

TUALITY HEALTH ALLIANCE

Provider Manual

January 1, 2010

Our mission is to facilitate quality, cost effective health care to the community.

Customer Service 503.844.8104

Prior Authorization fax503.681.1823



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Hillsboro, OR 97123**

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Welcome!

We are delighted that you have chosen us to help you bring quality care and services to your patients.

Tuality Health Alliance (THA) assembled this manual to give participating physicians and providers helpful and reliable information that you may need when working with THA. It is your desktop reference for information about our policies and procedures and can be used as a training tool when familiarizing new employees. Keep in mind that this is a dynamic resource and we will do our best to keep it updated. In addition to this provider manual, we will be sending you copies of our provider newsletter, and member newsletter.

Our goal is to treat professional providers, patients, hospitals and clinics, as we would like to be treated. That means we process claims quickly and our customer service staff is helpful, knowledgeable and even goes the extra mile for you.

If at any time you feel uncertain about a particular policy or procedure, please contact Customer Service for information. We value the partnership with our participating providers and appreciate the important role that each of you play.

Mission

Our mission is to facilitate quality, cost effective health care to the community.

We believe that compassion encourages healing, that knowledge is the foundation of wellness, and that attention to quality and fiscal stability will enable us to continue service to the community.

Our Values:

- Quality
- Compassion
- Integrity
- Customer satisfaction
- Commitment
- Fiscal responsibility

History of Tuality Health Alliance

Tuality Health Alliance (THA) is a physician-hospital-community organization (PHCO) dedicated to providing quality, community based care. This partnership is with Tuality Healthcare and includes Tuality Community Hospital, the local physicians and community members. The Board of Directors is comprised of physicians, community leaders and Tuality Healthcare staff. The Board oversees the work of two physician led committees that help set policy for the group. THA physician membership includes approximately 71 primary-care physicians and 200 specialists.

THA was first formed in 1994 as a fully capitated health plan for Oregon Health Plan (OHP) members in Western Washington County. THA is not an insurance company. THA's main goal in participating in this contract was to assist in managing a vulnerable population in our community and provide quality care. It also allowed THA to develop guidelines for member providers that ensured maximum participation from the community physicians. Most importantly, we could locally manage care, control utilization through an effective referral and authorization process and develop unique payment arrangements.

In 2008 THA became the Administrator for our Employee benefit plan known as Tuality Select Plan. This plan covers all Tuality employees and their families. Claims are paid through THA and medical management is done through Innovative Care Management.

THA also contracts on behalf of the physicians and the hospital with many of the Insurers and Managed Care Organizations operating in our service area. These include Aetna, First Health/CCN, First Choice Health, Health Net Health Plan of Oregon, Health Maintenance of Oregon, ODS Health Plan, PacifiCare of Oregon, PacificSource Health Plan, Providence Medicare Extra, Regence Blue Cross Blue Shield of Oregon, United HealthCare and Three Rivers Network. THA also directly contracts on behalf of Tuality Healthcare's Employee Benefits (Select) Plan. Over 1,000 referral specialist and five hospitals are also available for our OHP clients through contractual arrangements for specialty care that is not available in our immediate service area.

THA administrative staff provides medical management, delegated credentialing and quality improvement services to a variety of these contracted plans.

All of the partners within THA work to help ensure a focus on providing the best possible quality of care. Our goals include using appropriate standards and innovation to stretch limited healthcare dollars and support evidence based medicine. THA represents the interest of patients, physicians and other care providers who live and work in Western Washington County. We work to ensure

consistency in contract language and administrative requirements across multiple Health Plans and Insurers. This helps to reduce administrative costs and time, and it provides a structure and collective “voice” for local health care.

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Exceptional Needs Care Coordinator

Tuality Health Alliance is required by the Department of Medical Assistance Programs (DMAP) to provide Exceptional Needs Care Coordination (ENCC) to all members who have complex, exceptional, or special needs including those whose behavior affects their ability to appropriately obtain, maintain, and access medical care and services. This also includes members with special needs, challenging behaviors, mental and physical disabilities, alcohol/chemical dependencies, and others who may be vulnerable, fragile, or at-risk. These services will be provided while ensuring that dignity, confidentiality, and specific disability issues related to the member’s medical, social, and quality of life issues are respected.

Exceptional Needs Care Coordination services include:

- Assisting members as a Patient Advocate
- Assisting all members in obtaining care and services
- Assisting providers with patients who are non-compliant or disruptive

The Nurse Case Managers will:

- Work with the member and provider to identify and assess barriers to compliance
- Initiate the appropriate intervention such as provider and/or member education and provide active listening
- Be available to facilitate care conferences and initiate patient behavior contracts
- Work with the provider to complete member disenrollment from the practice as appropriate and work with the member to establish care with a new provider
- Document activity, follow through and proceed with member disenrollment from Tuality Health Alliance, as appropriate

For assistance, call Tuality Health Alliance Customer Service at (503) 844-8104, and request to speak with an Exceptional Needs Care Coordinator.

Member Rights & Responsibilities

In keeping with our commitment to provide the highest quality healthcare services to our members, Tuality Health Alliance acknowledges the importance of accountability and cooperation. We have a relationship of mutual respect among our members, practitioners, and the health plans. We also know that a quality health plan acts on new ideas and the changing needs of its members. Our member's rights and responsibilities are listed below.

Tuality Health Alliance Members have the **right** to:

- Be treated with respect and with due consideration for his or her dignity and privacy
- Be treated by providers the same as other people seeking health care services
- Choose a Primary Care Physician as permitted in OAR 410-141-0060 or service site with the right to change those choices as permitted in OAR 410-141-0840
- Refer directly to mental health, chemical dependency or family planning services without getting a referral from a Primary Care Physician (PCP)
- Have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- Be actively involved in the development of his/her treatment plan
- Be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s)
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand regardless of cost or benefit coverage
- Participate in the consent for treatment or to refuse services, and to be told the consequences of that decision, except for court ordered services
- Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- Have written materials explained in a manner that is understandable to the member. This includes enrollment notices, informational materials, and instructional materials relating to members or potential members in the prevalent non-English languages when indicated
- Receive necessary and reasonable services to diagnose the presenting condition
- Receive covered services, which meet generally accepted standards of practice and are medically appropriate
- Obtain covered preventive services

- Have access to urgent and emergency services 24 hours a day, 7 days a week
- Receive a referral to specialty providers for medically appropriate covered services
- Have a clinical record maintained which documents conditions, services received, and referrals made
- Have access to one's own medical record, unless restricted by statute
- Transfer a copy of his/her medical record to another provider
- Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health treatment and the right to execute directives and power of attorney for health care
- Receive written notice before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations
- Know how to make a complaint with THA and receive a response as defined in OAR-410-141-0260 through 0266
- Request an administrative hearing with the Department of Human Services
- Receive interpreter services free of charge
- Receive notice of an appointment cancellation in a timely manner
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion

Tuality Health Alliance Members have the **responsibility** to:

- Choose, or help with assignment to a Primary Care Physician (PCP)
- Treat the PCP and clinic staff with respect
- Be on time for appointments made with practitioners and other providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late
- Seek periodic health exams and preventive services from his/her PCP
- Use his/her PCP for diagnostic care before seeking care from a specialist unless self-referral to the specialist is allowed
- Obtain a referral to a specialist from their PCP before seeking care from a specialist unless self-referral to the specialist is allowed
- Use urgent and emergency care appropriately and notify THA within 72 hours of an emergency
- Give accurate information for inclusion in the medical record
- Help the practitioner obtain medical records from other providers which may include signing a release of information
- Ask questions about their conditions, treatments and other issues related to his/her care that is not understood
- Use information to make informed decisions about treatment before it is given
- Help in the creation of a treatment plan with the PCP
- Follow the prescribed agreed upon treatment plans

- Tell the PCP that his/her health care is covered under the Oregon Health Plan before services are received and to show the PCP or other provider the DMAP Medical Care Identification form
- Notify the Department of Human Services (DHS) worker of a change of address or phone number
- Tell the DHS worker if the member becomes pregnant and to notify the DHS worker of the birth of the member's child
- Tell the DHS worker if any family members move in or out of the household
- Tell the DHS 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
- Assist THA in pursuing any third party resources available and to pay THA the amount of benefits paid for an injury from any recovery received from that injury
- Bring issues or complaints to the attention to THA
- Sign a release so the DHS and THA can get information that is pertinent and needed to respond to an Administration Hearing request in an effective and efficient manner

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Tuality Health Alliance (THA) provides for access to medical care and all communication needs of those patients requiring assistance. Communication needs would include, but not be limited to, non-English speaking, vision or hearing impaired or other disabled needs.

Tuality HealthCare has contracted for Interpreter Services for our THA/OHP Members with these companies.

Interpreter Service	Type of Interpreting	Phone Number
Passport to Languages	All Languages – On Site	503-297-2707 After hours 877-722-2090
Certified Language Interpreters (CLI)	All languages, including in-person and deaf interpreting	1-800-225-5254 Access Code: TUALIT
Pacific Interpreters	All languages - Telephonic	1-800-264-1552
Sprint Relay	TTY - Hearing impaired	1-800-735-2900

Tuality Health Alliance regularly monitors the prevalence (other than English & Spanish) of languages in our enrollee population to identify the need to translate member materials into additional languages. Providers can order these materials

to have available for their patients by calling THA at (503)844-8104. Examples of health promotions and education materials include:

- Tobacco cessation materials
- Pregnancy materials
- Diabetes Education
- Asthma Education
- Member Handbook

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Emergency & Urgent Care

An emergency condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual (including self inflicted harm) or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency services are covered by THA if they are:

- Furnished by a provider qualified to provide emergency services; and
- Needed to evaluate or stabilize an emergency medical condition

Members with an emergency condition should be instructed to go to the nearest emergency provider.

If a member is traveling out of state and has an emergency, they should go to the nearest emergency room or call 9-1-1. Emergency services are only authorized as long as the emergency exists. If further care is required, the facility needs to contact Tuality Health Alliance.

Members who need urgent (but not emergent) care are advised to call their Primary Care Provider prior to obtaining urgently needed services.

Urgently needed services are covered services that are not emergency services and provided when:

- The member is temporarily out of area; and
- When such services are medically necessary and immediately required:
 - As a result of an unforeseen illness, injury, or condition; and
 - It is not reasonable given the circumstances, to obtain the service through a participating facility

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24 – Hour Coverage

Primary Care Providers are expected to provide coverage for THA members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers.

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Hospital Services

Non-emergent inpatient admissions require prior authorization from THA. If you are a Primary Care Provider, please contact THA as soon as you are aware of the planned admission of a member. Hospital personnel working with THA's Nurse Case Managers often carry out notifications of urgent or unscheduled admissions. These are RNs who work with admitting providers and hospital based physicians (hospitalists) to ensure members are receiving appropriate care and discharge planning. Our Case Managers will be of assistance in coordinating all services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding PCP.

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Member Accessibility

It is the policy of Tuality Health Alliance to ensure that our members have access to timely, appropriate preventive and curative health services that are delivered in a patient-friendly and culturally competent manner.

Provider offices are encouraged to have a triage system in place to provide access to medical care appropriate to the level of treatment needed. It is encouraged that the scheduling of appointments adheres to the following:

Regular and routine care appointments for members are scheduled within four weeks of request. A routine visit is defined as preventive or asymptomatic follow-up. This includes provider-directed or clinic-scheduled follow-up for a stable or chronic condition.

- Appointments may be scheduled Monday through Friday during normal business hours
- Patients may be scheduled by a telephone call (or visit) to the PCP's office during the weekdays
- If a wait of over 45 minutes from the time of a scheduled appointment is anticipated, members shall be afforded the opportunity to reschedule the

appointment. If a member does not keep the scheduled appointment time and arrives more than 15 minutes late without prior notification to the PCP office, then this time frame could increase based upon the patient load that day or the patient may be rescheduled

Members with urgent needs are encouraged to be seen within 48 hours or as indicated by initial screening. An urgent need is defined as an unforeseen illness or injury that is severe or painful enough to require treatment within 24 hours, but will not result in loss of life or limb.

- Appointment requests, which are determined to be “urgent”, will be triaged by the appropriate PCP office personnel to evaluate the patient complaint. A determination of the urgency of the patient need will result in scheduling within 24 hours and/or referral to another alternative setting to allow for immediate treatment
- The patient may contact the PCP office during normal office hours to be scheduled under the above guidelines
- After hours, the patient may contact the PCP through their medical exchange to advise of an urgent need. The PCP or their on-call representative will determine whether the patient is to be seen in the office the following day; whether to refer the patient to an urgent care setting; or whether to refer the patient to the emergency room
- THA Case Management will assist physicians with members that fail to keep scheduled appointments. The Case Manager will identify why appointments are not kept, and provide outreach and support services as appropriate

Walk In - Appointment / Scheduling:

- When a walk-in patient presents at their PCP’s office with a medical issue, trained office personnel who will triage the patient’s need and assess the urgency of the physician/patient appointment will assess the patient. The patient may also be redirected to a mental or dental health provider as appropriate
- If the member cannot be seen by their designated PCP and is referred to their on-call coverage or back-up, information about the visit, treatment and any other relevant information will be returned to the PCP upon completion of the visit and follow-up visit should be scheduled with the designated PCP

Tuality Health Alliance conducts routine monitoring of the scheduling of member appointments and after hours access in conjunction with the review of the provider office medical records. Additional monitoring activities include:

- Medical Record Audit
- Site Survey
- Member Satisfaction Surveys

- Member Complaints

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Provider Responsibility

When the Primary Care Provider is making a referral to a specialist, the PCP should check the THA online Provider Directory at www.payerconnection.com/tha to ensure the specialist is a participating provider within Tuality Health Alliance.

The PCP should provide the referral specialist with the following clinical information:

- Members name
- Referring Primary Care Provider/Mental Health Provider
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

The PCP should notify Tuality Health Alliance regarding the specialist referral. The notification should include the following information:

- PCP's name
- Member's name
- Subscriber's ID number
- Specialist's name
- Primary diagnosis
- Indication of "Consult Only" or "Consult and Management"
- Pertinent information

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Preventive Care

Tuality Health Alliance physicians need to provide Preventive Services, which are those services promoting health and/or reducing the risk of disease or illness. Such services include, but are not limited to:

- Periodic medical examinations based on age, sex and other risk factors
- Screening tests
- Immunizations
- Counseling regarding behavioral risk factors

Missed Appointments

Tuality Health Alliance physicians may terminate a member's care per their office policy as long as the policy applies the same to all members.

If there is no policy in place, THA's policy states you may terminate care after three (3) missed appointments.

Provider must implement the following before terminating:

- Mails missed appointment letter
- Documents the missed appointment and recall efforts in the patient's medical record
- Attempts to reschedule appointment as medically necessary

After terminating member from practice, notification must be mailed to the member and a copy to the appropriate nurse case manager at THA for assistance in facilitating care.

THA/ OHP Referral & Authorization Guidelines

Referral and authorization processes have been developed to assess, monitor, and ensure compliance with guidelines, medical review criteria, and to assess the impact of resource utilization on clinical outcomes.

When the PCP feels it is necessary to refer a patient to another provider, specialist, or lab, care should be taken to refer the patient to a participating provider. The criteria are as follows:

- All members need to be seen by a Primary Care Physician during the previous year and there must be some type of written communication that demonstrates medical necessity for the request
- The THA PCP/Specialist Communication/Referral Form must be used and filled out completely for those services that require a referral
- Providers should submit requests for "urgent" or "expedited" referrals or pre-authorizations to the THA Referral office on the referral form (by checking "Expedite") via fax or phone. The THA Referral Specialist or THA Case Manager will approve the request or immediately contact the THA Medical Director for a determination

- The THA Pre-Authorization list is utilized for THA/OHP. InterQual Criteria is utilized for establishing medical necessity and standards for length of stay. Specific health plan criteria may also be used as a reference
- Pre-authorization requests must be current and complete in order to provide timely responses to providers and members. A summary of pertinent clinical history and other data is required. Copies of legible office notes, lab or radiology reports, consults, etc. may be used. The patient's name and health plan identification number must be clear on all papers

The following services require pre-authorization:

- Out of plan (Non-Contracted) Specialist
- THA Full & Associate Specialist
 - Plastic Surgery procedures
 - Neurosurgery procedures
 - Pet Scan
 - Gamma Knife Therapy
 - Thoracic Surgeons
 - Blepharoplasty
 - Back Surgery
 - Outpatient Therapies (Home Health as 1 eval + Visit)
 - Home Infusion Service
 - Pain Management referrals
 - Neuro-Psychology
 - Requests for procedures for members who have DMAP with the Standard Plan
 - Genetic Testing
 - Hemophilia
 - Hysterectomies
 - Tubal Ligations/Vasectomies
 - All Durable Medical Equipment, Orthopedic braces and prosthetics (TMES has exceptions)
 - Chemical Dependency Inpatient Detox (4 days Max)
- In-patient & out-patient procedures

When THA does not have appropriate THA Contracted Specialists, certain out of plan specialists will be authorized when necessary. Case Managers will authorize these referrals according to established Referral Guidelines. The specialist must have an authorization numbers in order for THA to consider reimbursement for services rendered. A pre-authorization list is available upon request.

Chemical dependency services include diagnosis and treatment of alcohol and drug addictions. These services are provided to all Tuality Health Alliance members through any participating provider. Tuality Health Alliance covers the chemical dependency benefit.

Accessing Chemical Dependency Services:

- Members do not need a PCP referral in order to access chemical dependency services
- Members can self refer to any of Tuality Health Alliance contracted chemical dependency provider for an assessment
- Tuality Health Alliance members receive a Member Handbook at the time of their enrollment. This handbook gives them information regarding their chemical dependency benefits and how to access care. The Member may also contact Customer Service for additional information on available chemical dependency providers.
- Any provider who recognizes a chemical dependency problem in the course of caring for a THA member can assist the member in accessing care by contacting Tuality Health Alliance Nurse Case Manager to coordinate an assessment
- At the assessment, a screening evaluation is done to determine the appropriate level of service (outpatient treatment, methadone maintenance, or inpatient detox) warranted

Authorization of Services:

- No prior authorization is required for outpatient drug and alcohol treatment as defined under the DMAP Guidelines including Level 1 and Level 2 and this includes methadone treatment
- Medically Monitored Detoxification (Level 3.7D) requires an authorization by Tuality Health Alliance

Other Chemical Dependency Services:

- Other chemical dependency services, such as residential treatment, may be available to members through various public and/or private providers. However, these services are not included in the Oregon Health Plan benefit package and are not covered by Tuality Health Alliance

THA's Nurse Case Managers facilitates and collaborates with Washington County Mental Health Department to assure members receive appropriate medical treatment associated with mental health needs.

Tuality Health Alliance monitors utilization data for THA/OHP members and analyzes all data collected to detect under and over utilization.

Analysis is performed at least annually and includes:

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

Under or over-utilization thresholds

- HEDIS, CAHPS, OPIC or DHS data
- Length of Stay Data
- Member complaints and appeals

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

THA may provide utilization pattern reports to THA physicians in an effort to educate and assist them in implementing strategies to achieve appropriate utilization.

In the event there are problems of under and over utilization identified, THA will work with the physician, develop an action plan and re-evaluate the measures of the interventions to ensure effectiveness with the action plan.

All THA staff sign annual Conflict of Interest and Confidentiality Statements and financial incentive statements describing those staff and providers who make utilization related decisions and those who supervise them.

- Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage
- THA does not specifically reward physicians or other individuals conducting utilization review for issuing denials of coverage or service care
- There are no financial incentives for UM decision makers

306 Participation in Quality Management Program

Participation in the QM program is a requirement for all practitioners and organizational providers. Participation includes providing data for various QM activities and adhering to established standards of care.

Provider and member input into the delivery system is encouraged and made available through participation in appropriate committees. For information on the committees or if there is interest in participation, please contact the Provider

Relations/Contracting Specialist at (503) 681-1166 or the Medical Services Manager (503) 681-1397.

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Pharmacy Management

The Tuality Health Alliance Formulary has been developed to promote cost effective prescribing for conditions covered under the Oregon Health Plan. THA includes a prescription drug benefit. A comprehensive pharmacy services program is provided that includes utilization management, broad access to pharmacy services, technology assessment, cost management strategies, quality assurance, and overall member satisfaction.

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Using the Formulary

The drug formulary is a list of drugs that are covered under THA's benefits for eligible members.

The formulary is available:

- In online and downloadable formats to your desk top at www.epocrates.com
- On the THA website
- Also available in print form upon request

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

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Giving Feedback on the Formulary

Providers are encouraged to give suggestions, comments or concerns to the Medical Director at Tuality Health Alliance. You may contact the Medical Director at 503-681-1569, via email at walter.hardin@tuality.org or mail your input to:

Tuality Health Alliance
Attn: Medical Director
P.O. Box 925
Hillsboro, Or 97123

Contracted Pharmacies

Tuality Health Alliance contracts with the majority of the chain pharmacies as well as other local pharmacies; these are all available to our THA/OHP members and are located within three to five miles of member's place of residence.

You may obtain a list of contracted pharmacies by visiting our website at www.payerconnection.com/tha

A list of contracted pharmacies is also provided to the member by means of the Member Handbook when they become enrolled with Tuality Health Alliance.

Prior Authorization Process – Pharmacy

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

For drugs listed in the formulary with Step Therapy (ST), the member must follow Step Therapy Guidelines prior to approval of that medication. Step Therapy Guidelines require a member to try and fail, or simultaneously utilize other medications, prior to approval.

For drugs listed in the formulary with quantity limited (QLL), a prior authorization is required once the limit has been reached for quantities over the monthly allowable. To prevent delays in filling the prescription the provider or pharmacy ? can:

- Fax a completed Medication Request Form to (503) 681-1823. This form can be called customer service at (503) 681-8104
- Tuality Health Alliance will fax an authorization or denial letter back to the prescriber within 48 hours.

The following criteria will be applied when considering a request for a non-formulary drug:

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

410 Process for Injectables Through Specialty Pharmacies

Tuality Health Alliance in conjunction with Specialty Pharmacies has a program in place for High Cost/Self Injectables. This program significantly reduces the cost of injectables as well as provide ease of use for the member and the physician.

You can administer the medication in your office to provide oversight of your patient's health, or it can be sent directly to the patient's home. The medication and supplies necessary to administer the drug will be labeled specifically for each patient and delivered to your office or their residence within 24-48 hours after ordering.

Cura Scripts staff is available 24 hours a day, 365 days a year for:

- Phone in prescription to 1-888-773-7386
- Fax in prescription to 1-888-773-7376 using their Prescription Enrollment Form
- Consultation with an experienced pharmacist specially trained in injectable drugs
- Patient support and service from pharmacist and customer service staff

Provider or patient would need to contact Tuality Health Alliance at 503-844-8104 to obtain a prior authorization before ordering any drug through this program.

This program provides the following advantages to your injectable patients:

- Enhanced compliance to prescribed therapy
- Injectable drug refill reminders and a convenient drug re-order process

If you have further questions please contact Tuality Health Alliance at 503-844-8104 for more information.

500 Advance Directives

Tuality Health Alliance must inform its members about advance directives to comply with federal and state legislation regarding a patient's right to know about advance directives.

The Tuality Health Alliance Member Handbook contains information for members about advance directives and how to obtain copies of them.

Members or providers can call Tuality Health Alliance Customer Service to obtain copies of advance directives and instructions on completing them. The forms are available in languages other than English or Spanish upon request.

Tuality Health Alliance primary care physicians and/or referral specialist are responsible for keeping copies of members completed advance directives in their medical records.

600 Identification Card & Coverage Verification

Tuality Health Alliance members will receive a THA Identification (ID) Card in addition to their DMAP Identification Card. The THA ID Card contains the member's name, member number, and Primary Care Provider (PCP) name.

At each office visit, your office staff should:

- Ask for the member's ID card and have a copy of both sides in the member's office file
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- Verify eligibility (prior to services being rendered) using Tuality Health Alliance website www.payerconnection.com/tha or (the state's website)

602 Claims Process

The goal of Tuality Health Alliance is to pay all clean claims within the first fourteen (14) business days of receipt. Other claims requiring additional review and/or information are to be paid within forty-five (45) days of receipt.

Tuality Health Alliance can process and receive professional and institutional claims electronically or by mail. For questions regarding electronic claims contact Customer Service at 503-681-4213.

Participating Providers should submit claims to the Tuality Health Alliance claims address as soon as possible after service is rendered, using the standard CMS-1500 Claim Form for professional claims and the UB-92 (or UB04?) form for facility and/or hospital claims or electronically as discussed above. Claims should be submitted within one hundred and twenty (120) days of service. Exceptions would include the following:

- Errors causing the provider not to be able to bill
- Court or hearing officer orders payment
- When a client is determined to be retroactively eligible for coverage
- When THA is secondary

To expedite claims payment, identify the following items on your claims:

- Referral number (on specialists that require referrals)
- Member name
- Member address
- Member's DMAP ID Number
- Member's date of birth and sex
- Indication of: a) job-related injury or illness, or b) accident-related illness or injury, including pertinent details
- ICD-9 Diagnosis Codes
- CPT-4 Procedure Codes
- Date of services
- Charge for each service
- Provider's Tax Identification Number
- Provider's DMAP number
- Provider's NPI Number
- Place of Service Code
- Attach EOB if THA is secondary

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Coordination of Benefits

The 120-day timely filing rule begins on the Medicare Remittance date.

If there is a primary carrier, such as Medicare or private insurance, that carrier's Explanation of Benefits should be submitted with the claim as soon as the EOB is received.

606

Claims Dispute

You may dispute a claim payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact Tuality Health Alliance Customer Service Department.

608

Billing the Member

State and federal regulations prohibit billing Oregon Health Plan members for OHP covered services.

- Members cannot be billed for covered services that were denied due to a lack of referral or authorization
- Members cannot be billed for covered services that were denied because the member was assigned to a PCP other than the one who rendered the services

- Members cannot be “balance billed” for the amount not paid to the provider by Tuality Health Alliance

There are only two circumstances when a provider may legally bill an Oregon Health Plan recipient (see DMAP General Rules, rule 410-120-1280 at http://www.sos.state.or.us/archives/rules/number_index.html).

A provider may bill a member if the service provided is not covered by OHP and the member signed a DMAP approved waiver before he or she was seen

- The waiver must include the specific service that is not covered under the OHP, 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 provider may also bill a member if the member did not tell the provider that he or she had Medicaid 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 non-insurance.
- Merely billing or sending a statement to a member does not constitute an attempt to obtain insurance information.

700 Compliance Process

Participating providers acting within the lawful scope of practice are encouraged to advise patients who are members of Tuality Health Alliance about:

- The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; and
- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions
- Advanced Directives and Declaration of Mental Health Treatment

702 Marketing

Participating providers may not develop and use any materials that market Tuality Health Alliance without the prior approval of THA.

Termination of Membership

Physicians may resign from membership at any time by giving written notice to the Alliance of the date of termination, which date must be at least sixty (60) days after the date the notice is delivered to the Alliance. Alliance may terminate Physician's membership in the manner provided for in the Alliance Bylaws.

706 Notification to Members of Providers Termination

Tuality Health Alliance will make a good faith effort to provide written notice of a termination of a participating provider to all members who are patients seen on a regular basis by that provider at least thirty (30) calendar days before the termination effective date regardless of the reason for the termination. THA will notify all members who are patients of that PCP of the termination and assist with identifying a new PCP.

708 Credentialing

Providers must complete a credentialing application when contracting with Tuality Health Alliance.

Providers who are subject to the credentialing process include:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Nurse Practitioner
- Licensed Independent Practitioners such as physical therapists, occupational therapists, speech therapists
- Facilities, e.g. acute care hospitals, skilled nursing facilities, durable medical equipment companies

Newly credentialed providers are credentialed provisionally their first year.

Credentialed providers must submit recredentialing information between the second and third year.

Tuality Health Alliance reviews providers' practice utilization data, member complaints, quality of care assessments, and any changes in application status on an ongoing basis.

Initial Credentialing:

Prospective Tuality Health Alliance providers must submit an “Oregon Practitioner Credentialing” application and the following information to Tuality Health Alliance:

- Evidence of licensure by state (copy of wallet-sized license is sufficient);
- Evidence of DEA certification or prescriptive privileges, if applicable;
- Evidence of professional liability insurance coverage in the amount of \$1million per incident, \$3 million aggregate, or equivalent protection; and
- Copies of specialty board certificate(s) when applicable;
- Copy of current curriculum vitae

Providers must inform Tuality Health Alliance within 30 days when changes occur to any statements made on the application.

The application and all accompanying information are reviewed by the Tuality Health Alliance Medical Director and final approval occurs at the THA Quality Management Committee.

The THA Quality Management Committee requests additional information if necessary.

The THA Quality Management Committee will recommend acceptance or rejection of the application.

Recredentialing Verification:

THA physicians will be recredentialed following the Tuality Healthcare (THC) recredentialing process, and maintaining compliance with National Committee on Quality Assurance (NCQA) standards. THA will utilize the thirty six (36) month NCQA recredentialing standard for guidelines.

THA evaluates all recredentialing candidates for continuing participation, corrective action/improvement or termination.

Additional recredentialing criteria are reviewed with respect to utilization, quality, access and administrative concerns if applicable. This process provides an opportunity for informative and educational feedback to the providers.

710

Clinical Record Audits

Clinical records for Tuality Health Alliance clients are required to fully document the member’s condition, clinical encounters and medically appropriate service

provisions. The minimum requirements for the clinical record are those established by the State of Oregon and relevant federal regulations.

Tuality Health Alliance will audit clinical records as part of the Quality Management Program. An audit may serve either or both of the following purposes:

- Assess recordkeeping for documenting clinical information and provider activities/encounters
- Assess for quality of care

The first of these purposes is to ensure basic recordkeeping standards. The second refers to the review of clinical information for the purpose of credentialing and evaluating the quality of the service.

712 Abuse Reporting

As required by the state and federal regulations, our providers must cooperate fully with all processes and procedures of abuse reporting, investigations, and protective services.

Medicaid only:

- As described in ORS 430.735 through 430.765, Abuse Reporting for Mentally Ill; and
- OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities

714 False Claims Reporting

Tuality Health Alliance (THA) has a mechanism in place that will enable THA to prevent and detect fraud and abuse activities relating to THA members and providers. The goal is to identify, evaluate and reduce the potential risk management concerns associated with care and services by anticipating problems and taking preventive measures.

The Chief Compliance Officer for THA is the THC Corporate Chief Compliance Officer. This position is appointed by the CEO and is responsible for ensuring the operation and monitoring of the fraud and abuse program. The Chief Compliance Officer reports directly to the THA Board of Directors. This position is also responsible for ensuring the integrity of the claims payment and encounter reporting process as well as retaining overall responsibility for the financial relationships with providers.

THA will evaluate any allegations of improper/illegal activities through the

Utilization Management and Patient Care/Quality Improvement Committee and utilizes various risk evaluation techniques to monitor compliance and assist in the reduction of fraud and abuse.

Specifically the statute requires that the provider/entity establish written policies, procedures and protocols and provide training on such for all employees, contractors, and agents that must include:

- A detailed discussion of the Federal False Claims Act, federal administrative penalties for false claims and statements, and the whistleblower protection under such laws;
- The role of such laws in preventing and detecting fraud, waste and abuse in federally funded health care programs;
- A specific detailed discussion of the rights of employees to be protected from retribution as whistleblowers; and
- The provider/entity's own policies and procedures for detecting and preventing fraud waste and abuse.

Training for employees, contractors and agents is mandatory, and must be provided at the time for hiring/contracting. If requirements are not, provider/entity could lose Medicaid Funding, be subject to a FCA action for falsely certifying compliance, or be excluded as a Medicaid/Medicare provider by HHS-OIG.

As required by the contract with The Department of Human Services in the State of Oregon, THA maintains a system of detecting and responding to fraud and abuse allegations as such activities relate to the plan's administration of medical benefits to DMAP Clients. This may also include operational policies and controls in areas such as claims, prior authorization, utilization management and quality review, Member Complaint and Appeal resolution, Participating credentialing and contracting, Participating Provider and staff education, and corrective action plans to prevent potential fraud and abuse activities.

THA will allow and facilitate the Medically Fragile Children's Unit or the Department of Human Services to inspect, evaluate, or audit any records, documents, files, accounts and/or facilities maintained and contracted with THA as required to investigate an incident of fraud and abuse.

716 Restriction, Suspension, or Termination of Physicians

The THA Quality Management Committee (QMC) is accountable for recommending any disciplinary or termination action against a physician when, in the opinion of the Committee, a physician is performing below acceptable standards of quality.

The THA Medical Director or the QMC may counsel, educate, issues letters or warning or censure, request corrective action or institute retrospective or

concurrent monitoring in the course of carrying out their duties without initiating formal corrective or disciplinary action. These actions will be documented with a formal letter to the provider and copied to their credentialing file. Informal actions do not constitute a restriction of the physician's participating or grounds for a hearing.

A formal investigation that may result in restriction, suspension or termination of a physician's ability to provide health care services to THA members may be initiated when THA obtains reliable information, which indicates that a physician may have exhibited acts, demeanor, or conduct or rendered professional services to THA member's that is/are reasonably likely to be:

- Detrimental to patient health or safety or to the delivery of quality patient care
- Unethical
- Contrary to THA's applicable policies
- Below professional standards
- Disruptive of THA operations or
- An improper use of THA resource

A Disciplinary or termination action recommended by the Medical Director is taken to the THA Quality Management Committee for a final decision. All disciplinary or termination actions shall be reported to the THA Board of Directors.

THA provides for notice and a fair hearing as required under applicable state and federal laws prior to termination, suspension or restriction of privileges.

718

Complaints or Grievance

Tuality Health Alliance encourages members and providers to resolve complaint/grievance, problems, and concerns. However, we also provide more formal procedures for addressing complaint/grievance and problems when they cannot be resolved otherwise.

Member complaint/grievance must be made to Tuality Health Alliance. Then if not resolved, members have the right to request a hearing by the states' Division of Medical Assistance Program (DMAP) through its hearing process.

A complaint/grievance is defined as everything that is not an action (as defined under appeals for the THA Division of Medical Assistance Programs – DMAP member).

A complaint/grievance may be oral or written communication that address issues with any aspect of operations, activities, or behavior that pertains to the availability and deliver or quality of care.

Tuality Health Alliance takes member complaints/grievance seriously and will respond in a timely manner to them. THA is prepared to respond to member's concerns about any decision they find unacceptable regarding their care and service.

When a THA member files a complaint/grievance, THA will conduct a new review of the complaint/grievance. This will include the following:

- Documentation of the substance of the complaint and actions taken
- Investigation of the substance of the complaint, including any aspects of clinical care involved
- Notification to the member of the disposition of the complaint and the right to appeal, as appropriate

Standards for timeliness in responding to complaints that accommodate the clinical urgency of the situation:

- A decision/resolution must be made within five (5) working days from the date of receipt of complaint
- If unable to make a decision/resolution a letter to the member will be sent informing them that there is a delay in the decision/resolution for up to thirty (30) days from the receipt of the complaint

Complaints/grievance is a source of information that may be used to evaluate the quality of access, provider service, clinical care, or THA service to members. Complaints will be reported to both DMAP and Addictions and Mental Health quarterly within sixty (60) days of the end of the quarter.

720 Sterilizations & Hysterectomy

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

It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. Therefore, Tuality Health Alliance cannot reimburse providers for these procedures without proof of informed consent.

Voluntary Sterilization:

For a tubal ligation or vasectomy, the patient must sign the "Consent to Sterilization" (DMAP Form 742) 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.

Tuality Health Alliance 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 (DMAP 741-A or 742-B)
- Physicians must complete Part I including the portion "medical reasons for recommending a hysterectomy for this patient." THA will return the form to the provider for completion if this portion is omitted.
- Patients who are already sterile are not required to sign a consent form. In these cases, the physician must complete Part II including cause and date (if known) of sterility, e.g. "tubal ligation 1992."
- In cases of life threatening emergency when consent cannot be obtained, the physician must complete Part II including the nature of the emergency that made prior acknowledgement impossible.

722

Confidentiality

A healthcare provider who transmits or receives health information in one of the Health Insurance Portability and Accountability Act's (HIPPA) transactions must adhere to the HIPPA Privacy and Security regulations.

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

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

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

Health information contained in medical or financial records is to be disclosed only to the patient or legal guardian unless the patient or legal guardian authorizes the

disclosure to some other individual or organization, or a court order has been sent to the provider. Health information may only be disclosed to those immediate family members with the verbal or written permission of the patient or the patient's legal guardian. Health information may be disclosed to other providers involved in caring for the member without the member or member's legal representative's written or verbal permission.

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

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

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

Extra care shall be taken not to discuss patient information (financial 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.

Tuality Health Alliance staff adhere to the HIPPA mandated confidentiality standards as well.