

Jackson County

TransLink (Rogue Valley Transportation District)
Local: 541-842-2060
Toll-free: 888-518-8160

Transportation services are a covered Medicaid benefit for Jackson Care Connect members through their partner, TransLink. TransLink verifies members' eligibility prior to providing services. Transportation services are to be used when members have no other options available, such as public transportation or a friend or family member to drive them. Members should call TransLink at least two business days before their appointment to schedule a ride.

Health promotion materials

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

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

Doing Business with CareOregon

Provider relations

CareOregon Provider Relations Specialists (PRS) are assigned to PCPs, specialists, DME vendors, and hospitals based on geographic territories and health systems. Provider Relations Specialists are a link between our clinician network and CareOregon staff. They help clinic staff understand how to best work with CareOregon, and with questions or needs regarding our Medicaid (Oregon Health Plan) and CareOregon Advantage Plus (Medicare) plans and members that are best addressed outside of our Customer Service team.

Provider Relations Specialists provide training and education on the following topics:

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

To contact a PRS, visit *careoregon.org/providers/support*

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

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

The email address is *providerupdates@careoregon.org*

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

Provider Relations Specialists collaborate with clinicians, OHA, CMS and other partners to address health care-related issues in the communities we all serve. We see our role as a partnership. Do not hesitate to contact us to discuss solutions/ideas or schedule a meeting or training. If you cannot reach a PRS, contact Customer Service for assistance.

Contracting

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

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

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

Practice capacity and restrictions

During the contracting process, CareOregon and primary care practices agree to an initial monthly and maximum capacity number for the total number of CareOregon members to be assigned to the practice and set up appropriate practice restrictions, if applicable.

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

Provider directory data validation

CareOregon partners with an external partner to complete quarterly provider directory validation. Contracted offices will receive an email, a fax or a mailed letter with a key to be entered into their proprietary portal for provider demographic validation. CareOregon wants to ensure our provider directory is current and accurate for our providers and members. Contracted provider support and completion of this quarterly validation process is required.

Credentialing

General guidelines

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

- Acupuncturist
- Audiologist
- Behavioral Analyst and Assistant Behavioral Analyst
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Clinical Pharmacist
- Denturist (if covered under an active contract)
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Medicine
- Doctor of Naturopathic Medicine
- Doctor of Osteopathic Medicine
- Doctor of Podiatric Medicine
- Expanded Practice Dental Hygienist
- Licensed Clinical Social Worker
- Licensed Dietician
- Licensed Electrologist (if covered under an active contract)
- Licensed Marriage and Family Therapist

- Licensed Massage Therapist
- Licensed Professional Counselor
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physician Assistant
- Physical Therapist
- Psychologist
- Speech Therapist

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

The Fair Hearing Policy outlines the process for providers to appeal and/or challenge an adverse action. Fair hearing is offered to both initial and re-credentialed providers.

It is the responsibility of the provider to notify CareOregon of any changes in the available rendering providers and to submit appropriate credentialing information as per contract requirements. Failure to do so will result in reimbursement at non-participating rates or in denial as some services are required to be performed by participating providers. Refer to CareOregon authorization policies for details: *careoregon.org/providers/support/policies-and-forms*

Initial credentialing

Prospective providers intending to contract with CareOregon must submit the following:

- Oregon Practitioner Credentialing Application (OPCA).
  - » Signed and dated attestation.
  - » Attachment A or explanation, referring to the attestation questions answered "yes."
  - » Signed and dated Authorization and Release of Information form.
- Evidence of current licensure by State of Oregon.
- Evidence of current DEA certification or prescriptive privileges, if applicable.
- Evidence of current professional liability insurance coverage in the amount of no less than $1 million per incident, $3 million aggregate or equivalent protection.
- Copies of specialty board certificate(s), if applicable.
- Clinic restraint and seclusion policy or a statement on letterhead attesting that the practice prohibits the use of seclusion and restraint for patients.

IMPORTANT: The applicant must inform CareOregon within 30 days if changes occur to any statements on the application.

Recredentialing

All credentialed providers are recredentialed at least once every three years. Ninety (90) days before the provider's recredentialing date, CareOregon will send a recredentialing request to the provider.

The following information is needed to complete the recredentialing process:

- Oregon Practitioner Recredentialing Application (OPRA).
  - » Signed and dated attestation.
  - » Attachment A or explanation, referring to the attestation questions answered “yes”.
  - » Signed and dated Authorization and Release of Information form.
- Evidence of current licensure
- Evidence of current DEA certification or prescriptive privileges, if applicable
- Evidence of current professional liability insurance coverage in the amount of no less than $1 million per incident, $3 million aggregate or equivalent protection
- Copies of specialty board certificate(s), if applicable
- Clinic restraint and seclusion policy or a statement on letterhead attesting that the practice prohibits the use of seclusion and restraint for patient

Failure to provide recredentialing information in a timely manner may result in the provider being removed from CareOregon’s provider panel.

A CareOregon Medical Director reviews the initial or recredentialing application documents including the provider’s application, attached documents, verification of state licensure, National Practitioner Data Bank report, closed claim reports, license action report, Medicare Opt-Out Report and any additional supporting documents. The Medical Director may approve a clean credentialing file. Credentialing files that are deemed ‘not clean’ are reviewed by CareOregon’s Credentialing Committee. The Committee may request additional information, if necessary, and will recommend acceptance or rejection of the application.

Provider rights

CareOregon considers it essential to maintain a provider panel that has the legal authority, relevant training and experience to provide care for all members. Provider rights ensure that all participants are aware of their rights during the credentialing process. CareOregon advocates for provider rights to be readily accessible and understandable to all providers, available at the time of initial credentialing and at the beginning of each recredentialing cycle. This policy applies to all records maintained on behalf of CareOregon, including the credentials and performance improvement files of individual providers. Peer references, recommendations or other peer review protected information is excluded from this list of rights. CareOregon’s process adheres to standards established by the National Committee for Quality Assurance (NCQA), Medicare Manual, Ch. 6 and Oregon Administrative Rules 410-141-0120.

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

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

- To be free from discriminatory practices such as discrimination based solely on the applicant’s race, ethnicity, gender, national identity, age, sexual orientation or other types of procedures or by the type of patients the provider specializes in. Providers are free from discrimination based on serving high-risk populations or specializing in conditions that require costly treatment.
- To have the right to be notified in writing of any decision that denies participation on the CareOregon panel.

- To be aware of applicable credentialing/recredentialing policies and procedures.
- To review information submitted by the applicant to support the credentialing application.
- To correct erroneous information submitted by third parties that does not fall under the Oregon Peer Review Statute protections (Section 41.675).
- To be informed of the status of the provider's credentialing or recredentialing application on request, and to have that request granted within a reasonable period of time.
- To be notified of these rights via Provider Rights Policy and Procedure and by other means.

Organizational credentialing

CareOregon credentials the following institutional provider or supplier types:

- Ambulatory surgery centers (ASC)
- Behavioral health (inpatient, ambulatory and residential)
- Clinical laboratories (not affiliated with a hospital)
- Comprehensive outpatient rehab facilities (CORF)
- End stage renal disease (dialysis centers)
- Federally qualified health centers (FQHC)
- Free standing birthing centers
- Home care agencies (hospice, home health, home infusion)
- Hospitals
- Outpatient diabetes education (not affiliated with a hospital)
- Portable x-ray providers (not affiliated with a hospital)
- Rural health centers
- Skilled nursing facilities

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

Claims

Submit claims

To submit claims electronically, use EDI Payer ID 93975.

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

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

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

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

Incomplete claims are denied for resubmission with the missing information.

Claims must include the member's diagnostic code(s) to the highest level of specificity and the appropriate procedure codes(s). See OARs 410-130-0160 and 410-120-1280.

CareOregon denies the following claims for services:

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

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

For specific claims questions:

- Email *claimshelp@careoregon.org*
- Call CareOregon Customer Service

Timely filing

Eligible claims for covered services for CareOregon Advantage claims must be received within one calendar year from the date of service. Eligible claims for covered services for Medicaid members must be received within 120 days from the date of service per Oregon Administrative Rule 410-141-3420 (1). Medicaid Claims appeals or a corrected claims need to be submitted within 365 days from the remit date of the original submission. When CareOregon is secondary to another payor, the secondary claim must be submitted within 365 days of the date on the primary payor's explanation of benefits (EOB).

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

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

Oregon Medicaid Provider ID number (formerly DMAP ID)

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

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

To verify active enrollment status with HSD:

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

If the provider NPI is not actively enrolled for the date of service entered, submit claims to CareOregon and simultaneously complete and submit the Oregon Medicaid Provider ID Application form as instructed at the following link: *careoregon.org/providers/support/policies-and-forms*

CareOregon will enroll the NPI and automatically reprocess any previously denied claims received with the dates of service within the previous calendar year for that reason. CareOregon does not enroll out-of-area and non-participating providers without first receiving a claim; it is appropriate to submit both claims and Oregon Medicaid Provider ID Application Form simultaneously. CareOregon will not enroll providers until a claim has been received. Incomplete Oregon Medicaid Provider ID Application Forms received will not be processed.

Clinical editing

CareOregon uses a clinical editing system to ensure the efficiency and accuracy of our claims payment system.

Actions of the clinical editing system include:

- Re-bundling lab, X-ray, medicine, anesthesia and surgical procedure codes.
- Denial warning message when surgery is inconsistent with the diagnosis.
- Denial warning message on claims when a patient's age does not fall into the normal age range for the procedure or diagnosis.
- Denial of a procedure considered integral to another billed procedure.
- Denial of procedures not customarily billed on the same day as a surgical procedure.
- Denial of services normally included as follow-up care associated with a surgical procedure.

Valid exceptions to clinical editing exist. CareOregon reviews records for unusual or extraordinary circumstances that may influence the benefit.

Readmissions to Diagnosis Related Groups (DRG) hospitals

The following readmissions within 30 days of discharge are considered part of the initial admission and are included in payment for the initial admission:

- Additional surgery or follow-up care that was planned at the time of discharge
- Treatment for the same condition due to an inadequate discharge plan

Timely payment

CareOregon pays providers by the 45th day after a clean claim is received.

A clean claim can be processed accurately without additional information. For example, information is complete and correct and all diagnostic and CPT codes are valid.

Claims appeals - CareOregon/Medicaid and CareOregon Advantage/Medicare

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

Reconsideration for payment

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

Post-service provider claim appeal

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

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

Submit provider reconsideration/appeal request in writing by completing the Provider Post **Service Claim Reconsideration/Appeal form,** which may be found at *careoregon.org/providers/support/policies-and-forms*

Include the reason for the dispute and any relevant information and/or documentation related to the dispute.

If the claim was denied because of authorization issues, please send current medical documentation with the appeal.

Mail claim appeals to:

CareOregon Claims Department
Reconsideration/Claim Appeals
PO Box 40328
Portland, OR 97240-0328

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

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

CareOregon directly resolves the appeal and sends a notice of determination to the provider no later than 45 calendar days after the day the appeal is received.

An extension of 14 calendar days may be granted if either the provider or CareOregon requests it and if the extension meets criteria defined in OARS 410-141-0262.

Member billing

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

As allowed by 42 CFR 447.15 and per Oregon Administrative Rule 410-120-1280, members cannot be billed for the following covered services:

- Services that were denied due to lack of an authorization
- Services that were denied because the member was assigned to a PCP other than the one who rendered the services
- "Balance billing" for the amount not paid to the provider by CareOregon
- Out-of-state services (Oregon Administrative Rule 410-120-1180)

Generally, a provider may legally bill an OHP recipient in the following two circumstances: (refer to above OAR for other examples)

1. The service provided is not covered by OHP and the member signed an OHP Client Agreement to Pay for Health Services form before the member was seen. This form can be found at the following link: ***oregon.gov/oha/HSD/OHP/Pages/Forms.asp***

   The form must include the specific service that is not covered under OHP, the date of the service and the approximate cost of the service. The estimated cost of the covered service, including all related charges, cannot exceed the maximum OHA reimbursable rate or managed care plan rate. The form must be written in the primary language of the member.

2. The member did not tell the provider that they had Medicaid insurance and the provider tried to obtain insurance information.

   The provider must document attempts to obtain information on insurance or document a member's statement of non-insurance.

   Billing or sending a statement to a member does not qualify as an attempt to obtain insurance information. A member's eligibility can be verified by accessing CareOregon Connect at ***careoregon.org/providers/provider-portal*** or the state of Oregon's Medicaid Management Information System (MMIS) portal at ***or-medicaid.gov/ProdPortal/***

Coordination of benefits

If there is a primary carrier, such as Medicare or private insurance, or third-party resource, such as worker's compensation, and CareOregon is the secondary payor, submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received. Claims must be received within 365 days from the date the claim was processed on the primary EOB. If the member had any third-party resources, include detailed information documenting payment, allowances and claim denial reason, if applicable, on the claim.

Please do not submit a secondary claim if the member has CareOregon Advantage Plus (Medicare) and CareOregon OHP (Medicaid). CareOregon will automatically create a secondary claim after processing the primary claim.

If the member has both Medicare and Medicaid, CareOregon may not require Medicare be billed first for services when the claim meets criteria outlined in OAR 410-172-0860 and 410-141-3565.

Calculating coordination of benefits

On claims with primary payers including Medicare and private insurance, the total benefits that a member receives from CareOregon and the other medical plan cannot exceed what the CareOregon normal benefit would have been by itself.

For members with other primary payors, CareOregon compares our payment to the other carrier's payment to determine amount payable.

- If CareOregon's payment is **equal to or less** than the other carrier's payment, the benefit is zero (see example #1).
- If CareOregon's payment is **greater** than the other carrier's payment, CareOregon pays the difference, but does not exceed the member's responsibility (see examples #2 and #3).

EXAMPLE #1

Total billed $100
Other plan paid $40
member responsibility $60
CareOregon normal benefit $80
CareOregon pays $40

EXAMPLE #2

Total billed $100
Other plan paid $60
member responsibility $0
CareOregon normal benefit $57
CareOregon pays $0

EXAMPLE #3

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

Procedure-specific claims

Hysterectomy and sterilization

Oregon law requires that informed consent be obtained from any Oregon Health Plan member who wants a hysterectomy or voluntary sterilization (tubal ligation or vasectomy). State and federal money cannot be used to pay for hysterectomies and voluntary sterilizations that are performed without proper informed consent. **Therefore, CareOregon cannot reimburse providers for these procedures without proof of informed consent.**

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

The Hysterectomy Consent form can be found at *aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he0741.pdf*

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

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

Spanish consent forms:

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

Vaccines For Children (VFC) billing:

- *public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/index.aspx*

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

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

Childbirth education

Childbirth education is not a covered benefit on the Oregon Health Plan. CareOregon reimburses for childbirth education for OHP members only.

The maximum benefit is $50.00 per pregnancy for childbirth class sessions. If the sessions exceed $50.00, providers can bill the member for the balance after the member signs an **OHP Client Agreement to Pay for Health Services** form before the member is seen. See the *Member billing* section for more information.

Locum Tenens claims and payments

CareOregon allows licensed providers acting in a Locum Tenens capacity to temporarily submit claims under another licensed provider's NPI number when that provider is on leave from their practice. The Locum Tenens provider must have the same billing type or specialty as the provider on leave, e.g., a physician must substitute for another physician.

CareOregon is not responsible for compensation arrangements between the provider on leave and the Locum Tenens provider. CareOregon sends a payment to the billing office of the provider on leave. Per CMS guidelines, CareOregon allows Locum Tenens to substitute for another physician for 60 days. Providers serving in a Locum Tenens capacity should bill with Modifier Q6 to indicate the Locum Tenens arrangement.

Interim billing

CareOregon reimburses for the first and subsequent interim billings for facilities not reimbursed at Diagnosis Related Group (DRG) rates. Interim claims must be submitted in sequential order and in 30-day increments or on a monthly basis. Each claim must include all applicable diagnoses and procedures.

Facilities reimbursed based on DRG methodology are paid when the patient is discharged and the final billing is received.

All authorization guidelines apply.

Overpayment recovery

When an overpayment is identified from any source including but not limited to various audits and/or notification from the provider, CareOregon uses an auto-debit method to recover funds. This process involves reversing the appropriate group of claims future claims payments are automatically debited until the outstanding overpayment balance is settled.

The most efficient way for a provider to notify CareOregon of an overpayment is to call our Customer Service team as soon as the overpayment is found and no later than 60 days from the date of discovery. Our Customer Team will obtain all required information including why the overpayment occurred and can be reached Monday-Friday 8 a.m. to 5 p.m. at 800-224-4840.

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

Fraud, waste and abuse

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

CMS fraud, waste and abuse training can be found on our *Provider support* web page.

Provider audits

CareOregon is committed to promoting quality improvement, payment integrity and minimizing fraud, waste and abuse. CareOregon (or its designee) may perform pre-payment claim reviews and post-payment audits of paid claims, all of which may call for records, itemized bills and clinical documentation to be submitted for review for HEDIS or other quality program initiatives, risk management purposes or payment integrity monitoring and oversight practices. CareOregon may use extrapolation to establish the results of an audit's findings. As a CareOregon contracted provider, refusal to cooperate with the medical record review as part of the audit process, peer review requirements, corrective action plans or otherwise being unable to meet provider qualifications and requirements may result in contract termination.

Referrals and authorizations

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

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

Referrals

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

Refer to contracted providers/facilities

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

- Health Share/CareOregon: *careoregon.org/members/find-a-provider*
- Columbia Pacific CCO: *colpachealth.org/members/find-a-provider*

- Jackson Care Connect: *jacksoncareconnect.org/members/find-a-provider*
- CareOregon Advantage: *careoregonadvantage.org/provider-directory*

Authorizations

An **authorization** is the process of obtaining confirmation that the intended service is medically reasonable and appropriate. An authorization can be used to confirm that the intended service is a covered benefit with CareOregon Advantage or CareOregon OHP, but an authorization is not a guarantee of payment. Payment determination is made when the final claim is received.

Criteria for utilization management decisions

The table below identifies criteria used for utilization management (UM) decisions for CareOregon Medicare Advantage (COA) and CareOregon OHP.

UM Activity	Criteria Used
Medical/Surgical Prior Authorization Concurrent Review Retrospective Review (Retroactive Authorizations)	**OHP (Medicaid)** • Member eligibility (OHP) • OHP benefits (Prioritized List and Provider Guides): *oregon.gov/oha/HSD/OHP/Pages/Providers.aspx* • CareOregon authorization policies *careoregon.org/providers/support/policies-and-forms* • InterQual® criteria • Medical literature COA • CareOregon Advantage (Medicare) • Member eligibility • National and Local Coverage Determinations – Parts B and A (NCD/LCD) *cms.hhs.gov/mcd/index_list.asp?list_type=ncd noridianmedicare.com/p-medb/* • Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals

UM Activity	Criteria Used
Pharmacy Prior Authorization Retrospective Review (Retroactive Authorizations)	**OHP (Medicaid)** • Member eligibility • *OHP benefits* (Prioritized List and Provider Guides): *oregon.gov/oha/HSD/OHP/Pages/Providers.aspx* • CareOregon Medicaid Guidelines for OHP • CareOregon Advantage (Medicare) • National and Local Coverage Determinations – Parts B and A (NCD/LCD) *cms.hhs.gov/mcd/index_list.asp?list_type=ncd* *noridianmedicare.com/p-medb/* *noridianmedicare.com/p-meda/* • Centers for Medicare and Medicaid Services (CMS) Memoranda and Transmittals • *Medicare Prescription Drug Benefit Manual* • *CareOregon Advantage PA Guidelines for COA*

Requirements

Some services must be rendered by contracted providers. Out-of-network coverage is available for second opinions and for services not available in network. CareOregon will coordinate payment to ensure that cost to the member is no greater than if provided in network. Refer to CareOregon's authorization polices to confirm which services have in-network requirements: *careoregon.org/providers/support/policies-and-forms*

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

Responsibilities

The PCP is responsible for obtaining an authorization for the initial specialty or ancillary visit that requires an authorization when the specialist or ancillary provider has not previously seen the member. Once the specialist or ancillary provider has seen the member and subsequent services require an authorization, the specialist or ancillary provider is responsible for obtaining the authorization.

- For **elective** ambulatory surgery and facility admissions, the admitting or performing provider is responsible for obtaining the authorization. The facility is responsible for verifying that an authorization was issued. For urgent/emergent facility admissions, the facility is responsible for notifying CareOregon's Health Services Operations of the admission and for obtaining an authorization.
- For inpatient stays, the facility is responsible for providing CareOregon's concurrent review staff with ongoing clinical review information as requested in order to authorize the length of stay.
- For obstetrical admissions, the facility must notify CareOregon of all admissions within one business day of the member's admission.

- For deliveries, the facility must notify CareOregon of the date of delivery, type of delivery and discharge date. Hospital stays beyond federal guidelines (two days for vaginal delivery, four days for caesarean section) require authorization.

Authorization determinations

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

Prior authorization decisions are based on Medicare or Oregon Health Plan benefit rules, guidelines and limits, CareOregon policies and, as appropriate, evidence-based practice guidelines. Authorization time frames and number of visits approved differ based on the type of service being authorized and any benefit limits that may exist.

Continuity of care

CareOregon ensures continued authorization of services previously approved for members transitioning from another plan. These continuity of care authorizations are funded without requiring new authorization for the first 90 days after enrollment for members in an active course of treatment, regardless of the provider's contract status with CareOregon. Additionally, authorization timeframes are extended per the member's medical history and the treating provider's recommendations to avoid disruption in care**.**

Retroactive authorization requests

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

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

Denials

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

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

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

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

Appeals

Denial letters indicate to members that they may contact CareOregon to request an appeal. Appeals must be requested within 60 days of the date of the denial letter. Providers may appeal on behalf of a member with a valid, signed Appointment of Representative form or comparable document.

The Medical Director reviews all appeal requests. CareOregon has 16 days to review and make a determination on OHP appeals and 30 days on Medicare appeals.

The decision to uphold the denial or approve the requested service is sent in writing to the member, PCP or requesting provider and specialist (when applicable) within one week of the decision.

Members who want to appeal directly to the Oregon Health Authority and bypass CareOregon's appeal process must follow the instructions in the denial letter and complete the enclosed hearing request form. **Hearings must be requested within 120 days after the date on the denial letter.**

When an appeal is made to OHA, it is processed by CareOregon. The final decision, however, is made by an administrative law judge contracted by OHA to hear appeals.

Pharmacy program

Prescribing controlled substances

Providers are required by Oregon Administrative Rule to check the Prescription Drug Monitoring Program (PDMP) before prescribing any Schedule II controlled substance to any CareOregon member. Exceptions may include prescribing to members in hospice/palliative care, or members undergoing treatment for cancer. Providers shall maintain documentation of the prescription drug history of the individual being treated. In the case that an enrolled provider is not able to conduct the PDMP check, the providers shall maintain documentation of efforts, including reasons why the provider was unable to conduct the check. Documentation regarding the PDMP checks (including good faith efforts) may be required to be submitted to the CCO upon request. For details, please reference OAR 410-141-3855.

CareOregon formularies

The *CareOregon Medicaid Formulary* is a list of covered drugs selected by the CareOregon Pharmacy and Therapeutics (P&T) committee to treat medical conditions that are covered by the Oregon Health Plan.

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

The CareOregon Medicare Advantage formulary is a list of covered drugs selected by the CareOregon Pharmacy and Therapeutics (P&T) committee and approved by Centers for Medicare and Medicaid Services (CMS).

General Formulary Information

Formulary decisions are based on critical review of the available scientific evidence for efficacy, safety, outcomes, cost-effectiveness, value, OHP Prioritized List of Health Services (for Medicaid) and CMS Medicare Part D regulations (for Medicare).

In general, the following are **not** covered:

- The pharmacy benefit is limited to generics when Food and Drug Administration (FDA) rated generic equivalents are available, except select "narrow therapeutic index" drugs
- Drugs not listed in the formulary
- Drugs removed from the formulary by the P&T committee throughout the year
- Drugs used for non-medically accepted indications
- Drugs when used to treat conditions that are not covered by OHP, e.g. fibromyalgia, allergic rhinitis and chronic back pain (Medicaid only)
- Drugs used to promote fertility or to treat sexual dysfunction
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Drugs when used for anorexia, weight loss or weight gain (even if used for a non-cosmetic purpose, i.e. morbid obesity)
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride, and fluoride preparations (Medicaid)
- Prescription vitamins and minerals, except prenatal vitamins and fluoride (Medicare)
- Other drugs specifically excluded from coverage under Medicaid and/or Medicare, such as drugs not approved by the FDA

The formularies apply only to drugs provided by a pharmacy and do not apply to drugs used in inpatient settings or furnished by a provider. For more information on coverage of drugs furnished by a provider and administered in a clinic or facility, see the *Contracted pharmacies* section.

The drugs listed in the CareOregon Medicaid Formulary do not have copays. The drugs listed in the CareOregon Advantage Formularies might have copays which may change from year to year. For more information, see the *CareOregon Advantage Plus Evidence of Coverage*.

Drugs that require prior authorization, step therapy or age restriction or have quantity limits are designated as PA, ST, AR and QL, respectively.

- Drugs labeled **PA** or **PA Required** require prior authorization before a member can fill the prescription at a network pharmacy.
- Drugs labeled **ST** or **Step Therapy** are limited to coverage only when certain conditions have been met – for example, the member has an approved claim for a formulary alternative in their prescription profile. The member or provider must submit a Formulary Exception form if ST criteria are not met and the member has not demonstrated failure of or contraindication to the prerequisite drug(s).
- Drugs labeled **AR** or **Age Restriction** require the member to be younger than or older than a specific age. For example, a drug may be restricted to people under age 6 or over age 16. The member or provider must submit a Formulary Exception form if the member does not meet age criteria (Medicaid only).
- Drugs labeled **QL** or **Quantity Limit** are restricted to specific quantities. If a provider or member wants to exceed the limit, a Formulary Exception form must be submitted and approved.

The formularies and formulary updates for Medicaid are on the CareOregon web site at *careoregon.org/providers/pharmacy-resources/formulary-list-and-updates*

The formularies and formulary updates for Medicare are on the CareOregon Advantage web site at *careoregonadvantage.org/providers/pharmacy-benefits-and-resources*

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

If you would like to receive a paper copy or additional copies of the formulary book or formulary updates, have questions or concerns about the pharmacy benefit or a formulary or have suggestions for formulary changes, call CareOregon Customer Service.

Prior authorizations and the formulary exception process

Prior authorization (PA) is required for the following:

- Drugs listed in the formulary or formulary updates as "PA"
- Drugs listed in the formulary or formulary updates as "ST" if the member does not have claims history of the prerequisite drug(s)
- Non-formulary drugs
- Brand drugs with generic equivalents are considered non-formulary and can be requested through the Formulary Exception Process
- Drugs listed in the formulary or formulary updates with "AR" restrictions prescribed to members who do not meet age criteria (Medicaid only)
- Drugs listed in the formulary or formulary updates with quantity limits ("QL") that are prescribed in quantities greater than allowed
- Selected drugs administered incident to a physician's service in a clinic or facility. For more information, refer to section C4.5

For Medicaid (OHP), the prior authorization guidelines are available on the website at *careoregon.org/providers/support/policies-and-forms*

For Medicare, prior authorization guidelines can be found at *careoregonadvantage.org/providers/pharmacy-benefits-and-resources*

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

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

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

Providers will receive a faxed response that may include an approval, denial or a request for additional information in support of medical necessity within 24 to 72 hours.

If you have questions, call CareOregon Customer Service.

Office-administered injectables requiring prior authorization

Some drugs require prior authorization when furnished by and administered incident to a physician's service in a clinic or facility. For more information refer to the policies "Injectables/ Medications Administered Under the Medical Benefit" at *careoregon.org/providers/pharmacy-resources/formulary-list-and-updates*

To request prior authorization for a Medical Benefit Injectable:

1. Complete the appropriate "Injectable Medication Administered by Provider Authorization Form" available at ***careoregon.org/providers/support/policies-and-forms***
2. Attach medical record information supporting medical necessity, including diagnosis, co-morbidities and treatment history to the form.
3. Fax the documents to CareOregon at 503-416-4722.

Contracted pharmacies

Search for CareOregon contracted participating pharmacies by city or county in the Provider Type field at ***careoregon.org/members/find-a-provider***

Search for CareOregon Advantage contracted pharmacies in the COA Pharmacy Directory at *careoregonadvantage.org/members/find-a-pharmacy*

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

Drug denials and appeals

CareOregon can help answer questions about what information is needed for a drug decision. Please see our PA criteria online or give us a call if you don't find matching criteria or have questions. We encourage getting this information before submitting a PA because once a denial decision is made for Medicaid, it requires a member appeal for us to make a new decision.

The prior authorization guidelines are available at:
Medicaid: *careoregon.org/providers/pharmacy-resources*
Medicare: *careoregonadvantage.org/providers/pharmacy-benefits-and-resources*

Upon request, CareOregon can also provide the benefit provisions, guidelines or criteria on which the denial decision was based. This information can be provided by mail, fax, email or orally. Please call CareOregon Customer Service.

To appeal a denied pharmacy prior authorization, check the denial letter for instructions on the appeals process. Appeals for medications prescribed to Medicaid members must be started by a member. Members can appeal both verbally and/or in writing. Providers can participate in the process, but only with a member's written permission. For our Medicare members, appeals can also be started by mail, fax, or phone if you contact the Pharmacy Services department of CareOregon Advantage at 503-416-4279. For Medicare member appeals, providers can independently initiate an appeal.

Medicare Advantage terms and conditions

CareOregon operates a Medicare health plan called CareOregon Advantage (COA) Plus HMO-POS D-SNP, which participates in the Medicare program. COA Plus HMO-POS D-SNP is a Special Needs Plan for dual eligible beneficiaries. These beneficiaries qualify for both Medicare and Medicaid coverage. As a Medicare Plan, CareOregon Advantage also administers Part D, which is the Medicare prescription drug program.

Our provider agreement contains a Medicare Addendum that describes provider responsibilities for CareOregon Advantage. Some of those responsibilities, as well as requirements of CareOregon Advantage as a Medicare health plan, are listed on the next page.

For more information about CareOregon Advantage, visit the following link: *careoregonadvantage.org*.

Medicare Advantage requirements (policies and procedures)

COA and participating providers may not deny, limit or condition the coverage or furnishing of covered services to COA members on the basis of any factor related to health status. Health status includes, but is not limited to, the following: (1) medical condition, including mental as well as physical illness; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information and (6) evidence of insurability, including conditions arising out of acts of domestic violence. (42CFR 422.110[a])

- COA pays for emergency and urgently needed covered services as required in 42CFR 422.113 and consistent with CareOregon policies for referrals and authorizations (42CFR 422.100(b); 42CFR 422.112[b]).
- COA will cover renal dialysis services provided while the member is temporarily outside the COA service area (42CFR 422.100[b]).
- Medicare Advantage allows members to directly access (through self-referral) mammography screening and influenza vaccinations (42CFR 422.100[h]).
- COA and participating providers may not impose cost-sharing for influenza vaccine and pneumococcal vaccine for COA members (42CFR 422.100[h]).
- COA will maintain and monitor a network of participating providers that is sufficient to provide adequate access to covered services to COA members (42CFR 422.112(a)).
- Medicare Advantage gives members the option of direct access to a women's health specialist within the COA provider network for routine and preventive women's health care services (42CFR 422.112(a)).
- COA shall have credentialing and re-credentialing policies and procedures to select and evaluate participating providers and notify providers in writing of the reason for denial, suspension or termination (42CFR 422.204).
- COA and participating providers may not distribute any marketing materials or election forms without prior approval from CMS (42CFR 422.80).
- Medicare Advantage requires that COA use its best effort to conduct an initial assessment of each member's health care needs within 90 days of enrollment. After the initial health risk assessment, COA may contact participating provider(s) to jointly develop a treatment plan for members with significant health risk (42CFR 422.112(b)).
- Medicare Advantage requires that COA have policies and procedures for advance directives

for COA adult members. Participating providers must document in a prominent part of the medical record whether or not the COA member has executed an advance directive (42CFR 422.128).

- Participating providers will provide covered services in a manner consistent with professionally recognized standards of health care (42CFR 422.502(a)).
- COA does not place participating providers at substantial financial risk as defined in 42CFR 422.208, physician incentive plans. Participating providers agree to submit to COA any documentation regarding compliance with physician incentive plan regulations. Neither participating providers nor COA shall make any payment to a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any COA member (42CFR 22.208).
- Participating provider payments from COA are, in whole or in part, from federal funds (42CFR 422.502(h)).
- Medicare Advantage requires that COA and participating providers submit to CMS all information that is necessary for CMS to administer and evaluate COA. COA will establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare benefits (42CFR 422.64(a) and 42CFR 422.502(a) and (42CFR 422.502(f)).
- Participating providers and COA agree to adhere to the 90-day termination notification provision in the provider agreement to ensure that COA makes a good faith effort to provide written notice of a participating provider termination to all members seen on a regular basis by the provider 30 days prior to the termination (42CFR 422.111(e) and 42CFR 422.204).
- Participating providers agree to provide encounter data with all information required by CMS. Participating providers further certify that all information provided to COA for each member encounter is true, accurate and complete. Any falsification or concealment of material fact by participating providers when submitting claims may be prosecuted under federal and state laws (42CFR 422.502(a)).
- Participating providers agree to cooperate with and submit information to all independent quality review and improvement organizations approved by CMS to perform external review activities (42CFR 422.154).
- Participating providers agree to adhere to the requirements of the quality improvement program (see the “Quality Assurance Program”section). COA shall establish a mechanism to consult with participating providers regarding COA medical policies, quality improvement programs and medical management procedures (42CFR 422.202[b]).
- COA shall disclose to CMS disenrollment rates for Medicare members for the previous two years, information on Medicare member satisfaction and information on health outcomes (42CFR 422.502(f)).
- Medicare Advantage requires that COA and participating providers comply with all federal, state and local laws; regulations; executive orders and ordinances.
- Participating providers expressly agree to comply with (1) Title VI of Civil Rights Act of 1964; (2) The Rehabilitation Act of 1973; (3) Title II of the Americans with Disabilities Act of 1990 and ORS 659.425; (4) The Age Discrimination Act of 1975 (45 CFR part 91); (5) laws applicable to recipients of federal funds; (6) The Health Insurance Portability and Accountability Act of 1996 and (7) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations (42CFR 422.502[h] and 45CFR 160 and 45CFR 164).

- Medicare Advantage prohibits COA from contracting with participating providers (individuals or entities that employ individuals) who are excluded from participation in the Medicare program (42CFR 422.752).
- COA and participating providers agree to adhere to member appeal and grievance procedures (42CFR 422.562[a]).
- COA may not prohibit or otherwise restrict participating providers, acting within the lawful scope of practice, from advising or advocating on behalf of a COA member about (1) the member's health status; (2) the risks, benefits and consequences of treatment or non-treatment and (3) the opportunity for the member to refuse treatment and to express preferences about future treatment (42CFR 422.206[a]).

Terms and conditions for payment

CareOregon offers CareOregon Advantage (COA) Plus HMO-POS D-SNP. Members can use any primary care physician or specialty provider who agrees to treat the member and accepts these Terms and Conditions of payment, as long as provider is eligible to provide health care services under Medicare Part A and Part B ("Original Medicare") or COA Plus HMO-POS D-SNP for benefits not covered under Original Medicare.

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

Provider is deemed to accept COA Plus HMO-POS D-SNP: terms and conditions for payment

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

If all these conditions are met, the provider is deemed to have agreed to COA Plus HMO-POS D-SNP Terms and Conditions of payment for that specific member visit. As a provider, you can decide whether or not to accept these Terms and Conditions of payment each time you see a COA Plus HMO-POS D-SNP member. A decision to treat one plan member does not obligate you to treat other COA Plus HMO-POS D-SNP members.

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

Provider qualifications and requirements

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

- Have a National Provider Identifier in order to submit electronic transactions to CareOregon, in accordance to HIPAA requirements.
- Be licensed or certified by the state and furnish services to a COA Plus HMO-POS D-SNP member within the scope of licensure and/or certification.
- Provide only services that are covered by the member's plan benefits and that are medically necessary by Medicare definitions.
- Obtain prior authorization for services when required.
- Not have opted out of participation in the Medicare program.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations and program instructions, including laws protecting patient privacy rights that apply to covered services furnished to members (HIPAA).
- Agree to cooperate with CareOregon to resolve any member grievance involving the provider within the time frame required under federal law.
- Not charge the member in excess of cost-sharing under any condition.

Plan payment

CareOregon reimburses deemed providers at the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, minus any member required cost-sharing, for all medically necessary services covered by Medicare. Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost-sharing, as payment in full.

Balance billing of members

A provider may collect only applicable benefit plan cost-sharing amounts from a COA Plus HMO-POS D-SNP and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish benefit plan covered services to COA Plus HMO-POS D-SNP members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by CareOregon, insolvency of CareOregon, and/or breach of these Terms and Conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these Terms and Conditions.

Filing a claim for payment

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

Claims must be submitted using an industry standard claim form (CMS-1500, UB-04), or the appropriate electronic filing format and using the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers.

Diagnosis codes are required to be billed to the highest level of specificity.

Whenever possible, claims should be submitted electronically. For your clearinghouse's information, CareOregon's EDI# is 93975.

For paper claim submission, mail paper claims to the following address:
Claims
CareOregon
PO Box 40328
Portland, OR 97240-0328

Coordination of Benefits

All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at ***cms.hhs.gov/Manuals/IOM/list.asp***. Providers should identify primary coverage and provide information to CareOregon at the time of billing.

If you have general questions about COA Plus HMO-POS D-SNP plans Terms and Conditions of payment, contact CareOregon Customer Service.

Summary of Covered Services

Please review these documents for detailed information about covered services:
CareOregon Advantage Plus Summary of Benefits

Medicare Referrals and Authorizations

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

CareOregon/CCO Contracted Provider Cultural Responsiveness/Competence Training Requirement and Policy

Purpose

To ensure the delivery of healthcare services in a culturally responsive/competent manner to all members (including but not limited to: English language learners, those from diverse cultural and ethnic backgrounds, those with disabilities, and regardless of gender, sexual orientation or gender identity), CareOregon has developed a policy to help reduce disparities in health care.

CareOregon is requiring healthcare professionals within our contracted providers to annually participate in cultural responsiveness/competence training (CRC Training). There is a growing body of knowledge supporting the value of healthcare professionals receiving culturally responsive/competency training. Some of the benefits of CRC Training are improved patient/provider communication, increased mutual trust, improved medication and dietary adherence, and satisfaction with care and the healthcare experience.

There is also evidence that confirms understanding cultural differences is necessary to achieve the quadruple aim (Improved Patient Experience, Better Outcomes, Lower Costs, and Improved Clinician Experience). By understanding that cultural responsiveness/competency is "a self and process-driven, lifelong commitment to a tailored, dialogue-based approach that responds to the needs being presented by the individual(s) in front of the provider, within a contextual understanding of social/economic/political disparities," and English learning challenges, the lives of patients, colleagues and the communities we serve will improve.*

Policy

To help reduce disparities in health care, CareOregon requires contracted providers and their staff to complete cultural responsiveness/competence training annually. The training must cover:

- Review and demonstrate cultural awareness, knowledge, and skills including
  - » Adverse childhood experiences/trauma-informed care practices that are culturally responsive and address historical and present-day systemic trauma
  - » Health literacy
- Review and demonstrate how culture shapes values, beliefs, practices, and patient behaviors
- Review of your organization-specific policies, structures, and practices to support being a culturally responsive organization:
  - » Implicit bias/addressing structural barriers and systemic structures of oppression
  - » Universal access and accessibility in addition to compliance with ADA
  - » We encourage your organization to review your patient panels to identify racial/ethnic, linguistic, age, gender, gender self-identification and sexual orientation commonalities and differences to be addressed in training. Determine ways your data can identify and reduce disparities in access and delivery of care

- Training review of your organizational procedure to support language access needs for member who are English language learners and those who are hearing impaired, to explicitly include:
  - » The unlimited use of Certified or Qualified Health Care Interpreters and American Sign Language interpreters
- The use of Culturally and Linguistically Appropriate Services (CLAS) in the provision of health and healthcare services

Procedure

Annually CareOregon will randomly audit contracted providers. The audit will be a review of documented completed trainings as of the date of the audit, to ensure required training elements, as listed above, were covered. Within 12 months of first year contract date (new provider), and beginning in the 2nd and subsequent contract years, contracted providers are required to annually complete CRC trainings. If during any 12-month period the random audit findings indicate the contracted provider has not completed CRC training as called for by the contract, CareOregon (or named CCO) reserves the right to take any or all the following actions:

- Change payment rates.
- Remove contracting organization from Alternative Payment Models (APMs).
- Withhold annual quality payout.
- Collaboratively develop a CRC training improvement plan and strategy.

CareOregon resources

Below are resources we have to offer to help your organization successfully meet this requirement. If you are interested in these trainings, or other technical assistance please contact Provider Customer Service.

- Meaningful Language Access Training
- Primary Care Innovation Specialist coaching
- Web based cultural competence with CME (Columbia Pacific CCO network only)

Other resources

- *Oregon Health Authority - Office of Equity and Inclusion Approved Trainings*
  - » Follow the above link to navigate to OHA approved Cultural Competence Continuing Education.
- *A Physician's Practical Guide to Culturally Competent Care*
  - » A Physician's Practical Guide is accredited for AMA PRA Category 1 Credit(s) where you can earn up to nine free CME credits (physicians and physician assistants) or nine contact hours (nurse practitioners), while exploring engaging cases and learning about cultural competency in health care.
  - » *American Society of Healthcare Risk Management Equity of Care Assessment Tool*
  - » This is a great tool to help determine your organization's cultural competency and to assist in identifying potential gaps in equity of care.
- *Trauma Informed Oregon*
  - » Find information and resources about trauma informed care.

Terms and Definitions

Definitions

Cultural Competence - Ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care and can contribute to mitigating the impact of racial and ethnic health disparities.

NOTE: The term cultural competency is most often used (legislation, Joint Commission, etc.) but there is also debate about its applicability; the word competency suggests one is either competent or incompetent, which in turn points towards a kind of pass/fail attitude that necessitates measurement and doesn't recognize the continuous learning journey. As we learn in healthcare we adapt and with that the newer hopefully more applicable term is Cultural Responsiveness.

Culturally Responsive - Self and process-driven, lifelong commitment to a tailored, dialogue-based approach that responds to the needs being presented by the individual in front of the provider, within a contextual understanding of social, economic, political, and linguistic disparities.

Health Equity - Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices and the elimination of health and healthcare disparities.

Health Disparity - Health difference that is closely linked with social or economic disadvantage. Health disparities adversely afftect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean safe environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.

Social Determinants of Health (SDoH) - Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

The Social Determinants of Equity - Structural factors, such as racism, sexism, able-ism, and others, that determine how different groups of people experience SDOH.

Healthcare professionals - All staff who are employed by a contracted clinic, including but not limited to: physicians, nurse practitioners, physician assistants, pharmacists, behavioral health coordinators, nurses, social workers, medical assistants, support staff.

***NASTAD Cultural Responsiveness:** Credo
https://www.nastad.org/sites/default/files/Cultural-Responsiveness-November-2015.pdf
Retrieved online December 12, 2019.

Acronyms

Acronym	Definition
COA	CareOregon Advantage or Certificate of Authority
CPCCO	Columbia Pacific CCO
D-SNP	Dual Special Needs Plan
EOC	Evidence of Coverage
FFS	Fee-For-Service (aka, Open Card). Means covered directly through OHA/OHP, not through a CCO
HHS	US Office of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICN	Integrated Community Network
JCC	Jackson Care Connect
LEP	Limited English Proficiency
MA	Medicare Advantage
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OMPID	Oregon Medicaid Provider ID (formerly known as DMAP ID)
OPI	Over-the-Phone Interpreting
PCP	Primary Care Provider
PDP	Primary Dental Provider
PHI	Protected Healthcare Information
RAE	Risk Accepting Entity
VRI	Video Remote Interpreting

Appendices

Appendix A - PCP discharging a member

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

Process for discharging a member

MISSED APPOINTMENTS

Responsibilities and actions

PCP or PCP Staff:

If a member misses an appointment, consider sending a letter to the member emphasizing the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation.

If a member misses two appointments in a row after the initial office visit or three appointments over a six-month period, send a letter informing the patient that they must contact the clinic manager or other designated staff person before the member can receive further care.

Meet with the member. Ask the member to sign a completed contract outlining that they must contact the clinic manager or other designated staff person.

Fax a copy of the signed contract to the member's caseworker.

If the clinic management decides to discharge the member, send a letter to the member informing him or her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

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

Send relevant documentation to CareOregon Provider Services, including chart notes, copies of letter(s) sent to the member, signed contracts and/or documentation of case conferences. Fax a copy of the discharge letter to: **503-416-8117, Attn: Enrollment Department**

CareOregon Care Coordinator:

Fax a copy of the signed contract to the member's caseworker.

Process for discharging a member

DRUG-SEEKING BEHAVIOR

Responsibilities and actions

PCP or PCP Staff:

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

CareOregon Pharmacy Staff:

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

PCP or PCP Staff:

Document any contract violation in member's medical record.

If the provider cannot manage the member's care, try to find another provider within the primary care clinic to manage the member's care.

If another provider is not available within that clinic and clinic management decides to discharge the member:

Send a letter to the member informing him/her of the discharge.
The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

ALSO:
Fax a copy of the discharge letter to CareOregon,
Attn: Enrollment Department, 503-416-8117.

IMPORTANT:
PCPs must provide urgent care for the discharged member for 30 days following notification of the member.

CareOregon Care Coordinator:

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

Process for discharging a member

MEMBER COMMITS OR THREATENS ACTS OF PHYSICAL VIOLENCE AND/OR COMMITS FRAUDULENT OR ILLEGAL ACTIVITIES

Responsibilities and actions

PCP or PCP Staff:

Immediately contact the police to file an official report.

Contact CareOregon's Care Coordinator to describe the incident.

Fax chart notes and police report (when available) to the Care Coordinator.

A member may be discharged in the following situations:

- Member commits act of violence to staff, property or other patients.
- Member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation. This includes but is not limited to acts of theft, vandalism and/or forgery.

CareOregon Care Coordinator:

At the Care Coordinator's discretion, contact OHA by phone to request disenrollment of member.

Fax written documentation to OHA.

Inform PCP of OHA decision regarding disenrollment.

If OHA or the Care Coordinator decides that disenrollment is not necessary, work with PCP to plan the discharge process and work with CareOregon Customer Service to assign the member to a new PCP.

PCP or PCP Staff:

If clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number.

If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

Notify the CareOregon Care Coordinator.

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

Process for discharging a member

VERBAL ABUSE – VERBAL ABUSE JUSTIFYING DISCHARGE

Responsibilities and actions

Verbal abuse is abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

PCP or PCP Staff:

Document incident(s).

At discretion of Clinic Manager, contact police to file an official report.

Contact the CareOregon Care Coordinator to describe the incident.

Fax chart notes and police report, if one was filed, to the CareOregon Care Coordinator.

If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue.
The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

Notify the CareOregon Care Coordinator.

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

CareOregon Care Coordinator:

At the Care Coordinator's discretion, contact OHA by phone to request disenrollment.

Fax documentation to OHA.

Inform PCP of OHA decision regarding disenrollment.

If OHA decides not to disenroll member or if Care Coordinator does not feel disenrollment is necessary, work with PCP to plan for appropriate discharge process.

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

Process for discharging a member

DISCHARGE FROM PCP BY MUTUAL AGREEMENT BETWEEN THE MEMBER AND THE PROVIDER

Responsibilities and actions

PCP or PCP Staff:

Document the date and the reason for the mutual decision.

Try to find another provider within the primary care clinic to manage the member's care.

If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

Notify the CareOregon Care Coordinator.

IMPORTANT:
PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge. Work with CareOregon Customer Service to assign the member to a new PCP.

Process for discharging a member

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

Responsibilities and actions

PCP or PCP Staff:

Document the date and the reason for the mutual decision.

Try to find another provider within the primary care clinic to manage the member's care.

If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing him/her of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.

Notify the CareOregon Care Coordinator.

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

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

Appendix B - IIBHT- Intensive In-Home Behavioral Health Treatment

Service description	Initial clinical considerations	Concurrent clinical considerations	Transition/discharge considerations
The Intensive In-Home Behavioral Health Treatment (IIBHT) is an intensive, community based, multidisciplinary mental health treatment program for youth and young adults under the age of 21 and anyone covered under Early and Periodic Screening Diagnostic and Treatment (EPSDT) or Youth with Special Health Care Needs (YSHCN) and their families. The intent of IIBHT is to work collaboratively with youth, young adults and their families to address complex mental health concerns, reduce emergency department use, avoid out of home placement or facility-based treatment where possible, and support youth, young adults and their families when returning home from out of home placement or facility-based treatment.	Both must be met: • Covered diagnosis on the Prioritized List* • Current complex mental health needs At least one must be met: (a) Youth and family are experiencing intensive mental health needs which lead to increased conflict and crisis in the home, school and or community; or (b) Youth has a history of traumatic experiences that are impacting their ability to function in multiple domains; or (c) Youth is at risk of psychiatric hospitalization or residential treatment due to intense behavioral health challenges; or (d) Youth is at risk of losing their current living situation due to intense behavioral health challenges; or (e) Youth is transferring back to their home or community from an out of home placement and increased services to support of their mental health are needed for successful transition; or	Continues to meet admission criteria AND at least one of the following: • Demonstrating progress on treatment goals • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there are not more clinically appropriate services.	1) IIBHT is a time limited intervention. Youth/ young adults and their families may transition to other services when one of the following situations is present: (a) The youth/young person and their family have successfully reached their established goals and objectives in the Service Plan; or (b) The youth/young person and their family requests a transition to a lower level of care; or (c) The youth/young person transitions to a higher level of care, such as residential treatment; or (d) The youth/young person and their family choose to end treatment or move out of the area 2) IIBHT services may overlap with, but shall not duplicate other services, for continuity of care in the following circumstances: (a) prior to the youth/ young adult's discharge from a higher level of care including residential treatment or inpatient hospitalization; or

IIBHT- Intensive In-Home Behavioral Health Treatment (continued)			
Service description	**Initial clinical considerations**	**Concurrent clinical considerations**	**Transition/discharge considerations**
	(f) Youth is at high risk of harm to themselves or others; or (g) Youth requires an increased frequency and intensity of services and is exceeding what can be offered in the Outpatient level of care setting; or h) Other risk factors impacting the safety in the home or community Additional criteria for youth ages 18-20 may be found in the OARs		(b) When a youth/young person is temporarily placed in juvenile detention; or (c) When admitted to a brief inpatient psychiatric hospitalization, subacute, or psychiatric residential treatment stay.

Contact Customer Service:
503-416-4100 or 800-224-4840
TTY: 711
Hours: 8 a.m. to 5 p.m.
Monday-Friday

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