eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Eastern Oregon
Coordinated Care Organization

Provider Manual

2022

www.eocco.com

Table of Contents

Services covered by EOCCO 3
Services covered by The Oregon Health Plan 3
Services not covered by EOCCO or The Oregon Health Plan 4
The Prioritized List 4
EOCCO Eligibility 5
PCP assignment and selection 6
Dismissal and disenrollment guidelines 7
Member rosters 9
Provider Directory 10
Referral and authorization guidelines 10
Denials of referrals and authorizations 18
Member rights and responsibilities 19
Member complaints and appeals 22
Non-Emergent Medical Transportation (NEMT) 24
Telehealth or telemedicine 25
EOCCO services and benefits 26
Routine vision services 26
Dental services 27
Low Back Pain 27
Acute inpatient rehabilitation 28
Skilled nursing facility care 28
Hospice care 29
Durable medical equipment (DME) and home health 29
Hearing aids and hearing-aid repairs 29
Sterilizations and hysterectomies 30
Tobacco cessation 31
Pharmacy services 32
Synagis/Respigam (RSV) billing 34
Site of Care Program 35
Behavioral health services 35
Treatment for substance use disorders 45
Declaration for Mental Health Treatment 47

Advance directives 48
Pregnancy notification 49
Newborn notification 49
Interpreter services 49
National Provider Identifier 50
Credentialing and recredentialing of EOCCO providers 51
Traditional Health Worker 62
Medical record-keeping, Office site, access and after-hours standards and audits 64
Marketing 69
Claims 69
Billing members 72
Billing for children's vaccines (VFC) 73
Medicare 73
Dual-eligible members 74
Clinical editing 75
Coding and billing reviews 82
Provider inquiry 84
Care Coordination and Case Management 85
Transition of Care 86
Quality improvement 87
Incentive Measures 89
Risk Reports 89
Annual Clinician and Staff Summit 90
Cultural Competency Trainings 90
Community Advisory Council 90
Seclusion and restraint policy 90
Confidentiality 91
Release of information 92
Fraud, waste and abuse 92
Definitions 93
Federal laws 94
Applicable state laws 97
Conflict of Interest Requirements 107

Services covered by EOCCO

The following services are covered by Eastern Oregon Coordinated Care Organization (EOCCO):

- Preventive services, including immunizations, well-child checkups and routine office visits
- Treatment by the primary care physician
- Treatment by a physician at a Patient Centered Primary Care Home
- Treatment by a specialist
- Maternity care
- Laboratory, X-ray and other diagnostic tests
- Family planning
- Durable medical equipment and supplies
- Home health and home enteral, parenteral and intravenous services
- Routine vision care, including exams and hardware
- Physical and occupational rehabilitation
- Audiology and speech therapy
- Ambulance transportation
- Inpatient hospital stays
- Surgery
- Oncology
- Care in hospice and skilled nursing facilities
- Chemical dependency treatment
- Urgent and emergent services
- Prescriptions
- Smoking and tobacco cessation services
- Hearing services
- Mental health services
- Dental services
- Non-emergent medical transportation
- Second opinions
- Health Related services

Services covered by The Oregon Health Plan

Some services are covered only by The Oregon Health Plan, even if the patient is an eligible member with EOCCO:

- Elective abortion and related services
- Death with dignity
- Prescription drugs for mental health conditions

Claims for these services should be submitted directly to Oregon Health Authority: Health Systems Division.

Services not covered by EOCCO or The Oregon Health Plan

EOCCO providers must inform EOCCO members of any charges for non-covered services prior to services being delivered. If a member chooses to receive a specific service that is not covered by EOCCO or the Oregon Health Plan, arrangements must be made between you and the member prior to rendering the service. You are required to:

- Inform the member that the service is not covered
- Provide an estimate of the cost of the service
- Explain to the member his or her financial responsibility for the service

The agreement between you and the member to pursue non-covered treatment must be documented in writing and be able to be submitted to EOCCO, upon request. A patient responsibility waiver provided by your office must be signed by the member prior to rendering non-covered services. A HSD approved waiver form is available for your convenience at www.eocco.com/eocco/-/media/eocco/pdfs/member_waiver.pdf under Patient Responsibility Waiver.

A member cannot be held financially responsible for the following:

- Services that are covered by EOCCO or the Oregon Health Plan
- Services that have been denied because of provider error
- Missed appointments
- Unsigned and/or incomplete waiver on file

Services performed by a non-OHP provider will be denied and payment could be the responsibility of the member.

The Prioritized List

The Oregon Health Evidence Review Commission (HERC) maintains a list of condition and treatment pairs known as the Prioritized List of Health Services. The purpose of the Prioritized List is to define the Oregon Health Plan benefits. The list organizes the pairs by priority; each pair is assigned a line number that represents its rank order. The HERC designates a line as the funding level, where services above the line are covered and services below the line are not. Services that are below-the-line are typically for conditions that resolve on their own, treatments for cosmetic reasons or treatments that otherwise do not have beneficial outcomes.

The Oregon Health Plan and EOCCO cover all funded services. Some services require medical necessity review. Effective Jan 1, 2022 the funded lines are 1-472. The funding line will remain at this level through December 31, 2023.

Getting started

To verify whether a service is covered by EOCCO and to find out where the funding line is currently set, check the Prioritized List. Providers can access this information by visiting the Oregon Health Plan website, www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx. The website provides several resources to assist providers in determining the coverage status of a service. These include an index searchable by condition or treatment, guideline notes and past Prioritized List information.

Important reminders

- Due to legislative decisions, the funding line is subject to change. For the most current information, be sure to check with either the Oregon Health Plan or EOCCO
- Treatment may be covered for one condition but not covered for another. For example, arthrodesis may be covered for a dislocation, but not covered for an anomaly. Remember, the pairing of the condition with the treatment determines which line the service appears on

EOCCO Eligibility

The Oregon Health Authority: Health Systems Division (HSD) coordinates applications for the Oregon Health Plan. Oregon residents can apply online by going to www.oregonhealthcare.gov or by calling 800-699-9075 (TTY: 711) to request a paper application.

Verifying member eligibility

OHP recipients should bring their Oregon Health Plan (OHP) medical ID card, as well as their EOCCO ID card, to each visit. HSD sends each recipient his or her own medical ID card. Services should not be denied if a member is unable to present an ID card at the time of service.

Before providing covered services, providers must verify member eligibility at every visit. It is the responsibility of the provider to verify that the individual receiving medical services is, in fact, eligible on the date of service for the service provided and to determine whether EOCCO or another party is responsible for reimbursement. The provider assumes full financial risk in serving a person not identified as eligible or not confirming with EOCCO or HSD that they are eligible for the service provided on the date(s) of service. OAR 410-120-1140

There are five ways you can verify a member's eligibility:

- Option 1: Use OHP's Medicaid Management Information System (MMIS) provider Web portal. The Web portal can be found at www.or-medicaid.gov/ProdPortal/Home/Validate%20NPI/tabId/125/Default.aspx
- Option 2: Call OHP's automated voice response (AVR) system at 866-692-3864
- Option 3: Use Benefit Tracker. When you are signed up with Benefit Tracker, you do not need to give your office information, as you have already done this during registration. You will be able to view claim payment, eligibility and PCP assignment information. Benefit Tracker is available from 6 a.m. to 10:30 p.m., seven days a week, including holidays
- Option 4: Call EOCCO Customer Service at 888-788-9821. Our Customer Service representatives are knowledgeable and helpful when it comes to your questions. They have up-to-date information and policies so you can be confident that they will give you the best information available. You can reach them from 7:30 a.m. to 5:30 p.m., Monday through Friday, excluding holidays

  Because of Health Insurance Portability and Accountability Act (HIPAA) privacy rules, providers must give EOCCO the following information prior to verifying information about a patient:
  - Provider name

- The office from where the provider is calling
- Provider's tax identification number

To identify the patient you're inquiring about, we require the following:

- Member's Recipient Identification Number
- If the Recipient Identification Number is not known:
    - Patient's first and last name
    - Patient's date of birth

- Option 5: Contact EOCCO by e-mail at eoccomedical@eocco.com. You will need to identify yourself, your patient and what the issue is. Our goal is to send a response within 24 hours. Our e-mail correspondent's hours are from 7:30 a.m. to 5:30 p.m., Monday through Friday, excluding holidays

PCP assignment and selection

Member ID cards

EOCCO members receive a member ID card when they are first assigned to EOCCO only or upon request from the member. This card should be used for identification purposes only. The ID card does not list the member's assigned PCP. Providers should not rely on the member ID card to accurately verify a member's PCP eligibility.

PCP assignment and selection

Our goal is for members to select a PCP during the first 30 days of enrollment by contacting EOCCO or by returning the PCP selection card mailed to members with their member handbook. After the first 30 days of enrollment, EOCCO members are required to have a PCP. Members who have not selected a PCP after the first 30 days of enrollment are automatically assigned a PCP by EOCCO. The PCP will be a certified Patient Center Primary Care Home, when available. The PCP assignment is based on the geographic location of the member's home address and provider capacity.

Unassigned members

During the first 30 days of enrollment, members may be unassigned to allow members time to notify EOCCO of their PCP selection of choice. Any contracted EOCCO PCP can see unassigned members and write referrals for them until permanent care can be established. Whenever possible, please assist members in selecting your office as their permanent PCP by contacting EOCCO Medical Customer Service or faxing the PCP Change for to 503-243-3959. A copy of the form is located at www.eocco.com/providers/forms. Online submissions can be completed by filing out the form located: www.eocco.com/providers/pcp

Please remember that EOCCO may deny claims if the provider is not the PCP of record for the EOCCO member receiving services. PCPs should verify that the provider is the PCP of record for EOCCO members.

PCP changes

Members must select a PCP within the first 30 days of enrollment. After the first 30 days, members may change their PCP up to two times every six months. PCP assignments are effective on the first date of enrollment in which the PCP selection was made. If the member has seen a different PCP during the

month or would like to change their PCP, the PCP selection will be the day EOCCO is notified. PCPs should always verify that the provider is the PCP of record for EOCCO members.
A member's PCP request may not be approved if the provider is at full capacity. If a member is an established patient, please fax the completed referral request form to 503-243-5105.

Verifying PCP assignment

To verify PCP assignment for an EOCCO member:

- Check Benefit Tracker
- Call EOCCO Customer Service

Tips to ensure that your office is the PCP of record

Before the member comes in for his or her appointment, log onto Benefit Tracker or call EOCCO Customer Service to verify that your office is the PCP of record. If you do not have Benefit Tracker, please visit us online at www.modahealth.com/medical/mbt.shtml where you can preview Benefit Tracker, complete a service agreement, and register to obtain your free login and access information. For more information or registration assistance, call 503-265-5616 or toll-free 877-277-7270 or e-mail ebt@modahealth.com.

If you are not the PCP of record or if you are unclear, you can call EOCCO Medical Customer Service to confirm that you are the member's PCP. If you are not the member's PCP, fax the completed referral request form to 503-243-3959.

Dismissal and disenrollment guidelines

Dismissal is when a member is removed from the care of his or her assigned PCP.

Disenrollment is when a member is removed from his or her health plan.

Requirements

EOCCO must follow the guidelines established by the Department of Human Services regarding disenrolling members from the plan. EOCCO encourages members and their providers to resolve complaints, problems and concerns at the clinic level.

Key points when considering dismissing a member

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

- Timely, early communication
- Thorough documentation of events, problems, and behaviors
- A plan generated by the PCP to attempt to address the problem or concerns
- The use of contracts and case conferences
- Consider mental health diagnoses

When can a member be dismissed?

A member may be dismissed from a PCP or disenrolled from EOCCO only with just cause subject to Americans with Disabilities Act requirements. The list of just causes, identified by OHA, includes but is not limited to the following:

- Missed appointments, except prenatal care patients
- Disruptive, unruly, or abusive behavior
- Drug-seeking behavior
- Committing or threatening an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or EOCCO staff
- Dismissal from PCP by mutual agreement between the member and the provider
- Agreement between the provider and EOCCO that adequate, safe and effective care can no longer be provided
- Committing a fraudulent or illegal act, such as permitting someone else to use his or her medical ID card, altering a prescription or committing theft or another criminal act on any provider's premises

If PCP decides to dismiss a member

When the clinic management moves to dismiss a member, a letter is sent to the member informing him or her of the dismissal with a copy sent to EOCCOproviderinquiry@modahealth.com. PCPs are asked to provide urgent care and pharmacy refills for the dismissed member for 30 days following notification of the member.

If disenrollment is not considered, EOCCO Medical Customer Service Representatives work with the member to establish a new PCP.

When a member cannot be dismissed

Oregon Administrative Rules state that members shall not be dismissed from a PCP or disenrolled from EOCCO solely because:

- The member has a physical, intellectual, developmental, or mental disability
- There is an adverse change in the member's health
- The PCP or EOCCO believes that the member's utilization of services is either excessive or lacking or that the member's use of plan resources is excessive
- The member requests a hearing
- The member has been diagnosed with end-stage renal disease (ESRD)
- The member exercises his or her option to make decisions regarding his or her medical care with which the provider or the plan disagrees
- The member displays uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the OHP member's special needs

Causes for disenrollment requests

EOCCO requests disenrollment when notified of the following:

- Missed appointments, except prenatal care patients
- Disruptive, unruly or abusive behavior

- Drug-seeking behavior
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or EOCCO staff
- The member commits a fraudulent or illegal act, such as permitting someone else to use his or her medical ID card, altering a prescription, or committing theft or another criminal act on any provider's premises
- The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution.
- If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services

Send copies of relevant documentation, including chart notes, to EOCCO. EOCCO will contact OHP and request immediate disenrollment.

Missed appointment policy

Providers should individually establish an office policy for the number of missed appointments they allow before dismissing a member from their practice. This policy must be administered the same way for all patients. The provider's office must inform all members of their office policy on missed appointments at the member's first visit. The provider should have members sign an acknowledgement of the office policy. HSD rules do not allow providers to bill members or charge them a fee for missed appointments.

When a member misses an appointment, the provider's office should attempt to contact the member to reschedule and notify EOCCO Medical Customer Service of the missed appointment. EOCCO Medical Customer Service will contact the member and educate him or her on the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation.

If the member continues to miss appointments and the provider decides to dismiss the member, the provider must send a letter to the member informing him or her of the dismissal. A copy of the dismissal letter should be sent to EOCCOproviderinquiry@modahealth.com, along with a copy of the office policy on missed appointments and any other relevant documentation, including chart notes, correspondence sent to the member, signed contracts and documentation of case conferences.

The patient will be asked to select a new provider. PCPs are asked to provide urgent care and pharmacy refills for the dismissed member for 30 days following notification of the member. EOCCO requests disenrollment of a member after that member has been dismissed from two providers for missed appointments in a 12-month period.

Member rosters

EOCCO member rosters can be provided to PCPs upon request. Please contact EOCCOmetrics@modahealth.com for a current member roster.

Patient Centered Primary Care Medical Home (PCPCH) rosters and payment data summaries can be provided upon clinics request. Please contact noahpietz@modaheatlh.com to request the current roster and/or to be added on the monthly distribution list.

Provider Directory

EOCCO will update the electronic provider directory at least every 30 days. Providers are responsible for reporting necessary information within the following timeframes to ensure accurate information is available to members and providers:

- Notify EOCCO within ten (10) business days of all changes to the list of Group Providers, the services it/they provide, and all contact and billing information for Provider and Group Providers
- As requested by EOCCO, provider roster requests must be completed and returned no later than 30 days upon receipt

Referral and authorization guidelines

The EOCCO Referral and Authorization Guidelines provide information on referrals, authorization request requirements and services that do not require authorization. This information is subject to change and can be accessed from the EOCCO website at www.eocco.com/providers/referral-auths.

When reviewing a referral or authorization request, EOCCO may use one or more of the following criteria to approve or deny the request:

- Oregon Administrative Rules and supplemental information administered by the Division of Medical Assistance Programs
- Prioritized List of Health Services
- EOCCO Health Medical Necessity Criteria
- Milliman criteria
- Medicare criteria

The referral and authorization process

Providers must first check to see if a service is covered by EOCCO or the Oregon Health Plan before submitting an authorization or referral to EOCCO.

- To determine whether a service will be covered by EOCCO, please check the Prioritized List of Health Services at www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx
- A list of EOCCO's non-covered list of services is available at www.eocco.com/providers/referral-auths under the authorization list
- If the service is not covered by EOCCO or the Oregon Health Plan, but treatment is deemed essential, additional information such as chart notes should be submitted to EOCCO along with the authorization or referral request.
- An authorization guidelines document is available online at www.eocco.com/providers

Referrals

The requesting provider may call or fax

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886

Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

Services that do not require a referral

Members can see any network provider for

- Urgent and emergency care
- Family planning services and supplies, such as birth control
- Routine Vision exam
- Prenatal care
- Immunizations
- Women's routine and preventive health care
- Routine laboratory and radiology services
- Orthopedic providers
- Behavioral health services, including mental health and substance use disorder (SUD)
- Intensive care coordination

Referral timeframe and number of visits

- Referrals are made for a period of 180 days, starting with the date the referral is submitted
    - Two visits for below-the-line (BTL) our out-of-network (OON)
- 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

Referrals after a PCP change

- Referrals do not become invalid if a member changes his or her PCP during the timeframe 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 with EOCCO

Retroactive referrals

- We encourage providers to submit referrals prospectively
- Retroactive referrals need to be submitted to EOCCO within 90 days from the date of service. If the retro referral is submitted after a claim determination as been made the retro referral must be submitted as an appeal
- Retroactive referrals are subject to the same review process as referrals obtained prior to the date of service. Referral requests issued retroactively may be denied if the service provided is not covered by the Oregon Health Plan or EOCCO, or if the provider was not contracted with EOCCO
- If a situation arises where it is necessary to request a retroactive referral, specialists should submit the request to EOCCO 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 prior to the service. PCPs can 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 EOCCO according to the normal referral process
- EOCCO 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

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 EOCCO. The PCP must indicate the reason he/she is referring the member to another provider for primary care services on the referral

Referral process for PCPs

- The requesting provider may call or fax.

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

- Check to see if the member is eligible for EOCCO covered services prior to submitting any referral. OAR 410-120-1140
- Please visit www.eocco.com/providers/referral-auths for a copy of the Referral/Authorization form
- The referral form must be completed in its entirety. Omitting any of the required information may delay EOCCO in processing the referral. EOCCO notifies the PCP office within two 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, EOCCO 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 EOCCO
- If a referral request is denied, EOCCO 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
- If the referral request is to a non-contracted provider and the request is denied by EOCCO, a formal written denial is mailed to the PCP, the specialist and the member. The notification includes the reason for the denial

Referral process for specialists and ancillary providers

- Check to see if the member is eligible for EOCCO covered services prior to submitting any referral as outlined. OAR 410-120-1140
- Specialists must receive a referral from the member's PCP prior to 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 they have had an approved referral. The patient must be eligible with EOCCO on the date of service for the referral to be valid.
- Specialists can view referrals online by accessing Moda's Benefit Tracker
- Even when a referral is not required to be on file with EOCCO, specialists should be receiving verbal referrals from the member's assigned PCP. Specialists should also notify the PCP of any secondary specialists or ancillary providers that members are referred to
- A "courtesy referral" is when a referral is not required by EOCCO, but the specialist still requests that the PCP obtain a referral number. The PCP will notify EOCCO 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 EOCCO and notify the member's assigned PCP. Requests for additional visits may require chart notes
- The requesting provider may call or fax

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

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 (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)

Once care has been established authorization would apply if the service is outlined on the www.eocco.com/providers/referral-auths

As outlined in OAR 410-141-3160, members receiving Medicaid funded long-term care or long-term services and support should be assessed and considered as a population that often may have risks and health conditions that place them into SHCN populations.

Providers can verify a member is on a Special Healthcare Needs plan by checking Moda's Benefit Tracker and under the "Referral" section it will display "Referral is not required."

Primary care offices who would like a roster of members that are on an SHCN plan on a monthly basis please reach out to EOCCOproviderinquiry@modahealth.com

The referral requirement chart below outlines when a referral is required to be called or faxed into EOCCO:

	Service is to:			
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 PCP	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

Authorizations

The requesting provider may call fax.

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

EOCCO 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.

See the Prior Authorization list found on our website at www.eocco.com/providers/referral-auths for details about which services require an a prior authorization.

Authorization 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 EOCCO
- Check to see if the member is eligible for EOCCO covered services prior to submitting any referral as outlined. OAR 410-120-1140
- Check to see if the requested service is covered by EOCCO before submitting the authorization. To determine if a service is covered by EOCCO, please check the Prioritized List of Health Services at www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx.
- Submit all prior authorization requests at least 14 business days prior to the planned procedure. Failure to provide adequate time for processing may result in a decision still pending on the date of service

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. EOCCO's authorization turnaround times are listed below.

- For urgent services, alcohol and drug services, or care required while in a skilled nursing facility, EOCCO will make a determination on at least 95 percent of valid preauthorization requests within two working 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 timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, EOCCO will make an expedited authorization decision no later than 72 hours after the receipt of the request. An extension of no more than 14 calendar days will be granted if the member requests or the CCO justifies 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 timeframe will apply
- For all other preauthorization requests, the standard timeframe will apply. EOCCO will notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request. EOCCO may use an additional 14 calendar days to obtain follow-up information if justification to the Oregon Health Authority is obtained. If EOCCO extends the timeframe, EOCCO will notify the member in writing of the reason for the extension

The requesting provider may call or fax:

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

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

eviCore

eviCore Specialty now reviews and authorizes cardiology, and most advanced imaging services, such as CT and MRI scans. The requesting provider may call 844-303-8451 or web 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. Please remember to choose EOCCO when selecting the health plan option

Inpatient admissions

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

The requesting provider may call or fax.

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

Urgent and emergent admissions

The hospital or other facility (hospice, skilled nursing facility, etc.) contacts EOCCO directly when a member is admitted urgently from an office, clinic or through the emergency department.
The facility must notify EOCCO within one business day of the member's admission.
EOCCO will provide an authorization number at the time of the call unless further review is required. If additional review is required, EOCCO will call the requesting facility with the authorization decision, authorized dates, authorization number and contact information for additional review.

Based upon review, if the treatment is considered as non-emergency care, we will only pay the emergency room assessment fee for the facility and any other services billed will be denied as not medically necessary.

Concurrent review

The facility must provide ongoing clinical review information daily or as requested in order for EOCCO to authorize a continued length of stay.

EOCCO may deny days if requested information is not provided or is not provided in a timely manner.

Retroactive outpatient authorization request

Retroactive authorization requests 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 turn-around times.

If a retroactive authorization request is submitted after a claim determination has been made the retro request must be submitted as an appeal.

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 EOCCO at the time of admission. Retroactive authorization requests do not follow standard preauthorization turn-around times.

Obstetrical admissions

The facility must notify EOCCO of all admissions within one business day of the member's admission.

For deliveries, the facility must notify EOCCO of the date of delivery, type of delivery and discharge date.

Hospital stays beyond the federal guidelines (two days for vaginal delivery and 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. EOCCO 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. EOCCO will make one payment for the combined service.

Second opinions

EOCCO provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain a second opinion outside the network at no cost to the enrollee.

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

The member or provider (on behalf of the member) contacts EOCCO and/or GOBHI entity to request a referral for a second opinion. EOCCO or GOBHI 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 or fax

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

Health Related Services

EOCCO will utilize health-related services when appropriate. CCOs are required by the Oregon Health Authority to offer health-related services to EOCCO members.

In lieu of traditional benefits, health-related services are designed to improve care delivery, member health and lower costs. Requests for health-related services are reviewed on a case-by-case basis. Health-related services are a key lever for health system transformation and include flexible services and community benefit initiatives. Health Related services are cost-effective services offered to an individual member to supplement covered benefits. Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality.

Health Related services are:

- Complementary to the benefits covered under Oregon's State Plan
- Lacking billing or encounter codes
- Consistent with the member's treatment plan as developed by the member's primary care team and documented in the member's medical record
- Likely to be cost-effective alternatives to covered benefits and likely to generate savings
- Likely to improve health outcomes and prevent or delay health deterioration

Health Related services are considered in the context of the member's overall integrated care planning and management by the primary care team, including the member's behavioral and oral health providers. To be considered a health-related service, a service must meet the requirements for:

- Activities that improve health care quality, as defined in 45 CFR 158.150; or
- Expenditures related to health information technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.

To make a Health Related service request, providers may call EOCCO at 888-788-9821 or fax the completed authorization request form to 833-949-1886. Forms can be found on www.eocco.com/providers/referral-auths To request a community benefit initiative, providers may contact the local community advisory council.

Health-related services do not follow standard authorization turnaround times outlined in this manual. Turnaround time will be determined on a case-by-case basis depending on the nature of the request.

Members have the right to file a grievance regarding a flexible services decision; however, there is no right to an appeal.

Denials of referrals and authorizations

Denials

EOCCO verbally notifies the requesting provider when a referral or authorization request is denied. We also send the PCP and requesting provider a copy of the denial letter.

A written notification of the denial is mailed to the member, PCP or requesting provider and specialist (when applicable) within 14 days of the receipt of the request.

Denial letters include the following information:

- Service requested
- Reason for denial
- Member's appeal rights and instructions

If the member speaks a language other than English, the denial letter will be translated into the member's primary language. If the denial letter needs to be translated, it may take longer than one week to reach the member.

Reconsiderations

Provider reconsideration means a pre-service request by a provider for EOCCO to reconsider an authorization denial in light of additional information sent by the provider to Moda. Provider reconsiderations do not require member participation or permission and do not supplant any member appeal rights.

Member rights and responsibilities

- Be treated with dignity, respect, and consideration for your privacy
- Be treated by providers the same as other people seeking healthcare benefits. Providers are encouraged to work with the member's entire care team to help them meet their needs
- Pick a PCP or service site and to change those choices allowed in the EOCCO administrative policies
- Refer oneself to behavioral health or family planning services. They do not need a referral from a PCP or other participating provider
- Have a friend, family member or health advocate at visits as needed within clinical guidelines
- Be actively involved in developing their treatment plan. EOCCO, OHA, in-network provides and other EOCCO partners will not treat you differently based on your choices
- Be educated about their condition and covered/non-covered services to make informed decisions about treatments and to get this information in a language and format that works for them.
- Agree to treatment or refuse services and be told the results of that decision, except for court ordered services
- Have an OHP patient advocate
- Receive rights in plain language and other formats (video or audio)
- Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- Have written materials that are understandable
- Be educated about the coordinated care approach that is used in the community and how to navigate the coordinated care and health care system
- Get services that meet member's cultural and language needs as close to where members live or seek services, as possible. Pick providers within the delivery system network that are, if available,

offered in non-traditional settings accessible to families, diverse communities and underserved populations

- Receive oversight, care coordination, and transition and planning management from EOCCO within the targeted population. This helps ensure cultural and language appropriate care is provided that serves them in as natural and unified environment, as possible. It also minimizes the use of institutional care
- Get necessary and reasonable services to diagnose the presenting condition
- Get unified patient-centered care and services to provide choice, independence and dignity. These services should meet generally accepted standards of practice and be medically appropriate
- Have a consistent and stable relationship with a care team that is responsible for comprehensive care management
- Get help in the healthcare delivery system to access community and statewide social support services and resources from certified or qualified workers, including healthcare interpreters, community health workers, peer wellness specialists, peer support specialists, doulas, and personal health advocates. The member's care team should provide cultural and language assistance to help access appropriate services and participate in processes that affect their care.
- Get covered preventive services
- Access urgent and emergency services 24 hours a day, seven days a week without prior authorization
- Get a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in the EOCCO referral policy
- Have a clinical record that documents conditions, services received, and referrals made
- Access one's own clinical record, unless restricted by statute, at no charge to the member
- Ask that a clinical record be updated or corrected by mailing a request with supporting documentation to EOCCO. Please see page 6 for mailing address.
- Send a copy of the clinical record to another provider
- Create a statement of treatment wishes. This includes the right to accept or refuse medical, surgical, or behavioral health treatment. It also includes the right to execute directives and powers of attorney, for healthcare established under ORS 127
- Get written notices before a denial of, or change in, a benefit or service level is made. A notice will not be sent if it is not required by federal or state regulations
- Be able to make a complaint or appeal with EOCCO and receive a response
- Request a contested case hearing if you disagree with a decision made by EOCCO or OHP
- Get certified or qualified healthcare interpreter services, including sign language interpretation
- Get a notice of a cancelled appointment in a timely manner
- Be free from a restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations for restraints and seclusion
- Be treated fairly and file a complaint of discrimination if you feel you've been treated unfairly because of your: age, color, disability, gender identity, marital status, race, religion, sex, or sexual orientation
- Share information with EOCCO electronically. You can choose to do this or not

EOCCO members have the responsibility to:

- Pick or help with assignment to a PCP or service site
- Treat EOCCO, providers and clinic staff members with respect
- Be on time for visits made with providers. Call in advance to cancel if unable to keep the appointment or if expected to be late.
- Seek periodic health exams and preventive services from the PCP or clinic
- Use the PCP or clinic for diagnostic and other care except in an emergency
- Get a referral to a specialist from the PCP or clinic before seeking care from a specialist, unless self-referral to the specialist is allowed
- Self-refer means you can seek care or service without approval from your PCP. You may self-refer for:
- THW services
- In-network behavioral health services
- Health risk screenings for ICC services, sexual abuse exams and covered family planning services
- Use appropriate urgent and emergency services. Notify the member's PCP or clinic within 72 hours of using emergency services that follow the EOCCO referral policy
- Give accurate information for inclusion in the clinical record. Be honest with your provider so they can give you the best care.
- Help the provider or clinic get clinical records from other providers that may include signing an approval to release information
- Ask any care-related questions about conditions, treatments and other issues or if there is anything you do not understand
- Use information given by EOCCO providers or care teams to make informed decisions about treatments before they happen
- Work with the provider to create a treatment plan
- Follow prescribed agreed upon treatment plans and actively engage in their healthcare
- Tell the provider that the member's healthcare is covered under the OHP before services are received. If requested, show the member ID card to the provider.
- Tell the DHS or OHA worker of a change of address or phone number
- Tell the DHS or OHA worker if the member becomes pregnant. Notify the worker of the birth of the member's child.
- Tell the DHS or OHA worker if any family members move in or out of the household
- Tell the DHS or OHA worker if there is any other insurance available
- Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280
- If EOCCO becomes aware that a provider was paid by a third-party carrier, EOCCO will ask the provider for a refund. They will only ask making sure the provider got a payment from a third-party carrier. A third-party carrier may be motor-vehicle accident insurance or workers comp.
- Bring issues or complaints to the attention of EOCCO

Member complaints and appeals

EOCCO members or their authorized representative have the right to file appeals, complaints and hearings. EOCCO Customer Service will provide assistance to the member in filing an appeal, complaint or hearing.

Complaints

A complaint is an expression of dissatisfaction to EOCCO or a provider about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. A complaint is also known as a grievance. Examples of complaints include, but are not limited to, access to providers, waiting times, demeanor of medical care personnel, quality of care and adequacy of facilities.

Providers are encouraged to resolve complaints, problems and concerns brought to them by their EOCCO patients. If you cannot resolve a complaint yourself, inform the member that EOCCO has a formal complaint procedure. Member complaints must be made to EOCCO and the member can submit a complaint via the telephone or in writing. A provider or authorized representative may also submit a complaint on the members behalf with written consent from the member. Regardless of the outcome of the complaint filed with EOCCO, the member also has the right to file a complaint directly with the Oregon Health Authority Ombudsperson's Office or the Oregon Health Plan (OHP) Client Services Unit (CSU). There is no timeframe to file a complaint.

Appeals

An appeal is a request by an EOCCO member or his or her representative to review an EOCCO decision to deny, limit, reduce or terminate a requested covered service or to deny a claim payment. Member appeals must be made to EOCCO in writing within 60 calendar days of the members Notice of Adverse Benefit Determination. If a member calls EOCCO Customer Service, he or she must follow up with a written appeal. Providers may appeal on behalf of the member by including written permission from the member. If EOCCO upholds the members appeal the member also has the right to file an Oregon administrative hearing request with Health Systems. When requested by the member, the services that were reduced or terminated will continue if the appeal is filed within the required timeframes. However, the member may be required to pay the cost of the services furnished during the appeal process if the final decision is averse to the member.

An appeal may be requested as follows:

Write:

EOCCO Appeals Unit
601 SW Second Ave
Portland, OR 97204

Phone:

EOCCO Customer Service, 503-765-3521 or 888-788-9821 (TTY: 711)

Fax:

503-412-4003, Attention: Appeals Unit

If you call in an appeal, you must follow up with a written, signed appeal.
Once the appeal is received;

- We will inform the member we received their appeal within five working days
- We will complete the review and respond to the member's standard appeal within 16 days. If EOCCO cannot resolve the appeal within 16 days, the member will receive another letter explaining the delay. The appeal will be resolved within 30 days of receipt
- If you believe the member's problem is an emergency and cannot wait for a review, ask EOCCO for an expedited or "rush" appeal. If EOCCO agrees the appeal is an emergency, we will respond to your request within 72 hours
- Resolution of the expedited appeal may be extended up to 14 days if the member requests the extension or if EOCCO cannot resolve the appeal within 72 hours of receipt, and satisfactorily shows the need for additional information and how the delay is in the member's interest. EOCCO makes reasonable effort to give the member verbal notice of the delay and the reason for the delay and follows up with a letter explaining the delay within 2 days and that EOCCO will reach a decision and inform the member in writing within 72 hours plus 14 days of receipt of the expedited appeal. The letter will also inform the member of their right to file a grievance about this decision
- Members have the right to continue services during the appeal process if the appeal was filed within the required timeframes. If the denial is upheld, then the member will have to pay for those services
- Members will not be treated differently as EOCCO members while going through the appeal process and will be treated the same
- Members have the right to have someone file an appeal and speak for them. Please give us in writing the name of the person who will represent them
- If EOCCO upholds the members appeal the member also has the right to file an Oregon administrative hearing request with Health Systems

Resolving complaints and appeals and EOCCO

The EOCCO appeal staff facilitates the member complaint and appeal processes and seeks input from appropriate parties, such as the provider, Intensive Case Management (ICM), care coordination staff or the medical consultant, to reach an informed decision about the appeal. The appeal staff resolves the members complaint within five business days of receipt of a complaint (with applicable extension) and within 16 calendar days of receipt for an appeal (with applicable extension). Both processes can take up to 30 calendar days.

If EOCCO fails to adhere to required time frames for processing the appeal or fails to adhere to the notice and timing requirements for an extension of the appeal resolution time frame, the member is deemed to have exhausted the appeal process and may initiate a contested case hearing directly with the State of Oregon.

Contested case hearing and the administrative hearing process with the State of Oregon

Health Systems has an appeal process for members who are dissatisfied with EOCCO's response to an appeal of a denial, limitation, reduction, or termination of a requested covered service. This is the State of Oregon administrative hearing process.

When EOCCO denies, limits, reduces, or terminates a requested covered service, the EOCCO Notice of Adverse Benefit Determination outlines the member's right to file an appeal with EOCCO and the appeal timelines. The letter also informs the member of the right to request a state of Oregon administrative hearing and the required timelines if the member continues to be dissatisfied with the EOCCO appeal decision.

Members are not required to file a complaint with EOCCO, they may also file a complaint directly with OHA regardless of the outcome with EOCCO and/or if they choose not to submit one to EOCCO.

Members may obtain more information about this process by contacting their OHP caseworker or contacting EOCCO Customer Service at 503-765-3521 or toll-free at 888-788-9821 (TTY: 711) Complete the hearing form and return in to OHA. The address is listed on the form. Members can also give it to your OHP caseworker. Make sure to do this within 120 days from the date of the denial.

Members have the right to continue services during the administrative hearing process if the appeal was filed within the required timeframes. If the denial is upheld, then the member will have to pay for those services

Oregon Health Plan complaint forms are available through EOCCO Customer Service at 503-765-3521 or 888-788-9821 (TTY: 711) or through the member's OHP state caseworker. A member may file a complaint using the EOCCO Complaint Form or appeal using the Oregon Health Authority Appeal and hearing request form (OHP 3302). The forms can be found online at www.eocco.com/members/your-resources/member-forms.

Members may also seek free legal help from Legal Aid Services and Oregon Law Center by contacting Public Benefits Hotline at 1-800-520-5292 (TTY 711). Members can also find Legal Aid online by visiting oregonlawhelp.org/.

Non-Emergent Medical Transportation (NEMT)

EOCCO utilizes Greater Oregon Behavioral Health, Inc (GOBHI) Transportation Network to provide nonemergent medical transportation (NEMT) for EOCCO members to and from approved services. NEMT offers transportation in all 12 EOCCO counties.

- Baker
- Malheur
- Union
- Sherman
- Wallowa
- Gilliam
- Grant
- Harney
- Lake
- Morrow
- Umatilla

- Wheeler

NEMT may be contacted at 1-877-875-4657 to schedule transportation for EOCCO and Fee for Service members. NEMT advises members to call as soon as a ride needs to be scheduled to provide NEMT adequate time to schedule a ride. Short notice requests are available, but limited and based on finding providers. Members need the following information to schedule a ride:

- Full name
- Full street address
- Phone number or contact number
- Physician/Facility name
- Physician/Facility street address
- Physician/Facility phone number
- Date of appointment
- Time of appointment
- Pick-up time after appointment
- Medical/purpose of appointment
- Any special needs, such as using a wheelchair

Additional information can be found by visiting: www.eocco.com/members/resources

Reimbursement Payee Forms may be found at:

English Version:
www.eocco.com/-/media/EOCCO/PDFs/Member/Resources/reimbursement_payee_letter.pdf
Spanish Version:
www.eocco.com/-/media/EOCCO/PDFs/Member/Resources/EOCCO-Reimbursement-Payee-Letter_Spanish_Fillable.pdf

Proof of Healthcare Visit Forms may be found at:

English Version:
190dc63f-6484-4fe1-8f5f-5fc15096b3f7.filesusr.com/ugd/a5cb16_9c3c0147ab174de6959dc28fc322904e.pdf?index=true
Spanish Version:
a5cb1623-eea8-4b73-9e12-9c6d28ef8fb6.usrfiles.com/ugd/a5cb16_8d8a21e7869c4dd7bd7b42ef43fc75d8.pdf

Telehealth or telemedicine

EOCCO follows Oregon Administrative Rules (OAR)'s 410-120-1990, 410-141-3556, 410-141-3830, 410-146-0085, 410-147-0120, 410-172-0850 for coverage of Telehealth and Telemedicine services. Participating providers must comply with Medicaid Network Access standards as outlined in OAR 410-141-3515

Criteria for Tele-Video and Telephonic Services

Prior-authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

Services must meet all the following in-order to qualify for coverage:

- Limited to two-way real time video and/or phone communication as defined by state and/or federal mandates
- Services must be medically necessary and eligible for coverage
- Providers and originating site must be eligible for reimbursement
- Telemedical video and telephonic communication and other consultation services are subject to all terms and conditions of the plan and member benefit

Claim information for reimbursement

- Bill with Place of Service (POS) 02 The use of telehealth POS 02 certifies that the service meets the telehealth requirements
- Modifier GT is required for some behavioral health services. (Please see BH Fee Schedule)
- The GQ modifier is still required when applicable. GQ modifier means, via Asynchronous Telecommunication systems
- Bill with the transmission site code Q3014; (where the patient is located)
- Modifier 95 is allowed and optional for telemedicine services
- For members with Medicare as primary, please bill according to CMS guidelines. As secondary will process based on Medicare paid amounts, telemedicine coding doesn't have to match OHP claims coding to pay secondary

EOCCO services and benefits

Routine vision services

EOCCO members may use contracted vision providers for routine vision services, including refraction and glasses.

Routine vision services are only covered for EOCCO plan members who are pregnant or younger than 21 years of age.

Vision services

- Pregnant adults (21 or older) may have an eye exam and new glasses (lenses and frames) every 24 months
- Children and pregnant women (20 and younger) may have an eye exam and new glasses (lenses and frames) every 12 months. Additional exams and glasses may be covered more frequently when medically necessary
- Contact lenses are covered for the medical condition of keratoconus

Medical eye services are considered a specialty visit and follow the referral requirements outlined in this manual

Accessing care

- Eligible members may access routine vision services without a PCP referral
- Self-referrals may be made by members to any EOCCO contracted vision provider
- Upon enrollment with EOCCO, members receive an EOCCO Member Handbook. The handbook covers vision benefits and how to access care

Contracted vision providers

- A listing of contracted vision providers will be included in the EOCCO Provider Directory. Each member will receive a copy of the EOCCO Provider Directory at the time of enrollment
- Members may also access a listing of vision providers online at www.eocco.com/members/providersearch.

Dental services

Dental health services are provided by Advantage or ODS Dental.

If members need immediate dental care and they do not know the name of their dental plan, please contact EOCCO Customer Service at 888-788-9821 (TTY: 711).

The county a member lives in will determine which dental plan he or she is assigned to. Below we have listed each dental plan that works with EOCCO and the counties they service. The dental plan will send the member an ID card and member handbook.

Advantage Dental

866-268-9631 (TTY: 711)
Counties served: Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, and Wheeler

ODS Community Dental (ODS)

800-342-0526 (TTY: 711)
Counties served: Baker, Grant, Malheur, Umatilla, Union, Wallowa, and Wheeler

The following are issued by the dental plan:

- ID Cards

The following are submitted to the dental plan:

- All dental care claims

Low Back Pain

EOCCO covers certain treatments for lower back pain and will begin to implement changes to pharmacy benefits. Treatment options can include Physical, Occupational, Cognitive Behavioral therapy, Yoga or other Supervised Exercise Therapy, Chiropractic, Acupuncture, Massage, Osteopathic Manipulative Treatment, Concentrative Movement Therapy, and Intensive Interdisciplinary Rehabilitation.

Notification via phone or fax is required for the first four visits. Visits five and above require prior authorization. Request should include chart notes, the Keele STart Back Screening Tool scores, the opioid taper plan (if available), and an above the line diagnosis (if applicable).

The guidelines for prescribing opioids related to the treatment of back and spine pain are available on the EOCCO website at www.eocco.com/providers/painmanagement. This website includes additional resources for providers.

Acute inpatient rehabilitation

Acute inpatient rehabilitation requires prior authorization and is covered for EOCCO members. All acute inpatient rehabilitation requests are reviewed by Moda Health Medical Management staff. Moda Health Medical Management staff can assist with:

- Decisions about the appropriate level of care and a patient's candidacy for inpatient rehabilitation
- Finding rehabilitation centers within the EOCCO network

The requesting provider may call or fax.

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

Skilled nursing facility care

Placing a member in a nursing facility

Skilled nursing facility care requires prior authorization. When an EOCCO member is being discharged from the hospital and requires placement in a skilled nursing facility, the hospital discharge planner should coordinate placement. All skilled nursing facility requests are reviewed by EOCCO Health Medical Management staff. Moda Health Medical Management staff can help find participating nursing facilities within the EOCCO network.

The hospital discharge planner can call the Medical Intake unit at 800-258-2037 or fax the completed Authorization Request Form to 833-949-1886.

Coordination of care of a member in a nursing facility

Primary care providers can choose whether or not to manage the care of their patients when they are placed in a nursing facility. The PCP can elect to provide medical management to these patients or have the nursing facilities "house" physician provide medical management. Members will remain assigned to their existing PCP while they are in a nursing facility.

EOCCO Health Medical Management nurses coordinate any needed services with the house physician and staff. The hospital discharge planner coordinating placement should communicate with the patient's PCP to determine which of the above options the PCP prefers.

Hospice care

EOCCO covers hospice care when the member has a terminal illness and a physician-documented life expectancy of six months or less. The goal of hospice care is for comfort care and to make the end-of-life process as comfortable as possible. EOCCO Health Medical Management staff reviews all inpatient hospice requests and can provide information about hospice care options within the EOCCO network.

Durable medical equipment (DME) and home health

Durable medical equipment, prosthetics, orthotics and supplies, and home health services (including infusion) are subject to the following:

- EOCCO requires prior authorization of equipment, orthotics, supplies and all home care services as identified in the EOCCO Prior Authorization List to ensure that care is delivered to EOCCO members in the appropriate setting by participating providers

The requesting provider may call or fax.

Referral-Authorization Phone	800-258-2037
Referral-Authorization Fax Form	833-949-1886
Members residing Morrow & Umatilla County Phone	541-215-1208
Members in residing Morrow & Umatilla County Fax Form	541-215-1207

Hearing aids and hearing-aid repairs

Requirements

Hearing evaluations and audiograms require a referral from the member's PCP. Hearing aids and hearing-aid repairs require an authorization from EOCCO.

Hearing evaluation and audiogram referrals

The member's PCP refers the member to an audiologist for hearing evaluations and audiograms following the normal referral process.

If a specialist who does not do audiograms, such as an ENT provider, would like to refer the member to another provider for an audiogram, he or she should make a referral request to the member's PCP.

Hearing aids

If the audiologist determines that a hearing aid is needed, they can fax the audiogram results to EOCCO, along with a letter indicating the services and items being requested and the associated costs.

EOCCO Health Medical Management staff members review the request to determine whether it meets coverage criteria.

- If the request does meet criteria, EOCCO faxes an approval form with the allowed costs back to the requesting audiologist
- If the request does not meet criteria, EOCCO calls the audiologist to notify that the request is denied. A denial letter will be mailed to the member, audiologist and PCP

Hearing-aid repairs

If a member's hearing aid is in need of repair, the member's PCP refers the member to an audiologist to evaluate what repairs need to be done. If the audiologist determines that the hearing aid can be successfully repaired, he or she follows the process as outlined above to request approval to repair the hearing aid.

Sterilizations and hysterectomies

Requirements

- Oregon law requires that informed consent be obtained from any individual seeking voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy
- It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. Therefore, EOCCO cannot reimburse providers for these procedures without proof of informed consent

Voluntary sterilization

- For a tubal ligation or vasectomy, patients must sign the Consent to Sterilization Form (OHP 742A or OHP 742B) located at www.eocco.com/providers/forms at least 30 days, but not more than 180 days, prior to the sterilization procedure
- In the case of premature delivery, the sterilization may be performed less than 30 days, but more than 72 hours, after the date of the individual's signature on the consent form. The individual's expected date of delivery must be entered
- In the case of emergency abdominal surgery, the sterilization may be performed less than 30 days, but more than 72 hours, after the date of the individual's signature on the consent form. The circumstances of the emergency must be described
- The person obtaining the consent must sign and date the form. The date should be the date the patient signs or after. It cannot be the date of service or later. The person obtaining consent must provide the address of the facility where consent was obtained
- If an interpreter assists the patient in completing the form, the interpreter must also sign and date the form
- The physician must sign and date the form either on or after the date the sterilization was performed.
- Fully and accurately completed consent forms, including the physician's signature, should be submitted with all sterilization claims. Incomplete forms are invalid and will be returned to the provider for correction
- The provider should ensure the correct age-appropriate consent form is used. Forms for individuals 21 years and older (OHP 742A) and individuals 15–20 years (OHP 742B) can be found at www.eocco.com/providers/forms
- EOCCO cannot pay for sterilizations that do not have a correctly completed consent form

Hysterectomies

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

- Patients who are not already sterile must sign the Hysterectomy Consent Form (OHP 741). The form can be found at www.eocco.com/providers/forms
- Hysterectomies require prior authorization

Tobacco cessation

Tobacco cessation treatment and counseling

Tobacco cessation is covered service for EOCCO members. Treatment interventions may include one or more of these services: basic, intensive and telephone calls. Tobacco cessation treatment and counseling does not require a referral.

Basic tobacco cessation treatment

Basic treatment includes the following:

- Ask — systematically identify all tobacco users; usually done at each visit
- Advise — strongly urge all tobacco users to quit
- Assess — measure willingness to attempt to quit using tobacco within 30 days
- Assist — help with brief behavioral counseling, treatment materials and the recommendation or prescription of tobacco cessation therapy products (e.g., nicotine patches and gum, oral medications intended for tobacco cessation treatment)
- Arrange — schedule follow-up support or give a referral to more intensive treatments, if needed

When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than six minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.

Intensive tobacco cessation treatment

Intensive treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. EOCCO will pay for a maximum of 10 sessions every three months for intensive tobacco cessation treatment and counseling. Intensive treatment should be reserved for clients who are not able to quit using tobacco with the basic intervention measures.

Tobacco cessation therapy products

EOCCO will cover the following tobacco cessation therapy products:

- Nicotine patches, gum and lozenges
- Prescription commonly used for quitting smoking and tobacco use, see Pharmacy Formulary on www.eocco.com/providers/pharmacy

Health coaching for quitting tobacco

Personalized health coaching for quitting smoking and tobacco use is available at no cost to you. Tools and services are included in the program to help you make healthy choices and take care of yourself. To contact a tobacco quit coach, call 877-277-7281 or email careprograms@modahealth.com.

Pharmacy services

Providers are able to access information pertaining to EOCCO members through the EOCCO website and Electronic Benefit Tracker (EBT). A provider may log onto EBT by going to www.eocco.com/providers?s=1 and clicking on the Benefit Tracker Link. As a reference, some of the information practitioners may find on the EOCCO's website and EBT is listed below:

- Preferred Drug List
- Prior authorization drug list
- Value tier list
- Vaccine list

Formulary overview

EOCCO uses a closed formulary in administering pharmacy services on behalf of our EOCCO members. A copy of the formulary can be viewed at www.eocco.com/members/pharmacy.

The formulary, or list of covered medications, is selected by the Moda Health's Pharmacy and Therapeutics (P&T) Committee. Formulary decisions are based on critical review of the available scientific evidence for efficacy, safety, outcomes, cost-effectiveness, and value to treat medical conditions that are eligible for coverage under the Oregon Health Plan as determined by the Prioritized List of Health Services. See the list at www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx.

New FDA-approved medications are subject to a 180-day review and may be subject to additional coverage requirements or limits established. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the 180-day review period prior to Moda Health's P&T Committee evaluation.
The EOCCO prescription benefit includes coverage of prescription drugs provided to eligible members from a pharmacy and does not include medications administered or furnished by the provider in an office or inpatient setting.

Additional coverage limitations include the following:

- Non-formulary drugs and devices that are not listed on the EOCCO formulary
- Experimental drug products or newly approved drug products that have not been reviewed
- by the EOCCO Pharmacy and Therapeutics Committee for inclusion on the EOCCO formulary
- Drugs or devices prescribed for conditions that are not eligible for coverage under the Oregon Health Plan (e.g. fibromyalgia, allergic rhinitis, and acne)
- Drugs used for non-medically accepted indications
- Drugs used to promote fertility or to treat sexual dysfunction
- Drugs used for cosmetic purposes or hair growth
- Drugs when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose, i.e. morbid obesity)
- Most prescription vitamins and minerals, except prenatal vitamins and pediatric multivitamins with fluoride, and fluoride preparations
- Other drugs specifically excluded from coverage under Medicaid and/or Medicare, such as drugs not approved by the FDA

- All Class 7 and 11 medications used to treat mental health disorders, including Depakote, Lamictal and their generic equivalents — these are covered by HSD through the fee-¬for-service (Open card) benefit. Pharmacies must bill prescriptions for mental health drugs to the HSD Pharmacy Benefit Manager (PBM). The HSD PBM can be reached at 888-202-2126
- Part D-covered drugs for members with Medicare Part D coverage — EOCCO will pay only for drugs not covered by the member's Part D plan that are on the EOCCO formulary. These drugs typically include some Over-The-Counter (OTC) medications

Formulary exception and prior authorization procedure

Formulary exceptions will be reviewed and granted when there is no suitable formulary alternative available for treatment of a condition covered by the Oregon Health Plan or when the patient has documented unsuccessful treatment with formulary medications available.

Drugs that require prior authorization, step therapy, have quantity limits or an age restriction are designated on the formulary as PA, Step, QLL and Age, respectively.

- Drugs labeled 'PA' require prior authorization before a member can fill the prescription at a network pharmacy. The member or provider must submit a prior authorization form to request coverage of these drugs
- Drugs labeled 'Step' are subject to step therapy requirements and are limited to coverage only when certain conditions have been met – for example, the member has an approved claim for a formulary alternative in their prescription profile. The member or provider must submit a prior authorization form if step criteria are not met and the member has not demonstrated failure of or contraindication to the prerequisite drug(s)
- Drugs labeled 'Age' have an age restriction and require the member to be younger than or older than a specific age. For example, a drug may be restricted to people under age 6 or over age 16. The member or provider must submit a prior authorization form if member does not meet age criteria

Drugs labeled 'QLL' are subject to a quantity limit and are restricted to specific quantities. If a provider or member wants to exceed the limit, a request must be submitted using a prior authorization form and approved by EOCCO. Providers are instructed to download a prior authorization (PA) form from the EOCCO website at www.eocco.com/providers/pharmacy. Fax the completed PA Form to EOCCO at 800-207-8235.

EOCCO will fax a response for approved authorizations, denied authorizations or a request additional supporting documentation to the provider within 24 hours.

Pharmacists and physicians can contact EOCCO Pharmacy Customer Service for assistance with formulary questions or prior authorization procedures.

The EOCCO Pharmacy Customer Service line is 503-265-2939 or 888-474-8539 (TTY: 771). Navitus Health Solutions, LLCs telephone number is 844-268-9789

Specialty drug program

EOCCO provides members prescribed specialty medications and access to enhanced clinical services through Ardon Health Pharmacy, our exclusive specialty pharmacy provider. Certain prescription drugs or medicines, including most self-injectables, as well as other medications, must be purchased through an exclusive specialty pharmacy provider for coverage. If a member does not purchase these drugs from Ardon Health or another designated limited distribution drug pharmacy, the drug expense will not be covered.

Information about EOCCO specialty pharmacy is available by calling Ardon Health at 855-425-4085 or by visiting www.ardonhealth.com.

Biosimilar pharmaceuticals

Biosimilar pharmaceuticals are closely matched successors to off-patent biologics and offer more cost-effective versions of their branded originators. An interchangeable biosimilar is a type of biological product that is licensed by the FDA because it is highly similar to an already FDA-approved biological product (reference product); has been shown to have no clinically meaningful difference from the reference product; and is expected to produce the same clinical result as the reference product in any given patient. EOCCO Rx's goal is to provide members with a balanced pharmacy benefit that reflects our dedication to the health and safety of our members while ensuring the most effective distribution of therapeutic options at the best available cost. Because FDA-approved biosimilar agents deliver the same therapeutic result at a lower cost, EOCCO encourages the use of FDA-approved interchangeable biosimilar pharmaceutical products for its members.

National Drug Code (NDC) requirement

For claims payment consideration under the medical or prescription benefit, claims for medications must include the National Drug Code (NDC). Billing with the NDC helps facilitate a more accurate payment and better management of drug costs based on what is being dispensed. Prescribers are required to submit a prescription drug's 11-digit NDC in a 5-4-2 format when submitting medical claims for drugs dispensed in a practice setting.

Some packages will display fewer than 11 digits, but leading "0"s can be assumed and need to be used when billing. For example:

NDC on label	Configuration on label	NDC in required 5-4-2 format
05678-123-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-1	5-4-1	05678-0123-01

Synagis/Respigam (RSV) billing

- EOCCO covers Synagis/Respigam only for high-risk infants and children as defined by the American Academy of Pediatrics guidelines, as outlined in OHA's Oregon Medicaid Pharmaceutical service prior authorization criteria for RSV prophylaxis

- EOCCO requires an authorization for Synagis/Respigam
- EOCCO notifies the provider requesting the Synagis/Respigam vaccine once the authorization has been approved
- Synagis can be submitted to EOCCO under the medical benefit using CPT code 90378 or 90379.
- Synagis can also be covered under the members pharmacy benefits if they are having a hard time obtaining it through the buy and bill process.
- Providers who administer the Synagis/Respigam vaccine should work with the pharmacy to coordinate monthly shipping, according to the member's scheduled appointments
- EOCCO will reimburse either the provider or the pharmacy for the authorized Synagis/Respigam vaccine, but not both

Site of Care Program

EOCCO has teamed up with Magellan Rx to help members have easy access to some specialty IV medications. This is called the Site of Care Program. It offers other places besides a hospital to receive infusions. The site of service will be either at home or in an office. Infusions for the specified drugs will not be covered in a hospital outpatient center. Members will still need to get prior authorization for the drugs included in the Site of Care program.
You do not need to change prescribers for this program. What will change is the place where you go for medicine. Your infusion will change from a hospital outpatient setting to a home or office.

If the prescriber believes a hospital outpatient infusion center is the right setting for the member, EOCCO will consider that exception. This is done case-by-case and is based on the information the prescriber gives us about the members medical needs.

Magellan Rx and EOCCO will give members a preferred site of service. Coram is the preferred home infusion provider in most cases. However, OHSU prescribers may refer patients to OHSU Home Infusion Services.

For more information on the Site of Care program, please call us at 888-788-9821. TTY users, please dial 711

Behavioral health services

All EOCCO members have access to behavioral health services, including preventive and educational services, and can access services through physical, mental, behavioral, and dental providers.

Providers are responsible to do all of the following:

- Use a comprehensive behavioral health assessment tool, in accordance with OAR 309-019-0135, to assist in adapting the intensity and frequency of behavioral health services to the behavioral health needs of the member
- Screen members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)
- Screen members for, and provide, medically appropriate and evidence-based treatments for members who have both mental illness and substance use disorders

- Assess for opioid use disorders for populations at high risk for severe health outcomes, including overdose and death, including pregnant members and members being discharged from residential, acute care, and other institutional settings
- Screen members and provide prevention, early detection, brief intervention, and refer to behavioral health services in any of the following circumstances:
    - At an initial contact or during a routine physical exam;
    - At an initial prenatal exam;
    - When the member shows evidence of substance use disorders or abuse;
    - When the member over-utilizes covered services; and
    - When a member exhibits a reassessment trigger for Intensive care coordination needs.
- Referrals are not required for most behavioral health services; however, referrals may be completed by filling out a referral form and sent to the appropriate mental health and/or SUD provider
- Provide supervision to program staff in accordance with OAR 309-019-0130.

Behavioral health coverage

All covered treatment, as outlined in the Oregon Health Authority Procedure Codes and Reimbursement Rates for Behavioral Health Services, provided by a qualified health provider is covered by EOCCO.

Greater Oregon Behavioral Health, Inc. (GOBHI), administers the behavioral health benefit (coverage) for EOCCO. GOBHI can be contacted at:

Phone:

Local: 541-298-2101
Toll-free: 800-493-0040

Fax:

541-298-7996

Claims for behavioral health services should be submitted to EOCCO at:

Mail:

P.O. Box 40384
Portland, OR 97240

Behavioral Health Outpatient Services:

Members do not need a referral for outpatient behavioral health services however if they see an out-of-network provider a prior authorization may be needed. A PDF list of behavioral health network providers is available on EOCCO's website at:
Spanish Version
www.eocco.com/eocco/-/media/eocco/pdfs/gobhi/ghobi_behavioral_provider_esp.pdf?la=en&hash=5F6BA520168BD3BDA4B86879996F0A2E
English Version
www.eocco.com/eocco/-/media/eocco/pdfs/gobhi/gobhi_behavioral_provider.pdf?la=en&hash=F4DA43EFE8B9E5E412FB9D25ADD7CBB9

Infant & Early Childhood Mental Health:

EOCCO providers have the capacity to provide mental health services and support to children, ages 0-5 and their caregivers. Early Childhood Mental Health is focused on improving the health outcomes for children ages 0-5 through integrated services by improving developmental screening rates for children ages 0-36 months with a focus on wellness visits which encompass mental health assessments, increasing prenatal care, and providing enhanced alignment between public health services and EOCCO activities for population health management with focus on programs and services that are provided to children and their families. Child-Parent Psychotherapy focuses on young witnesses of family violence and experiences of traumatic events. Clinicians are trained through an 18-month learning collaborative which is funded through a contract with OHA and implemented by community mental health providers. The Triple P – Positive Parenting Program® is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise and to create family environments that encourage children to realize their potential.

For Infant & Early Childhood Mental Health questions please contact:

cmaranville@gobhi.org

Applied Behavioral Analysis:

GOBHI's Applied Behavior Analysis (ABA) Program offers comprehensive medically necessary ABA treatment services to children diagnosed with Autism Spectrum Disorder (ASD). The ABA program provides parent coaching and 1:1 intensive individualized teaching. The goal of ABA treatment is to reduce and/or manage the interrupting effects of ASD symptoms on the natural progression of developmental milestones and to support the child in learning the missing skills needed to increase a child's level of independence, personal safety, self-advocacy and overall quality of life.

ABA Authorization – Before services start

1. Diagnosis from a medical professional (MD, FNP, Psychiatrist with experience in the diagnosis of ASD in children)
2. Primary Care Physician writes prescription for ABA therapy
3. Collect necessary documentation: well child visits, audio and vision screening, diagnosis paperwork.
4. Schedule an appointment with your QMHP provider for an intake appointment.
5. Your QMHP will submit your medical information to GOBHI to verify prior authorization for an initial assessment
6. GOBHI will contact you to inform you of placement on the waitlist or to set up an appointment for the initial assessment.

ABA Referrals

Referrals to the ABA program can be made by any provider and/or individual. To make a referral, visit www.gobhi.org/applied-behavior-analysis. You will be prompted to complete a checklist of required information and upload the outlined clinical documentation above.

For ABA questions please contact:

Board Certified Behavioral Analyst: fzody@gobhi.org

Wraparound and Children's System of Care:

What is Systems of Care?

Systems of Care is a spectrum of effective services and supports for children, youth, and families with or at risk of health or other challenges and their families organized into a coordinated network that builds meaningful partnerships with youth and families and addresses their cultural and linguistic needs in order to help them to function better in all life domains. Youth and Family with lived experiences within systems are encouraged to become part of their local Systems of Care governance structures. Each county has their own specific Systems of Care.

For Systems of Care questions please email:

Children's System of Care Manager: cbarnes@gobh.org

What Providers can expect from Wraparound Staff

- Coordination of all professional providers and natural supports in facilitating Child and Family Team
- (CFT) monthly meetings. The first CFT will take place within 30 days of enrollment.
- Community based Wraparound supports to maintain the youth in the community and/or the least restrictive environment possible
- Assist youth and families in effectively using and understanding community resources and legal expectations (if relevant) that effect the youth and their family
- An individualized and single Plan of Care that identifies: Family Vision, Team Mission, Strengths, Needs
- Strategies and Action Items to prioritized needs
- Co-Authored team-based Safety/Crisis plan that addresses all necessary domains in one plan.
- Centralize youth and family voice and choice
- Youth and family are critical members of the team, Wrap Team meetings will not be held without the family or youth present

Who is eligible for Wraparound?

1. Medicaid Eligible
2. Multi-system involved (Mental Health, Child Welfare, Juvenile Justice, Developmental Disabilities, Medical, Mental Health needs affecting academic, social and emotional developmental progress) (IEP/504)
3. 0-17 years of age
4. Identified family/guardian and youth are willing to engage in the Wraparound Process
    - Wraparound is a voluntary process and not a mandatory service
5. Care Coordination needs cannot be met by other system partners

Wraparound Referrals

Each county has their own referral packet; any youth, family, provider, or community member can complete a referral packet. County Specific forms and resources for Wraparound is located at: www.gobhi.org/systems-of-care-wraparound

For Wraparound questions please email:

Children's System of Care Manager: cbarnes@gobhi.org

Intensive In-Home Behavioral Health Treatment (IIBHT):

Intensive In-Home Behavioral Health Treatment (IIBHT) is a level of care Intended to help children, youth, and young adults through age 20, and their families, who require more frequent and intensive mental health treatment to help youth stay in their placement or safely step back into the community from residential care or hospitalization. Youth who use this level of care have difficult behavioral health symptoms, needs from more than one system, and/or are at risk of placement disruption. IIBHT is available to youth and families who need more help with mental health support services given in the home and in the community.

Who is eligible for IIBHT?

Youth who are eligible for Medicaid and under age 21. These youth have intensive behavioral health needs, which include one or a combination of:

- Multiple behavioral health diagnoses; and
- Impact on multiple life domains (school, home, community); and
- Significant safety risks or concerns; or
- Are at risk of out-of-home treatment or placement; or
- Are transitioning home from an out-of-home treatment or placement

This level of care requires prior authorization. Please reference the authorization section of this document for more information on IIBHT authorization for services.

IIBHT Referral Process:

Referrals to IIBHT can be made by a certified IIBHT provider. To make a referral, contact the IIBHT program in the County where the youth lives. A list of IIBHT programs is in the link provided www.oregon.gov/oha/HSD/BH-Child-Family/Pages/IIBHT.aspx

Contact information for providers in your area can be found here www.eocco.com/eocco-provider-search/caretype/search

For IIBHT questions please email:

Behavioral Health Manager: jserrano@gobhi.org

Early Assessment and Support Services:

EASA is a transitional program, services people for approximately two years. EASA programs serve young adults who are at risk for developing symptoms of psychosis (those who meet criteria for psychosis risk syndrome, also known as clinical high risk) and those who meet criteria for schizophrenia or bipolar I disorder with psychosis. EASA also helps clarify diagnosis and appropriate treatment and supports

referents in linking to appropriate care. Acute symptoms of psychosis include hallucinations (seeing and hearing things others don't), delusions (bizarre, out-of-character, fixed beliefs); and disturbances to speech, emotional expression, and movement. Onset of these symptoms usually occurs gradually

In order to meet criteria for EASA an individual must:

Reside in appropriate geographical areas

- Be within minimum age range of 15-25; can go as low as 12 or as high as 30
- The person has an IQ of 70 or above and /or is not eligible for intellectual disabilities services
- Symptoms not known to be cause by a medical condition or drug use
- No more than 12 months since diagnosed with a major psychotic disorder, if applicable

EASA Referral Process:

Referrals to EASA can be made by any provider and/or individual. To make a referral, contact the EASA program in the County where the person lives. A list of EASA program and contact information is in the link provided easacommunity.org/easa-programs.php

For EASA question please email:

Clinical Care Coordinator: kreed@gobhi.org

Assertive Community Treatment (ACT):

Assertive Community Treatment (ACT) is a specialized model of treatment and service delivery designed to provide comprehensive community-based mental health services to persons with serious and persistent mental illness (SPMI) who are at least 18 years of age, have severe functional impairments, and who have not responded to traditional psychiatric outpatient treatment or less intensive non-standard levels of outpatient mental health treatment. Services are available to individuals with SPMI who have had a history of multiple psychiatric hospitalizations and/or crisis interventions. ACT services are provided over an extended period of time and include clinical, rehabilitation, recovery, supportive and case management services provided directly by a multidisciplinary team in the individual's natural environment. The primary goal of ACT is recovery through community treatment and habilitation.

ACT Referral Process:

Referrals to ACT programs can be made by any provider and/or individual. To make a referral, download the ACT referral form in the County where the person lives, then submit the completed referral on the GOBHI website by following the link https://gobhi.org/act-referral/

- Applied Behavior Analysis (ABA);
- Electroconvulsive Therapy (ECT);
- Intensive In-Home Behavioral Health Treatment (IIBHT);
- Neuropsychological and Psychological evaluations; and
- Transcranial Magnetic Stimulation (TMS)

Beginning in spring 2021, day treatment services for youth will require prior authorization.

A PDF list of network providers is available on EOCCO's website at www.eocco.com/members/resources.

Choice Model Program and IOSS services for mental health treatment

The Choice Model program, funded through OHA, supports intensive care coordination for individuals who are Severe & Persistent Mental Illness (SPMI) and are at high risk for civil commitment. EOCCO uses a collaborative process of assessment, planning, facilitation, and advocacy to coordinate housing services for members in the Choice Model program. The ICC/ICM assessment and the Individual Management Plan include questions to assess the member's housing needs; a resulting care plan addresses goals, interventions, and barriers related to housing.

Community-Based Children, Youth, and Family Intensive Services Community-Based Children, Youth, and Family Intensive Services include Intensive Outpatient Services and Supports (IOSS), Wraparound, and Intensive In-Home Behavioral Health Treatment (IIBHT). These Fidelity Programs are comprehensive in-home and/or community-based programs that offer outpatient supports and mental health treatment services for children, youth, and families. Providers offer these services for youth who are experiencing complex needs in two or more child-serving systems. When enrolled, youth and family form their Child and Family Team with their assigned provider and participate in a Plan of Care to address strengths and needs/concerns. Referrals are accepted by child-serving agencies, as well as parents and/or guardians. For additional information, please contact Chris Barnes at cbarnes@gobhi.org or Jacque Serrano at jserrano@gobhi.org.

Mental health in the primary care setting

Primary care providers can treat members for behavioral health diagnoses.

Mental health services, such as medication management or therapy, provided by a member's primary care provider will be covered under the medical benefit rather than the mental health benefit. These claims should be submitted to:

Mail:

P.O. Box 40384
Portland, Or 97240

GOBHI Utilization Management Overview

As stewards of OHP public funds, GOBHI Utilization Management (UM) Program ensures that appropriate behavioral health services and care are provided to GOBHI members with the goal to improve quality of care. The UM Program works to facilitate and develop partnerships between members, practitioners and providers while managing, evaluating and monitoring the health care services provided to members.
The UM Program is available to answer telephone calls Monday through Friday, during the business hours of 8:00 a.m. to 5:00 p.m. Pacific Time (excluding holidays and business closures). The UM Program strives to provide members with better care, health and outcomes, The UM Program staff process authorization requests 365 days of the year.

- GOBHI Main Phone Number: 541-298-2101
- GOBHI Toll Free Phone Number: 1-800-493-0040
- GOBHI TTY: 1-800-399-7335

What Types of Services Are Covered and Require Authorization?

OHP does not cover all treatments for all behavioral health conditions. Some services are limited and only covered for certain conditions. GOBHI develops and maintains a list of services and care that are covered and require authorization, which contains different requirements for in-network and out-of-network providers.

This list, titled "Behavioral Health Services Guidelines," is posted to EOCCO's website, at www.eocco.com/providers/referral-auths. Providers may also request a copy of the list by mail, email, or fax

Authorization Request and Documentation Requirements

If a member needs services or care that requires GOBHI authorization, the provider of the services or care must complete and submit to the GOBHI UM Program an authorization request form along with supporting documentation.

Providers may contact GOBHI by phone or email to request GOBHI authorization forms. Providers may also download current authorization forms at www.eocco.com/providers/referral-auths.

There are three types of authorization forms:

- UM Authorization Form (for most services and care)
- UM Psychological/Neuropsychological Authorization Form (specific for Psychological/Neuropsychological Assessments)
- UM Out of Network Authorization Form (specific for Out-of-Network services and care)

GOBHI UM staff members are available during regular business hours to provide technical assistance to providers regarding authorization forms and documentation requirements. Providers submitting authorization requests may also visit the EOCCO website, www.eocco.com/providers/referral-auths, for specific documentation requirements based on the type of services or care being requested. This information may also be requested and sent to a provider via mail or email.

Methods for Submission of Authorization Request and Documentation

The GOBHI UM Program offers multiple options for submitting authorization requests, clinical updates, and documentation. Providers may submit information via telephone, fax, secure email, or mail.

Phone:

Main Line: 541-298-2101
Toll Free Phone Number: 1-800-493-0040
TTY: 1-800-399-7335

Fax:

541-296-1036

Email:

UM Email Address: um@gobhi.org

Mail:

401 East 3rd Street, Suite 101, The Dalles, OR 97058

Types of Authorization Requests and Time Frames of UM Decisions

Post service/Retrospective Request: A request for coverage of care or services after the member received the services or care

- Time Frame: GOBHI makes a decision and provides written or electronic notification of the decision to the provider within 14 days of receipt of the request

Expedited Request: A request for coverage of services and care while a member is in the process of receiving the requested services or care, even if GOBHI did not previously approve the earlier care.

- Time Frame: GOBHI makes a decision and provides written or electronic notification of the decision to the provider within 72 hours of receipt of the request

Standard Request: A request for services or care prior to a member receiving services or care

- Time Frame: GOBHI makes a decision and provides written or electronic notification of the decision to the provider within 14 days of receipt of the request

Urgent Request: A request for services or care where application of the time frame for making routine or non-life threatening care determinations could: seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. This includes authorizations for alcohol and drug services and expedited prior authorizations.

- Time Frame: GOBHI makes a decision and provides written or electronic notification of the decision to the provider within 48 hours of receipt of the urgent preservice request

What Criteria are Used for UM Determinations?

GOBHI uses applicable federal, state, or MCG Behavioral Health Care criteria to determine medical necessity. MCG Behavioral Health Care guidelines provide the UM Program, an evidence-based tool to support consistent decisions and better outcomes for members.

Who Makes UM Determinations?

- Initial Review: A GOBHI Utilization Management Coordinator conducts the first step of the review process, using applicable federal, state, or MCG Behavioral Health Care criteria. If the criteria are met, the authorization request is approved. If not, the authorization request is referred for Physician Review
- Physician Review: A licensed physician qualified to render a clinical decision conducts a Physician Review of all available information and then determines whether to approve, deny, reduce, or suspend services

Communication of Authorization Decisions

- **Approved Authorizations:** The GOBHI UM Program will communicate an approved determination and authorization number to the provider via phone, fax, mail, or email
- **Denied Authorizations:** A written Adverse Benefit Determination (ABD) notice is mailed to the member and provider when services are denied, reduced or suspended

What if a Provider Does Not Agree with an Adverse Benefit Determination?

The written notice of any ABD will contain information regarding options if a provider disagrees with the decision.

Options Include:

- **Reconsideration Request:** A provider may request a reconsideration within 45 days of the date of the notice. A written request for reconsideration must be submitted to the GOBHI UM Program with any additional supporting documentation. A GOBHI physician reviewer will make a decision on the reconsideration request. A written decision will be sent to the provider
- **Member Appeal:** A provider may appeal on behalf of the member with the written consent of the member or the member's representative. Providers may refer to OAR 410-141-3890 to 410-141-3915 for details on filing a Member Appeal through EOCCO
- **Provider Appeal:** Providers may refer to OAR 410-120-1560 for details on filing a Provider Appeal through Oregon Health Authority

Prohibition of Financial Incentives

GOBHI UM Program decisions are made independent of financial incentives. Utilization management decision making is based only on the appropriateness of care and the existence of coverage. Practitioners or other individuals involved in UM are not specifically awarded for issuing denials of coverage, and this program does not encourage decisions that result in under-utilization. This information may also be found on GOBHI's website, www.eocco.com.

Encounter Data

GOBHI maintains an Encounter Data manual, which is available its website at: www.eocco.com

Facility Support

EOCCO provides technical assistance and additional supportive direction to providers based on request of provider, data, required reporting, grievances, or trends. Technical assistance is provided by staff with knowledge and/or experience of the provider's field.

Technical assistance is available in the form of:

- On-site/virtual visits;
- Video conference/meetings;
- Trainings;
- Peer-review;
- Documentation review;
- Policy development;

- Consultation; and
- Other trouble-shooting tailored to the provider's needs.

EOCCO's goal is to allow providers to deliver high quality services while still meeting all regulatory and contractual requirements. Please see the "Provider Resources" section of EOCCO's website for additional information and resources: www.eocco.com/providers?s=1

Field Reports

For providers of Assertive Community Treatment (ACT) and supported employment services, all fidelity reports must be submitted to EOCCO on an annual basis. In order to be eligible for payment, each provider must demonstrate it meets Fidelity or is cooperating with OHA's Division approved ACT or supported employment reviewer (OAR 309-019-0235).

Treatment for substance use disorders

All EOCCO members have access to treatment for substance use disorders (SUDs). Greater Oregon Behavioral Health, Inc., (GOBHI) administers the substance use disorders coverage. GOBHI can be contacted at:

Phone:

Local: 541-298-2101
Toll-free: 800-493-0040

Fax:

541-296-1036

Claims for SUD services should be submitted to EOCCO at:

Mail:

P.O. Box 40384
Portland, Or 97240

Accessing services for substance use disorders

- Services for SUDs do not require a referral from the Primary Care Physician (PCP)
- Members can self-refer to any of the EOCCO contracted Outpatient SUD providers for an assessment or/and follow up substance use disorder treatment. A PDF list of network providers is available on EOCCO's website at: www.eocco.com/eocco-provider-search/
- EOCCO members also receive an EOCCO Member Handbook at the time of their enrollment. This handbook provides them with information regarding their benefits for SUDs and how to access care
- If a provider identifies a possible substance use disorder in the course of caring for an EOCCO member they can make a referral for an assessment to any EOCCO contracted substance use disorder provider
- A list of EOCCO SUD providers may be obtained by calling EOCCO at 503-765-3521 or toll-free at 888-788-9821
- The initial assessment consists of screening, and the use of the American Society of Addiction

Medicine (ASAM) criteria for level of care placement. Depending on the outcome of the assessment, the member may be asked to engage in a level of care. The levels of care that may be warranted are: Outpatient, Medically Assisted Treatment (MAT), Residential, Withdrawal Management (either social or medically monitored). Once an assessment has been completed, the member is provided information on the level of care that is indicated

Substance use disorders authorization of services

- SUD claims for residential services are authorized by Behavioral Health Utilization (BH UM) Management. Once the SUD provider contacts BH UM with a written request for authorization of services, BH UM will provide an authorization number to the SUD provider for billing purposes.
- Contracted providers meeting Oregon Administrative Rule (OAR) criteria may assess and treat any EOCCO member who meets intake and placement criteria for appropriate outpatient level of care or higher
- Prior authorization is not required for initial assessment
- Residential and inpatient withdrawal management require prior authorization by EOCCO
- Providers should submit claims to EOCCO for members assigned under the managed care of EOCCO

Medically Assisted Treatment (MAT)

- Does not require prior approval for services

Inpatient withdrawal management (detoxification)

- Inpatient medical withdrawal management is covered by EOCCO when 24-hour medical supervision is necessary for the member to detoxify safely, subject to retrospective review of medical necessity criteria
- Inpatient detoxification services in either a hospital or freestanding subacute detoxification facility require a written authorization from Behavioral Health Utilization Management. In emergency situations, a verbal authorization may be made by Behavioral Health UM if followed within three business days by a written authorization request. If on a nonbusiness day, verbal authorization will be made on the first business day

Subacute detoxification

- EOCCO prefers subacute, free-standing detoxification facilities for members who can be detoxified safely outside of a hospital setting
- To receive a verbal authorization for subacute detoxification, call Behavioral Health Utilization Management at 541-298-2101 and provide clinical information demonstrating medical necessity
- A verbal authorization is given over the phone if subacute detoxification is deemed appropriate. The provider must still provide a written authorization request to Behavioral Health UM at which time an authorization number is initiated by Behavioral Health UM

Hospital detoxification

- EOCCO will authorize detoxification in a hospital setting if medical necessity with co-morbidities

justify that level of care or if subacute detoxification is not available in that service area
- To request authorization for hospital detoxification, call Behavioral Health Utilization Management at 541-298-2101

Other substance use disorder services

- Providers are responsible for obtaining authorization for all residential treatment services (evaluation does not require authorization)
- To request initial authorization for treatment, providers must also include initial assessment, American Society of Addiction Medicine (ASAM) Patient Placement Criteria and a service plan that has been created with the member
- For members who want or need to continue in treatment beyond the initially authorized episode of care, providers should make requests for additional authorization in writing to GOBHI with an updated service plan, progress notes and, if necessary, an updated ASAM addendum
- Providers must complete the request for extension on the original authorization form and send by fax or secure email to Behavioral Health Utilization Management for approval. Providers should be prepared to discuss ASAM Continued Service Criteria and plans for completing treatment.
- Members whose assessment has determined the need for non-covered services can obtain more information or access the services through the provider who performs the assessment. Even if the recommended treatment is not covered by GOBHI, the assessment is covered if performed by a contracted provider

Quality review

- Periodic chart audits and internal outcome measures obtained from administrative data will be used to track the quality of care provided by contracted SUD providers
- EOCCO will also track providers' utilization and claims data over time

Declaration for Mental Health Treatment

Oregon has a form called a Declaration for Mental Health Treatment. This form is a legal document. It allows you to make decisions now about future mental healthcare in case you are unable to make your own care decisions. If you do not have this form in place, and you are not able to make your own decisions, your family or providers will decide your treatment. Only a court or two doctors can decide that you cannot make your own care decisions.

You may also use this form to name an adult who can make mental health decisions for you when you cannot make them for yourself. This person must agree in writing to represent you. The person you name must follow your wishes. If your wishes are unknown, the person you name must make decisions that are in your best interest.

A Declaration of Mental Health Care is effective for three years. If you become unable to make decisions, this document will remain in effect until you are capable of making decisions. You may change or cancel

your declaration at any time as long as you are capable of making decisions for yourself. It is important to give this form to your doctor and to give a copy to the person you name to represent you.
For a copy and more information on the Declaration for Mental Health Treatment, go to the State of Oregon's website at www.oregon.gov/oha/HSD/OHP/Pages/Member-Rights.aspx

Advance directives

To comply with federal and state legislation regarding a patient's right to know about advance directives, EOCCO must inform its members about advance directives.

EOCCO and provider partners educate and assist members with accessing, understanding and completing advance planning documents, such as an Advance Directive or Declaration for Mental Health Treatment. Members their families, surrogates, and/or authorized representatives can call EOCCO Health Medical Customer Service to obtain copies of advance directives and instructions on completing them. Forms can be found at www.eocco.com/members/your-resources/member-forms.

EOCCO PCP's are responsible for keeping copies of members completed advance directives in their medical records for all adults.

Every Oregon adult has the right to make decisions about his or her medical treatment. This includes the right to accept or refuse medical treatment.

An illness or injury may keep you from telling your doctor and family members what your wishes are about the medical care you want to receive. Oregon law allows you to say your wishes in advance while you are able to do so. The form used to write down your wishes is called an advance directive. Every Oregon adult has the right to fill out an advance directive form. You can make a complaint if your provider does not do what you ask in your advance directive. Send it to:

Mail:

Oregon Health Authority Ombudsman
500 Summer St. N.E., E17
Salem, OR 97310-1097
Telephone: 800-442-5238
TTY: 503-945-6214

Completing an advance directive is your choice. If you choose not to fill out and sign the Advance Directive Form, your choice will not affect your health plan coverage or your access to care.

An advance directive booklet, "Making Health Care Decisions," is available at no cost from EOCCO. Please call our Customer Service Department to request information on advance directives. You may find out more about advance directives by calling Oregon Health Decisions at 503-692-0894 or 1-800-422-4805, TTY 711.

Pregnancy notification

If a member becomes pregnant, providers should notify the member's caseworker or HSD right away. Notification ensures that the member and her baby receive the additional benefits offered. Notification also ensures that you will be reimbursed for maternity-related services.

Below are two options providers have to report pregnant mothers currently on the OHP Standard plan:
Complete the Pregnancy Notification Form (OHP 3360). A copy of this form can be found at www.eocco.com/providers/forms. The form can be filled out online and faxed or mailed back to HSD (see form for instructions)
Contact the member's DHS caseworker, explain that she is now pregnant and request a review of her file for additional benefits

The member's benefit information will be updated on the first of the month following the notification.

Newborn notification

To receive payment for delivery services covered by Oregon Health Plan, it is important to notify DHS right away when a provider delivers a newborn for an EOCCO member. Prompt notification ensures that the member's baby is also enrolled with EOCCO.

To report a newborn, complete the Newborn Notification Form (OHP 2410). A copy of this form can be found at www.eocco.com/providers/forms. The form can be filled out online and faxed or mailed back to OHP Customer Service (see form for instructions).

Interpreter services

EOCCO can provide phone interpreter and/or in person services for eligible members at no cost. These services are provided through our contracted vendor, Passport to Languages. Passport to Languages is available at 800-297-2707, Monday through Friday, 7:30 a.m. to 6 p.m.

Passport to Languages is a national company, founded and located in Oregon. To obtain additional information about Passport to Languages or to view the language list of over 160 languages and dialects, please visit the company's home page at www.passporttolanguages.com/index.htm.

Follow the below steps to access phone interpreter services:

- Determine whether an interpreter is needed for an EOCCO member
- Call Passport to Languages at 800-297-2707 and let them know you need interpreter services for an EOCCO member. You will be asked to provide the following:
  (Please allow a minimum of 20 minutes prior to the interpretation need.)
    - Date and time interpreter is needed
    - Member name
    - Member ID number
    - Language needed
    - Phone number for interpreter to call back

- Passport to Languages will end the call and contact EOCCO Customer Service to verify member eligibility
- Once eligibility has been verified, Passport to Languages will contact the provider for translation at the scheduled date and time

This service is provided for members who are eligible with EOCCO at the time of interpreter service. Passport to Languages will not provide interpreter services for other lines of business with Moda Health or if a member is not eligible. If you have questions about a member's eligibility, please contact EOCCO Customer Service at 888-788-9821. Passport to Languages does not have access to member eligibility.

Language Access Report

As part of our contract with the OHA, EOCCO clinics are required to complete a quarterly Language Access Report that describes the use of language (interpreter) services at their practice. Clinics will be asked to provide detailed information including member ID, type of care setting, date, type of interpreter service (in-person, telephonic, etc.) and if the interpreter is recognized as a qualified or certified health care interpreter by the OHA. This information will be required for each member visit.

National Provider Identifier

The National Provider Identifier (NPI) is a standard unique health identifier for healthcare providers and was mandated by HIPAA. Anyone who meets the criteria of a healthcare provider will need an NPI.

The Centers for Medicare & Medicaid Services (CMS) is the official source for information and education about the NPI. For more information, visit the CMS website at www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/.

EOCCO requires that all EOCCO providers register their NPI number with EOCCO and with the Department of Human Services. EOCCO will not reimburse the provider for services performed if the provider's NPI is not registered with Oregon Medicaid Provider Enrollment

EOCCO is required to have an NPI on file for all providers that bill EOCCO both electronically and on paper.

If you don't have an NPI, apply through the National Plan and Provider Enumeration System (NPPES) website at nppes.cms.hhs.gov/#/ or call 800-465-3203.

Follow these steps to register your NPI number with DHS and EOCCO:

- Register your NPI with DHS
  - Visit the DHS website at www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx
  - Complete the online form and follow the instructions for how to return your completed form
- Register your NPI with EOCCO
  - Visit EOCCO's website at www.eocco.com/providers/becomeaprovider
  - Complete the online form and follow the instructions for how to return your completed form

- If you have questions or want to verify whether your NPI is on file with EOCCO, please contact ProviderDMAPApps@modahealth.com.

Credentialing and recredentialing of EOCCO providers

Moda Health performs the credentialing and recredentialing activities entail, but are not limited to, credentials verification, review and monitoring of past and present malpractice claims, state licensing disciplinary activity and adverse outcomes, medical record keeping, office site visits, and member accessibility to providers. Providers must complete the credentialing process and approval prior to treating EOCCO members.

Providers must meet the following criteria, applicable to their degree and specialty, to participate on the EOCCO Provider Panel. Moda Health has the right to deny participation based on, but not limited to, this criteria.

- Completion of undergraduate, graduate, medical or dental school
- Completion of an accredited residency program in the credentialed area of practice
- Ability to prescribe medication or have a documented prescription-writing process with another Moda Health participating provider
- Ability to admit patients to a Moda Health–contracted hospital independently or have a documented hospital admitting process with another Moda Health participating provider
- Adequate malpractice insurance coverage of a minimum of $1,000,000 per claim and $3,000,000 annual aggregate
- Current, active and unrestricted state license(s) for all practicing locations
- Ability to provide 24 hours a day, seven days a week care coverage with other Moda Health participating providers or a coverage plan for continuity of care for members
- Ability to practice within the scope of practice as defined by law and appropriate state licensing boards
- Never proven guilty of a federal crime within a court of law

Questions about adding or updating a provider? For more information, please visit www.eocco.com/providers/becomeaprovider

Who requires credentialing?

Refer to the provider classification table below. Providers who are new to the Moda Health's panel and have been working in a locum tenens capacity for 91 or more calendar days must complete a credentialing application. If already credentialed by Moda Health, providers must submit the documents listed below.

If providers have completed 90 calendar days or less of service, they must complete the locum tenens form which includes the following:

- Full name
- Other names used
- Date of birth

- Social Security number
- Name of practitioner requiring coverage, or reason for coverage
- Duration Coverage
- Practice and billing information

In addition, providers must:

- Attach copies of state licensure, malpractice insurance coverage and DEA certificate (if applicable), and complete the attestation attached to an initial application.
- Complete and sign the OPCA attestation and authorization to release information pages.

Primary care provider status

A primary care provider is licensed as an M.D., D.O., N.P., N.D., or P.A. and specializes in family practice, internal medicine, obstetrics/gynecology, naturopathic medicine, pediatrics or geriatrics. PCPs are able to provide services within their scope of practice as defined by law and state licensure, have completed the necessary education requirements, have hospital admitting privileges or acceptable admittance arrangements, have after hour's coverage available to patients, and possess the authority to prescribe medication or acceptable prescribing arrangements. A PCP is required to participate in medical record audits, an office site visit, and access and after-hours surveys. For more information, see "Medical record, office site, access and after-hour standards and audits."

Application required

The following providers require credentialing:

- Providers new to the Moda Health panel
- Returning providers whose contracts were terminated and new contracts were not put in place within 30 days
- Locum tenens providers who have been offering services for 91 calendar days or longer

The following providers require recredentialing:

- All established providers — within three years from the last application approval date. This requirement is to continue participating on the Moda Health's panel. Moda Health will remind providers by mailing applications to them.
- All established providers who have returned from a leave of absence within three years and would like to be reinstated
- Providers who were on a Moda Health's panel through a delegated entity and would now like direct participation on the panel

Application forms are accepted:

- The current Advisory Committee on Physician Credentialing Information (ACPCI), approved Oregon Practitioner Credentialing Application (OPCA) or Recredentialing Application (OPRA) for providers practicing in Oregon and/or any other state
- The Washington Provider Credentialing Application if the provider's primary practice is in Washington State
- Organizational Provider Credentialing Application (for facility credentialing)

Provider applications must still be returned directly to Moda Health for processing.

Moda Health does not accept and will return, applications that are:

- Incomplete or unsigned
- Combined credentialing or recredentialing applications
- Combined state applications

Application and attestation

Providers are responsible for the accuracy of the information on their application and for signing and dating the application, the attestation and the authorization to release information form. The application should be completed in accordance with the instructions on page 1 of the application. Legible copies of the following applicable, current and valid documents must be attached to the application. Moda Health does not accept documents that have been altered:

- Federal Drug Enforcement Administration (DEA) certificate or documented prescribe plan
- All active state professional licenses
- Malpractice insurance carrier face sheet or a dated letter from the insurance carrier stating the intent to insure; the provider's name, coverage amount and effective dates must be included
- Explanation of all affirmative answers on the Attestation statement
- Completed Attachment A explaining malpractice claims activity
- Educational Commission for Foreign Medical Graduates (ECFMG) certificate
- Federally commissioned physician status
- Federal tort claim status

Moda Health will return the application if the required documents are missing, expired, illegible or missing necessary information and will request an acceptable copy or written explanation if a provider is unable to comply with the request.

The Attestation statement addresses the following:

- A provider's inability to perform the essential functions of the position because of health status, with or without accommodation
- Past or present abuse of alcohol or prescription or illegal drugs
- Any state license, certification, registration to practice, participation in a public program (i.e., Medicare or Medicaid), clinical privileges or hospital privileges that have been or are currently voluntarily or involuntarily denied, limited, restricted, suspended or revoked
- History of misdemeanor or felony criminal activity
- Past and present malpractice activity
- Reports to a state or federal data bank

Helpful hint

Keep the original copy of the completed application (not signed and dated) for future use. A copy of the original can be signed, dated and submitted to organizations that request copies. Provider credentialing Organizational provider credentialing documentation may be returned via fax, email or regular mail:

Mailing:

Moda Health
Attn: Credentialing Department
601 S. W. 2nd Ave.
Portland, OR 97204

Fax:

(503) 265-5707

Email:

credentialing@modahealth.com

Primary source verification of credential application elements

Moda Health verifies application elements by performing primary source verification (PSV) through the original entity directly responsible for issuing the credential or a National Committee for Quality Assurance (NCQA)–approved alternative source. A query of the National Provider Data Bank (NPDB is performed. Education and training are not reverified at the time of recredentialing.

Application elements related to the provider that may be subject to verification include the following:

- Current and past state license(s)
- DEA certificate or documented prescribe plan
- Malpractice insurance coverage or letter of intent from the malpractice insurance carrier (limits of liability required are $1 million per claim and $3 million aggregate)
- Hospital affiliation or receipt of a documented admitting process with other EOCCO participating providers
- Current practice information
- Gaps in work history of two months or more
- Work history
- Medical, dental or undergraduate education from an accredited school
- Educational Commission for Foreign Medical Graduates (ECFMG) certificate
- Postgraduate training (i.e., internship, residency, etc.)
- Board certification
- Malpractice claim history
- Medicare/Medicaid sanctions or exclusions
- State license sanctions
- Additional administrative data relating to a provider's ability to provide care and service to EOCCO members

Behavioral Health provider responsibilities

EOCCO Contracted behavioral health network providers must maintain the following current facility credentialing documentation in paper or digital form as applicable to the scope of their contracted services. Any changes to the status of credentialing documentation (example expiration without renewal, restrictions, or other changes must be immediately reported to EOCCO):

- As applicable, active health care accreditation for all locations providing services under the contract with Health Share. Examples of accreditation includes, but is not limited to:
    - CARF Accreditation
    - Joint Commission Accreditation
- As applicable, active licensure for locations providing services under the contract with EOCCO. Examples of licensure include, but not limited to:
    - Current Certificate of Approval (COA) from the Oregon Health Authority (OHA) for all locations which provide outpatient mental health or substance use disorder services and have unlicensed practitioners providing services;
    - Current DEA registration for locations which provide covered maintenance and withdrawal management services;
    - Current OHA licensure(s) for locations which provide covered adult residential treatment services;
    - Current DHS licensure(s) for any facility that will be providing covered child residential treatment services;
    - Current Opioid Treatment Program Certification for locations that provide Medication Assisted Treatment (MAT);
    - Any other current health care related licensure granted to any facility which provides EOCCO covered services.

Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA), Mental Health Intern, Peer Support Specialist, Board Registered Intern practitioners, and Substance Use Disorder practitioners exempt from board licensure who are employed by or contracted with a COA covered EOCCO behavioral health network provider will be required by OHA in 2022 to be certified through MHACBO to meet qualifications for their designation type. OHA and EOCCO advises providers to be aware of these upcoming changes and begin preparations for this new requirement. Upon OHA's QMHA and QMHP MACBO certification requirement's effective date, claims for services provided by QMHP's and QMHA's who are not certified through MHACBO will be denied. For questions or comments on the OHA QMHA and QMHP certification process, please contact Greta Coe at greta.l.coe@dhsoha.state.or.us or 503-602-4444.

EOCCO's planned implementation process for OHA's QMHA and QMHP MACBO certification Requirement:

Upon the QMHA and QMHP certification requirement implementation date, verification of MHACBO certification will be documented in the Delivery System Report (DSN) Practitioner List (roster), including date of certification, type of certification (initial certification, recertification, or varianced QMHP certification), along with LPCI, LMFTI and CSWA designations. Providers will be required to remove QMHP's and QMHA's not certified with MHACBO, or appropriate licensure board, from the DSN Practitioner List upon the OHA implementation date of this requirement. Services provided to EOCCO members by non-certified MHACBO QMHP's and QMHA's will not qualify for Medicaid reimbursement upon the OHA implementation date of this requirement.

Important certification links for providers:

- MhACBo: www.mhacbo.org/en/registry/

- OHA Office of Equity and Inclusion Peer Registry: traditionalhealthworkerregistry.oregon.gov/Search
- Oregon Board of Licensed Professional Counselors and Therapists: oblpct.us.thentiacloud.net/webs/oblpct/register/#
- Oregon Board of Licensed Social Workers: blsw.onlineservice.oregon.gov/webs/blsw/register/#/search/CSWA/0/10/false

EOCCO network providers shall perform monthly exclusion list checks of all employees, contractors, volunteers, interns and any other persons providing, arranging, or paying for behavioral health services paid in whole or in part with Medicaid dollars, against the OIG List of Excluded Individuals/Entities (LEIE) and the SAM database. Provider will maintain monthly verification of this check.

Discrepancy in credentialing information

Information obtained during the verification process that varies substantially from the information submitted by the applicant requires a written explanation from the applicant.

- Moda Health will notify the applicant in writing of the discrepancy and requests a written explanation within 7 calendar days. The response is reviewed by the medical director or the Moda Health Credentialing Committee
- If the applicant does not respond within 7 calendar days, then the applicant is contacted by telephone requesting a response in writing within 7 calendar days. If no response is received, the application process is terminated

Application approval or denial

The EOCCO Medical Director or Moda Health's Credentialing Committee will review the application information and decide to take one of the following actions:

- Approve the application
- Approve the application but request additional information — the provider will then be monitored until the requested information is reviewed
- Pend the application and request additional information to be reviewed at a future committee meeting — the applicant will be monitored as a pending applicant.
- Deny the application completely. Only the Credentialing Committee is authorized to make this decision

Moda Health will notify the provider or appropriate credentialing contact person in writing within 30 calendar days of the medical director's or Credentialing Committee's decision and the appeal process.

Provider rights

Providers have the right to:

- Not be discriminated against based on race, ethnic or national identity, gender, age or sexual orientation, as well as on the types of procedures performed, as long as they are legal under U.S. law, or on the patients in whom the provider specializes
- Review information obtained by Moda Health to evaluate the credentialing application. Information that is peer-protected and protected by law is not shared with the provider.
- Correct erroneous information discovered during the verification process

- Request, from the Moda Health credentialing staff, the credentialing application status via telephone, e-mail or correspondence
- Withdraw the application, in writing, at any time
- Have the confidentiality of the application and supporting documents protected and the information used for the sole purpose of application verification, peer review and panel participation decisions
- Be notified of these rights

Provider appeal of adverse action

Participating providers or practitioners have the right to appeal a Moda Health decision to take adverse action against the provider's or practitioner's participation status. The provider or practitioner is notified of his or her appeal rights through various Moda Health sources. Moda Health reserves the right to decide if the appeal is in compliance with Moda Health's standards. The appeal process is compliant with the Health Care Quality Improvement Act (HCQIA) of 1986.

- The provider or practitioner has up to 60 calendar days following the receipt of the medical director's letter of the Moda Health's decision to take adverse action to file a written request for a hearing with the Credentialing Committee. The written request is mailed to the medical director by certified mail. A provider or practitioner who fails to request a hearing within the time and in the manner specified waives any right to a hearing in the future. There is no right to appeal granted to nonparticipating providers.

Confidentiality

All credentialing related information is considered strictly confidential. No disclosure of peer review information in accordance with ORS 41.675 will be made, except to those authorized to receive such information to conduct credentialing activities. The data utilized by the Moda Health's Credentialing Committee is strictly confidential and is available only to authorized personnel in accordance with local, state, federal and other regulatory agencies' statutes, rules and regulations.

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
Medical physicians	Doctor of chiropractic medicine (D.C.) Doctor of osteopathic medicine (D.O.) Doctor of podiatric medicine (D.P.M.) Doctor of medicine (M.D.) Doctor of naturopathic medicine (N.D.)	All Specialties Psychiatry Radiologists, pathologists or anesthesiologists providing services to independent physicians who are practicing in an outpatient setting	Contract – Yes Credential – Yes Not applicable – Physicians who are not contracted directly with EOCCO through an individual, clinic, medical group or independent physician association

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
	Doctor of optometry (O.D.)		Physicians accessed through a delegated third-party panel. Providers practicing exclusively in an in-patient setting. See below.
Allied Health Professionals	Certified nurse midwife (C.N.M., N.P. and R.N. licensed) Licensed acupuncturist (L.Ac.) Nurse practitioner (N.P.) Physician assistant (P.A.) Physical therapist (P.T.) Occupational therapist (O.T.) Speech and language pathology/audiology, hearing-aid specialists (M.A., M.S.) Mental health providers – see below	Alternative Medicine: • Naturopath • Homeopath • Acupuncture Midwifery: • Certified nurse midwife (with active N.P. and R.N. license) • Nurse midwife nurse practitioner • Registered nurse Speech and language pathology, audiology, hearing-aid specialists Nurse Practitioner (NP) Specialties that can practice as a PCP: ▪ ACNP – Acute Care ▪ ANP – Adult ▪ FNP – Family ▪ GNP – Geriatric ▪ NMNP – Nurse Midwife ▪ NNP – Neonatal ▪ PNP – Pediatric	Contract – Yes Credential – Yes

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
		▪ WHCNP – Women's Health Care ▪ CNS-Certified Nurse Specialist Therapist specialties: ▪ Occupational ▪ Physical	
Mental health practitioners	Licensed clinical social worker (L.C.S.W.) Doctor of philosophy (Ph.D.) Doctor of psychology (Psy.D.) Licensed Marriage and Family Therapist (L.M.F.T.) Licensed Professional Counselor (L.P.C.) Psychiatric Mental health Nurse Practitioner (P.M.H.N.P.) Nurse Practitioner Physician Assistant Doctor of education (ED.D.)	Alcohol and drug abuse counselor Clinical psychologist License independent clinical social worker Mental and behavioral health counselor	Contract – Yes Credential – Yes Physicians who are certified in addiction medicine Doctoral- and master's-level psychologists who are state licensed or state certified Licensed or certified master's-level, clinical social workers Master's-level, clinical nurse specialists or psychiatric nurse practitioners who are nationally or state-certified or state-licensed Other licensed, certified or registered behavioral health specialists
Dental physicians Dentists or dental surgeons	Doctor of dental surgery (D.D.S.)	Surgery Pathology	Contract – Yes Credential – Yes

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
who provide care under a medical benefit program	Doctor of medical dentistry (D.M.D.) Denturists (L.D.) Limited Access Permit, Dental Hygienists (LAP)	Oral maxillofacial surgery Periodontists Endodontists Orthodontists Dental hygienists with LAP only	
Locum Tenens If in place for 90 calendar days or less, these providers are not required to fully complete an application, but they must submit specific documents If in place for 91 calendar days or more, these providers must complete an application within one calendar year	All degrees	All specialties	Contract – Yes Credential – Yes
Providers not requiring credentialing Providers practicing in an	Certified midwife (C.M.) Clinical specialist (C.S.) Licensed direct-entry midwife (L.D.E.M.) Lay midwife (L.M.)	Therapist Specialties: • Aroma • Hand • Massage Other: • Anesthesiologist assistant	Contract – Yes Credential – No

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
in-patient setting — see below Dentists who provide primary dental care only under a dental plan or rider	Registered nurse (R.N.) Registered nurse first assist (R.N.F.A.)	• Biofeedback • Cardiovascular (clinical) perfusionist • Cardiovascular technologist • Diagnostic medical sonographer • Electroneurodiagnostic technologist • Nonphysician surgical assistant	
Inpatient setting–only employees or providers Practitioners who practice exclusively within the inpatient setting (health delivery organizations) and provide care only as a result of EOCCO members being directed to the inpatient setting Practitioners who do not provide care for members in a treatment	All degrees	Inpatient settings (health delivery organizations) • Employees • Radiologist* • Pathologist* • Anesthesiologist only • Neonatologists • ER physicians • Behavioral health Freestanding Facilities • Mammography centers • Ambulatory behavioral health facilities • Psychiatric and addiction disorder clinics	Contract – No Credential – No Contract and credential the hospital or facility – see Credentialing Health Care Delivery Organizations

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
setting (e.g., board certified consultants)		* If a radiologist or pathologist is also offering services to independent physicians who are practicing in an outpatient setting, they must be credentialed. See Medical Physicians above.	

Traditional Health Worker

Traditional Health Workers (THWs) are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for patients, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health. THW's are available to help connect members to a broad range of services to support their health and wellness. THW consist of

- Birth Doulas
- Personal Health Navigators (PHN)
- Peer Support Specialist (PSS)
- Peer Wellness Specialist (PWS)
- Community Health Workers (CHW)

THW Training and Supervision

To qualify for reimbursement under the Oregon Health Plan, THW's must be certified by the Oregon Health Authority (OHA) through successful completion of an approved training program and enrolled in the State's central registry. THW training requirements differ depending on THW type.

Training requirements for each THW type can be found here:
www.oregon.gov/oha/OEI/Pages/How-to-Become-a-THW.aspx

EOCCO will collect the names of THW's from contracted entities and validate their certification in the State's registry. EOCCO will also report the names of THW's as contractually required when reporting EOCCO's network adequacy to OHA. THW's must be supervised by licensed healthcare professionals, including but not limited to physicians and licensed behavioral health professionals. Youth and Family Peer Support Specialists must be supervised by a Peer Support Specialists Supervisor in addition to clinical supervision. If a member receives peer services for BH needs, the service must be documented in the member's treatment plan by a licensed Behavioral health professional.

The entity/provider employing THW's is responsible for the cost of training and certification.

CHW's must complete 80 hours of training from an approved training program and meet required competencies to become certified. EOCCO has partnered with the Oregon State University to provide training within the EOCCO service area. Training costs for individuals that reside in the EOCCO service area is $800.00. Training will be on-line with the exception of two in person trainings (at the beginning and end of the program) in local Extension offices.

Details can be found at: www.pace.oregonstate.edu/CHW.

Providers need to also do background checks on THW's a described in OAR 410-180-0326

Covered and Non-Covered Services

CHW's must be supervised by licensed healthcare professionals, including but not limited to physicians and licensed behavioral health professionals.
A licensed provider must order the member education service(s) and must order that they be provided by a CHW.

Covered Services:

- The service involves teaching the member how to effectively self-manage their medical, behavioral, and/or oral health in conjunction with a health care team
- The service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home or clinic, or other community setting. In order to be reimbursed for CHW administrative tasks, such as documentation, phone outreach, and the navigation of community resources, it is recommended they be conducted with the member as part of their self-management skill building curriculum
- The content of the educational and training program is a standardized curriculum consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual members

Non-Covered Services:

- Does not cover social service such as enrollment assistance or case management

Billing:

- Claims for CHW services must be billed on a standard CMS-1500 or UB-04 billing form (as applicable to the billing provider/entity) following standard coding and billing requirements. Bill separate lines for each day a service is provided
- Claims should be submitted to EOCCO for processing no different than billings for any other medical services
- CHW must be certified and registered with the OHA Office of Equity and Inclusion and be DMAP enrolled in order to receive reimbursement from EOCCO.

- Refer to the EOCCO's guidance document to become eligible for EOCCO reimbursement www.eocco.com/-/media/EOCCO/Providers/Community-Health-Workers-DMAP-Enrollment-and-Reimbursement-Instructions.docx;

Payment:

- Refer to the OHA guidance document for billable codes for CHW services covered by Oregon Medicaid www.oregon.gov/oha/HSD/OHP/Tools/CHW_Billing%20Guide.pdf

Clinical Documentation Requirements:

- An order for services signed by the licensed professional specifying the number of units ordered and whether group and/or individual service(s)
- Documentation of the date of service, start and end time for the service, whether the service was group or individual and if group, number of patients present, summary of the session's content, and the CHWs signature and printed name

Medical record-keeping, Office site, access and after-hours standards and audits

Providers are responsible for complying with medical and treatment record-keeping and office site, access and after-hours standards as part of the contract between Moda Health (on behalf of EOCCO) and the provider. Following NCQA guidelines, Moda Health performs audits to ensure that Moda Health's standards are met. A minimum audit score of 80 percent is required.

The practitioners are subject to audits:

- Primary care providers (M.D., D.O., N.P., P.A.)
- Certified nurse midwives
- Obstetrics/gynecologists
- Specialists

Noncompliant providers:

- Can appeal their score and request a review of the files and reviewer's scores
- Are required to submit a corrective action plan and a re-audit within six months

Continued noncompliance may result in termination of participation.

Medical records standards

Paper-based medical and treatment records must follow these standards:

- Legible file markers efficiently identify files (such as color coding)
- Records can be easily located
- Records are legible, organized, securely attached and dated, with the patient's name on each page

- If a consent form for the release of protected health information (PHI) is used, it is signed by the patient and documented in the records
- Medical records do not leave the office. If they are taken from the office, it is according to written procedures, which ensure tracking, safety and confidentiality of the record

Electronic medical records systems must follow these standards:

- Access to key information. Caregivers have immediate access to key health information and data, such as patients' diagnoses, allergies, lab test results and medications, to make clinical decisions in a timely manner
- Result management. All providers participating in the care of a patient in multiple settings can quickly access new and past test results to ensure patient safety and the effectiveness of care
- Order management. Providers can enter and store orders for prescriptions, tests and other services in a computer-based system to ensure legibility, reduce duplication and improve the speed with which orders are executed
- Decision support. Providers use computerized reminders, prompts and alerts to improve compliance with best clinical practices, such as ensuring regular screenings and other preventive practices, identifying possible drug interactions and facilitating diagnoses and treatments
- Electronic communication and connectivity. Providers and patients communicate efficiently, securely and accessibly to improve the continuity of care, increase the timeliness of diagnoses and treatments, and reduce the frequency of adverse events
- Patient support. Online tools give patients access to their health records, provide interactive patient education and help them carry out home-monitoring and self-testing to improve control of chronic conditions
- Administrative processes. Computerized administrative tools, such as scheduling systems, help improve efficiency and provide more timely service to patients
- Reporting. Electronic data storage employs uniform data standards to enable timely response to federal, state and private reporting requirements, including those that support patient safety and disease surveillance
- Information tracking. Providers can track release of information
- Security. The electronic record system has a screen saver and is password protected
- Identification. The patient’s name is on each screen and contains all relevant biographical information

All medical record-keeping systems must follow these standards:

- The practice has a documented HIPAA-compliant policy on the security, privacy, storage and transport of patient data
- The practice uses methods of storing and transporting all patient data that complies with applicable privacy and security laws, such as encrypting all backup data before transport or storing data at a secure off-site facility (bank vault) or in a fireproof safe on premise
- Medical records and patient information are not accessible by non-authorized individuals

- Written procedures dictate release of patient information and these procedures include a system for tracking to whom medical records are released and which staff members have access to the medical records
- Procedures are in place to address whether or not patients have executed an advance directive or Physician Orders for Life-Sustaining Treatment (POLST)

Office site standards

EOCCO conducts surveys to assess the quality, safety and accessibility of provider office sites when the threshold of two site-related member complaints has been met. EOCCO's standards include requirements of the Occupational Safety and Health Act (OSHA), Americans with Disabilities Act (ADA) and HIPAA.

Site visits occur at the following times:

- When any provider meets the threshold criteria for member complaints regarding:
    - Physical access
    - Physical appearance
    - Adequacy of waiting or examining room space
    - Patient safety
    - Adequacy of medical and treatment record keeping

- At the time of a six-month re-audit. This applies if the provider's office site or medical record-keeping practices do not meet the standards of acceptable performance. The credentialing supervisor sends a letter to the provider requesting an action plan to improve the nonacceptable practices. The medical director will review the action plan and specify the date for completion and re-review.

Office sites must meet these standards:

- Working fire extinguishers and fire exit doors that are clearly marked
- Reasonable accommodations (exam room, parking, elevator, restroom) for patients in wheelchairs or other walking-assist devices and for the sight- and hearing-impaired
- Adequate waiting room space for the volume of people to be seen
- Regular routine maintenance inside and outside
- At least two exam rooms per practitioner
- Provisions for non-English-speaking patients — including written privacy policy resources for translating the privacy policy into other languages
- Provisions for safe, tamper-proof disposition of syringes and needles in each exam room
- Appropriate disposal of biohazardous material
- Drugs, including samples, stored within the office area with access restricted to only authorized personnel
- Controlled substances stored in a locked space with access restricted to authorized individuals — log of the dispensing of controlled substances maintained

- Drug expiration dates, including samples and vaccines, checked on a monthly basis and initialed as checked
- Prescription pads secured away from unauthorized access and not pre-signed or postdated
- Crash cart, if present, is accessible, checked and initialed on a monthly basis.
- Advance directives available

Privacy and security standards

The following privacy and security standards are required:

- Give each patient a copy of the privacy policy
- Restrict the patient's medical records to only those authorized by the patient or persons involved with the patient's direct medical care
- Have the fax machine in a private area and use a confidential coversheet
- Ensure that people in the reception area cannot overhear discussions of confidential patient matters or see confidential papers or computer screens
- If using electronic records:
    - Have a process to track the release of information
    - Have screen savers with password protection
    - Review any request by patients to see their medical records

Physical access

All participating EOCCO provider sites must comply with the requirements of the Americans with Disabilities Act (ADA) of 1990, including but not limited to, street-level access or an accessible ramp into the facility and wheelchair access to the lavatory.

Provider and facilities will meet the special needs of members who require accommodations because of a disability or limited English proficiency

Timely access

To ensure that EOCCO members have access to high-quality service and medical care in a timely manner, EOCCO has established the following standards, which we monitor through periodic surveys, audits and member complaints.

EOCCO access standards for services are:

- Travel times and distances
    - In urban areas, 30 miles or 30 minutes
    - In rural areas, 60 miles or 60 minutes
- Medical coverage is available 24 hours a day, seven days a week
- Emergency needs are immediately assessed and referred or treated
- Members requiring urgent acute care are seen within 72 hours of request
- Members with non-urgent care (symptomatic), including walk-ins and telephone calls, are seen within seven calendar days of request
- Well Care services are seen within four weeks
- Emergency oral care is seen or treated within 24 hours

- Urgent oral care is seen within one week
- Routine oral care is seen within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate
- Established members requesting an appointment for stable or chronic conditions that are asymptomatic at the time of the call are scheduled within 30 calendar days of the request
- Members requesting history and physical, preventive exams and new patient exams are scheduled within 42 calendar days of the request
- Members with prescheduled appointments wait no longer than 60 minutes unless the reason is explained to them and another time is offered;
    - If the member requests to reschedule, they shall not be penalized for failing to keep the appointment
- Office personnel notify the provider when a member has missed an appointment. Providers are required to follow up with EOCCO members to address defined medical needs as appropriate Failed or missed appointments and follow-up efforts are documented in the medical record

On-call and after-hours coverage is monitored through member complaints and the site visit, as well as medical record-keeping practices surveys. Providers must also respond to quarterly access surveys that EOCCO will send out.

Behavioral Health Access Standards:

- Urgent behavioral health care for all populations: Immediately
- Routine behavioral health care for non- priority populations: assessment within seven days of the request, with a second appointment occurring as clinically appropriate
- Specialty behavioral health care for priority populations:
    - If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist.
    - Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry
    - IV drug users, including heroin: Immediate assessment and entry.
    - Opioid use disorder: Assessment and entry within 72 hours;
    - Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry; and
    - Children with serious emotional disturbance as defined in OAR 410-141-3500

Access to care monitoring for behavioral health providers

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee (QIC) Network Management Subcommittee on bimonthly basis. Member access to care data and practitioner to member ratios are monitored via a manual reporting process:

- Practitioner rosters must be submitted monthly and updated within 10 days of any termination or hire of a practitioner.
- All practitioners must be certified if unlicensed and credentialed if licensed prior to being listed on the roster.

- All practitioners must be enrolled with a Medicaid ID number prior to being listed on the roster
- Aggregate Member access to care reports are submitted monthly via electronic from

Additionally, on-call and after-hours coverage is monitored through member complaints, site visits, member surveys, and "secret shopper" calls.

Marketing

EOCCO providers are not allowed to market, entice or influence a potential or current Health Systems Division (HSD) members to enroll specifically with the EOCCO plan or not to enroll with another CCO medical plan, per OAR 410-141-3575.

EOCCO providers are allowed to distribute any outreach materials, brochures, newsletters or pamphlets, etc., created by EOCCO for the purpose of enhancing health promotion or education to any potential or current HSD member.

EOCCO providers may post a sign listing all OHP medical plans in which they participate and display any sponsored health promotional materials.

Claims

ICD-10 codes

The member's diagnosis codes must be provided to the highest level of specificity. The most accurate and current codes for the billed date of service should be used (ICD-10). EOCCO uses the billed diagnosis code and the Prioritized List to determine whether a service is covered.

If a member's diagnosis has changed since the initial referral was submitted, follow-up referral requests should be submitted with the most current diagnosis code(s).

Symptom codes

Treatment for symptom codes are not covered by EOCCO. EOCCO will approve two visits for referrals submitted with symptom codes if diagnostic assistance is needed.

Filing a claim

Participating providers agree to bill EOCCO directly for covered services provided to OHP members with coverage through EOCCO. Once the coverage through EOCCO has been verified either by Oregon Health Authority: Health Systems Division (HSD) or EOCCO, members should not be asked for payment at the time of services.

Use your provider number

For claims to be processed correctly, each claim must include the correct Taxpayer Identification Number (TIN), correct NPI(s) and correct Medicaid ID number. If you operate within a clinic with multiple physicians or providers, the name of the individual who provided the service must also be noted. If this information is not provided, the claim may be returned for resubmission with the missing information

Acceptable claim forms

Please file all claims using the standard CMS (formerly HCFA) 1500 or CMS 1450 (UB04) claim forms. Incomplete claim forms may be returned for resubmission with the missing information. Please do not use highlighters on paper claims. This has the effect of blacking out the information that was highlighted when the claim is scanned by our systems.

Electronic billing

EOCCO can receive claims submitted electronically. Current electronic connections include these clearinghouses:

- Ability/MD Online
- Availity
- Change Healthcare
- MCPS –Medical Claims Processing Solutions
- Office Ally
- Payer Connection

The Moda Health Payer ID is 13350

For information on setting up any of these processes, please contact your clearinghouse. For further questions, contact the Moda Health Electronic Data Interchange (EDI) department at edigroup@modahealth.com or toll-free at 800-852-5195.

Timely filing guidelines

EOCCO requires that all eligible claims for covered services be received in our office within 120 days of the date of service. If a claim meets one of the following criteria, EOCCO may waive the 120-day timely filing rule:

- 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 HSD
- Other reasonable circumstances for delay

Failure to furnish a claim within 120 days shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within the required period, provided it is submitted as soon as reasonably possible. However, claims received later than 12 months after the date of service shall be invalid and not payable. The absence of legal capacity constitutes the only exception to this policy. Providers (direct contract or secondary networks) may not balance bill the member for services that were denied for not meeting the timely filing requirements.

Claims may not be submitted before the date of service. For services billed with a date span (e.g., durable medical equipment (DME) rentals or infusion services) claims must be submitted after the end date of the billing.

If a payment disbursement register (PDR) is not received within 45 days of submission of the claim, the billing office should contact EOCCO Medical Customer Service or check Benefit Tracker to verify that the claim has been received. When submitting a claim electronically using an electronic claims service or clearinghouse, it is important to check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing. All information required to process a claim must be submitted in a timely manner (e.g., date of onset, accident information, medical records as requested). Any adjustments needed must be identified, and the adjustment request must be received within 12 months of the date of service for the request to be considered. The adjustment must also follow the timeframes required for corrected billings, additional information request or denial, and the appeal process, if applicable.

Clean Claim Timeline

We shall make prompt payment in accordance with Fee-For-Service timely payment, including paying of 90% of all Valid Claims from providers, within 30 days of the date of receipt; and paying 99 percent of all valid claims from providers within 90 days of the date of receipt. We shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt; A "Valid Claim" is a "clean claim."

"Valid Claim" means a claim received by the Contractor for payment of Covered and Non-Covered Services rendered to a Member which: (1) Can be processed without obtaining additional information from the Provider of the service; and (2) Has been received within the time limitations prescribed in OHP Rules. A "Valid Claim" does not include a claim from a Provider who is under investigation for Fraud or Abuse, or a claim under review for being Medically Appropriate

Corrected billings

All claims submitted to EOCCO as corrected billings to previously submitted claims need to be clearly marked "corrected billing." In addition, medical records need to accompany the claim if the corrected billing involves a change in diagnosis code(s), additional procedure code(s) or a change in procedure code(s).

- Corrected billings for previously paid claims must be received within 12 months of the date of service. Claims received more than 12 months from the date of service shall be invalid and not payable

When submitting a corrected claim please remember this replaces the original claim. If you had some services covered and others denied, please do not submit a corrected claim with only the outstanding unpaid services as this will cause the original payment to be returned.

If a claim was previously denied for lack of timely filing, sending a corrected claim will not supersede the timely filing denial.

Additional information request or denial

If a claim was previously denied or additional information is requested, the provider has 95 days to submit the requested information or appeal the denied charges for the claim to be reconsidered. This time period starts with the original denial and ends when the necessary information is received.

Privacy Claims

For members who request special confidentiality regarding their claims please reach out to Noah Pietz at 503-265-4786 or noah.pietz@modahealth.com and request the members claims be processed as "confidential." EOCCO will withhold any paperwork that would typically be sent to the members for the date of service request.

For Family planning services if the provider is contracted with EOCCO the provider must bill the CCO. If the provider is an enrolled OHP provider but is not contracted with the clients CCO for family planning services, the provider may bill OHP directly. When submitting the claim to OHP, be sure to:

- Enter "Y" in the family planning box (24H) on the CMS-1500 claim form
- Add the FP modifier after all CPT and HCPCS codes

This will prevent EOCCO from pursuing third party payment from the client's private insurance plan which could result in an explanation of benefits (EOB) being sent to the policy holder.

Billing members

State and federal regulations define the circumstances in which a provider may bill an Oregon Health Plan recipient. The following are examples of when members cannot be billed:

- For covered services that were denied because of a lack of referral or authorization
- For covered services that were denied because the member was assigned to a PCP other than the one who rendered the services
- For services that are covered by EOCCO or the Oregon Health Plan — this includes balance billing the member for the difference between the EOCCO allowed amount and the provider's billed charges
- Missed appointments

Very limited circumstances exist when a provider may legally bill an Oregon Health Plan recipient. Examples include the following:

- A provider may bill a member if the service provided is not covered by OHP or EOCCO and the member signed a waiver before he or she was seen
    - The waiver must include the specific services that are not covered by OHP or EOCCO, the date of the service and the approximate cost of the service
    - The waiver must be written in the primary language of the member. A HSD-approved Patient Responsibility waiver form is available at www.eocco.com/providers/forms. If inadequate waive is used or the waiver is incomplete, the member can't be billed
- A provider may bill a member if the member did not advise the provider that he or she had Medicaid or EOCCO insurance and attempts were made to obtain insurance information.
    - The provider must document attempts to obtain information on insurance or document a member's statement of noninsurance
    - Merely billing or sending a statement to a member does not constitute an attempt to obtain insurance information

For a complete description of the rules, please refer to OAR 410-120-1280,

Billing for children's vaccines (VFC)

The Vaccines for Children (VFC) Program is a federal program that provides free immunizations for children ages 0–18 years.

EOCCO does not reimburse for the cost of vaccine serums covered by the VFC Program. EOCCO members must receive these immunizations from a participating VFC provider.

Providers should bill EOCCO only for the administration of the vaccines covered under the VFC Program. This is identified by billing the specific immunization CPT code with modifier 26 or SL, which indicates administration only.

Providers should not bill for the administration of these vaccines using CPT codes 90465–90474 or 99211 (immunization administration codes). EOCCO is unable to reimburse providers who do not participate with the VFC Program for the cost of the serum.

Providers should use standard billing procedures for vaccines that are not part of the VFC program. EOCCO will not reimburse providers who are not participating in the VFC Program. For providers who do not participate they can direct their patients to the County Health Department to receive the vaccines covered under the program. County Health Departments can bill EOCCO for the administration of the vaccines.

The following CPT codes that are covered under the Vaccines for Children Program can be found: www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Documents/NewCPTcodes.pdf. Please also note that the CPT codes for the VFC Program frequently change and the state-supplied vaccine CPT codes are subject to change. This is especially true around flu season. Please visit OHA's website at www.public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx for more information about the most recent VFC Program guidelines.

Medicare

Medicare has four parts:

- **Part A:** Hospital insurance covers facility care, such as inpatient hospitalization, skilled nursing care and hospice care
- **Part B:** Medical insurance covers outpatient care, including outpatient surgery and office visits
- **Part C:** Medical insurance that is administered by private insurance companies contracted with Medicare. Part C covers everything original Medicare (Part A and Part B) covers and may cover extra benefits as well
- **Part D:** Drug benefit covers prescription drugs

Medicare enrollees may be eligible for any one or all four parts.

Medicare is always primary over the member's OHP coverage. This means that Medicare is responsible for paying first for all of the member's care and OHP (or EOCCO) is responsible for coordinating its benefits with Medicare after Medicare has made payment.

It is important to know exactly what coverage the member has in order to determine whether a referral or authorization is required. A referral or authorization is not required for members with Medicare, except for the following:

- Any service or procedure not covered by Medicare
- All transplants — solid organ, autologous or allogeneic bone marrow
- Drugs requiring prior authorization
- Services below the line or not covered for OHP (when consideration for coverage is being requested)

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

Dual-eligible members

"Dual-eligible" members are members who are eligible for both the Oregon Health Plan and Medicare and/or a Commercial plan.

Summit Health is the affiliated Medicare Advantage Plan for EOCCO members. Summit Health offers a dual-eligible Medicare Advantage Plan for individuals living in the same 12-county service area that EOCCO covers. Dual-eligible OHP recipients enrolled in the Summit Health Medicare Advantage plan and EOCCO will have their benefits coordinated and members may be able to get extra assistance in paying prescription drug premiums and costs. For more information about the Summit Health Medicare Advantage plan, you can visit the Summit Health website at https://www.yoursummithealth.com or call 888-217-2355.

Coordination of benefits

EOCCO will always pay secondary to other insurance carriers. If there is a primary carrier, such as Medicare or private insurance, that carrier's Explanation of Benefits (EOB) should be submitted with the claim as soon as the EOB is received.

The four-month (120-day) timely filing rule is waived when EOCCO is the secondary payer. However, claims must be submitted within 12 months of the date of service for the claim to be considered.

If EOCCO members notify you of new other insurance coverage, please notify OHA by completing the Other Health Insurance Form found at www.eocco.com/providers/forms. The Other Health Insurance Form can be faxed to OHA at 503-765-3570. Please also contact EOCCO Customer Service at 888-788-9821 to update the members Other Insurance.

Calculating coordination of benefits

As secondary payer, EOCCO issues benefits only when the primary carrier paid less than the EOCCO allowed amount. Payment is the difference between our allowed amount and the primary carrier's payment or the patient responsibility, whichever is less.

If the primary plan pays more than the EOCCO allowed amount, no additional benefit is issued.

Clinical editing

Moda Health uses HIPAA-compliant code editing software in the processing of medical claims to improve accuracy and efficiency in claims processing, payment, and reporting. Our clinical edit set focuses on correct coding methodologies and accurate, appropriate adjudication of claims.

Our claims editing software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, place of service, and revenue codes against correct coding guidelines. The software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, cross-provider unbundling or duplication, laterality inconsistencies, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle.

The EOCCO clinical edit policies are based on coding conventions defined by a variety of established sources, including:

- American Medical Association's (AMA) CPT manual
- AMA CPT Assistant newsletter articles
- Centers for Medicare & Medicaid Services (CMS) policies, fee schedule status indicators and guidelines
- Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (CCI) and associated policies
- Coding guidelines developed by national professional specialty societies
- Specialty clinical practice guidelines
- Clinical research and practice pattern analysis
- Clinical experience of physician reviewers
- Numerous medical journals
- Medical texts
- Medical newsletters
- Coding industry newsletters
- Public health data studies
- Proprietary health data analysis
- Other general coding and claim payment references

If you would like to learn more, please submit a request to EOCCO Customer Service, and Moda Health will research and respond back to you with either the abbreviated or the verbatim citation of the source

that defines the policy standard for a specific clinical edit. A complete copy of this policy is also available at www.modahealth.com/pdfs/reimburse/RPM002.pdf.

Multiple procedure reductions

See Reimbursement Policy #RPM022, "Modifier 51 — Multiple Procedure Fee Reductions."

Multiple procedure reductions are applied to procedure codes with a CMS multiple procedure indicator of "1," "2," "3," "4," "5," "6," and "7."

For procedure codes with a multiple procedure indicator or "1," "2," or "3":
All procedure codes, including bilateral procedures, performed in one operative session must be submitted together. Splitting the codes on separate claims (fragmenting) may lead to incorrect payment of services.

Surgical codes are subject to multiple procedure fee reductions, unless they are either exempt from modifier 51 or "add on" codes; exemptions are designated with multiple procedure indicator of "0" or "9" on the Medicare Physician Fee Schedule Database (MPFSDB). Multiple procedure fee reductions are not applied to nonsurgical codes. The absence of modifier 51 on the line item will not prevent multiple surgery fee reductions from being applied when appropriate. Other payment adjustments (e.g., assistant surgeon, related procedure within postoperative period) also apply to the line item(s), when appropriate.

Moda Health (on behalf of EOCCO) applies CMS multiple procedure fee reduction methodology to ASC claims for out-of-network ASCs and for contracted ASCs on a 2017 CMS-based ASC fee schedule or newer. These reductions do apply to any codes with carve-out pricing.
The primary procedure is considered at 100 percent of allowance, the secondary and tertiary procedures are considered at 50 percent of allowance, and all remaining codes are considered at 25 percent of allowance.

Regardless of the order in which the procedures are listed on the claim, the surgical code with the highest allowable fee (before the bilateral procedure adjustment) will be considered the primary procedure (processed at 100 percent) for the purpose of calculating multiple procedure adjustments. This ensures that the best possible total reimbursement is issued for the allowed surgical codes.
Surgical codes that are designated as "add-on" codes are not eligible to be billed without the primary surgical code that they are added onto (base-code). Add-on codes (Multiple Procedure indicator of "O" or "9") will be considered at 100 percent of allowance.

Surgical codes that are designated as modifier-51-exempt (Multiple Procedure indicator of "O" or "9") will be considered at 100 percent of allowance.

Certain procedures are considered "incidental" and are not eligible for payment as secondary procedures. An incidental procedure is one that does not add significant time or complexity to the major procedure. Please see the information about our Clinical Editing Policy listed in this manual.

For procedure codes with CMS multiple procedure indicators of "4," "5," "6," or "7":

Moda Health applies the following multiple procedure reduction rules:

- Multiple radiology procedure reductions (indicator of "4").
- Multiple therapy services reductions (indicator of "5").
- Multiple diagnostic cardiovascular services reductions (indicator of "6").
- Multiple diagnostic ophthalmology services reductions (indicator of "7").

For details of these reductions, see Reimbursement Policy #RPM022, "Modifier 51 — Multiple Procedure Fee Reductions."

Bilateral procedures

See reimbursement policy # RPM057, "Modifier 50 – Bilateral Procedure."

Bilateral procedures performed at the same operative session are reported by adding modifier 50 to the appropriate five-digit procedure code. The CPT Editorial Panel originally intended modifier 50 to be used as a one-line entry with units = 1 to report all of the work done on both sides. (CPT Assistant, Spring 1992, page 19.)

EOCCO requires that all bilateral services be reported as a one-line entry using modifier 50 and units = 1. We have identified that claims with bilateral services submitted as a two-line entry (e.g., 31254, units = 1, and 31254-50, units = 1) are not always feeing correctly; if problems do occur, then a corrected claim using a one-line entry will be needed.
Not all procedure codes are eligible to be billed with modifier 50. The Medicare Physician Fee Schedule Database (MPFSDB) published by CMS contains a variety of indicators for each CPT and HCPCS code. The bilateral indicator identifies which procedure codes are eligible for bilateral reimbursement with modifier 50. Modifier 50 should only be added to procedure codes with a bilateral indicator of "1." If modifier 50 is submitted attached to procedure codes with a bilateral indicator of "0," "2," or "9," our system will recognize an inappropriate combination and generate a denial code for invalid procedure to modifier combination. A corrected claim will be needed.

MPFSDB bilateral indicators:
"0" — Bilateral surgery rules do not apply. Do not use -50 modifier
"1" — Bilateral surgery rules do apply. If performed bilaterally, use modifier 50, units = 1
Bilateral payment adjustment of 150 percent applies
"2" — Bilateral surgery rules do not apply — already priced as bilateral. Do not use -50 modifier. Units = 1
"3" — The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests. Report bilateral services without modifier 50 (preferred), or with modifier 50 and units = 1.
"9" — Bilateral surgery concept does not apply

If bilateral procedures are reported with other procedure codes on the same day, multiple surgery procedure adjustments apply as usual in addition to the bilateral payment adjustment. Other payment adjustments (e.g., assistant surgeon, related procedure within postoperative period, multiple procedure reductions, etc.) also apply, when appropriate.

Bilateral procedures performed on only one anatomical side

Procedures performed on only one anatomical side should not be billed with modifier 50. Modifiers LT and RT are only programmed as valid for procedures on body parts that exist only twice in the body, once on the left and once on the right (paired body parts). If the procedure code can only be performed in a single possible location on each side of the body, then modifier RT or LT may be used to indicate on which side the procedure was performed.

However, if the procedure code can be performed on more than one possible location on each side of the body, modifier RT or LT should not be used in combination with that procedure code. Our system will recognize an inappropriate combination and generate a denial code for invalid procedure to modifier combination. (See Reimbursement Policy #RPM019, "Valid Modifier to Procedure Code Combinations.") In these cases, modifier 59 or XS may be the most appropriate choice to indicate that the procedure has been performed in a separate and distinct location, organ or incision. A corrected claim will be needed.

Reduced or discontinued procedures

See reimbursement policies #RPM003, "Modifier 52 — Reduced Services." #RPM018 "Modifier 53 — Discontinued Procedure" and # RPM049, "Modifiers 73 & 74 - Discontinued Procedures for Facilities." When modifiers 52 (Reduced Services) or 53 (Discontinued Procedure) are submitted on a line item, Moda Health reviews these claims against records on a case-by-case basis and adjusts the allowances based on the percentage of the full service that had been performed or documented.

A letter or brief statement should be attached to the claim or included with the records indicating what was different about the reduced procedure or at what point the procedure was discontinued and why. It would be extremely helpful if this statement included an estimate of the percentage of work actually performed as compared with the work usually required or performed for the procedure code. For example, if a CT scan is billed with modifier 52, a notation that "only seven slices done; 15 are usually taken" clearly indicates the nature and amount of the reduction. This information should be attached to paper claims. For electronic claims, please be prepared to supply this information for review.

Modifier 53 (Discontinued Procedure) may not be considered separately reimbursable or valid if other procedures were completed during the same session.

Co-surgery reimbursement

See reimbursement policy #RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons)."

Modifier 62 indicates that two surgeons worked together as primary surgeons (co-surgeons), each performing a distinct part of a procedure. Modifier 62 must be added to the shared procedure code(s) on the claim from both co-surgeons. If modifier 62 is attached to the procedure code(s) on one surgeon's claim but is not present on the other surgeon's claim, claims cannot be adjudicated correctly. The second claim processed will be denied and a corrected claim or claims will need to be submitted so that both surgeon's claims are in agreement. If an overpayment occurred on the first claim processed, a refund will be needed from the surgeon who did not add modifier 62 to the shared procedure codes.

If multiple procedures are performed in a single operative session, some procedures can be shared as co-surgeons and billed with modifier 62, and other procedures may be performed as usual with one surgeon acting as primary and the other as assistant. Modifier 62 should be added only to the shared procedures.

Co-surgery fee adjustment rates:

- Moda Health (on behalf of EOCCO) allows 60 percent of the usual contracted fee when modifier 62 is attached

Other fee adjustments apply in addition to the co-surgery fee adjustment as appropriate (e.g., bilateral, related surgery during postoperative period, etc.). Multiple surgery procedure adjustments also apply. Regardless of whether part or all of the procedure codes are billed with modifier 62 for co-surgery, only one procedure code is eligible to be processed at 100 percent (primary) under the multiple surgery fee adjustment rule.

Modifiers for surgical codes

When surgical CPT codes are billed with certain modifiers, records will be needed to correctly process the claim. Please refer to the list below and attach the needed records to the claim when the claim is submitted. This will avoid unnecessary delays in processing (for Moda Health to request the needed records) and ensure that you receive payment for services as soon as possible.

		Modifier description	Records needed
-22		Unusual procedural services	Operative report and summary explanation of unusual circumstances. (See reimbursement policy # RPM007, "Modifier 22 - Increased Procedural Services")
-52		Reduced services	Statement indicating how the service was reduced and the percentage of work actually done is compared to the usual work required, and records for the reduced code or service billed (see reimbursement policy #RPM003, "Modifier 52 — Reduced Services" and # RPM049, "Modifiers 73 & 74 - Discontinued Procedures For Facilities.")
-53		Discontinued procedure	Medical records documenting procedure planned, at what stage it was discontinued, and why. Indicate the percentage of work actually completed as compared to the complete procedure. (See reimbursement policies # RPM018, "Modifier 53 – Discontinued

			Procedure" and # RPM049, "Modifiers 73 & 74 - Discontinued Procedures for Facilities.")
-58		Staged or related procedure	Pre-operative history and physical and operative report for original and current surgeries. (See reimbursement policy # RPM010, "Modifiers 58, 78 and 79 — Staged, Related and Unrelated Procedures")
-59		Distinct procedural service	Operative report and/or chart notes (see reimbursement policy # RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")
-62		Two surgeons	For procedure codes with a co-surgeon indicator of "1" on the MPFSDB: • All operative reports (covering work of all surgeons). • Documentation of reason for necessity of two surgeons. (See reimbursement policy # RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons).")
-66		Surgical team	For procedure codes with a team surgeon indicator of "1" on the MPFSDB: • All operative reports (covering work of all surgeons). • Documentation of reason for necessity of team of more than two surgeons. (See reimbursement policy # RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons).")
-76		Repeat procedure by same physician	Operative report and/or chart notes
-77		Repeat procedure by another physician	Operative report and/or chart notes
-78		Return to the operating room for a related procedure	Pre-operative history and physical and operative report for both surgeries

			(see reimbursement policy # RPM010, "Modifiers 58, 78 and 79 — Staged, Related and Unrelated Procedures")
-79		Unrelated procedure or service by the same physician during the postoperative period	Pre-operative history and physical and operative report for both surgeries (see reimbursement policy # RPM010, "Modifiers 58, 78 and 79 — Staged, Related and Unrelated Procedures")
-XE		Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter	Operative report and/or chart notes (see reimbursement policy # RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")
-XS		Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure	Operative report and/or chart notes (see reimbursement policy # RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")
-XU		Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service	Operative report and/or chart notes (see reimbursement policy # RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")

Note: When an operative report is indicated or requested, the records needed are always the most complete documentation of the procedures billed that are available. This documentation comes in various formats, depending on the type of surgical code billed and the documentation variations that exist among facilities or providers.

- If a formal, dictated operative report is available, this is always what is needed
- If the surgical code is associated with a radiology procedure, the dictated procedure report may be considered an X-ray report by some offices or facilities
- Depending on the extent of the procedure billed, some physicians do not dictate a formal operative report for certain surgical procedure codes. In that case, all medical records (including dictated and handwritten notes and any diagrams) documenting the visit and the surgical procedure code should be submitted when the operative report is requested

Modifiers for assistant surgeons

See reimbursement policy #RPM013 Modifiers 80, 81, 82, and AS - Assistant at Surgery
EOCCO makes determinations regarding whether or not assistant at surgery services are reimbursable on a code-by-code basis. When multiple procedure codes are billed for a surgical session and only some of the codes are eligible for assistant surgeon reimbursement, only the eligible codes will be reimbursed.

The assistant surgeon must report the same codes as the surgeon. An exception to this is when the surgeon bills a global code (e.g. maternity care). In that case, the assistant at surgery must bill the specific surgery-only code (e.g. delivery only).

Non-physician assistant at surgery services are to be submitted with modifier -AS appended, not modifier -81. Non-physician assistant at surgery services submitted with modifier -81 appended will be reimbursed at the same rate as if submitted with modifier –AS appended.

Coding and billing reviews

Overpayment prevention

The Moda Health program for prevention of overpayments, fraud and abuse includes:

- Clinical editing
- Prepayment reviews
- Post payment reviews
- Use of vendor services and review vendors

Claim reviews

During the normal course of our claims processing, claims will be selected for review to ensure correct coding, completeness of documentation, billing practices, contractual compliance, and any benefit or coverage issues that may apply. Services are expected to be billed with correct coding and billing.

Claim reviews are performed to identify overpayments as well as uncover and identify unacceptable misleading billing practices or actions that otherwise interfere with timely and accurate claims adjudication, including but not limited to:

- Falsifying documentation or claims
- Allowing another individual or entity to bill using provider's name
- Billing for services not actually rendered
- Billing for services that cannot be substantiated from written medical records
- Failing to supply information requested for claims adjudication
- Using incorrect billing codes, unlisted codes or multiple codes for a single charge, or up-coding
- Unbundling charges (for the purpose of this agreement, "unbundling" means separating charges for services that are normally covered together under one procedure code or included in other services)

Providing records for review

See reimbursement policy # RPM039 "Medical Records Documentation Standards."

All information required to support the codes and services submitted on the claim is expected to be in the member's medical record and available for review. Upon request, the provider submitting the claim is responsible for providing all pertinent information and records needed to support the services billed. When the billing provider receives a letter or fax requesting information needed for a claim review or post-payment review, if the requested documents and information are not received by EOCCO within the required timeframe, the record is deemed not to exist and the services not documented. If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented.

Any records, documentation or information not received in response to the original records request or discovered after the review is complete will be included for possible reconsideration review at EOCCO's sole discretion. Please ensure that your response to records requests is both prompt and complete.

When services (procedure codes) are not documented, the record does not support that the services were performed and so they are not billable. Therefore, services that are determined to be not documented are denied to provider responsibility, and members should not be balance-billed for the items denied. A refund will be requested if necessary (e.g., claim already released, post payment review).

Records considered for review

See reimbursement policy # RPM039 "Medical Records Documentation Standards."
When submitting claims to the carrier, procedure codes are to be selected based on the services documented in the patient's medical record at the time of code selection.
Legally amended corrections to the medical record made within 30 days of the date of service and prior to claims submission or selection for claim review will be considered in determining the validity of services billed.

Any changes that appear in the record more than 30 days after the date of service or after a records request or payment determination will not be considered. In those cases, only the original record will be reviewed in determining payment of services billed to Moda Health.

Legibility of records

See reimbursement policy # RPM039 "Medical Records Documentation Standards."

All records must be legible for purposes of review. Please use care to ensure that records are not rendered illegible by poor handwriting or poor copy quality. If the records cannot be read after review by three different people at Moda Health, the documentation (or any unreadable portion) is considered illegible. When illegible records are received, the services are considered not documented and therefore non-billable. This is consistent with legibility standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Medicare auditors.

Amended medical records

See reimbursement policy # RPM039 "Medical Records Documentation Standards."

Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record bears the current date of that entry and is signed by the person making the addition or change.

A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date and signature of the person adding the late entry, is added as soon as possible and is written only if the person documenting has total recall of the omitted information.

> Example: A late entry following treatment of multiple trauma might add: *"12/17/2009 late entry for 12/14/2009 — The left foot was noted to be abraded laterally."*

An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

> Example: An addendum for a 1/8/2010 visit could note: *"1/13/2010 addendum — Past records arrived from previous PCP and were reviewed. The chest X-ray report was reviewed and showed an enlarged cardiac silhouette was present in October 2009."*

When making a correction to the medical record, never write over or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change and the identity of the person making that entry.

Falsified documentation

See reimbursement policy #RPM039 "Medical Records Documentation Standards."

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Predating entries
- Writing over
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrected claims

Corrected claims or additional codes and charges will not be accepted on claims that have been reviewed against records (coding and documentation verification). The review determination and the explanation codes provided can and should be used to correct the underlying documentation and/or coding problems on all services and claims on a go-forward basis to avoid similar denials in the future. The review determination for a prepayment review will be documented in a claim note; this information can be obtained by contacting Moda Health Customer Service.

Provider inquiry

If you have a question regarding claim status, member eligibility, payment methodology, medical policy or third-party issues, please send a written request to:

EOCCO Appeals Unit
P.O. Box 40384
Portland, OR 97240

All claim inquiries must be communicated to the EOCCO Appeals Unit within 365 days from the last action on the claims.

Care Coordination and Case Management

Care coordination

Care coordination has registered nurses work directly with facilities and providers to facilitate preauthorization of scheduled procedures, review of inpatient stays, and discharge planning or follow-up care for members during urgent or emergent admissions. When a member is receiving care or is hospitalized, care coordination nurses may refer them to the Care Management department for additional assistance and coordination for complex or catastrophic conditions. The hospital calls EOCCO to notify us of all urgent or emergent admissions within 24 hours, or as soon as possible.

Care Management services

Intensive Care Coordination (ICC) and Intensive Case Management (ICM) are voluntary services for EOCCO members. These programs are for members experiencing severe and chronic conditions or those with complex medical or special needs.

ICC/ICM services include:

- Identification of EOCCO members who are aged, blind or disabled or have complex medical needs and are receiving long-term care services
- Assistance to members and providers to ensure timely access to needed services
- Coordination with providers to ensure that consideration is given to unique needs in treatment planning
- Assistance to providers with coordination of services and discharge planning, including when they cannot be provided locally
- Assistance with coordinating community support and social service linkage with medical care systems
- Assistance for members requiring special medical supplies or equipment
- Assistance with children with special needs
- Explain and maximize available benefits
- Communicate with providers
- Work with the facility case managers to coordinate discharge plans
- Contact patients at home to confirm and support the provider's treatment plan
- Connect members with community resources

ICC/ICM referrals

Potential candidates for referral to EOCCO case management services include the following:

- Members experiencing difficulty accessing providers
- Members experiencing difficulty receiving medical services

- Members with issues requiring community support
- Members who need assistance with discharge planning or care coordination
- Members with severe and chronic conditions that need additional supports
- Members who have complex medical or special needs that require increased coordination

ICM referrals can be made by the**:**

- Member
- Member's representative
- Providers (including physicians, hospitals, long-term care facilities and residential house physicians)
- State agency staff

To make a referral, call EOCCO Customer Service toll free at 888-788-9821. Case Management referral forms are available on our website at www.eocco.com/providers/referral-auths.

Please include:

- Member name and ID number available on the member's EOCCO ID card
- Contact name and number
- Reason for referral

Once a referral is received, a case manager will respond to the referring provider within 1 business day. In addition, a case manager will evaluate the member's situation and contact the member within five business days.

Transition of Care

Transition of Care is the continued access to services during a member's transition from a predecessor plan to EOCCO. A predecessor plan may be another CCO or Medicaid fee-for-service (FFS.) Primary care teams, hospitals and specialty service providers are required to meet requirements of transition of care.

EOCCO will provide transition of care to, at minimum, the following members:

- Medically fragile children;
- Breast and Cervical Cancer Treatment program members;
- Members receiving CareAssist assistance due to HIV/AIDS;
- Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and
- Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

The transition of care period is the greater of the following periods after the effective date of enrollment with the receiving EOCCO:

- Thirty days for physical and oral health and sixty days for behavioral health or until the members new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan, whichever comes first;

- Ninety days for members who are dually eligible for Medicaid and Medicare.

EOCCO will also ensure that any of the members identified above have continued access to care. This includes seeing their previous out of network providers without referral until the authorized prescribed course of treatment has been completed or the reviewing provider determines the treatment is no longer medically necessary.

EOCCO will provide coverage for the entire course of treatment for members who are receiving:

- Prenatal and/or postpartum care;
- First year of post-transplant year service;
- Current radiation or chemotherapy services; or
- Prescriptions that exceed the transition of care period

During the transition of care period, EOCCO will honor any written documentation of prior authorization of ongoing covered services:

- We will not delay service authorization if written documentation of prior authorization is not available in a timely manner

In such instances, we will approve claims for which it has received no written documentation during the transition of care time period, as if the services were prior authorized. The predecessor plan shall comply with requests from the receiving EOCCO for complete historical utilization data within 21 calendar days of the member's effective date with the receiving EOCCO:

- Data shall be provided in a HIPAA compliant format to facilitate transitions of care
- The minimum elements provided are:
    - Current prior authorizations and pre-existing orders
    - Prior authorizations for any services rendered in the last 24 months
    - Current behavioral health services provided
    - List of all active prescriptions
    - Current ICD-10 diagnosis

Quality improvement

Program goals

The goals of our quality improvement (QI) program are to improve the quality of healthcare and service delivery for our EOCCO members and thereby improve their health status and patient experience.

Program objectives

Our quality improvement program objectives are to:

- Establish and maintain integrated organizational systems to ensure that EOCCO members receive quality healthcare and service delivery
- Continuously improve the quality of healthcare and service delivery, thereby improving the health status of members
- Continuously evaluate the quality of healthcare and service delivery provided to our members

- Promote communication within our organization and between our organization and our business partners, providers and members
- Partner with providers to improve the safety of medical care in their clinical practices
- Ensure quality and accountability through measurement of performance and utilization.
- Participate in initiatives that improve healthcare for our EOCCO members and all Oregonians by:
    - Supporting community, state and national health initiatives
    - Building partnerships with other healthcare organizations
    - Seeking collaborations to identify and eliminate healthcare disparities

Our CCO meets these objectives by focusing on QI projects that have a significant impact on the health of our members and have measurable outcomes in terms of quality of life, satisfaction with patient experience or health resource utilization. We base the selection of QI projects on a number of factors including acuity, high volume, high cost, high outcomes variance and population-based healthcare standards such as preventive services, early diagnosis and appropriate therapies, patient safety, member satisfaction levels, and available resources.

QI committee structure

The EOCCO Quality Improvement Committee (QIC) has operational authority and responsibility for the EOCCO transformation and quality strategy (TQS) with the goal of advancing the Triple Aim for EOCCO members. The Committee prioritizes, develops, implements and evaluates integrated transformational and quality improvement activities to improve the patient experience of care and the health of its EOCCO populations, and to reduce the cost of healthcare. The EOCCO QIC recommends policy decisions that affect the quality of healthcare and service provided to EOCCO members. The EOCCO QIC reports its progress on TQS initiatives to the EOCCO Board of Directors.

Scope of service and issues reviewed

The EOCCO QIC defines its QI activities in an annual TQS work plan. This plan includes the processes that will be implemented, measured and monitored. Major plan components include the processes involved with quality outcomes, patient safety and service as it pertains to access, availability, satisfaction, eliminating healthcare disparities and health equity. The scope of service includes any and all regulatory requirements, including external quality review activities for which the EOCCO ensures access to medical records, information systems, personnel and documentation requested by the external quality review organizations.

The EOCCO network of providers includes primary care providers, physical health specialists, behavioral health specialists, community mental health programs, chemical dependency treatment providers and dentists. Network providers are involved in EOCCO TQS initiatives and regulatory requirements.
The issues reviewed by the EOCCO QIC include, but may not be limited to:

- Access to care
- Compliance with government regulations
- Member satisfaction
- Outcomes of care
- Patient safety
- Performance measures and quality indicators stipulated by the Oregon Health Authority

- Utilization of services

Data sources include claims data, medical record data, patient complaints and appeals, case management reports, pharmacy data, satisfaction surveys and QI projects. The data sources are used to develop reports and studies that help the EOCCO QIC make recommendations for interventions and activities aimed at improving the healthcare of EOCCO members and their satisfaction with their healthcare experience.

Any member-specific or provider-specific data is considered confidential and treated according to the EOCCO's confidentiality and privacy policy.

Annually EOCCO completes an evaluation of the TQS — the results of activities and processes, analyses of barriers and the resulting improvement opportunities and plans for the ensuing year. A summary report is presented to the EOCCO Board of Directors.

Incentive Measures

Each year, the Oregon Health Authority (OHA) releases a set of quality metrics. OHA intends to use these metrics to determine how well coordinated care organizations (CCOs) are improving care, making quality care accessible, eliminating health disparities and curbing the rise in healthcare cost. For more information regarding the current quality metrics please refer to www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx.

EOCCO has developed an Incentive Measure Reference Guide which serves as an additional resource for providers. This can be found at www.eocco.com/providers/incentivemeasures.

Each month, the EOCCO Analytics Team sends out Quality Measure progress reports to clinics via the Provider Reports Portal, which can be found at https://www.modahealth.com/riskshare/#/login. The progress reports are a tool to help clinics identify patients who require action in order to meet incentive measure improvement targets. These reports include all members currently enrolled in the EOCCO and/or a Moda Health Coordinated Care Model (CCM) commercial plan and are assigned to the clinic for primary care.

If you have any comments or questions or would like additional information on the quality metrics or progress reports, please contact EOCCOmetrics@modahealth.com.

Risk Reports

Additional EOCCO member reports are available on the Provider Reports Portal for Shared Risk Model participants. These reports contain data on each member's medical conditions and treatments. The purpose of these reports is to help clinical staff at provider organizations identify opportunities to improve care for individual members. Below are a list of these reports and a summary of what data is included on each.

Report name	Purpose/description

Member Roster	Shows which members are assigned to each provider and provides basic information on risk and utilization. This report is posted to the portal on a monthly basis.
ER and IP Detail	Lists all inpatient and emergency room visits for members. This report is distributed by secure email two times per week.
Pharmacy Opportunity Report	Details all medical utilization data for members with chronic conditions or identified as high-risk. Identifies members who fall into certain intervention opportunity categories such as low medication adherence or high-risk opioid use. This report is posted to the portal on a monthly basis.

For more information or to be granted access to your clinic's portal, please contact: ProviderReports@modahealth.com

Annual Clinician and Staff Summit

The EOCCO Summit is our annual conference in Eastern Oregon to network with fellow EOCCO peers, earn CMEs through trainings, and engage in important discussions about healthcare transformation. For more information or to request an event invitation please contact: EOCCOmetrics@modahealth.com.

Cultural Competency Trainings

EOCCO will share OHA-approved opportunities for providers to attend cultural competency trainings, as they become available. EOCCO will outreach to providers at least once a year to gather information about providers who have met their cultural competency continuing education requirements. Providers should also inform EOCCO of changes to the status of meeting the cultural competency requirement.

Community Advisory Council

The Community Advisory Council (CAC) is a group of locally identified volunteers from each of the 12 counties who have an interest in the health deliverables within their communities. Each local CAC meets on a monthly basis to address the social determinants of health within their diverse populations.

For more information about the CACs or how to get involved, please visit www.eocco.com/providers/cac.

Seclusion and restraint policy

In accordance with federal law, we recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

A restraint is (a) any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely or (b) a drug or medication when used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and that is not a standard treatment or dosage for the patient's condition.

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

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

- 4 hours for adults 18 years of age or older;
- 2 hours for children and adolescents 9 to 17 years of age; or
- 1 hour for children under 9 years of age.

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

EOCCO requires their participating providers to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations and also requires the provider to provide EOCCO a copy of their policy upon request.

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

Confidentiality

Confidentiality of member information is extremely important. Healthcare providers who transmit or receive protected health information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA) transactions must adhere to the HIPAA privacy and security regulations. State and federal laws may contain additional rules regarding the protection of member's PHI.

Providers must offer privacy and security training to any staff members who have contact with Patient PHI. All PHI individually identifiable health information contained in the medical record, billing records or any computer database is considered confidential, regardless of how and where it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disc, compact disk or optical media formats.

PHI contained in medical or financial records must be disclosed only to the patient or personal representative unless the patient or personal representative authorizes the disclosure to some other individual or organization, or a court order has been sent to the provider. PHI may only be disclosed to immediate family members with the verbal or written permission of the patient or the patient's personal representative. PHI may be disclosed to other providers involved in caring for the member without the member's or the 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 as required by federal law.

Information may be disclosed to insurance companies or the patient's representatives for the purposes of quality and utilization review, payment or medical management. Providers may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.
All healthcare personnel who generate, use or otherwise deal with PHI must uphold the patient's right to privacy. Extra care must be taken not to discuss patient information (financial as well as clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

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

EOCCO staff members adhere to HIPAA-mandated confidentiality standards. EOCCO protects a member's information in several ways:

- Written policies protect the confidentiality of health information
- Employee can only access a member's information when necessary to perform their job;
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage or when otherwise allowed by law; and
- Documentation is stored securely in electronic files with designated access

Release of information

In general, information about a member's health condition, care, treatment, records or personal affairs that is received, created, or transmitted by EOCCO may not be discussed with anyone, unless the reason for the discussion pertains to treatment, payment or plan operations. If member health information is requested for other reasons, the member or the member's healthcare representative must have completed an authorization allowing the use or release of the member's PHI. The form must be signed by the patient or his or her healthcare representative and must be provided to EOCCO for its records.

Release forms require specific authorization from the patient to disclose information pertaining to HIV/AIDS, mental health, genetic testing, drug and alcohol diagnosis, or reproductive health.
The authorization form and instructions on how to complete the forms can be found on our website at www.eocco.com/providers/forms.

Fraud, waste and abuse

This policy sets forth EOCCO's plan for fraud, waste and abuse prevention, detection, and reporting, and applies to all EOCCO staff, delegates, and contractors and providers. It is the policy of EOCCO that its staff, delegates, and contractors and providers comply with all applicable federal and state laws and regulations regarding the detection, prevention, and correction of fraud, waste, and/or abuse. EOCCO has internal controls and procedures designed to prevent and detect potential fraud, waste, and/or abuse activities by members, staff, delegates, and contractors.

This plan includes operational policies and procedures, internal controls, and corrective action plans (if applicable) in areas such as sales, enrollment and billing, utilization management and quality review,

claims (medical, pharmacy, and dental), member and provider appeal and grievance resolution, practitioner credentialing and contracting, and human resources. EOCCO reviews and revises this policy on an annual basis or more frequently if needed.

The Special Investigations Unit (SIU) will coordinate investigations into incidents of suspected fraud, waste and abuse that impact or may impact EOCCO with the Medicaid Compliance Officer and/or the legal department (if applicable). The Medicaid Compliance Officer has direct access to the CEO and the EOCCO Board of Directors. The EOCCO Board of Directors, by way of the Compliance Committee, shall oversee and receive regular updates regarding EOCCO's Compliance Program from the EOCCO Compliance Officer.

Definitions

Abuse - includes actions that may, directly or indirectly, result in unnecessary costs to EOCCO or other federal programs such as Medicare or Medicaid. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

Contractor – means any entity that provides services to EOCCO pursuant to the terms of a written agreement. Additionally for the purposes of this plan, the term contractor includes subcontractors with whom the contractor subcontracts work relating to Medicaid plans. This term shall expressly include, but not be limited to first tier, downstream, and related entities.

Delegated Entity – means any entity that EOCCO determines meets the definition of a first tier, downstream, or related entity. See First Tier Entity, Downstream Entity, and Related Entity definitions for additional detail.

Downstream Entity – as defined by 42 C.F.R. §423.501, means any party that enters into an acceptable written arrangement below the level of the arrangement between EOCCO and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Employee – means any full time, part time, or temporary employee of EOCCO who works directly or indirectly on Medicaid plans. Additionally, for the purposes of this plan, the term employee includes EOCCO volunteers who work directly or indirectly on Medicaid plans.

Fraud – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

First Tier Entity – as defined by 42 C.F.R. §423.501, means any party that enters into a written arrangement with EOCCO to provide administrative services or health care services for a Medicaid eligible individual.

Incident – A situation of possible fraud, waste, and/or abuse which has the potential for liability for EOCCO or EOCCO's contracted delegates and/or contractors.

Knowingly – as defined in 31 U.S.C §3729(b) means that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Potential – If, in one's professional judgement, it appears as if an incident of fraud or abuse may have occurred, the standard of judgement used would be that judgement exercised by a reasonable and prudent person acting in a similar capacity.

Related Entity – as defined by 42 C.F.R. §423.501, means any entity that is related to EOCCO by common ownership or control and;

a. Performs some of EOCCO's management functions under contract or delegation;
b. Furnishes services to Medicaid enrollees under an oral or written agreement; or
c. Leases real property or sells materials to EOCCO at a cost of more than $2,500 during a contract period.

Waste – overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to EOCCO or other federal programs such as Medicare or Medicaid. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Federal laws

As a participant in federal programs such as Medicare and Medicaid, EOCCO, its employees, agents and contractors are required to comply with the following federal laws:

Basic civil and criminal penalties and exclusions

The Office of the Inspector General (OIG) is authorized to impose civil penalties on any person, including an organization or other entity, that knowingly presents or causes to be presented to a federal or state employee or agent false or fraudulent claims. Examples of actions that would give rise to penalties include submitting a claim for services that were not rendered or providing services that were known to be not medically necessary. In addition to specified monetary penalties, treble damages may also be assessed against any person who submits a false or fraudulent claim.

Section 1128B of the Social Security Act provides for criminal penalties involving federal healthcare programs. Under this section, certain false statements and representations, made knowingly and willfully, are criminal offenses. For example, it is unlawful to make or cause to be made false statements or representations in either applying for benefits or payments or in determining rights to benefits or payments under a federal healthcare program. In addition, people who conceal any event affecting an individual's right to receive a benefit or payment with the intent to either fraudulently receive the benefit or payment (in an amount or quantity greater than that which is due) or to convert a benefit or payment

to use other than for the use or benefit of the person for which it was intended may be criminally liable. Individuals who violate this statute may be guilty of a felony, punishable by a fine of up to $25,000, up to five years' imprisonment or both. Other people involved in connection with the provision of false information to a federal health program may be guilty of a misdemeanor and may be fined up to $10,000 and imprisoned for up to one year.
The Social Security Act also provides the OIG with the authority to exclude individuals and entities from participation in federal healthcare programs. Exclusions from federal health programs are mandatory under certain circumstances and permissive in others (i.e., OIG has discretion in whether to exclude an entity or individual).

The Anti-Kickback Statute

Under the federal Anti-Kickback Statute, it is a felony for a person to knowingly and willfully offer, pay, solicit or receive anything of value (i.e., remuneration), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a federal healthcare program. The statute prohibits the offering or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, arranging for or recommending the purchase, lease or ordering of any item or service that is reimbursable by a federal healthcare program. Individuals found guilty of violating the Anti-Kickback Statute may be subject to fines, imprisonment and exclusion from participation in federal healthcare programs.
There are certain statutory exceptions to the Anti-Kickback Statute. Under one exception, "remuneration" does not include a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under a federal healthcare program.
In addition to the statutory exceptions, the OIG has identified several "safe harbors" for common business arrangements, under which the Anti-Kickback Statute would not be violated. The list of safe harbors is not exhaustive, and legitimate business arrangements exist that that do not comply with a safe harbor.

Stark law: physician self-referrals

The Stark law prohibits certain physician referrals for designated health services that may be paid for by Medicare, Medicaid or other state healthcare plans. The Stark law provides that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician (or immediate family member) and the entity.

The Stark law includes a large number of exceptions, which may apply to ownership interests, compensation arrangements or both. Unlike the Anti-Kickback Statute, which recognizes that arrangements falling outside of the safe harbors may still be permitted, the Stark law is a strict prohibition against self-referrals; accordingly, if a referral arrangement does not meet one of the exceptions, it will be considered unlawful.

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000, and in certain cases not to exceed $100,000, per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute or investment interest in any entity providing the designated health service. A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

False Claims Act

The federal civil False Claims Act (FCA) is one of the most effective tools used to recover amounts improperly paid because of fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement to secure payment from the federal government for such a claim or conspiring to get such a claim allowed or paid. Under the statute the terms "knowing" and "knowingly" mean that a person (1) has actual knowledge of the information, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered and upcoding (billing for a more highly reimbursed service or product than the one actually provided).
The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than 10 years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $5,500 and not more than $11,000, plus up to three times the amount of damages sustained by the federal government.

Qui tam and whistleblower protection provisions

The False Claims Act contains qui tam, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A qui tam action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has 60 days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim. However, if the government initially decides not to join, the whistleblower may pursue the action alone, with the government maintaining the ability to join the action at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 percent and 25 percent) plus attorneys' fees and costs.
Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistleblowing activity are entitled to all relief

necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest and compensation for any special damages including attorneys' fees and costs of litigation.

Federal Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against individuals who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents, submits or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

Applicable state laws

Public assistance: submitting wrongful claims or payment

Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment, (2) submitting or causing to be submitted to the department any claim for payment that has been submitted for payment already unless such claim is clearly labeled as a duplicate, (3) submitting or causing to be submitted to the department any claim for payment that is a claim upon which payment has been made by the department or any other source unless clearly labeled as such, or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C felony.

Any person who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) the amount of the payment so accepted from the department or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Any person who, after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

False claims for healthcare payments

A person commits the crime of making a false claim for healthcare payment when the person (1) knowingly makes or causes to be made a claim for healthcare payment that contains any false statement or false representation of a material fact in order to receive a healthcare payment or (2) knowingly conceals from or fails to disclose to a healthcare payor the occurrence of any event or the existence of any information with the intent to obtain a healthcare payment to which the person is not entitled or to obtain or retain a healthcare payment in an amount greater than that to which the person is or was

entitled. The district attorney or the attorney general may commence a prosecution under this law and the Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Program integrity

The Oregon Health Authority (OHA) has established certain goals designed to ensure that payment is made only for medically appropriate covered services provided to an eligible member in accordance with the member's benefit package in effect on the date of service. EOCCO must maintain financial and other records capable of being audited or reviewed, consistent with state law, and must cooperate with OHA in the conduct of any such audit. EOCCO shall require its subcontractors to cooperate with OHA in the conduct of any investigations.

Medicaid fraud and abuse

EOCCO must promptly refer all suspected fraud or abuse, including fraud or abuse by its employees and subcontractors, to the Medicaid Fraud Control Unit (MFCU) or the OHA Program Integrity Audit Unit (PIAU). EOCCO may also refer cases of suspected fraud and abuse to the MFCU or to the PIAU prior to verification. If EOCCO is aware that there are credible allegations of fraud for which an investigation by MFCU or PIAU is pending against a provider, EOCCO shall suspend payments to the provider unless MCFU or PIAU determines there is good cause not to suspend payments or to suspend payments in part. If the act does not meet the good cause criteria, EOCCO shall work with the MFCU and PIAU to determine if any participating provider contract should be terminated.

EOCCO shall report to the MFCU or PIAU any incident found to have characteristics that indicate fraud or abuse or cases in which EOCCO has verified fraud or abuse. The Department of Justice Medicaid Fraud Control Unit phone number is (971) 673-1880, address 100 SW Market St, Portland OR 97201, and fax is (971)-673-1890. The OHA Program Integrity Audit Unit phone number is 1-888-FRAUD01 (888-372-8301), address 3406 Cherry Ave. NE, Salem, OR 97303-4924, and fax is (503) 378-2557.

If EOCCO learns of suspected fraud or abuse committed by a member, EOCCO will report the incident to the DHS/OHA Fraud Investigations Unit. Such reports will be sent to DHS/OHA Fraud Investigations Unit, P.O. Box 14150, Salem, Oregon 97309., phone number 888-FRAUD01 (888-372-8301), fax 503-373-1525, Attn: HOTLINE.

With respect to any suspected fraud or abuse case, EOCCO shall permit, and shall require its subcontractors to permit, the applicable state agencies to inspect, copy, evaluate or audit books, records, documents, files, accounts and facilities, without charge, as required to investigate such incident. In addition, EOCCO and its subcontractors shall provide copies of reports or other documentation, including those requested from subcontractors regarding suspected fraud or abuse at no cost to such state agencies during an investigation.

Provider sanctions

The Oregon Health Authority (OHA) will impose mandatory sanctions and suspend a provider from participation in Oregon's medical assistance programs (a) when the provider has been convicted of certain felonies or misdemeanors, (b) when a provider is excluded from participation in federal or state

healthcare programs or (c) if the provider fails to disclose ownership or control information required under 42 CFR 455. OHA may impose discretionary sanctions when OHA determines that the provider fails to meet one or more of OHA's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary sanction include, but are not limited to, when a provider has:

- Been convicted of fraud related to any federal, state or locally financed healthcare program or committed fraud, received kickbacks or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes
- Been convicted of interfering with the investigation of healthcare fraud
- Failed to disclose required ownership information
- Failed to supply requested information on subcontractors and suppliers of goods or services
- Failed to supply requested payment information
- Failed to grant access to or furnish requested records, or to grant access to facilities upon request of OHA or the State of Oregon's Medicaid Fraud Unit conducting its regulatory or statutory functions
- Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules or regulations
- Failed to correct deficiencies in operations after receiving written notice of the deficiencies from OHA
- Threatened, intimidated or harassed clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the provider and OHA

A provider may not submit claims for payment for any services or supplies provided by a person or healthcare provider or entity that has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

Whistleblowing and non-retaliation

EOCCO may not terminate, demote, suspend, or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported fraud, waste or abuse by any person; has in good faith caused a complainant's information or complaint to be filed against any person; has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste or abuse; has in good faith brought a civil proceeding against an employer; or has testified in good faith at a civil proceeding or criminal trial.

Racketeering

An individual who commits; attempts to commit; or solicits, coerces or intimidates another to make a false claim for healthcare payment may also be guilty of unlawful racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

Perjury and related offenses

A person commits the crime of perjury if the person makes a false sworn statement in regard to a material issue, knowing it to be false. The crime of false swearing is related to perjury and occurs when an individual makes a false sworn statement, knowing it to be false. A "sworn statement" means any statement that verifies to the truth of what has been stated and that is knowingly given under any form of oath or affirmation or by declaration under penalty of perjury. A person commits the crime of unsworn falsification if the person knowingly makes any false written statement to a public servant in connection with an application for any benefit, such as Medicaid benefits. As used herein, a "benefit" means gain or advantage to the beneficiary or to a third person pursuant to the desire or consent of the beneficiary.

Theft

A person commits theft when, with intent to deprive another of property or to appropriate property of a third person, someone takes, appropriates, obtains or withholds such property from its rightful owner. Theft also includes theft by means of extortion, deception, receiving (receipt of stolen property), and theft or wrongful retention of property that has been lost, mislaid or delivered by mistake. The degree of the crime with which an individual may be charged depends on the nature of the theft, the value of the property at issue and other circumstances occurring at the time of the theft, such as a fire or emergency situation.

Forgery

A person commits the crime of forgery if, with intent to injure or defraud, the person falsely makes, completes or alters a written instrument or utters a written instrument that the person knows to be forged. The severity of the crime with which an individual may be charged can be increased by a variety of factors, including the number of victims involved in the same scheme or the nature of the written instrument involved. Forgery involves the modification of a written instrument without authority to do so. A forged document is "uttered" when it is issued, delivered, published, circulated, disseminated, transferred or otherwise tendered to another party.

Fraudulently obtaining a signature.

A person commits the crime of fraudulently obtaining a signature if, with intent to defraud or injure another, the person obtains the signature of a person to a written instrument by knowingly misrepresenting any fact.

Falsifying business records

A person commits the crime of falsifying business records if, with intent to defraud, the person:

- Makes or causes a false entry in the business records of an enterprise
- Alters, erases, obliterates, deletes, removes or destroys a true entry in the business records of an enterprise
- Fails to make a true entry in the business records of an enterprise in violation of a known duty imposed upon the person by law or by the nature of the position of the person
- Prevents the making of a true entry or causes the omission thereof in the business records of an enterprise

Identity theft

A person commits the crime of identity theft if the person, with the intent to deceive or to defraud, obtains, possesses, transfers, creates, utters or converts to the person's own use the personal

identification of another person. As used herein, "personal identification" includes information concerning the individual's name, address, telephone number, Social Security number, employment status, employer and place of employment.

Unlawful trade practices

Unlawful trade practices is a category of crimes that include certain harmful actions taken against consumers. The state implemented laws to protect consumers and prevent businesses and individuals from engaging in such practices. In general, unlawful trade practices include activities where an individual or business seeks to take advantage of consumers for the financial or pecuniary gain of the individual or business. As defined under the law, unlawful trade practices include but are not limited to the following:

- Knowingly taking advantage of a customer's physical infirmity, ignorance, illiteracy or inability to understand the language of an agreement
- Knowingly permitting a customer to enter into a transaction from which the customer will derive no material benefit
- Permitting a customer to enter into a transaction with knowledge that there is no reasonable probability that the customer can pay the financial obligations associated with the transaction when due
- Failure to deliver all or any portion of goods or services as promised, and upon request of the customer, failure to refund any money that has been received from the customer that was for the purchase of the undelivered goods or services and that is not retained by the seller pursuant to any right, claim or defense asserted in good faith
- Passing off goods or services as those of another
- Causing likelihood of confusion or misunderstanding as to the source, sponsorship, approval or certification of goods or services or as to the affiliation, connection or association with or certification by another
- Using deceptive representations or designations of geographic origin in connection with goods or services
- Representing that goods or services have sponsorship, approval, characteristics, uses, benefits, quantities or qualities that they do not have or that a person has a sponsorship, approval, status, qualification, affiliation or connection that the person does not have
- Representing that goods or services are of a particular standard, quality or grade or that goods are of a particular style or model, if they are of another
- Disparaging the goods, services, property or business of a customer or another by false or misleading representations of fact

Unlawful debt collection practices

Any business that engages in transactions in which it sells services to consumers is subject to the laws regarding unlawful debt collection practices. In seeking to collect any amounts owed to it by a consumer, a business (referred to herein as a debtor) is limited in the manner in which it may communicate with the consumer. It shall be an unlawful collection practice for a debtor or anyone acting on behalf of the debtor (referred to herein as a debt collector), while collecting or attempting to collect a debt to do any of the following:

- Use or threaten the use of force or violence to cause physical harm to a debtor or to the debtor's family or property

- Threaten arrest or criminal prosecution
- Threaten the seizure, attachment or sale of a debtor's property when such action can only be taken pursuant to court order without disclosing that prior court proceedings are required
- Use profane, obscene or abusive language in communicating with a debtor or the debtor's family
- Communicate with the debtor or any member of the debtor's family repeatedly or continuously or at times known to be inconvenient to that person with intent to harass or annoy the debtor or any member of the debtor's family
- Communicate or threaten to communicate with a debtor's employer concerning the nature or existence of the debt
- Communicate without the debtor's permission or threaten to communicate with the debtor at the debtor's place of employment if the place is other than the debtor's residence except under certain limited circumstances defined by law
- Communicate with the debtor in writing without clearly identifying the name of the debt collector, the name of the person, if any, for whom the debt collector is attempting to collect the debt and the debt collector's business address on all initial communications. In subsequent communications involving multiple accounts, the debt collector may eliminate the name of the person, if any, for whom the debt collector is attempting to collect the debt and the term "various" may be substituted in its place
- Communicate with the debtor orally without disclosing to the debtor within 30 seconds the name of the individual making the contact and the true purpose thereof
- Cause any expense to the debtor in the form of long-distance telephone calls, telegram fees or other charges incurred by a medium of communication by concealing the true purpose of the debt collector's communication
- Attempt to or threaten to enforce a right or remedy with knowledge or reason to know that the right or remedy does not exist or threaten to take any action that the debt collector in the regular course of business does not take
- Use any form of communication that simulates legal or judicial process or that gives the appearance of being authorized, issued or approved by a governmental agency, governmental official or an attorney at law when it is not in fact so approved or authorized
- Represent that an existing debt may be increased by the addition of attorney fees, investigation fees or any other fees or charges when such fees or charges may not legally be added to the existing debt
- Collect or attempt to collect any interest or any other charges or fees in excess of the actual debt unless they are expressly authorized by the agreement creating the debt or expressly allowed by law
- Threaten to assign or sell the debtor's account with an attending misrepresentation or implication that the debtor would lose any defense to the debt or would be subjected to harsh, vindictive or abusive collection tactics
- Enforce or attempt to enforce an obligation made void and unenforceable by state law

Fraud, waste and abuse plan components

EOCCO's plan to detect and prevent fraud, waste and abuse contains the following components:

Internal activities and controls

EOCCO maintains the following activities and controls within various departments to promote effective utilization of dental and medical resources and to identify potential fraud, waste or abuse occurrences (not inclusive):

- Information system claims edit hierarchy and reference tables
- Post-processing review of claims and other claims analysis activities
- Practitioner credentialing and recredentialing policies and procedures, including on-site reviews
- Practitioner profiling policies and procedures
- Prior authorization policies and procedures (member eligibility verification, medical necessity, appropriateness of service requested for authorization, covered service verification, appropriate referral)
- Utilization management practices, as delineated in EOCCO's Utilization Management Plan for prior authorization, concurrent review, discharge planning, retrospective review
- Quality improvement practices, as delineated in EOCCO's Quality Improvement Plan
- Dental and medical claims review such as appropriateness of services and level(s) of care, reasonable charges, potential excessive over-utilization
- As circumstances warrant, referrals from committees such as Quality Improvement Operations, Dental Quality Improvement, Credentialing and Pharmacy & Therapeutics Committees
- Practitioner and member handbooks language regarding the reporting of potential fraud, waste and abuse occurrences
- Employee training regarding potential fraud, waste and abuse occurrences, detection and reporting. Such training must occur at a least annually and be a part of the orientation for new employees
- Training of contracted providers. First-tier, downstream and related entities that meet the fraud, waste and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste and abuse
- Claims processing manual
- Monitoring of practitioner and member complaints and grievances
- With respect to OHP members, confirmation with a statistically valid portion of the population that services as billed by the provider were actually received by the member. As part of this process, EOCCO will send member verification letters to OHP members and follow-up in the event a timely response is not received

Primary Contact

There is a designated compliance officer for EOCCO, whose sole responsibility is to work to ensure compliance for the company. The compliance officer has direct access to management personnel of all operations of the company, as well as the chief executive officer and board of directors. The compliance officer reports any material issues of fraud, waste and abuse to the board.

EOCCO has established lines of reporting for potential fraud, waste and abuse as defined in the EOCCO Users Procedure Manual. These are communicated to all employees through periodic employee education and training programs. Employees who interact with providers and members receive training in fraud, waste and abuse detection and reporting. Employees are trained to be familiar with the types of

fraud, waste and abuse claims that may be encountered and the steps to report any incident or potential fraud, waste or abuse incident.

Applicability of the plan to agents and contractors

EOCCO's agents and contractors are required to comply with these policies and procedures. EOCCO will provide agents, contractors and subcontractors with written standards of conduct, as well as written policies and procedures that:

- Promote the commitment to compliance on behalf of the agent or contractor
- Require the agent or contractor to address specific areas of potential fraud, such as claims submission process, and financial relationships with employees and permitted subcontractors
- Provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal healthcare programs (as defined in 42 USC 1320a-7b
- Provide as part of the written policies, detailed provisions regarding the agent's or contractor's policies and procedures for detecting and preventing fraud, waste and abuse
- Include in any employee handbook for the agent or contractor a specific discussion of the laws described in the third bullet point of this section, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse

Reporting suspected fraud, waste or abuse

Each EOCCO employee, provider, agent and contractor has an obligation to report suspected fraud, waste or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, provider or member. When an employee suspects fraud, waste or abuse, the employee should submit a report through one of the following reporting processes:

- Via phone or online through EthicsPoint
- By completing an EOCCO Investigations Referral Form
- By submitting a report via phone or email to EOCCO's Special Investigations Unit or the Compliance Officer

The fraud hotline for non-Medicare matters is (855) 801-2991 and the fraud hotline for Medicare maters is (855) 801-2992. Email reports may be submitted to the Special Investigation Unit at stopfraud@modahealth.com or to the Compliance Officer at compliance@eocco.com.

EOCCO members, agents, contractors and other parties who would like to report suspected fraud, waste or abuse may submit a report through EthicsPoint or through use of the toll-free numbers and email address for the Special Investigations Unit noted above. This will ensure the confidentiality of the report.

Fraud, waste and abuse investigations

When conducting an investigation within the scope of this policy, EOCCO personnel have the right to access practitioner, member and employee records necessary to audit or conduct an investigation into

allegations of fraud, waste or abuse. This right to audit or inspect does not extend to information subject to legal privilege.

The following summary provides a general overview of the steps typically taken when EOCCO receives a report of suspected fraud, waste or abuse, though additional steps may be necessary depending on the circumstances of each case.

Member or provider fraud

When member fraud, waste or abuse is reported, upon receipt of Referral Form (See Attachment A) or other communication, the EOCCO Special Investigations Unit shall perform an audit of the relevant materials to determine if a preliminary case of fraud, waste or abuse is detected. As part of this audit, the Special Investigations Unit may:

- Review member demographic or provider database information
- Review member claims or other claims submitted by the provider to identify existence and scope of possible fraudulent activity
- Contact other EOCCO departments for relevant information or obtain necessary information from outside sources, including the billing or treating provider
- Analyze encounter data, billing, medical or dental procedure coding, or other information as circumstances warrant to develop data for further analysis and decision
- Review assembled case file information and make a referral assessment decision. If the circumstances and data warrant referral to an outside entity, the Special Investigations Unit will forward information to the appropriate city, county, state or federal regulatory agencies or forward OHP plan information to the Oregon Department of Justice's Medicaid Fraud Control Unit, the Program Integrity Audit Unit or the appropriate state or federal regulatory agency. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will be included in the file and the case will be closed
- Provide feedback to originator and management, as appropriate

Employees

If an employee, agent or contractor suspects that an EOCCO employee has engaged in fraud, waste or abuse, the individual should immediately report the incident to the employee's supervisor (if known) or to the EOCCO Human Resources department. Such reports may also be submitted through EthicsPoint at (866) 297-0224 or www.ethicspoint.com. Appropriate disciplinary action, up to and including immediate termination of employment, is taken against employees who have violated EOCCO fraud, waste and abuse policies, applicable statutes, regulations, or federal or state healthcare program requirements.

Confidentiality of investigation

Information identified, researched or obtained for or as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used or developed by participants in the investigation of a potential fraud, waste or abuse occurrence is maintained solely for this specific purpose and no other. EOCCO ensures the anonymity of complainants to the extent permitted by law. EOCCO is responsible for maintaining the confidentiality of all potential fraud, waste and abuse information identified, researched or obtained, in accordance with the terms and conditions of EOCCO's Confidentiality Policy.

EOCCO will not permit or tolerate any form of retaliation or intimidation toward an individual who, in good faith, reports an incident of suspected fraud, waste or abuse, including but not limited to reporting potential issues; investigating issues; conducting self-evaluations, audits and remedial actions; and reporting to appropriate officials. Any employee who attempts to retaliate against or intimidate an individual who has reported suspected fraud, waste or abuse will be subject to disciplinary action up to and including termination of employment. If an agent or contractor of EOCCO commits the act of retaliation or intimidation, the continued participation of such agent or contractor of EOCCO will be evaluated and, if warranted, the relationship with such agent or contractor will be terminated.

Corrective action plans

If fraud, waste or abuse is discovered, EOCCO will develop a corrective action plan designed to correct or eliminate the cause of the fraud. In certain instances, EOCCO may need to work with and obtain approval from appropriate external agencies in developing the scope of any such corrective action plan.

Coordination with external agencies

The EOCCO Special Investigations Unit, along with Legal and Regulatory Affairs, coordinates all information requests and reporting, whether initiated internally or externally. EOCCO promptly refers all suspected cases of fraud, waste and abuse by groups, members, practitioners and employees of the organization to the appropriate regulatory agencies for further investigation. In addition, EOCCO assists various governmental agencies as practical in providing information and other resources during the course of investigations of potential practitioner or member fraud or abuse. These agencies include but are not limited to city, county, state and federal agencies; the Program Integrity Audit Unit; the Medicaid Fraud Control Unit of the Oregon Attorney Generals' Office; and the United States Office of the Inspector General.

EOCCO should self-report any suspected or potential cases of fraud, waste or abuse involving Medicare or Medicaid to CMS or the applicable state agency, including instances of member fraud. EOCCO may disenroll an individual from its Medicare Advantage plans if the individual knowingly provides on the election form fraudulent information that materially affects the individual's eligibility to enroll in the Medicare Advantage plan or if the individual intentionally permits others to use his or her enrollment card to obtain services under the Medicare Advantage plan. If a Medicare Advantage member is disenrolled for fraud or abuse, EOCCO must report any such disenrollment to CMS. An individual who is disenrolled for fraud or abuse will be considered to have elected original Medicare.

If EOCCO disenrolls a member or terminates a provider because of an illegal act, including member or provider Medicaid fraud, EOCCO shall report such disenrollment or suspected fraud to the OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR 455.13. Such reports shall be submitted to the Fraud hotline 888-FRAUD01 (888-372-8301) or online at www.apps.state.or.us/cf1/OPR_Fraud_Ref/index.cfm?act=evt.subm_web.

Suspended, debarred and excluded practitioners

Participating practitioner contracts stipulate practitioner responsibilities to comply with all applicable federal, state and local laws, rules and regulations to maintain and furnish records and documents as

required by law. Practitioners who are found to have violated a state or federal law regarding fraud, waste and abuse are often suspended, debarred or excluded from participation in federal programs, and thus, such practitioner's participating provider agreement with EOCCO will likely terminate.
Except in very limited circumstances (i.e., provision of emergency services, sole source provider), the following individuals or entities may not be reimbursed from federal funds for otherwise covered services provided to EOCCO members:

- Practitioners who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order
- People or entities that are currently suspended or terminated from OMAP or excluded from participation in the Medicare program
- People who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII or Title XX of the Social Security Act or related laws (or entered a plea of nolo contendere)

EOCCO does not refer members to such suspended or terminated practitioners and does not accept billings for services to EOCCO members submitted by such practitioners.

Conflict of Interest Requirements

Ownership/Control Interest Disclosures

EOCCO, as a Coordinated Care Organization (CCO), must comply with all federal and state laws, statutes, regulations, and guidelines including disclosure requirements for potential and actual conflicts of interests with the providers and hospitals with which it contracts to provide care to its Oregon Health Plan (OHP) members. As a CCO, EOCCO must require each Participating Provider and Participating Hospital to disclose any (1) person or entity with an ownership or control interest of 5% or more of the Participating Provider/Hospital; (2) any subcontractor and/or supplier with which the Participating Provider/Hospital contracts to provide services to EOCCO patients AND which the Participating Provider/Hospital has an ownership or control interest of 5% or more; and (3) the extent to which there are familial relations (spouse, parent, child, or other family members by marriage or otherwise) between the Participating Provider or managing employee of a Participating Hospital and any managing employee of a subcontractor/supplier under (2) above. Under this policy, a disclosing entity does not have a financial interest in a transaction or arrangement solely because that person is employed by an organization that receives remuneration in the form of claims payment, risk model returns, grants or other services provided by EOCCO through the course of normal business activities.
In the sections below, EOCCO has provided a list of helpful definitions, instructions on how to disclose, and timelines for disclosure.

Definitions

Disclosing Entity - A Participating Provider and/or Participating Hospital for purposes of disclosures obligations to EOCCO
Indirect Ownership - An ownership interest in any entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity

Managing Employee Any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency

Person with an Ownership or Control Interest - Any person or corporation that –

a. Has an ownership interest totaling 5 percent or more in the disclosing entity

b. Has an indirect ownership interest equal to 5 percent or more in the disclosing entity

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in the disclosing entity

d. Owns an interest of 5 percent or more in any mortgage, deed, trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value` of the property or assets of the disclosing entity

e. Is an officer or director of a disclosing entity that is organized as a corporation; or

f. Is a partner in a disclosing entity that is organized as a partnership [42 CFR 422.101]

Subcontractor- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients

Supplier - An individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid

Disclosure Requirements

If an actual or potential conflict exists each Participating Provider and/or Participating Hospital must disclose the following information to EOCCO in accordance with the timelines listed in the following section "Timelines and Manner of Disclosure".

1. The name and address of each Person with an Ownership or Control Interest in the Disclosing Entity or

2. The name and address of each Person with an Ownership or Control Interest in any Subcontractor with which the Disclosing Entity has a direct or indirect ownership of 5% or more;

3. Date of birth and SSN (in the case of an individual)

4. Tax identification number (in the case of a corporation)

5. Whether any of the persons named above in (1) of this section, is related to another as a spouse, parent, child, or sibling.

6. The name of any other disclosing entity in which a person with an ownership or control interest in the Disclosing Entity also has an ownership or control interest. This requirement applies only to the extent that the Disclosing Entity can obtain this information by requesting it in writing from the person. Please note that the Disclosing entity must:

(i) keep all copies of the request and response to them;

(ii) make them available to EOCCO, the Oregon surveying agency, or Oregon Health Authority upon request; and

(iii) advise EOCCO and/or Oregon Health Authority when there is no response to the request

Timeline and Manner of Disclosure

The information in the Disclosure Requirements section must be provided to EOCCO as follows:

1. At the time of initial contracting between EOCCO and the Participating Provider and/or Hospital or upon re-contracting between the same;

2. Within 25 calendar days of a written request from EOCCO as a result of a request by Oregon Health Authority or a state-engaged survey agency;
3. Within 10 business days of an addition or change to any of the disclosures previously provided by the Participating Provider and/or Hospital

The disclosures may be provided on the Participating Provider Disclosure Statement Form available at www.eocco.com/providers/forms and sent to EOCCO via the mail, fax, or email listed below:

Mail:

EOCCO, Inc.
Attn: Medicaid Compliance Officer
601 SW Second Ave
Portland, OR 97003

Fax:

503-412-4068

Email:

compliance@eocco.com

eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

601 SW Second Avenue
Portland, Oregon 97204-3156

503-765-3521 or 888-788-9821

Visit our website: **www.eocco.com**