OHSU HEALTH IDS

Provider Manual

November 2023

OHSUHealth

Contact Information

OHSU Health IDS Customer Service	P: 844-827-6572 Hours 7:30 a.m. – 5:30 p.m. weekdays **OHSUOHPMedical@modahealth.com**
OHSU Health Compliance Hotline	P: 877-733-8313 **www.ohsu.edu/hotline**
Medical Referrals and Prior Authorization	P: 844-931-1774 F: 833-949-1887
Pharmacy Prior Authorization	F: 503-346-8351
EviCore – Radiology, Cardiology and Advanced Imaging	P: 844-303-8451 **www.eviCore.com** **www.eviCore.com/provider#ReferenceGuidelines**
Magellan Rx – Specialty Pharmacy	P: 800-424-8114 **www.IH.MagellanRx.com** **www1.magellanrx.com/medical-rx-prior-authorization**
Provider Relations	P: 503-418-7750 F: 503-346-8041 **OHSUHealthPrvRelations@ohsu.edu**
Care Integration and Coordination	P: 844-827-6572 **OHSUHSCareTeam@ohsu.edu**
Contracting	P: 503-418-7750 F: 503-346-8041 **OHSUHealthPrvRelations@ohsu.edu**
OHSU Health IDS Website	**https://www.ohsu.edu/health-services**
Provider Portal	**https://www.modahealth.com/EBTWeb** Tax ID number driven • Eligibility and benefits • PCP history • Referral inquiry • Claim status
Medical Claim Submission	OHSU Health IDS P.O. Box 40384 Portland, OR 97240 To submit claims electronically, please use Payer ID 13350. If you would like information on billing claims electronically, please contact our Electronic Data Interchange department at **edigroup@modahealth.com**.
Voluntary Sterilization Form Submission	F: 833-949-1556 Must be submitted with prior authorization, otherwise it will be denied.

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Welcome

In 2019, OHSU Health IDS partnered with Moda Health to operate as an integrated delivery system (IDS) under Health Share of Oregon, a coordinated care organization (CCO) certified by the Oregon Health Authority (OHA) to serve Oregon Health Plan (Medicaid) members in Clackamas, Multnomah and Washington counties. Our legal corporate name is registered as OHSU Health IDS, LLC. We are internally referred to as OHSU Health IDS or the IDS. Health Share member ID Cards will list us as OHSU Health.

OHSU Health IDS administers more than 50,000 Medicaid lives. The OHSU Health IDS network includes more than 1,000 referral specialists and four hospital systems in the tri-county service area.

OHSU Health IDS administrative staff support our providers with medical case management, care coordination, health-related services, pharmacy, compliance oversight, delegated credentialing and quality improvement services.

Moda Health performs most administrative functions, such as medical claims processing, customer service, primary care provider (PCP) assignments, provider directory, finance/accounting, prior authorizations, grievances and appeals, compliance and Fraud, Waste and Abuse (FWA).

All the partners within OHSU Health IDS work to help ensure a focus on providing safe, effective, efficient, patient-centered (culturally appropriate and linguistically sensitive), timely and equitable standards of care. OHSU Health IDS reflects the Institute for Healthcare Improvement's (IHI) Quadruple Aim Initiative Health Equity, which seeks to:

- Improve the members' experience of care.
- Improve the health of populations.
- Reduce the per capita cost of care.
- Improve health equity.

Find more information about IHI's Quadruple Aim Initiative Health Equity at: https://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy

OREGON HEALTH PLAN (OHP)

The Oregon Health Plan (OHP) is the Oregon Medicaid program administered by the Health Systems Division (HSD) of the State of Oregon. HSD 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.

For more information about Health Share of Oregon please visit **www.healthshareoregon.org**

Member enrollment in OHSU Health IDS

Individuals become members of OHSU Health IDS by enrolling in the Health Share of Oregon CCO and choosing OHSU Health or by stating their provider preference.

Coordinated care organizations (CCOs)

CCOs were developed by the State of Oregon to provide better health and better care at lower costs for all Oregonians. Through an integrated model, CCOs provide locally managed care, emphasizing prevention, chronic disease management and education for members who may be high utilizers in need of additional assistance. OHSU Health IDS administers Oregon Health Plan benefits through Health Share of Oregon.

Oregon Health Plan (OHP) eligibility

OHP eligibility is determined by a simple screening and application process managed by OHA. OHP members must meet income and residency requirements but may also qualify based upon age and disability status.

OHP members' eligibility effective dates are retroactively granted to recipients' application dates. Adult recipients are eligible for six months and must reapply before the conclusion of each six-month period. Children must reapply every 12 months. If recipients do not reapply before their eligibility ends, their OHP eligibility terminates until they reapply. Member eligibility effective dates and application renewal dates are available in the CIM6 portal located at https://cim6.phtech.com/cim/login?CFID=3073&CFTO-KEN=67BBFFC8-5BB6-4E12-BBD58D62CD07C486

OHP members' rights and responsibilities

OHSU Health IDS members receive their rights and responsibilities statement in their member handbook at onboarding and with each revision of the handbook. Members and participating providers can access the handbook via the Health Share of Oregon website at www.healthshareoregon.org/members/my-health-plan/member-handbook. For a full list of member rights, please visit Health Share of Oregon's website at https://www.healthshareoregon.org/members/get-help/member-rights.

OHP members have the right to:

- Be treated with dignity, respect and privacy.
- Be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with a care team, including providers and community resources appropriate to needs.
- Be treated during hours of operation that are no less than the hours of operation offered to commercially insured members or comparable to Medicaid Fee-for-Service (FFS), if the provider serves only Medicaid members.
- Be free from discrimination in receiving entitled benefits and services.
- Receive equal access for both males and females under 18 years of age to appropriate treatment, services and facilities. This includes homeless youth and those in gangs, as required by ORS 417.270.
- Choose a primary care provider (PCP), primary care dentist (PCD), mental health provider or service site, and to make changes to these as permitted in Health Share of Oregon's administrative policies.
- Get behavioral health services without a referral from a PCP or other participating provider.
- Seek family planning services outside the network and will ensure the cost to the member is no greater than it would be if services were provided within the network.

HOW TO APPLY FOR OHP

The OHP application can be completed:

- Online: **https://one.oregon.gov**
- On paper: **www.oregon.gov/oha/HSD/OHP/Pages/apply.aspx**
- In person at a trained community partner facility: **http://healthcare.oregon.gov/Pages/find-help.aspx**

Application assistance can be provided by calling **1-800-633-9075 or 711 (TTY)**.

Members

PROVIDER SUPPORT SERVICES

OHSU Health IDS provides cultural and language assistance appropriate to the need to encourage members to participate in making decisions about care and services. Receive assistance using the health care delivery system and accessing community and social support services and statewide resources, including (but not limited to) certified or qualified health care interpreters, advocates, community health workers, peer wellness specialists and personal health navigators who are part of the care team.

- Have a friend, family member or advocate with you during appointments and other times as needed within clinical guidelines.
- Be actively involved in the development of your treatment plan; to talk honestly with your provider about appropriate or medically necessary treatment choices for your conditions, regardless of the cost or benefit coverage.
- Be informed about your condition, covered and non-covered services in a way that you can understand, so as to allow an informed decision about proposed treatments.
- Consent to treatment or refuse services, and be told the consequences of that decision, except for court-ordered services.
- Receive written materials describing rights, responsibilities, benefits available, how to access services and what to do in an emergency.
- Have written materials explained in a manner that is understandable to you, including the coordinated care approach and how to get services in the coordinated health care system.
- Receive services and support in a language you understand, and in a way that respects your culture, as close to home as possible.
- To choose providers (if available within the network) that are in nontraditional settings and accessible to families, diverse communities and underserved populations.
- Receive care coordination and transition planning from OHSU Health IDS in a language you understand and in a way that respects your culture to ensure that community-based care is provided in as natural and integrated an environment as possible and in a way that keeps you out of the hospital.
- Receive necessary and reasonable services to diagnose your condition.
- Receive integrated, person-centered care and services that provide choice, independence and dignity, and that meet generally accepted standards of medically appropriate practice.
- Receive the level of service that you expect and deserve, as approved by your providers.
- Have a consistent and stable relationship with a care team that is responsible for comprehensive care management.
- Obtain covered preventive services.
- Have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization.
- Receive a referral to specialty providers for medically appropriate covered services, following the CCO's referral policy.
- Have a clinical record that documents conditions, services received and referrals made.
- To have access to your own clinical record unless restricted by statute and to receive a copy and have corrections made to your health information.
- To know that information in your medical record is confidential, with exceptions determined by law; to receive a notice that tells you how your health information may be used and shared; to decide if you want to give your permission before your health information can be used or shared for certain purposes and to get a report on when and why your health information was shared for certain purposes.
- Transfer of a copy of the clinical record to another provider.
- Write a statement of wishes for treatment, including the right to accept or refuse medical, surgical, dental or behavioral health treatment.
- Write advance directives and powers of attorney for health care established under ORS 127.

Members

SUPPORT SERVICES

Receive assistance using the health care delivery system and accessing community and social support services and statewide resources, including (but not limited to) certified or qualified health care interpreters, advocates, community health workers, peer wellness specialists and personal health navigators who are part of the care team. This is to provide cultural and language assistance appropriate to the need to encourage members to participate in making decisions about care and services.

- To be free from any form of restraint or seclusion (isolation) that is not medically necessary or is used by staff to bully or punish you. Staff may not restrain or isolate you for the staff's convenience. You have the right to report violations to OHSU Health IDS, Health Share and to the Oregon Health Plan.
- Receive written notices before denials or changes in benefits or service levels if a notice is required by federal or state regulations.
- Be able to make a complaint or appeal with OHSU Health IDS or Health Share and receive a response.
- Request a contested case hearing.
- Receive qualified health care interpreter services; and to have information provided in a way that works for you. For example, you can get it in other languages, in Braille, in large print or another format such as electronic. If you have a disability, we must give you information about the plan's benefits in a way that is best for you.
- Receive notice of an appointment cancellation in a timely manner.
- The right to obtain a second opinion.
- To receive information about OHSU Health IDS, Health Share, our Providers and services
- To make recommendations about Health Share's member rights and responsibilities policy.
- To request and receive information on the structure and operation of OHSU Health IDS or any physician incentive plan.
- To know that if you believe your rights are being denied or your health information isn't being protected, you can do either or both of the following: File a complaint with your Provider or health insurer, File a complaint with the Client Services Unit for the Oregon Health Plan.
- Help choose a PCP or clinic, a primary care dentist (PCD) and a primary mental health provider if needed.
- Treat OHSU Health IDS, Health Share, providers and clinic staff members with respect.
- Be on time for appointments and call in advance to cancel if unable to keep the appointment or if you expect to be late.
- Seek periodic health exams and preventive services from your PCP, PCD or clinic.
- Use your PCP or clinic for diagnostic and other care except in an emergency.
- Obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed.
- Use urgent and emergency services appropriately and tell your PCP or clinic within three (3) days of using emergency services.
- Give accurate information that may be included in the clinical record.
- Help the provider or clinic obtain clinical records from other providers, which may include signing an authorization for release of information.
- Ask questions about conditions, treatments and other issues related to your care that you do not understand.
- Use information provided by OHSU Health IDS providers or care teams to make informed decisions about a treatment before you receive it.
- Help your providers make a treatment plan.
- Follow treatment plans as agreed and take active part in your health care.
- Tell your providers that your health care is covered under the OHP before you receive services and, if requested, show the provider your Oregon Health ID card.

- Call OHP Customer Service to tell them of a change of address or phone number.
- Call OHSU Health IDS, Health Share and OHP Customer Service if you become pregnant, and when the baby is born.
- Tell OHP Customer Service if any family members move in or out of the household.
- Call Health Share Customer Service if there is any other insurance available.
- Assist your health plan in pursing any third-party resources available and reimburse the health plan the number of benefits it paid for an injury if you receive a settlement for that injury.
- Bring issues, complaints and grievances to the attention of OHSU Health IDS or Health Share of Oregon.

PCP assignment and selection

Assigning a PCP to OHSU Health IDS members

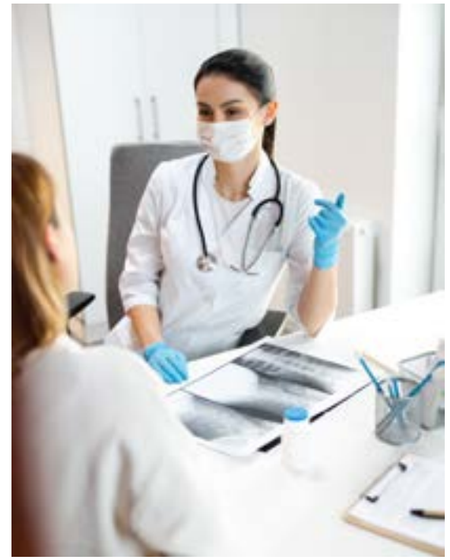
OHSU Health IDS encourages members to choose their own PCPs, which allows members to establish care with providers who best meet their cultural and personal preferences. If an OHSU Health IDS member does not choose a PCP within 25 calendar days from enrollment, OHSU Health IDS will formally assign a PCP, keeping in mind any cultural, language or special needs of the member.

Verification of PCP assignment

Provider offices are required to verify current member eligibility before providing medical assistance services.

Changing PCPs

Members are allowed to change their PCPs at any time by calling the OHSU Health IDS Customer Service line at 844-827-6572. New PCP assignments become effective the day they are requested. Providers may not be notified of the new member assignment until they receive their member roster. Members will receive an updated ID card from Health Share reflecting the new PCP choice.



Member rosters
PCP clinics receive a roster of members monthly. Use the Moda Health Benefit Tracker portal (**https://www.modahealth.com/EBTWeb**) to verify PCP assignment. Should you have any questions regarding member assignment, you may also reach out to Provider Relations at 503-418-7750 or **ohsuhealthprvrelations@ohsu.edu** or Customer Service at 844-827-6572.

Members complaints

FILING A COMPLAINT

OHSU Health IDS members have the right to informally discuss their health care service-related concerns, or to submit a formal written or oral complaint/grievance. OHSU Health IDS addresses all complaints and facilitates the member complaint process.

If an OHSU Health IDS member is uncomfortable contacting OHSU Health IDS for assistance with their complaint, they may contact Health Share of Oregon Customer Service at 503-416-8090 or by emailing OHSU Health Customer Service at **OHSUOHPMedical@modahealth.com**.

They may also contact OHP Client Services by calling 800-273-0557 or the Oregon Health Authority's Ombudsman at 503-947-2346.

Resolving complaints with a provider or facility

OHSU Health IDS will review, research and resolve all concerns within five (5) business days. If the complaint requires additional follow-up, a letter will be issued to the member within five (5) business days. A final answer will be provided within 30 calendar days. Complaints are monitored by the OHSU Health IDS Complaints and Grievances Committee on a monthly basis as well as reviewed quarterly by the OHSU Health IDS Regulatory Compliance Committee.

Additional information about the OHSU Health IDS Complaint and Grievance process can be found at the OHSU Health IDS website at www.healthshareoregon.org/members/get-help/member-rights/appeals-and-grievances.

Restraint and seclusion

OHSU Health IDS members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move their arms, legs, body or head freely. Restraint is also a drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and 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. Under no circumstances may an individual be secluded for more than one hour.

OHA requires providers to have a policy and procedure regarding use of restraint and seclusion in compliance with the Code of Federal Regulations Title 42 Public Health.

Providers are required to provide this policy to OHSU Health IDS upon request. If a provider and/or clinic does not use restraint and seclusion, they are not required to maintain a policy. In these cases, OHSU Health IDS requires that the provider and/or clinic submit a written statement and complete a restraint and seclusion waiver.

UPDATES TO YOUR INBOX

You can automatically receive updates to the Prioritized List by subscribing to updates at **https://public.govdelivery.com/accounts/ORDHS/subscriber/new**.

OHP covered services

OHP covers a comprehensive set of medical services defined by a list of diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Evidence Review Commission (HERC). Known as the "Prioritized List of Health Services," the list is regularly updated by OHA. To determine if a service is covered under the Oregon Health Plan, providers may search via www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx.

You can automatically receive updates to the Prioritized List by subscribing to updates at https://public.govdelivery.com/accounts/ORDHS/subscriber/new.

Diagnosis and treatment pairs that rank below-the-line are not covered benefits under OHP, and therefore not covered by OHSU Health IDS. If a service is not covered by OHP and a provider has determined the treatment is necessary, an authorization request may be submitted with the proper documentation to OHSU Health IDS ' Prior Authorization Department. Requests for noncovered services are denied automatically if additional information is not included with an authorization request.

Exception: Routine newborn circumcisions are now covered without a prior authorization. OHSU Health IDS will allow routine circumcisions up to 31 days after birth. After this period, routine newborn circumcisions will not be covered without a prior authorization to document medical necessity following Oregon Health Plan criteria for coverage. Find the billing codes in the chart below.

ROUTINE NEWBORN CIRCUMCISION CODES	
54150	Circumcision with regional block
54160	Circumcision neonate
54161	Circumcision 28 days or older

OHP COVERAGE

OHP coverage is determined based upon the lines of the Prioritized List of Health Services. Covered lines are updated regularly. Effective Jan. 1, 2020, lines 1-472 are above-the-line (funded) and lines 472-662 are considered below-the-line (unfunded). Codes not on the list are considered annually.

To view the list of covered services **www.oregon.gov/oha/hpa/dsi-herc/pages/index.aspx**.

Provider Web Portal
https://www.or-medicaid.gov/

OHP Code Pairing and Prioritized List Hotline
800-393-9855

BEHAVIORAL HEALTH CARE TELEHEALTH CODING AND BILLING

For behavioral health providers, please review the fee-for-service behavioral health fee schedule for all codes and required GT modifiers that allow for telemedicine reimbursement.

Telehealth Coding and Billing

OHSU Health IDS follows Ancillary Guideline A5, telehealth, teleconsultations and electronic/telephonic services guidelines as well as OHA guidance related to coding and billing. Please visit the Ancillary/Diagnostic Guideline Notes for additional information.

- Bill covered telemedicine procedure codes with place of service 02. The use of telehealth POS 02 certifies that the service meets the telehealth requirements. Modifier GT is required when applicable (see fee schedules at https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx)
- The GQ modifier is still required when applicable. GQ modifier means via Asynchronous Telecommunication systems.
- Do not use modifier 95 for telemedicine services, unless specified otherwise by OHSU Health IDS.
- Bill with the transmission site code Q3014 (where the patient is located).
- The evaluating provider at the distant site may bill for the evaluation, but not for the transmission site code.

Skilled Nursing Facility Care

Skilled Nursing Facility (SNF) Care is a post hospital extended care coordination benefit for twenty (20) days post hospitalization. The benefit is provided according to criteria established by Medicare and is available at www.medicare.gov/publications. To participate in the OHSU Health IDS, a SNF must meet CMS 3-STAR quality ratings.

Prior authorization is required for admission to a SNF by calling 844-931-1774 or faxing to 833-949-1887.

Palliative and hospice care

OHSU Health IDS covers palliative and hospice care with prior authorization.

Palliative care is specialized medical care for people with a serious illness. This type of care is focused on providing the member relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the member and the family. Palliative care can be received by members at any time, at any stage of illness, whether it be terminal or not.

Hospice care is when the member has a terminal illness and a life expectancy of six months or less. The goal of hospice care is comfort care only to make the dying process as comfortable and tolerable as possible.

Mental health and substance use services

OHSU Health IDS members' mental health and substance use services are administered through CareOregon. Benefits include counseling/therapy, residential treatment, detox and more. Low-level behavioral health counseling and therapy can be administered through the PCPCH. Find a mental health or substance use provider online https://healthshare-bhplan-directory.com/. Call CareOregon at 503-416-4100.

MENTAL HEALTH AND SUBSTANCE USE SERVICES	
CAREOREGON	503-416-4100 or toll-free 800-224-4840 TTY/TDD 711 8 a.m.-5 p.m., Monday – Friday **customerservice@careoregon.org** Text Message 503-488-2887 8 a.m.-5 p.m. Monday – Friday Secure Message: **http://careoregon.org/portal**
COUNTY CRISIS LINES	
Clackamas County	503-655-8585
Multnomah County	503-988-4888
Washington County	503-291-9111
Suicide & Crisis	988

TOBACCO CESSATION

Tobacco cessation services are covered by OHSU Health IDS in the form of counseling, treatment, nicotine patches and prescriptions commonly used for tobacco cessation. No referral is required to provide tobacco cessation treatment and counseling.

OHSU Health IDS is contracted with the Quit for Life Program which offers telephonic counseling, resources and additional treatment. These resources can be accessed by calling 1-866-QUIT-4-LIFE or by visiting **www.quitnow.net**.

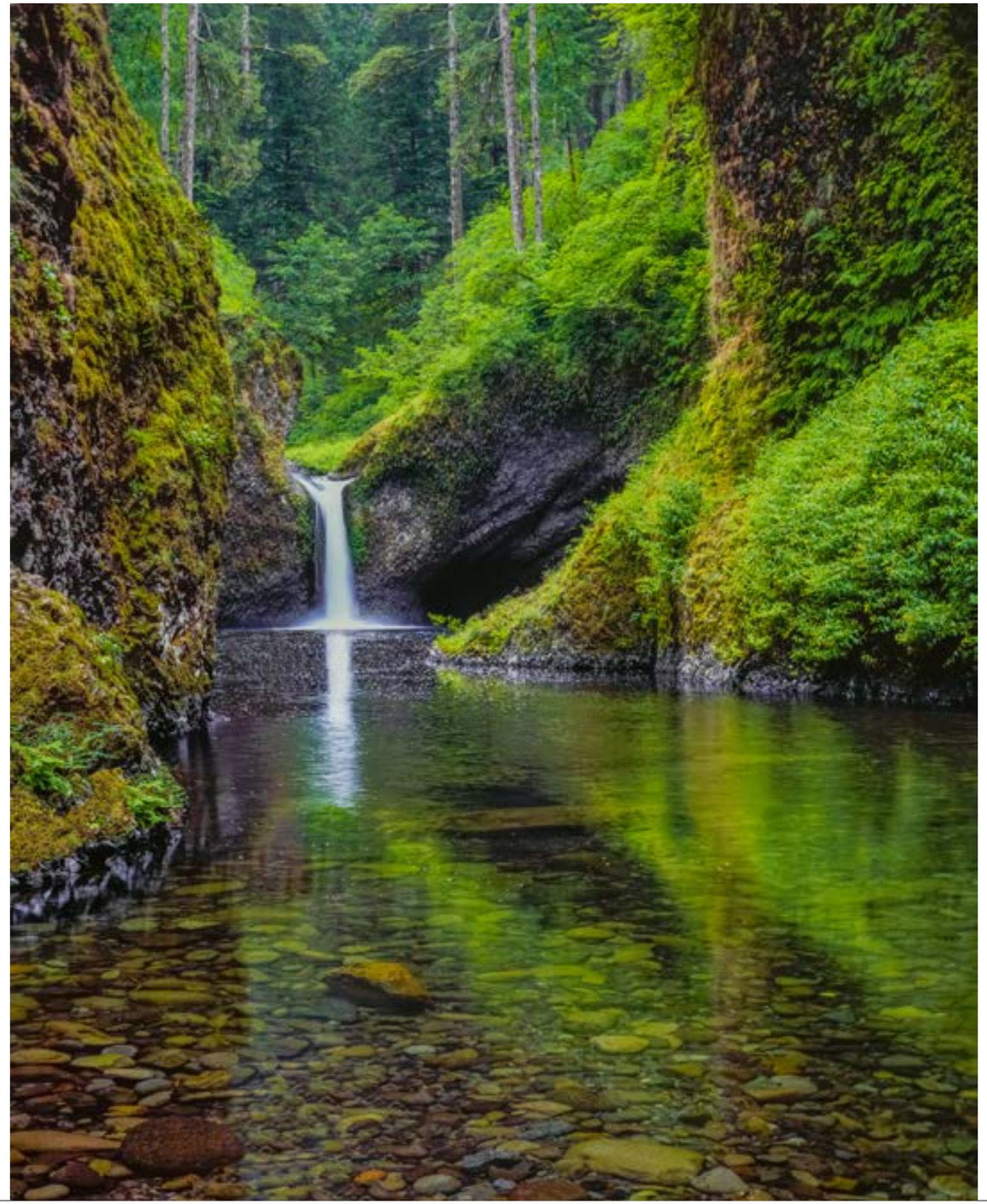
Benefits

Members seeking mental health services must have access to appointments according to the following standards:

- Emergency care: Member must be seen or treated within 24 hours or as indicated in initial screening.
- Urgent Behavioral Health Treatment: All populations must be seen within 24 hours.
- Nonurgent care: Member must be seen for an intake assessment within two weeks from date of request.
- Concurrent requests must occur when a member is in the process of receiving requested services even if the organization did not previously approve the earlier care.
- Post psychiatric hospitalization: Must occur within seven (7) days of being released from said hospitalization.
- Routine behavioral health care for traditional outpatient, nonintensive services: an intake assessment scheduled within seven days from date of request, with second appointment occurring as clinically appropriate.

Members in need of Substance Use Disorders treatment must have access to appointments according to the following standards:

- Members in emergent need will be seen the same day.
- Members who are pregnant or are in need of urgent care will be seen within 48 hours.
- Members who are intravenous drug users will be seen within 10 business days or within the community standards, whichever is shorter for routine Substance Use Disorders Services.
- Members who are intravenous drug users will have access to immediate assessment and intake. Admission to a residential setting will occur within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist.
- Members with opioid disorder will have access to assessment and intake within 72 hours.
- Members who request medication-assisted treatment (MAT) will be seen for an assessment within 72 hours.



Benefits

REQUESTING FUNDS FOR HEALTH-RELATED SERVICES

Our care coordinators can help your patients get flexible services to support their health and wellbeing. To request a flexible service, contact Community Care Team at 844-827-6572 or ohsuhscareteam@ohsu.edu.

If their request for a flexible service is denied, they will get a written notice. If this happens, they can file a grievance (complaint) with Health Share. If Health Share does not approve the service, they may not appeal or request a hearing.

If you have questions about either community benefit initiatives or flexible services, please contact OHSU Health IDS Integrated Community Care Team or call the Health Share Customer Service team at 503-416-8090.

Health-Related services

Health-Related Services are nonbillable health-related services intended to improve care delivery and Oregon Health Plan (OHP) member health. Health-Related Services are unable to be reported using CPT or HCPCS codes. If a service has a CPT or HCPCS code, it may not be covered using Health-Related Services even if it is not a covered benefit.

Health-Related Services funds are used when no other funding source is available to cover the cost of the service or items purchased (e.g., adult mental health initiative (AMHI), prioritized populations/special needs and client funds). These services may effectively treat or prevent physical, oral or behavioral health conditions, improve health outcomes, and prevent or delay health deterioration. Health-Related Services are cost-effective alternatives to traditional services. Covered services may include (but are not limited to) classes, programs, equipment, appliances, special clothing or footwear.

Health-Related Services funds for Health Share/OHSU Health IDS members are allocated from OHP state funds. They are subject to all applicable rules and regulations for Medicaid expenditures.

You can use health-related services to supplement covered benefits. There are two types of health-related services: community benefit initiatives and flexible services.

Community benefit initiatives support interventions to improve the health of the community and the quality of health care. A diabetes health education program is an example of a community-level intervention.

Flexible services are items or services like temporary lodging, supplemental food, an air conditioner during very hot weather. Our Care Coordinators can help you get flexible services to support your health and well-being.

OHP noncovered services

PCPs can provide services not covered under OHP to OHSU Health IDS 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 (OHP 3165) before services are performed.

The State of Oregon requires the form be filled out preservice with estimated costs, date span, other associated fees (anesthesiology, hospital charges, etc.) and be signed both by the rendering physician and the member. If the form is improperly filed or incomplete, services are ruled invalid and not payable by the member. OHP prohibits billing OHP recipients for covered services.

Primary Care services

OHSU Health IDS' PCPs are responsible for providing primary care services to their assigned patients.

Preventive services, health maintenance and disease screening:

- Adolescent well care
- Blood pressure screening
- Immunizations
- Physical exams, including annual gynecological exams

Managing common chronic primary care problems:

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

Managing common acute primary care problems:

- Communicating with specialists and managing the ongoing referral process.
- Coordinating hospital care and discharge planning, including planning done by a consultant.

OHP CLIENT AGREEMENT

OHP Client Agreement to Pay for Health Services form (OHP 3165) may be found at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3165.pdf.

Benefits

Nonprimary care services

PCPs can choose to provide nonprimary care services to their patients or to refer patients to specialists to provide these services. The following are examples of services considered nonprimary care services.

Inpatient physician care:

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

Outpatient procedures, such as:

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

Family planning, including:

- Counseling to address reproductive health issues
- Emergency contraception
- Injectable hormonal contraceptives
- Intrauterine device (IUD), including procedures for insertion and removal
- Laboratory tests
- Medical and surgical procedures, including tubal ligations
- Pharmaceutical supplies and devices
- Prescription contraceptives
- Radiology services
- Vasectomy

Behavioral health integration

OHSU Health Services can reimburse certain eligible services rendered by behavioral health providers where such behavioral health services are ancillary to and included in the scope of specialty/primary care services delivered in a physical health setting.

If your clinic employees the below provider specialty types, then the list of eligible codes can be billed to OHSU Health Services for reimbursement.

Provider Specialty Types:

- PMHNPs, Psychiatrists, Psychologists, LCSWs, LPCs, LMFTs, and LCSW/LPC/LMFT board registered interns.

Reimbursable Codes:

- 90785, 90791, 90792, 90832, 90834, 90837, 90839, 90840, 90846, 90847, 90849, 90853, 99448, 99449, 99451, T1016, 99441-99443, and 98966-98968.

If you have questions regarding Behavioral Health integration, please contact ohsuidsproviderinquiry@modahealth.com.

Benefits

OHSU Health Service OHP members can use these doula services:

Community Doula Alliance

Doula Love

Gateway Doula Group

Heartstrings Birth Doula

Birth doula services

Birth doula care is a covered benefit for OHP members.

OHSU Health Services will pay for licensed, enrolled practitioners for certain services provided by doulas.

Services covered include a minimum of:

- Two prenatal care visits
- Care during delivery
- Two required postpartum home visits

Claims:

Participant agrees to follow all Oregon Health Authority guidelines for billing doula claims.

- Claims will be billed as a case rate.
- The U9 modifier is required for claims to process.
- Claims for services outside the listed codes are not accepted.
- Doulas must be certified and registered as Traditional Health Workers through Oregon Health Authority and enrolled with OHA as Oregon Medicaid Providers

Traditional health workers

OHSU Health IDS promotes the use and inclusion of licensed/certified traditional health workers (THW). These are trusted individuals within local communities who share lived experience with health plan members. No referral is needed and services are free for members.

In addition to birth doulas, there are four other types of THWs licensed in Oregon:

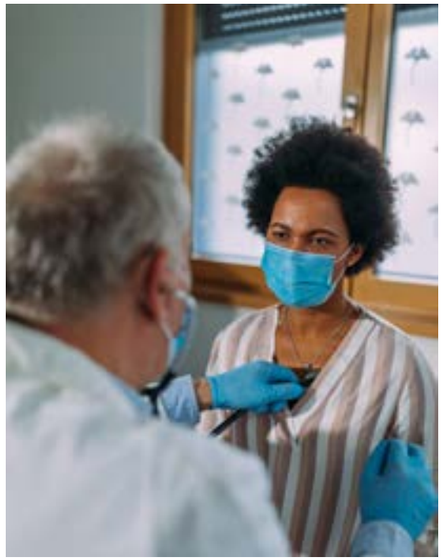
- Peer support specialists
- Peer wellness specialists
- Personal health navigators
- Community health workers

Responsibilities of the PCP

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

Responsibilities include:

- Maintain in members' records a comprehensive problem list of all medical, surgical and psycho-social problems for each patient.
- Maintain a comprehensive medication list that includes all prescription medications that the member is taking and their medication allergies. This includes medications prescribed by specialists.
- Provide Information to members on where to receive appropriate urgent care services. (Do not refer to the Emergency Department for non-life-threatening medical needs.)
- Provide accessible outpatient care within 72 hours for any member with an urgent problem.
- Provide accessible outpatient care within four weeks for any routine visit.
- U.S. Preventive Services Task Force Preventive Services recommended preventative services or all age-appropriate immunization recommendations by the Centers for Disease Control.
- Arrange and/or request authorization for specialty consultation with a network consultant within 72 hours for any member with an urgent problem needing such consultation.
- Arrange and/or request authorization for specialty consultation with a network consultant within two weeks for any member with a nonurgent problem needing such consultation.
- Ensure appropriate and complete medical records, including (but not limited to) initial diagnosis and procedures requested as part of each referral.
- Arrange for hospitalization in a network institution when required.



Member care and support services

- 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.
- Arrange interpretation services with a qualified interpretation service by telephone or on-site.
- Have a policy and/or procedure to arrange for and provide access to an appropriate backup physician or practitioner for any leave of absence.

Member care and support services

Care Coordination and Integration Services

Care coordination and care integration coordinates the physical health, behavioral health, intellectual and developmental disability, and ancillary services between settings of care with the services the member receives from any managed care entity (MCE), the services the member receives in Medicaid, and the services received from community and/or social support providers.

- Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities.
- With services received outside of our delivery system, including (but not limited to) community and social support providers.
- With the Oregon State Hospital, other state institutions or other behavioral health hospital settings to facilitate a member's transition into the most appropriate, independent and integrated community-based setting.
- Intensive care coordination services within one (1) business day for prioritized populations (serious and persistent mental illness (SPMI), human immunodeficiency virus (HIV), medication-assisted treatment (MAT), pregnant women, children 0-5 at risk for behavioral issues or abuse, children in foster care, intravenous drug user (IVDU), intellectual or developmental disability (IDD), etc.).
- Integrated treatment and care plan for all patients with Special Health Care Needs, Long Term Services and Supports (LTSS) and at transitions between levels of care.

Access to care

It is the policy of OHSU Health IDS to ensure that our members have access to timely, appropriate health services that are delivered in a patient-centered, culturally and linguistically appropriate manner. OHSU Health IDS requires providers to have policies and procedures that prohibit discrimination and adhere to member rights in the delivery of health care services.

If OHSU Health IDS is not able to provide any necessary covered service that is culturally, linguistically and medically appropriate to a particular member within the Provider Network, OHSU will adequately cover these services out-of-network in a timely manner and will ensure that the cost to the member is no greater than it would be if services were provided within the network.

Access to Women's Services

OHSU Health IDS provides female members with direct access to women's health specialists within the OHSU Health IDS Provider Network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated primary care provider if the designated PCP is not a women's health specialist.

Women's Services include family planning services, such as:

- Counseling to address reproductive health issues
- Emergency contraception
- Injectable hormonal contraceptives
- Intrauterine device (IUD), including procedures for insertion and removal
- Laboratory tests
- Medical and surgical procedures, including tubal ligations
- Pharmaceutical supplies and devices
- Prescription contraceptives
- Radiology services
- Vasectomy

CARE COORDINATOR TRAINING

Periodic training and support are available from our Care Team through quarterly provider meetings, regularly scheduled clinic meetings and direct provider outreach.

For specific questions, please email **ohsuhscareteam@ohsu.edu**

Member care and support services

Physical access

All participating OHSU Health IDS 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. For specific questions, please email ohsuhscareteam@ohsu.edu.

Appointment availability and standard schedule procedures

Medical care:

- Well-care and follow-up medical appointments should be scheduled to occur as medically appropriate within four weeks of member request or as otherwise required by the applicable care coordination rules, including OAR-410-141-3860 through 410-141-3870.
- Appointments for initial history and physical assessment should be scheduled in longer appointment slots to allow for preventive care and health education as needed.

Urgent medical cases:

- Urgent medical cases should be scheduled to be seen within 24 hours or as indicated in initial screening.

Dental care:

- Routine dental care should be scheduled within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate for non-pregnant individuals or children. Pregnant individuals should be seen within four weeks, unless there is a documented special clinical reason that makes a period of longer than four weeks appropriate for pregnant individuals.
- Urgent dental care should be scheduled within two weeks or as indicated in the initial screening for non-pregnant individuals or children. Pregnant individuals should be scheduled within one week or as indicated in the initial screening.
- Emergency dental care should be seen or treated within 24 hours.

Providers should apply the same standards to their OHSU Health IDS members as they do to their commercially insured or private pay patients.
In support of the Institute for Healthcare Improvement Quadruple Aim, OHSU Health IDS strongly encourages provider offices to consider alternative scheduling, such as:

- Same day/walk-in appointments
- Non-standard business hour appointments
- Weekend appointments

Follow-up on missed appointments

The OHSU Health IDS Care team is available to help providers having problems with members missing repeated appointments.

All OHSU Health IDS participating providers should document and follow-up with members who do not keep their scheduled appointments. It is important to have written documentation of continually missed appointments.

Providers should have a procedure for follow-up of missed appointments that encourages rescheduling of the appointment based on medical necessity of the patient.

Members cannot be charged for missed appointments.

Office hours criteria

A clinic must have a triage process for member calls to determine appropriate care and assist the member with advice, an appointment or a referral. Calls may be answered by, but not screened by, nonclinical support staff. If calls are answered by nonclinical support staff, the member should be informed of the estimated response time from a clinician. The nature of the call and intervention are documented in the member's medical record. Interpreter services are available for telephone calls.

TRANSPORTATION SERVICES

If members are missing appointments due to transportation issues, please see Medical Transportation Services. If members do not qualify for Medical Transportation Services, please see the Health-Related Services section.

Member care and support services

24-hour telephone access

Providers are required to provide 24-hour telephone access to OHSU Health IDS members. OHSU Health IDS Providers must have a telephone triage system with the following features.

After-hours access criteria

Answering service urgent: Person who answers the phone must offer to either page the Provider on call and call the member back OR transfer the member directly to the provider on call.

Answering service emergency: Person who answers the phone must tell the member to call 911 or go to the nearest emergency room if the member feels it is too emergent to wait for the provider to call them.

Voicemail urgent message: Message must give instructions on how to page the provider for urgent situations or tell members to go to the hospital emergency room or urgent care if they cannot wait until the next business day.

Voicemail emergency: Message must provide information on accessing emergency services, such as calling 911 or going to the nearest emergency room if the member feels the situation is emergent.

Transformation Quality Strategy

Participation in the Transformation Quality Strategy (TQS) program is a requirement for all providers. Participation includes providing data for various TQS activities and adhering to established standards of care. Provider and member input into the delivery system is encouraged and made available through participation in appropriate committees.

OHSU Health IDS' TQS is the structure and processes to ensure that care provided to members is accessible, cost-effective and improves health outcomes. The TQS is designed to support achievement of clinical and operational performance goals and to ensure that OHSU Health IDS meets its regulatory and contractual deliverables to Health Share of Oregon (OHSU Health IDS ' Coordinated Care Organization), the Oregon Health Authority (OHA), the Centers for Medicare and Medicaid Services (CMS), and other relevant accrediting bodies.

- The TQS reflects the imperative of the Institute for Healthcare Improvement Quadruple Aim to improve members' experience of care, improve the health of populations, reduce the per capita cost of care and improve health equity.

OHSU Health IDS 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 meaningfully impact health status and/or quality of life.

CLINICAL VALUE AND TRANSFORMATION COMMITTEE

The committee includes the OHSU Health IDS Chief Administrative Officer, OHSU Health IDS Chief Medical Officer, Director, Network Development, OHSU Health IDS Director of Operations, OHSU Health IDS Director of Care Integration and Coordination, OHSU Health IDS Quality Improvement Manager and representative(s) of the OHSU Health IDS Board of Directors. The Board President is ex-officio and can attend any Clinical Value and Transformation Committee meeting.

For information on the committees or if there is interest in participation, please contact OHSU Health IDS Provider Relations at **503-418-7750**.

Member care and support services

- 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, dental and physical health care services.
- Join in efforts that improve health care for all Oregonians by:
  - Supporting community, state and national health initiatives.
  - Building partnerships with other health care organizations.
- Seek out 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 TQS is monitored through OHSU Health IDS' Clinical Value and Transformation Committee (CVT), which reports directly to OHSU Health IDS ' Board of Directors. The CVT 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 CVT consists of at least five physician members, including primary care and specialist providers.

Medical Records

OHSU Health IDS requires medical records to be maintained in a manner that is current, detailed and organized, and that permits effective and confidential member care and quality review.

Criteria for what constitutes a complete medical record:

- Each medical record must contain information for one patient only.
- Medical records must have dated and legible entries for each patient visit. Entries are identified by the author.
- Signatures are full and legible and include the writer's title. Acceptable forms of signature include handwritten, electronic or facsimiles of original written or electronic signatures. Stamped signatures are not acceptable.
- A medical record is reviewed and completed by an appropriate 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 number of patient's next of kin, legal guardian or 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 comprehensive and reconciled medication list, including an indication of allergies and adverse reactions to medications and documentation if no allergies are identified.
- History of presenting problems and a record of a physical exam for the presenting problem(s).

HIPAA PRIVACY AND SECURITY

OHSU Health IDS and 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 are required to provide privacy and security training to any staff that have contact with individually identifiable health information.

- Diagnoses for presenting problems.
- Treatment plan consistent with diagnoses.
- Vital signs, height, weight, body mass index.
- 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 and current documentation of tobacco and alcohol use.
- Documentation of past and present use or misuse of illegal, prescribed and/or over-the-counter drugs.
- Documentation of behavioral health status assessments.
- Copies of signed release of information forms.
- Copies of medical and/or mental health directives.
- Age-appropriate screenings and developmental assessments.

OHSU Health IDS access to records

On a periodic basis, OHSU Health IDS staff may require access to member medical records for the purpose of quality assessment, investigating grievances and appeals, monitoring of fraud and abuse, and review of credentialing issues. On an annual basis, OHSU Health IDS staff may require provider assistance in collecting medical record information for the OHP Health Services Division of Medical Assistance Program reporting.

Third-party access to records

Member records must be disclosed to contracted health plans or their representatives for quality and utilization review, payment or medical management. An OHSU Health IDS provider may have their contract terminated with cause if they refuse to cooperate with the medical record review process, peer review requirements and/or corrective action plans or are otherwise unable to meet provider qualifications and requirements.

Confidentiality

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.

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 must 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.

HEALTH INFORMATION

Do not discuss patient information, financial or clinical, with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

Providers, clinical and nonclinical staff including physicians and OHSU Health IDS staff must not have unapproved access to their own records or records of anyone known to them who is not under their care.

Member care and support services

ACCESS TO INTERPRETERS

During normal business hours, OHSU Health IDS provides access to qualified interpreters who can translate in the primary language of each substantial population of non-English speakers among members. Such interpreters shall be capable of communicating in English and in the primary language of the members and able to translate medical information effectively.

Access to qualified interpreter services shall be provided by telephone or in person. After normal business hours, weekends and holidays. Interpreter Services will be available for emergency and urgent care needs.

Interpreter Services

Alternate forms of communication are provided free of charge to all members who do not speak English as a primary language or who have sensory impairments.

The utilized interpreter services shall demonstrate both awareness for and sensitivity to sociodemographic and cultural differences and similarities among members. A minor child is not to be used as an interpreter. Family members or friends should only be used as adjunctive interpreters if this is the member's preference.

Upon identifying a member with vision impairment, OHSU Health IDS and/or the provider will initiate measures to ensure clear and secure communication. At a minimum, braille documentation may be offered to members with vision impairment.

Providers may choose to coordinate interpretation services themselves instead of through OHSU Health IDS; however, the provider will be responsible for paying for interpretation services. OHSU Health IDS only pays for interpretation services that are coordinated through our preferred vendors.

OHSU interpreter services process

- Only available for OHSU Health IDS Medicaid Members.
- Clinic should complete the form in advance of the member's appointment in order to schedule interpreter service. Find the form **here.**
- Completed form should be sent to:
  - Email **interpreter@ohsu.edu**
  - For changes and/or cancellations, call 503-494-2800 option 1
  - For immediate needs, call 503-494-2800 option 1

Member care and support services

SPECIAL HEALTH CARE NEEDS IDENTIFICATION

Members with Special Healthcare Needs are identified through the Health Services enrollment files and medical screening criteria. Members may also be identified for services through self-referral, high utilization, from their PCP, agency caseworker, their representative or other health care social service agencies.

Members with Special Health Care Needs/prioritized populations

Special healthcare needs members are individuals who are aged, blind, disabled or who have complex medical needs. As a prioritized population, these are members who have high healthcare needs, multiple chronic conditions, mental illness or substance use disorders, demonstrate high utilization and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care).

Special Healthcare Needs member services include:

- Assistance to ensure timely access to providers and services.
- Waived referrals.
- Coordination with providers to ensure consideration is given to unique needs in treatment planning.
- Assistance to providers with coordination of services and discharge planning.
- Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

Medical Transportation for OHP Members

RIDE TO CARE	
Scheduling TTY	503-416-3955 503-802-8058
Website	**https://ridetocare.com/**
Hours	7 :00 a.m. – 7:00 p.m (Monday-Saturday)

Nonemergent medical transportation to medical appointments is a benefit to OHP members. Ride to Care provides free rides to covered medical appointments for OHP members who have no other transportation options.

- OHSU Health IDS members must call Ride to Care to schedule a ride at least two (2) business days in advance of their appointments. Members may schedule a trip up to 90 days before their appointment date.
- OHSU Health IDS members need to have ready their OHP number, time and date of their appointment, and name, complete address and phone number of their medical caregiver.
- Ride to Care can help provide transportation for members with short notice. Members need to tell the operator if they have urgent transportation needs. For example, a ride to an urgent care clinic, or if the member requires transportation to and from dialysis or chemotherapy.
- Ride to Care has interpreters available for non-English-speaking members. This service is free. Members can call Ride to Care and say the language they speak and stay on the line. A Ride to Care representative and interpreter will help them.
- OHSU Health IDS members may call Ride to Care to obtain bus tickets.
- Ride to Care operators answer calls 24 hours a day, seven days a week, 365 days a year.

Provider relations and contracting

PROVIDER RELATIONS AND CONTRACTING

OHSU Health IDS Provider Relations and Network Development is a link between our provider network, OHSU Health IDS staff and Health Share. They provide valuable resources to provider offices through direct contracting with Health Share, credentialing and other key Provider Relations services.

Reach Provider Relations and Network Development by phone at **503-418-7750** or by emailing **OHSUHealthPrvRelations@ohsu.edu**

Health promotion materials

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

Provider Relations and Contracting staff assist provider offices with questions or needs regarding Oregon Health Plan.

Through quarterly office manager meetings and routine site visits, the Provider Relations staff offer provider training on the following topics:

- Orientation to health plan operations, policies and procedures.
- Refresher orientations for clinic, billing or management staff as needed.
- Online resources such as OHSU Health IDS Provider Portal and website.

Please email updates to Provider Relations regarding new or terminated providers or clinic staff, locations, telephone numbers and email addresses. Timely updates facilitate accurate directory listings, mailings, correct claims payment, system access for your staff and appropriate member assignment.

New or non-contracted providers interested in contracting with OHSU Health IDS should contact Provider Relations to initiate determination of network needs. OHSU Health IDS identifies provider additions through network analysis and committee. Upon committee approval, Provider Relations will coordinate the contract and coordinate the contract and credentialing process.

Network Development

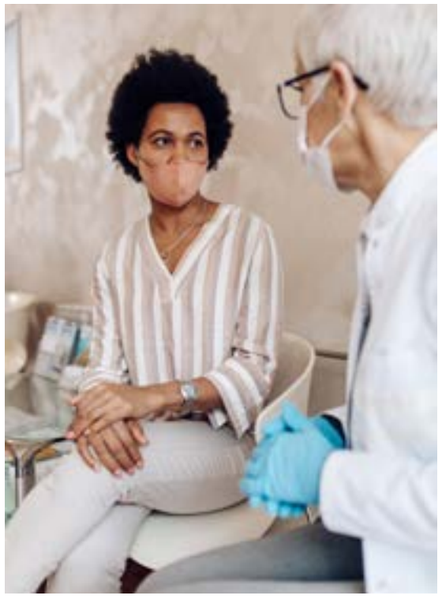
Our provider network is made up of OHSU Health IDS member physicians and associated clinicians through Adventist Hospital; OHSU Hospital and Hillsboro Medical Center, community providers and other ancillary providers, including durable medical equipment and skilled nursing facilities. This network of providers ensures adequate access and quality care to our OHP members.

In addition to our direct participation in the Medicaid program, OHSU Health contracts on behalf of our OHSU Health IDS members and non-ancillary providers with several commercial and Medicare Advantage plans that provide coverage in our service area. OHSU Health IDS staff negotiate these contracts on behalf of our member providers.

Provider rights

OHSU Health IDS 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. OHSU Health IDS 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 OHSU Health IDS including the credentials and performance improvement files of individual providers. Peer references, recommendations or other peer review protected information are excluded from this list of rights. OHSU Health IDS ' process adheres to standards established by the National Committee for Quality Assurance (NCQA).

Provider relations and contracting



OHSU Health IDS 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 the types of procedures or the type of patients in the providers' specialty. 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 OHSU Health IDS 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.
- 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.

When a provider intends to withdraw from or terminate care of a member who needs continuing care at that time, the provider must take the following steps:

- Give reasonable notice of the intent to withdraw by notifying the member's OHSU Health IDS ' Integrated Community Care Manager, thus allowing time to develop an action plan for provider-member relationship alterations as agreeable to both the provider and the member.
- When there isn't compliance to an action plan, the provider-member relationship may be terminated with a 180-day written notice for termination without cause.

The provider is required to send a written and signed notification to the member upon termination of the patient's care. OHSU Health IDS suggests that providers give written notice of the termination via mail by a certified return receipt letter.

- Members residing in nursing homes or otherwise incapacitated must have letters sent to the person acting on their behalf to make medical decisions.
- Written notification of member termination must also be submitted to OHSU Health IDS, either to the appropriate OHSU Health IDS Integrated Community Care Manager or to the OHSU Health IDS Community Outreach Specialist who will notify the Integrated Community Care Manager.

Provider termination of member care

The provider-member relationship may be terminated through:

- Mutual consent
- The member's dismissal of the provider
- The provider's dismissal

It is not necessary to indicate to the member why the relationship is being terminated.

When there isn't compliance to an action plan, the provider-member relationship may be terminated with a 30-day written notice.

Providers should continue to meet the member's medical needs during the 30-day period following termination. If the basis for termination is a threat of dangerous behavior to other patients or staff, the period may be shortened to as little as one (1) day, depending on the seriousness of the threat. The provider must work with OHSU Health IDS to ensure appropriate documentation is received about a member's mental state and any or all attempts to coordinate behavioral needs with their mental health provider. In this situation, emergent care may be provided in OHSU, Hillsboro Medical Center or Adventist Health Portland emergency departments.

Traditional Healthcare Workers

All traditional health workers (THWs), whether they are CCO employees or subcontractor employees, shall undergo and meet the requirements for, and pass the background check required of for THWs, as described in OAR 410-180-0326.

Claims

TIMELY FILING

Claims will be denied for missing or incomplete information. Claim submissions that are missing required data fields will be returned via electronic remittance or on an Explanation of Payment register. The resubmission of the claim with all required data elements must be received within 120 days of the date of service to be considered for reimbursement.

Claim appeals or submissions for reconsideration must be received within 60 days of denial date.

Submitting Claims

OHSU Health IDS can receive claims submitted electronically through Moda Health's electronic connections that include the following clearinghouses:

- Ability/MD Online
- MCPS
- Relay Health
- Availity
- Office Ally
- Change Healthcare
- Payer Connection

The Moda Health Payor ID is 13350

Contact your practice management system vendor or clearinghouse to initiate electronic claim submission. OHSU Health IDS accepts HIPAA-compliant EDI 837 electronic claims through any of the above clearinghouses.

For assistance with claims submitted but Moda Health has not received, **the first point of contact for resolving an EDI issue is the practice-specific clearinghouse or vendor**. They will be able to confirm their receipt of the claim and if their submission to the clearinghouse was successful.

Claims must include the member's diagnostic codes to the highest level of specificity and the appropriate procedure. OHSU Health IDS may waive the 120-day timely filing rule for:

- Eligibility issues, such as retroactive deletions or retroactive enrollments
- Pregnancy
- Medicare as the primary payer
- Third-party resources, including workers' compensation
- Covered services provided by nonparticipating providers that are enrolled with the OHA Health Services Division (HSD)
- Other reasonable circumstances for delay

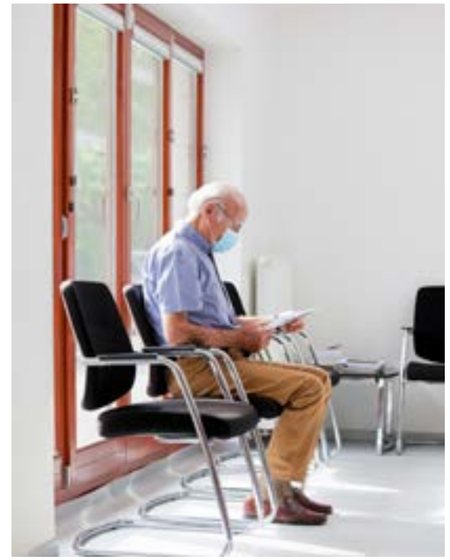
Failure to furnish a claim within 120 days does not constitute waiving of this rule.

Medicaid provider ID number

As a provider of OHSU Health IDS serving OHP members, providers must be enrolled in both Medicare and Medicaid and have an active Medicaid ID, along with a unique provider number (National Provider Identifier-NPI) through the National Plan and Provider Enumeration System (NPPES). 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 Medicaid and enrolled with a Medicaid ID number. The Medicaid ID Number and the NPI number are considered minimum requirements for claims processing and must be maintained.

The Oregon Health Authority (OHA) conducts site visits for provider types designated as "moderate" or "high" risk. Provider types designated as "high" risk must be actively enrolled in Medicare, and OHA relies on Medicare site visits and fingerprint background check screening for these provider types. OHSU Health IDS will not enroll a provider type classified as "moderate" or "high" risk without OHA **and** CMS enrollment.

Providers of OHSU Health IDS serving OHP members must have an active Medicaid ID to maintain participating status and to be eligible for payment. To process a claim, the rendering, attending and billing provider's National Provider Identifier (NPI) is verified as eligible to receive payment by Medicaid and enrolled with an ID number. The Medicaid ID number is considered a minimum requirement for claims processing and must be maintained.
A rendering, attending or billing provider's Medicaid ID can be inactivated due to a number of reasons, such as license expiration, returned mail, etc.



CLAIMS APPEALS

All requests for claims appeals must be submitted in writing. You must include a copy of the original claim and any supporting documents (clinical notes, system reports, screen shots, etc.) to support your request. Claim appeals must be received within 60 days of the original denial date.

OHSU Health IDS
Appeals Unit
P.O. Box 40384
Portland, OR 97240

To verify active enrollment status with DMAP:

1. Go to: www.or-medicaid.gov/ProdPortal/Account/Secure%20Site/tabid/63/Default.aspx
2. Enter the provider NPI and date of inquiry.
3. Click on the search button.

If the provider NPI is not actively enrolled for the date of service entered, submit claims to OHSU Health IDS and simultaneously complete and submit the Oregon Medicaid ID application form to OHSU Health IDS .

National Correct Coding Initiative (NCCI) edits

OHSU Health IDS adheres to all applicable edits under NCCI.

Member billing

State and federal regulations require that a provider accepting Medicaid payment accept it as payment in full. Providers are prohibited from billing Oregon Health Plan recipients for missed appointments and OHP covered services.

Members cannot be billed for the following covered services:

- Services that were denied due to lack of a referral or an authorization.
- Balance billing for the amount not paid to the provider by OHSU Health IDS.
- Missed appointments.

OHSU Health IDS does not withhold payment due to provider assignment. A provider may legally bill an OHP recipient in the following circumstances:

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

ELIGIBILITY VERIFICATION

Billing or sending a statement to a member does not qualify as an attempt to obtain insurance information. Check member eligibility and health plans online without picking up the phone. Use the Moda Health Benefit Tracker at **https://www.modahealth.com/EBTWeb** or click below to log in to the Provider Portal (Health Share's CIM). Through the portal, you can verify member eligibility and health plans at **https://cim6.phtech.com/cim/login**.

For more information regarding the portal, registration and use: **https://www.healthshareoregon.org/providers/provider-portal**

Coordination of Benefits

If there is a primary carrier, such as Medicare or private insurance, or third-party resource such as workers' compensation, and OHSU Health IDS is the secondary payer, submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received. The four-month (120-day) timely filing rule is waived when OHSU Health IDS is the secondary payer; however, claims must be received within 12 months from the date of service for the claim to be considered. OHSU Health IDS can accept secondary claims electronically.

Calculating coordination of benefits

On claims with primary payers including Medicare and private insurance, the total benefits that a member receives from OHSU Health IDS and the other medical plan cannot exceed what the OHSU Health IDS normal benefit would have been by itself. If the primary plan pays more than the OHSU Health IDS allowed amount, no additional benefit is issued.

Sterilizations and hysterectomies

Oregon law requires that informed consent be obtained from any OHP individual seeking voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy (ORS 677.097). 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, OHSU Health IDS cannot reimburse providers for these procedures without proof of informed consent.

For OHSU Health IDS to pay any claims, providers must submit a completed and signed consent form with hysterectomy and sterilization claims.

For a tubal ligation or vasectomy, the patient must sign the Consent to Sterilization form (DMAP form 741, available in English and Spanish) at least 30 days but not more than 180 days before the sterilization procedure. The person obtaining the consent must sign and date the form. The date should be the date the patient signs. 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 (OAR 410-130-0580). 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. Should a claim without a proper consent form be mistakenly paid, a recoupment shall be initiated.

Exceptions

Premature delivery: 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 included.

Emergency abdominal surgery: 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, and the physician must complete Part II, including the nature of the emergency that made prior acknowledgement impossible.

HYSTERECTOMY CONSENT FORM

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 English and Spanish). Physicians must complete Part I including the portion "medical reasons for recommending a hysterectomy for this patient." OHSU Health IDS 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.

DMAP 742A is for people aged 21 years and older.
DMAP 742B is for people who are at least age 15 but not older than 20 years.

ENGLISH FORM:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he0741.pdf

SPANISH FORM:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hs0741.pdf

Claims

THE VACCINES FOR CHILDREN (VFC) PROGRAM

This is a federal program that provides free immunizations for children ages 0–18 years.

Vaccines For Children (VFC) billing

OHSU Health IDS 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, OHSU Health IDS will not reimburse for the cost of the vaccine serum and any fees associated with administering the vaccine.

Providers should bill only for the administration of the vaccines covered under the VFC Program. This is identified by billing the specific immunization CPT code with modifier SL, which indicates administration only.

Use standard billing procedure for vaccines that are not part of the VFC Program.

Locum tenens claims and payments

OHSU Health IDS 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.

OHSU Health IDS is not responsible for compensation arrangements between the provider on leave and the locum tenens provider. OHSU Health IDS sends a payment to the billing office of the provider on leave. Per CMS guidelines, OHSU Health IDS allows locum tenens providers 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.

Overpayment recovery

OHSU Health IDS uses an auto-debit method to recover identified overpayments. When an overpayment is identified, the appropriate group of claims are reversed and future claims payments are automatically debited until the outstanding overpayment balance is settled. As stated in CFR 438.608(d)(2), when a provider receives an overpayment from OHSU Health IDS , the provider must report and return the overpayment to OHSU Health IDS within 60 calendar days after the date on which the overpayment was identified and notify OHSU Health IDS (in writing) the reason for overpayment. OHSU Health IDS may collect and retain overpayments as a result of an investigation or audit due to fraud, waste and abuse. OHSU Health IDS IDS will notify all overpayments due to fraud or excess to Health Share within 60 days.

Fraud, Waste and Abuse

All participating OHSU Health IDS provider clinics must adopt and implement an effective compliance program, which must include measures that prevent, detect and correct noncompliance with Centers for Medicare and Medicaid Services (CMS) program requirements and fraud, waste and abuse (FWA). Training and education must occur annually at a minimum 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.

REPORT FRAUD, WASTE OR ABUSE

OHSU Health IDS encourages reporting through our secure hotline at 1-877-733-8313 (tollfree) or **www.ohsu.edu/hotline**.

Referrals and authorizations

Referrals are made for a period of 180 days, starting with the date the referral is submitted. A new referral is required if the referral has expired, or the number of allowed visits has been exhausted. A new referral must be issued if the referral date has expired, regardless of the number of remaining visits.

The requesting provider may call 844-931-1774 or fax the completed referral/authorization request form to 833-949-1887.

Referrals after a PCP change

Referrals do not become invalid if a member changes his or her PCP during the period of the referral. Referrals remain valid until the expiration date of the referral or the number of visits has been exhausted, whichever comes first, as long as the member remains eligible for OHSU Health IDS.

Retroactive referrals

We encourage providers to submit referrals prospectively. Retroactive referrals need to be submitted to OHSU Health IDS within 90 days from the date of service. Retroactive referrals are subject to the same review process as referrals obtained before the date of service. Referral requests issued retroactively may be denied if the service provided is not covered by the OHP or OHSU Health IDS, or if the provider was not contracted with OHSU Health IDS.

If a situation arises where it is necessary to request a retroactive referral, specialists should submit the request to OHSU Health IDS and notify the member's assigned PCP. Notification to the member's PCP may occur via phone, fax or email. The member's assigned PCP may also submit the retroactive referral request.

Specialists should indicate the reason the referral request is being made retroactively and include any relevant chart notes. If a specialist requests the PCP to submit the retroactive referral, the PCP should consider whether the service is something he or she would have referred the member for had the request been made before the service.

PCPs could decline to process the referral requests made retroactively if the service provided was something the PCP would not have referred the member for (such as primary care services). If the PCP chooses to process the retroactive referral request, the request is submitted to OHSU Health IDS according to the normal referral process.

OHSU Health IDS reviews retroactive referral requests on a case-by-case basis. Decisions regarding approval or denial of retroactive referrals will be based on the individual circumstances of each request.

Referral process for PCPs

- The requesting provider may call 844-931-1774 or fax the completed referral/authorization request form to 833-949-1887.
- Before submitting a referral request, member eligibility status should be verified. (OAR 410-120-1140) Please visit the OHSU Health IDS website for a copy of the referral/authorization form at www.ohsu.edu/sites/default/files/2020-10/OHSU%20Health%20Services%20Referral%20and%20Authorization_Oct2020.pdf
- The referral form must be completed in its entirety. Omitting any of the required information may delay OHSU Health IDS in processing the referral. OHSU Health IDS notifies the PCP office within two (2) business days of receiving the referral request as to whether the referral is being denied or approved or is pending further review.
- Once the referral is approved, OHSU Health IDS faxes the request back to the PCP with the referral number. PCPs should not schedule appointments for patients or notify specialists of a referral until the referral has been approved by OHSU Health IDS.
- If a referral request is denied, OHSU Health IDS faxes the referral request back to the PCP and includes the reason for the denial. The PCP's office will need to notify the specialist of the denial.

PCPS REFERRING MEMBERS TO ANOTHER PROVIDER FOR PRIMARY CARE SERVICES

PCPs can refer their assigned members to another provider (PCP or specialist) for primary care services. Such referrals are subject to the normal referral review process by OHSU Health IDS. The PCP must indicate the reason he/she is referring the member to another provider for primary care services on the referral.

Referrals and authorizations

Referral process for specialists and ancillary providers

- Before submitting a referral request, member eligibility status should be verified. (OAR 410-120-1140)
- Please visit the OHSU Health IDS website for a copy of the referral/authorization form under the medical forms tab.
- Specialists must receive a referral from the member's PCP before seeing the member as outlined in the chart below, unless the request occurs while the member is hospitalized or as a result of an emergency department consult visit that requires follow-up. If the latter is the case, the specialist must notify the PCP as soon as possible after the visit.
- Specialists must check eligibility before seeing a patient, regardless of whether he or she has an approved referral. The patient must be eligible with OHSU Health IDS on the date of service for the referral to be valid.
- Specialists can view referrals online by accessing Benefit Tracker at https://www.modahealth.com/EBTWeb.
- Even when a referral is not required to be on file at OHSU Health IDS, specialists should receive verbal referrals from the member's assigned PCP. Specialists should also notify the PCP of any secondary specialists or ancillary providers to whom members are referred.
- A "courtesy referral" is when a referral is not required by OHSU Health IDS , but the specialist still requests that the PCP obtain a referral number. The PCP will notify OHSU Health IDS verbally that a courtesy referral is being requested or write "courtesy referral" on the referral form if faxed.
- Specialists requesting additional follow-up visits or wanting to send a patient to another specialist for consultation or treatment will call in the referral to OHSU Health IDS and notify the member's assigned PCP. Requests for additional visits may require chart notes.
- The requesting provider may call 844-931-1774 or fax the completed referral/authorization request form to 833-949-1887.

Referral for members with Special Health Care Needs (SHCN)

Members with Special Health Care Needs do not require referrals. These members are individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders and either have functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities, e.g., serious chronic illnesses or certain environmental risk factors, such as homelessness or family problems that lead to the need for placement in foster care.

Referrals and authorizations

Authorizations

The requesting provider may call 844-931-1774 or fax the completed referral/authorization request form to 833-949-1887.

OHSU Health IDS requires an authorization request to be submitted for facility admissions, home care services, medical equipment and supplies, some outpatient procedures and certain medications and diagnostic procedures. Facilities include hospitals, skilled nursing homes and inpatient rehabilitation centers.

REFERRAL REQUIREMENTS

Who is requesting the referral?	In-network specialist or ancillary provider, above-the-line diagnosis	In-network specialist or ancillary provider, below-the-line or unlisted diagnosis	Out-of-network specialist or ancillary provider, above-the-line diagnosis	Out-of-network specialist or ancillary provider, below-the-line or unlisted diagnosis
Assigned PCP	No referral required, unless provider is requesting a courtesy referral.	Referral required.	Referral required.	Referral required.
In-network specialist	No referral required, unless provider is requesting a courtesy referral; specialist must notify the member's.	Referral required; specialist must notify the member's PCP.	Referral required; specialist must notify the member's PCP.	Referral required; specialist must notify the member's PCP.
Out-of-network specialist	Referral required; specialist must notify the member's PCP. A valid referral from the PCP to the out-of-network specialist calling must be on file.	Referral required; specialist must notify the member's PCP. A valid referral from the PCP to the out-of-network specialist calling must be on file.	Referral required; specialist must notify the member's PCP. A valid referral from the PCP to the out-of-network specialist calling must be on file.	Referral required; specialist must notify the member's PCP. A valid referral from the PCP to the out-of-network specialist calling must be on file.

See the Referral and Authorization Guidelines found on the website for details about which services require an authorization. Prior authorization requirement for all durable medical equipment (DME) with total billed charges above $150 has been removed. OHSU Health IDS requires prior authorization for select HCPC codes.

Authorizations process

As the specialist or PCP who is admitting the member or performing a surgery or procedure, follow these steps to help accelerate the authorization request process:

- Request the authorization directly from OHSU Health IDS.
- Check to see if the member is eligible for OHSU Health IDS covered services before submitting any referral as outlined. (OAR 410-120-1140)
- Submit all prior authorization requests at least 14 business days before the planned procedure. Failure to provide adequate time for processing may result in a decision still pending on the date of service.
- To determine if a service is covered, please contact customer service at 844-827-6572 or email OHSUOHPMedical@modahealth.com.

MEDICAID-FUNDED LONG-TERM CARE

As outlined in OAR 410-141-3860, members receiving Medicaid-funded long-term care or long-term services and support should be assessed and considered as a prioritized population that often may have risks and health conditions that place them into SHCN populations.

Referrals and authorizations

REFERRAL/AUTHORIZATION

Once the authorization is approved, OHSU Health IDS will provide an authorization number and other details. When an authorization is denied, limited, reduced or terminated, OHSU Health IDS will notify the PCP, member and specialist in writing of the reason for denial.

The requesting provider may call **844-931-1774** or fax the completed referral/authorization request form to **833-949-1887**.

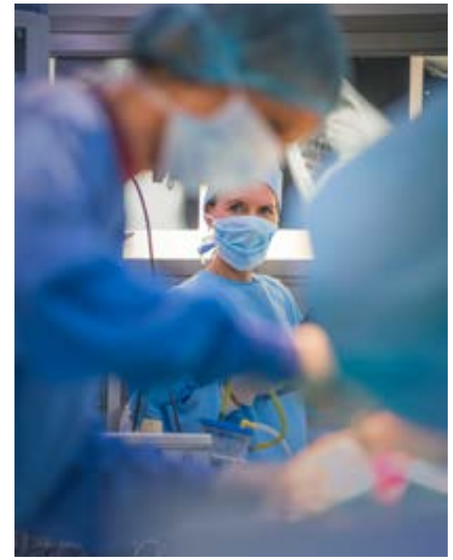
It is the responsibility of the admitting or performing provider to obtain authorizations for prescheduled admissions, surgeries or procedures. It is the hospital's responsibility to verify that an authorization has been approved.

Failure to submit the authorization in a timely manner may cause the need to delay or reschedule a procedure. OHSU Health IDS authorization turnaround times are listed below:

- For urgent services, alcohol and drug services, or care required while in a skilled nursing facility, OHSU Health IDS will determine at least 95% of valid preauthorization requests within two (2) business days of receipt of the preauthorization or reauthorization request.
- For expedited prior authorization requests, in which the provider indicates or the CCO determines that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, OHSU Health IDS shall make an expedited authorization decision no later than 72 hours after the receipt of the request. An extension to no more than 14 calendar days will be granted if the member requests or Health Share justifies it to the Oregon Health Authority a need for additional information and how the extension is in the member's best interest. If the procedure does not seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the standard time frame will apply.
- For all other preauthorization requests, the standard time frame will apply. OHSU Health IDS shall notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request. OHSU Health IDS may use an additional 14 calendar days to obtain follow-up information if justification to the Authority is obtained. If OHSU Health IDS extends the time frame, OHSU Health IDS will notify the member in writing of the reason for the extension.

EviCore

EviCore reviews and authorizes cardiology and most advanced imaging services, such as CT and MRI scans. The requesting provider may call 844-303-8451 or visit www.eviCore.com to request these authorizations. If no authorization is on file for cardiology and/or imaging services through eviCore, claims will be denied.



Inpatient admissions

OHSU Health IDS requires authorization of all scheduled inpatient admissions for surgeries or procedures to ensure that care is delivered to OHSU Health IDS members in the most appropriate setting by participating providers. OHSU Health IDS will review all inpatient authorization requests.

The requesting provider may call 888-474-8540 or fax the completed referral/authorization request form to 503-243-5105.

Urgent and emergent admissions

The hospital or other facility (hospice, skilled nursing facility, etc.) contacts OHSU Health IDS directly when a member is admitted urgently from an office, clinic or through the emergency department.

The facility must notify OHSU Health IDS within one (1) business day of the member's admission.

OHSU Health IDS will provide an authorization number at the time of the call unless further review is required. If additional review is required, OHSU Health IDS will call the requesting facility with the authorization decision, authorized dates, authorization number and contact information for additional review.

Concurrent review

The facility must provide ongoing clinical review information daily or as requested for OHSU Health IDS to authorize a continued length of stay.

OHSU Health IDS may deny days if requested information is not provided or is not provided in a timely manner.

Retroactive outpatient authorization request

Retroactive authorization requests received after 90 days from the date of service will not be accepted or approved. This will follow standard timely filing guidelines. Retroactive authorization requests do not follow standard preauthorization turnaround times.

Retroactive inpatient authorization requests

Retroactive authorization requests are denied unless it is established that the practitioner and the hospital did not know and could not reasonably have known that the patient was enrolled with OHSU Health IDS at the time of admission. Retroactive authorization requests do not follow standard preauthorization turnaround times.

Obstetrical admissions

The facility must notify OHSU Health IDS of all admissions within one (1) business day of the member's admission. For deliveries, the facility must notify OHSU Health IDS of the date of delivery, type of delivery and discharge date. Hospital stays beyond the federal guidelines (two days for vaginal delivery/four days for cesarean section) require authorization.

Readmission (DRG hospitals)

A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status and both admissions must be combined into a single billing. OHSU Health IDS will make one payment for the combined service.

A patient whose discharge and readmission to the hospital is within 15 days for the same or related diagnosis must be combined into a single billing. OHSU Health IDS will make one payment for the combined service.

Second opinions

OHSU Health IDS provides for a second opinion from a qualified health care professional within the network or arranges for the member to obtain a second opinion outside the network at no cost to the member.

A second opinion is defined as a patient privilege of requesting an examination and evaluation of a physical, mental or dental health condition by an appropriate qualified health care professional or clinician to verify or challenge the diagnosis by a first health care professional or clinician.

The member or provider (on behalf of the member) contacts OHSU Health IDS or the delegated entity to request a referral for a second opinion. OHSU Health IDS or the delegated entity reviews the request according to its respective referral processing guidelines and assists the member or provider acting on behalf of the member to locate an appropriate in-network provider for the second opinion. If no appropriate provider is available in-network, the member may access an out-of-network provider at no cost.

The requesting provider may call 888-474-8540 or fax the completed referral/authorization request form to 503-243-5105.

Clinical practice guidelines

OHSU Health IDS posts its clinical guidelines information at www.ohsu.edu/health-services/ohsu-health-services-providers-and-clinics for provider and member education and access. Resources used include, but are not limited to, the following:

Behavioral Health

- American Society of Addiction Medicine Patient Placement Criteria, 2nd edition, Revised
- Milliman Care Guidelines Health Behavioral Health Care Guidelines
- Oregon Administrative Rules
- Prioritized List of Health Services

Oral Health

- ADA Center for Evidence-based Dentistry
- American Dental Association (ADA) Practice Parameters
- California Dental Association Quality Evaluation for Dental Care Clinical Practice Guidelines
- DCO-specific internal policies and procedures
- FDA Guidelines for Prescribing Dental Radiographs
- OHP Prioritized List
- Oregon Administrative Rules
- Pediatric Dentistry Reference Manual
- Various dental specialty protocols, (e.g., pediatric oral surgery, periodontal, endodontic)

Physical Health

- Oregon Administrative Rules
- Prioritized List of Health Services
- Milliman Care Guidelines
- DMEPOS (CMS) Local Coverage Determinations

CLINICAL PRACTICE GUIDELINES

OHSU Health IDS staff use evidence-based guidelines for their clinical support tools and written policies. OHSU Health IDS applies criteria based on the individual circumstances and conditions of OHSU Health IDS' members. OHSU Health IDS staff complete an assessment of the local delivery systems to support clinical interventions and access to current health care resources for assistance in providing services to OHSU Health IDS members.

Monitoring appropriate utilization

OHSU Health IDS monitors utilization data for OHP members and analyzes all data collected to detect under- and overutilization. Analysis is performed at least annually and includes:

- Annual reports of findings
- Evidence that analysis results in identified areas or procedures in need of improvement

Under- or overutilization thresholds

- Health Share Quality Incentive Measures and CAHPS
- Length-of-stay data
- Member complaints and appeals

OHSU Health IDS may conduct qualitative and quantitative analysis to determine the cause and effect of all data not within thresholds.

OHSU Health IDS may provide utilization pattern reports to OHSU Health IDS providers to educate and assist them in implementing strategies to achieve appropriate utilization. In the event there are problems of under- or overutilization identified, OHSU Health IDS will work with the provider to develop an action plan and reevaluate the measures of the interventions to ensure effectiveness with the action plan.

- Utilization management (UM) decision making is based only on appropriateness of care /service and existence of coverage as presented in Oregon's prioritized list.
- OHSU Health IDS does not specifically reward providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- There are no financial incentives for UM decision makers.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A,655 before prescribing a schedule II-controlled substance pursuant to 42 U.S.C 1396w-3a.

The PDMP check does not apply to clients in exempt populations:

- Individuals receiving hospice
- Individuals receiving palliative care
- Individuals receiving cancer treatment
- Individuals with sickle cell disease
- Residents of a long-term care facility, of a facility described in 42 U.S.C. 1396d, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w–3a(h)(2)(B)
- Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.

PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.

Pharmacy Benefit Program (PBM)

CONTRACTED PHARMACIES

OHSU Health IDS contracts with most retail chain pharmacies as well as other local pharmacies. You may obtain a list of contracted pharmacies by visiting **https://www.ohsu.edu/health-services/ohsu-health-services-pharmacy-resources**.

Using the formulary

The drug formulary is a list of drugs that are covered under OHSU Health IDS' benefits for eligible members. The formulary is available on the OHSU Health IDS website at www.ohsu.edu/health-services/ohsu-health-services-pharmacy-resources.

These resources enable the provider or office staff to access up-to-date information regarding covered medications, Step Therapy Guidelines and Prior Authorization Criteria. The formulary is subdivided into therapeutic classes. It lists both generic and commonly used brand names for each covered medication. If a medication is not listed on the formulary, it will require prior authorization.

Prior authorization process

Medications listed on the formulary as "Prior Authorization Required (PA)" must have an approval before the prescription can be dispensed by a network pharmacy. If the criteria for ordering the medication are not met, OHSU PBM will contact the prescribing provider to discuss alternative therapy.

- For drugs listed in the formulary with Step Therapy (ST), the member must follow Step Therapy Guidelines before approval of that medication. Step Therapy Guidelines require a member to try and fail, or simultaneously utilize other medications before approval.
- For drugs listed in the formulary as quantity-limited (QL), a prior authorization is required once the limit has been reached for quantities over the monthly allowable.

The following criteria applies when OHSU PBM is considering a request for nonformulary drug:

- The patient has failed an appropriate trial of formulary or related drugs.
- The choice available in the formulary is not suited for the member's needs.
- The use of the formulary drug product may be a risk to member safety.
- The use of formulary drug products is contraindicated for the member.

Injectables and high-cost medication through specialty pharmacies

OHSU Health IDS, in conjunction with Specialty Pharmacies, has a program in place for high cost/self-injectable medications.

- Providers may administer a one-time dose of the patient's medication in the office for the purposes of educating the member and/or family on administration of the medicine. The medication and supplies necessary to administer the drug will be labeled specifically for each member and delivered to the providers' offices or members' residences.
- Prior authorization is required for specialty medications through this program and may be requested from OHSU Health IDS.

OHSU SPECIALTY PHARMACY PROGRAM OFFERS

- Refill reminders
- Easy home delivery of medications
- Care coordination and medication support
- Call center support Monday-Friday, 8 a.m. – 4:30 p.m. PST at 866-263-5580
- 24-hour access to a pharmacist
- Insurance benefit review
- Prior authorization help
- Financial assistance screening

Further questions can be directed to OHSU Heath Services at **844-827-6572**.

Specialty medications can be ordered in several different ways:

P: **503-418-8228**
F: **503-346-3371**

Electronic prescribing:
OHSU Specialty Pharmacy


OHSUHealth