Willamette Valley Community Health
Coordinated Care Organization

PROVIDER MANUAL
2018

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INTRODUCTION

The provider manual is a reference tool for providers and contains important information for providers and office staff for the delivery of health care for the Willamette Valley Community Health Coordinated Care Organization (WVCH CCO) members. Areas in which the process is different for contracted vs non-contracted providers will be specified in the applicable section. This document should be used in conjunction with your contract with WVCH CCO. If any information in this manual is inconsistent with your contract terms, your contract will take precedence over this manual.

For information on dental services, policy and procedure please refer to the provider manual and contract for the members Dental Provider Network: Capitol Dental, Advantage Dental, Willamette Dental or Delta Dental of Oregon (formally ODS).

As a Coordinated Care Organization (CCO), WVCH's providers render a variety of services which may include physical health, mental health and substance use disorder treatment. Some instructions in this manual may vary based on the service type. These differences will be specified in the applicable sections.

WVCH provides OHP members with second opinions at no cost for physical health, behavioral health, and/or dental health, by appropriately qualified health care professionals acting within their scope of practice and who possess a clinical background related to particular illness, disease, or condition(s) associated with request. WVCH also provides second opinions at no cost when requested by providers who in their professional opinion believe it would benefit the member.

Please let us know if you have questions about any information in this manual or have suggestions for improving this document in the future. Please contact Provider Relations with concerns or suggestions for this manual at ProviderRelations@mvipa.org.

Fraud, Waste and Abuse

WVCH CCO is committed to the prevention and detection of potential fraud, waste and abuse occurrences as those occurrences relate to the administration of WVCH CCO and the quality of service provided to health plan members. WVCH CCO has established a process for reporting and responding to occurrences of suspected fraud, waste and abuse.

Confidentiality

All information identified, researched, or obtained for or as part of a suspected fraud, waste, and abuse audit is considered confidential by WVCH CCO. Any material used in the audit of a potential occurrence of fraud, waste, or abuse will be used only by the appropriate people and only for purposes of the audit and/or for referral to the Medicaid Provider Audit Unit of the Office of Program Integrity for the Oregon Health

Authority, Oregon's Department of Justices' Medicaid Fraud Control Unit (MFCU) and U.S. Department of Health and Human Services, Office of the Inspector General. The WVCH CCO Compliance Officer is responsible for maintaining the confidentiality of information and records obtained and used during the course of any audit, according to plan confidentiality policies, and in compliance with all state and federal laws regarding confidentiality.

Definitions

Fraud	An intentional deception or misrepresentation made by an individual who knows that the false information reported could result in an unauthorized benefit to him/herself or another person.
Waste	Provider practices that are inconsistent with sound business, fiscal or medical practices that result in unnecessary costs to the Medicare and/or Medicaid programs.
Abuse (of system)	Incidents or practices that are not consistent with sound medical, business, or fiscal practices, which may result in unnecessary program costs and improper payment for services not meeting standards of care or medical appropriateness.
Abuse (of member)	Physical abuse, sexual abuse, neglect, or inappropriate treatment of a member.

Reporting Suspected Fraud or Abuse please refer to the Health Plan Contacts page.

Reporting Process

Any suspected fraud, waste, and/or abuse occurrence identified by a WVCH CCO employee or an employee of contracted plan subcontractor, reported by a provider or vendor, or submitted by a member, shall be reported to the Compliance Officer at WVCH CCO immediately. The Compliance Officer has been designated as the coordinator for all audits and occurrences of potential fraud, waste, and abuse, and for all information and records obtained during such audit. To report an occurrence of suspected fraud, waste, or abuse of a provider, a member, an employee of WVCH CCO or of its subcontractors, call the Fraud and Abuse Hotline. Include information on the origin of request, member information, provider information, and claim information. This information along with copies of any related claims (if available), should be submitted to the Compliance Officer.

Audit Process

Upon receipt of the information, the Compliance Officer will either conduct the audit or delegate the request for audit to the appropriate department to begin the process of

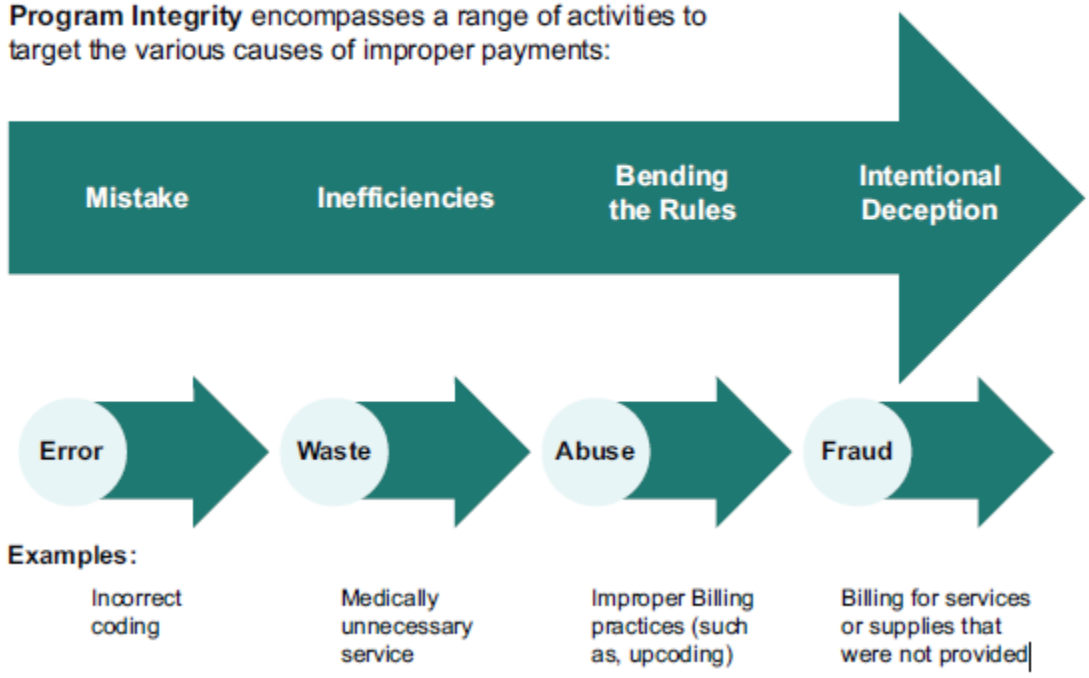
research and inquiry regarding the occurrence. If the case is delegated to a specific department, the department will conduct the audit and report the findings to the Compliance Officer.

What is the impact of health care fraud and abuse?

- It is estimated that between 3 to 10 percent of health care programs' (both public and private) total expenditures result from fraudulent billings
- CMS estimates that fraud costs the Medicare program $60 billion per year.
- Health care fraud and abuse hurts everyone.

Figure 1 shows examples along the spectrum of causes of improper payments.

Figure 1. Types of Improper Payments



Fraud, Waste & Abuse Training Requirements

WVCH CCO contracted providers and other contracted and sub-contracted entities responsible for the administration or delivery of health plan benefits must complete fraud and abuse training ***annually***.

- Examples of responsible external entities include (but are not limited to):
  - Individual health care providers and health care facilities and office staff
  - Individual pharmacists and pharmacy staff
  - Providers of Durable Medical Equipment
  - Home Health Providers
  - Non-Emergent Medical Transportation providers

External entities must maintain records of the attendance and completion of a compliance training course by themselves and their staff. The external entity is required to complete and return the attestation to the Compliance Officer at WVCH CCO. If the external entity decides to use a different training course than the one provided by WVCH CCO, a copy of the training course the entity used must be submitted to WVCH CCO Compliance Officer along with the attestation.

Why is training necessary?

- All organizations, providers and individuals that contract directly or indirectly with the Federal government, including through WVCH CCO, are subject to the fraud and abuse laws and regulations as found in 42 CFR § 423.504 (b)(4)(vi)(C).
- Penalties for violation of fraud, waste and abuse laws can be severe:
    - Suspension of payments from federal health care programs
    - Exclusion from federal health care programs
    - Monetary penalties (both civil and criminal)
    - Imprisonment

Provider Risks for Fraud and Abuse

- Billing for services/supplies that were not provided
- Incorrectly reporting diagnoses or procedures to maximize payment
- Billing for services/supplies or writing prescriptions for drugs that are not medically necessary
- Remuneration schemes that unlawfully induce or reward the provider to bill for services/supplies or write prescriptions
- Provision of false information (e.g. falsifying information on a prior authorization request, misrepresenting dates of service, etc.)
- Unbundling charges
- Violating the assignment agreement, Fee Schedule, or Maximum Allowable Actual Charge Limits

Pharmacy Risks for Fraud and Abuse

- Inappropriate billing practices (e.g. billing for non-existent prescriptions, billing multiple payers, billing for brand medications when dispensing generics, billing for prescriptions never picked up)
- Remuneration schemes that unlawfully induce or reward the pharmacy to steer members to certain drugs or plans
- Prescription drug shorting
- Prescription forging or altering
- Dispensing expired or adulterated drugs

- True Out-of-Pocket (TROOP) Costs manipulation
- Failing to offer negotiated prices

Pharmaceutical Manufacturer Risks for Fraud and Abuse

- Inappropriate relationships with physicians including "switching" arrangements, offering unlawful incentives, and consulting and advisory payments
- Illegal off-label promotion
- Illegal usage of free samples

Where can I get additional information?

- Office of the Inspector General (OIG) website: http://www.oig.hhs.gov/
- The Centers for Medicare and Medicaid Services (CMS) website: http://www.cms.hhs.gov

Office of the Inspector General (OIG) Exclusion List 42 CFR § 1001.1901

The US Department of Health and Human Services Office of the Inspector General (OIG) has been mandated by the US Congress to protect the health and welfare of the nation's elderly and poor by preventing certain individuals from participating in Federally-funded health care programs (i.e. Medicare and Medicaid). The OIG established a program to exclude individuals and entities affected by these mandates contained in the Social Security Act. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities. This list can be found at http://oig.hhs.gov/fraud/exclusions.asp.

Some of the reasons for exclusion include: convictions for program-related fraud and member abuse, licensing board actions and default on Health Education Assistance Loans.

The effect of the exclusion (not being able to participate) is:

- No program payment will be made by any Federal health care program for anything that an excluded person furnishes, orders, or prescribes. ***This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services.*** The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.
- There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room. See regulations at 42 CFR 1001.1901(c)

For a more detailed explanation of the effect of the exclusion program, go to: http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp.

The OIG is in the process of recovering millions of dollars from entities who have billed Medicare/Medicaid for services that were provided by an "excluded employee". It is important for ALL entities who receive payment to care for Medicare/Medicaid members to check the HHS-OIG online exclusion database monthly. At WVCH CCO, all prospective employees are checked in the database prior to receiving a job offer. The database is checked monthly for current employees and board/committee members.

Discrimination Based on Health Status

In accordance with regulations, neither the Health Plan nor the health care providers servicing members of the health plans administered by WVCH CCO will under any circumstances discriminate in the acceptance, denial, initial consultation, or continuing treatment of members based upon the member's health status.

Civil Rights Act, Members' Bill of Rights, Discrimination, and Affordable Care Act and Americans with Disabilities Act

WVCH CCO and all contracted providers/entities, in compliance with regulations, will maintain policies for complying with the Civil Rights Act, the Americans with Disabilities Act (ADA), the Affordable Care Act (ACA), Age Discrimination guidelines, and all applicable federal laws. The United States Department of Health and Human Services and The Members' Bill of Rights in Medicare and Medicaid prohibit any health care entity from discrimination against members based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment. Members have the right to considerate, respectful care from providers at all times and under all circumstances.

Under the Affordable Care Act, Section 1557 prohibits sex discrimination in health care, which may include, but is not limited to, discrimination based on an individual's sex, including pregnancy, related medical conditions, termination of pregnancy, gender identity, and sex stereotypes. Gender identity means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female. Sex stereotypes means stereotypical notions of masculinity or femininity.

Under the American Disabilities Act (ADA), the ADA requires that providers have reasonable accommodations made in employment, service delivery, and facility accessibility for all members. The ACA states that reasonable changes must be made to policies, procedures, and practices where necessary to provide equal access for individuals with disabilities. These disabilities are not limited to physical, but also include auditory, visual, emotional, behavioral, or mental disabilities. These services must be offered to the member free of charge.

Professionally-Recognized Standards of Care

In accordance with regulations, health care providers (contracted and/or employed) servicing WVCH CCO members agree to ensure that all health care services provided to members are conducted in a manner consistent with professionally-recognized standards of health care for the applicable specialty, field, and scope of practice including but not limited to nationally recognized clinical protocols and guidelines.

Laws Pertinent to Medicare/Medicaid Fraud and Abuse

The False Claims Act (31 U.S.C § 3729-3733)

The False Claims Act prohibits knowingly presenting, or causing to be presented, to the federal government, a false or fraudulent claim for payment or approval. It also prohibits knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved.
Penalties for violation include:

- Fine of $10,957 - $21,916 per false claim
- Up to 3 times the amount of damages sustained by the Government

Deficit Reduction Act of 2005-Qui Tam Whistleblower Protections

The Deficit Reduction Act of 2005 encourages individuals to report False Claims. It allows an individual to file a lawsuit on behalf of the government. The lawsuit is filed in a federal district court and is under "seal" while the government investigates. If it is found that the lawsuit has merits, the Department of Justice will prosecute. An individual may receive 15-30% of the amount recovered and may also be able to recoup reasonable expenses such as attorney fees.

No retaliation is allowed by the entity to an employee who reports any fraud. In addition to the financial award, the individual is entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, attorney's fees and costs.

The Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

The Anti-Kickback Statue prohibits knowingly or willfully soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe or rebate) in order to induce or reward business that is payable under a Federal health care program. Penalties for violation of this act include:

- Criminal penalty of fines of up to $25,000 and/or imprisonment of up to 5 years;
- Civil penalty of up to $50,000 per act plus 3 times the amount of remuneration;
- Exclusion from Federal health care programs.

Physician Self-Referral ("Stark") Statute (42 U.S.C § 1395nn)
The Physician Self-Referral Statute prohibits a physician from making referrals for certain designated health services to an entity in which the physician, or a member of his/her family, has an ownership/investment interest or with which he/she has a compensation arrangement. Penalties for violation include:

- Up to $15,000 for each claim submitted in violation of the law
- Up to $100,000 for each "scheme" that violates the law
- Penalties of up to 3 times the amount claimed
- Exclusion from Federal health care programs

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Care Fraud and Abuse Control Program (HCFAC)
The national Health Care Fraud and Abuse Control Program (HCFAC) was established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and coordinates federal, State, and local law enforcement activities with respect to health care fraud and abuse. It created the offense of "health care fraud" and established criminal penalties for violation:

- Fines
- Imprisonment of up to 10 years
- Violations resulting in physical injury can be punished by imprisonment of up to 20 years
- Violations resulting in death will be punished by imprisonment for life

All participating providers are required to comply with HIPAA Privacy and Security rules and regulations. Providers have the responsibility to safeguard their members protected health information (PHI).

Under HIPAA, any use or disclosure of an individual PHI may or may not require a signed disclosure form from the individual.

Requests not requiring signed disclosure
Requests by or disclosures to health care practitioners for payment, treatment, and operation purposes are not subject to the requirements of the minimum necessary standard. For example: if you contact WVCH CCO as a member's PCP office for information relating to a PA or referral, a signed disclosure form from the member giving you authorization to his/her PHI is not required as long as the request for PHI is related to the member's care.

PROVIDER RESPONSIBILITY

WVCH CCO Eligibility Verification

Provider users can view WVCH CCO eligibility in the Community Integration Manager (CIM) system which contains information based enrollment data supplied by Health Systems Division (HSD). Subsequent changes by Health Systems Division to eligibility may alter the WVCH CCO member's eligibility with a prospective or retroactive date. Accordingly, verification of eligibility is not a guarantee of coverage. WVCH CCO offers and encourages Providers to check online for member eligibility, authorizations/referrals, and claims through the CIM system. If you do not currently have access to the CIM system, please contact the Information Systems Department. Please refer to Health Plan Contacts page for contact information.

Providers can also verify OHP eligibility through the HSD provider web portal, automated voice response or 270/271 transaction. Details can be found at the following website: http://www.oregon.gov/OHA/healthplan/pages/verify.aspx.

Providers are required to verify eligibility on the date of service, coverage limitations and obtain necessary authorizations before rendering services. Providers must inform the member of any charges for non-covered services prior to the service being delivered and must have a valid, signed waiver if the member is to be held financially responsible for non-covered services**. Please see Waiver for Non-Covered Services section below.**

Community Integration Manager (CIM)

Through the CIM system you can verify eligibility, check claim status, and request a referral or prior authorization.
Provider users may contact Information Systems to request access to Community Integration Manager (CIM). Please refer to Health Plan Contacts page for contact information.

Upon access approval the user must agree to the End-User Level Agreement. The user is being granted limited license to access the Protected Health Information of members in CIM solely for the purposes of fulfilling your duties as an employee, contracted community partner, provider, health plan staff, administrator or business associate. The license will terminate immediately if the user ceases to be employed by, or associated with, an entity whose data is represented in CIM. The user represents and warrants that they will not access or attempt to access CIM after the license has terminated. The user represents and warrants that they will promptly notify WVCH of any change in their employment status or professional affiliation. Each office should have a designated person to report any user changes within the practice that would affect CIM users to Provider Customer Service.

Primary Care Provider Responsibility

The Primary Care Provider (PCP) will provide, or facilitate referrals to specialists to provide services for the complete health care needs of the member Members may

choose their PCP based on the past history with the provider, or from the listing of available PCP's in WVCH CCO service area.

Members may select a PCP from the following providers:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Specialist as approved by the Health Plan

The PCP's responsibility as the manager of the member's care is as follows:

- The PCP provides all primary preventive health care services with the exception of yearly gynecological exam for which the member may choose to seek services from a participating Women's Health Care Specialist.
- When specialized care is medically necessary, the PCP will facilitate a referral to a specialist or specialty facility.
- The PCP must contact the Health Plan to obtain a referral or prior authorization to specialty providers, if required.
- The PCP coordinates care and share appropriate medical information with the Health Plan as well as with specialty providers to whom they refer their members.
- Document in a prominent place in their member's records whether or not an individual has executed an Advance Directive.
- The PCP will adhere to the medical record standards that were developed and approved by the Ambulatory Record Certification (ARC) Program of the Oregon Medical Association.
- Per HIPAA Privacy rule – providers are responsible for safeguarding their members' personal health information (PHI). Disclosure of any PHI is limited to the minimum necessary and a disclosure form is required prior to any release of PHI.

Specialist as PCP

A specialist may consider being a PCP for an established member, if the specialist is willing to assume **all** of the responsibilities of a primary care physician for that member. Examples of this include an OB becoming the PCP for their pregnant member or an Oncologist becoming the PCP for their member during the member's cancer treatment program.

If you would like to become a PCP, contact Provider Relations to request PCP status. Please refer to Health Plan Contacts page for contact information.

Referral Specialist

In cases where referrals to Specialty Providers are required to adequately address the medical needs of the member, the Primary Care Provider will refer the member's care to the Specialty Provider. Routine specialty services are not eligible for reimbursement without an approved referral from the member's PCP and the Health Plan, except as noted on the Prior Authorization Grid.

In order for services to be eligible for reimbursement by the Health Plan, the PCP must complete a referral. The Specialist should verify that a referral has been authorized. It is not the responsibility of the member to obtain a referral number from their PCP before receiving services from a referral specialist. The referral specialist and PCP together are responsible for completion of the referral process.
If a specialist does not have a referral from the PCP, please call Provider Customer Services prior to denying a member an appointment. Please refer to Health Plan Contacts page for contact information.

Contracted Specialty Providers have the responsibility to:

- Treat members within the scope of their practice.
- Assure prior authorization is in place before treating the member.
- Coordinate and share appropriate medical information with the member, the member's PCP, and the Health Plan.

Availability

Participating Providers agree to accept new members unless his/her practice has closed to new members of any health plan. Providers may not close their practices to only select health plans. Please notify Provider Relations in writing when your practice is closed to new members and when it reopens.

Participating Providers agree to provide 24-hour, 7-day-a-week coverage for Health Plan members in a culturally competent manner and in a manner consistent with professionally recognized standards of health care, including the Affordable Care Act's – Section 1557. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care personally or to direct members to the setting most appropriate for treatment.

Access to Care Standards (OAR 410-141-3220(8)(a-c) and (g))

- Emergent needs are immediately assessed/referred/treated.
- Urgent, acute care is available within 72 hours.
- Non-urgent care (symptomatic) is available within 7 calendar days.*
- Routine visits for chronic or ongoing medical problems are available within 10 working days.*
- Visits for routine health assessment and physical exams are available within 4 weeks or community standard.
- The average wait to see a provider is less than 45 minutes.

- If a provider must cancel an appointment, the provider must make a good-faith effort to contact the member and reschedule for a later time.

Mental Health and Substance Use Disorder

- Intake assessment for routine mental health or substance use disorder treatment services with 14 calendar days
- Appointment within 48 hours for urgent mental health or substance use disorder treatment services and within 24 hours for emergency services

*WVCH CCO additional/specific requirements.

Call Share

Participating Providers will establish call share arrangements with other participating providers when they are unavailable. In such situations, the call share provider may bill the plans for the services provided to the member. If changes are made in call share arrangements, please notify Provider Relations and the Credentialing Department. Please refer to Health Plan Contacts page for contact information.

If electronic answering machines are used, messages must include the following:

- Name and telephone number of the on-call provider along with instructions on how to contact that provider.
- A disclaimer that if the member presents to the emergency room without contacting the on-call physician, payment by insurers may be denied.

NOTE: A tape-recorded telephone message instructing members to present to or call a hospital emergency room is not sufficient for 24-hour coverage.

Closing Practice

A Primary Care Provider cannot close their practice to WVCH CCO members unless the PCP is closing their practice to all new members, regardless of insurance source. The exception to this rule allows the provider office to temporarily close to new WVCH CCO members if the current payer mix includes at least 400 WVCH CCO members or if those WVCH CCO members represent 20% of the entire practice (whichever number is lower). WVCH CCO requires that providers forward notification of closing a practice, **in writing**, at least thirty-days in advance of closing, to the attention of the WVP Provider Relations Department. This information will be tracked in the credentialing database.

Following receipt of written notification of closing, WVP Health Authority will contact the provider office to verify receipt, and within five (5) working days will forward an internal update appropriate staff.

Termination of Provider's Panel Participation

If a participating provider terminates his/her contract with WVCH CCO without cause, written notice must be given to WVCH CCO, and all affected members no less than 30 days prior to the date of termination.

Mental Health providers must provide notice no less than 90 days prior to the date of termination.

Termination of Member Care

WVCH CCO supports the Oregon Medical Association's policy regarding the termination of member care. Providers may withdraw from the care of a member, when, in the medical judgment of the provider, it is in the best interest of the member to do so. Clinic termination policies may include termination of members who do not comply with internal clinic policies affecting the health and safety of other clinic patients. Clinic termination policies must be applied uniformly to all clinic patients regardless of payer source. Below is a summary of the OMA policy regarding termination of member care.

Note: CONTINUITY OF CARE MUST BE ASSURED TO THE BEST OF THE PROVIDER'S ABILITY.

Physicians have a duty to provide medical care to a member until the proper termination of that relationship. A member-physician relationship may be terminated by:

- Mutual consent
- Member dismissal of the physician
- The lack of need for further medical treatment, or
- Withdrawal of the physician

When a physician withdraws from a member who is in need of continuing care at that time, the physician must take the following steps:

- Give reasonable notice of the intent to withdraw; and
- Provide the member with a reasonable time to find alternative care, and
- Continue to be available during this time to treat the member until the date indicated in the notice.

Reasonable Notice

In most cases a thirty (30) day notice is considered reasonable. If the basis for termination of a member from your practice is disruptive behavior or behavior which is dangerous to other members or staff, the period may be shortened to as little as one (1) day. Depending upon the seriousness of the threat and the CCO's ability to locate another panel provider willing to accept the member as his/her member within the range of one (1) to thirty (30) days, consider both the severity of the member's condition, and the availability of other care in the community when selecting the time

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

WVCH CCO is available to provide consultation and care management support for providers dealing with challenging patients. Please see Health Plan Contacts page for Intensive Case Management contact information.

When the provider is the only source of a particular type of specialized medical care, he or she is obligated to continue this care until the member can be safely transferred to another provider who is able to provide treatment and follow up.

Behavioral health providers are asked to contact WVCH CCO in order to obtain consultation and care management support prior to discharging challenging individuals so that a transition to other services may be organized. Please see Health Plan Contacts page for Behavioral Care Networks contact information.

Note: Please notify Customer Service of the termination at the same time you notify the member.

Applicability of Federal Laws
As a federal contractor, WVCH CCO receives federal funds to provide services to WVCH CCO members. As a participating provider delivering services to these members, you are subject to laws applicable to individuals and entities receiving federal funds. Participating providers who treat our members are required to comply with applicable State and Federal laws and regulations regarding Medicaid and Medicare.

Restraint and Seclusion in Delivery of Health Care
WVCH CCO providers will ensure that members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal and State regulations on the use of restraints and seclusion, as found in 42 CFR 438.100 (b)(2)(v). Contractor's shall comply with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated there under. Contractors shall also comply with all applicable requirements of State Civil Rights and rehabilitation statutes and rules.

Medical Record Documentation Policies

Participating providers are required to safeguard member-identifying information and to maintain the records in an accurate and timely manner consistent with state and federal law. Compliance with medical record policies will be monitored by the plan. By agreeing to participate, providers agree to cooperate in random medical record reviews that are conducted by WVP Health Authority for WVCH CCO. If evidence of substandard

medical record keeping is identified by random chart review, the provider will be educated regarding this policy and further monitoring as deemed necessary. Participating providers shall be required to submit corrective action plans for non-compliant processes if continued evidence of substandard medical record keeping is identified by random chart note review.
The Medical Record Review Process is detailed in WVP Health Authority Policies and Procedures on Policy Tech.

Participating providers agree to adhere to the medical record standards outlined below. These standards were developed and approved by the Ambulatory Record Certification (ARC) program.

- All pages contain member name.
- Address is contained in biographical/personal data.
- Home telephone number is contained in biographical/personal data.
- Work telephone number is contained in biographical/personal data.
- Employer is contained in biographical/personal data.
- Marital status is contained in biographical/personal data.
- All entries contain author identification.
- All entries must contain complete date (dd/mm/yy).
- The record is legible.
- There is a completed problem list, which states significant illnesses and medical conditions.
- Medication allergies and adverse reactions to medications, or the lack of (NKDA/NKA) is prominently displayed.
- There is an appropriate past medical history in the chart, which includes serious illness, surgeries, accidents, family history, and mental health history. Applies to members seen three times or more and must be easily found in record.
- If OB member, there is an Oregon uniform prenatal record or its equivalent in the record. The form must be complete to current date.
- There is documentation of tobacco habits and history of alcohol use and substance abuse. Applies to records of members 14 years old and older who have been seen three or more times; or who have been seen before the third visit for an annual health exam.
- There is pertinent history with subjective and objective reasons for presenting problem.
- There is a pertinent physical exam for presenting problem.
- Lab and other studies are ordered as appropriate.
- Working diagnosis is consistent with findings. Diagnosis is specific and clearly identified.
- Plans of action/treatment are consistent with diagnosis. Includes tests, medications, member education, and ancillary services.
- The encounter forms, or notes, have a notation, when indicated, regarding follow-up care calls or visits. (Includes hospital discharge planning when member is hospitalized.)

- Unresolved problems from previous visits are addressed.
- There is evidence of appropriate use of consultants.
- If a consultation is requested, there is a note from the consultant in the record.
- All consultation, lab, and imaging reports filed in the chart are initialed by the primary care physician. (Includes hospital and ER records.)
- Consultation and abnormal lab and imaging study results have an explicit notation in the chart regarding follow up plans when appropriate.
- There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic problem. Includes tests, medications, and referrals to consultants, treatments, preventive care, and follow up.
- An immunization record has been initiated for children (10 years old and under) or an appropriate history has been made in the medical record for adults.
- Preventive services are appropriately used.
- Medical records are organized, permitting effective member care and quality review.
- There is one member in each chart.
- There is documentation of member education.
- If medications are prescribed, they are recorded on a medication sheet that is easily found and is current in the record or all current medications are listed in each and every chart note.

Regulatory Access to Books and Records

Participating providers are required by law and the Oregon Health Authority CCO contract to permit State and/or federal regulatory agencies timely access to records and facilities for the purpose of collecting information to audit, evaluate and inspect books, contracts, medical records, member care documentation, and other records for seven (10) years, or until completion of the regulatory audit, whichever is later, for purposes of evaluating the timeliness, quality, and appropriateness of care, or to evaluate any aspect of services performed.

These standards are used in conjunction with the Medical Record Keeping requirements stated in OAR 410-141-0180 (revised 10-15-2016) to which Participating Providers are subject.

All Medical Records pertaining to the health plan members must be retained for seven (10) years after the date of services for which claims are made. If an audit, litigation, research, evaluation or other action involving the records is started before the end of the seven (10) year period, the Clinical Records must be retained until all issues arising out of the action are resolved.

Advanced Directives Policy

An Advance Directive gives the provider specific information on how a member would like his/her medical care handled in the event that they are unable to make those decisions for themselves. Providers are required to document in a prominent place in

the medical record whether the individual member has executed an Advance Directive. If the member does not already have such Directive, the record must document that he/she was informed about Advance Directives and offered to execute one.

Individuals may request assistance from their behavioral health clinician to develop an Advance Directive which documents their wishes regarding end of life care. Support in making end of life decisions is most likely to be needed in situations where the individual does not have family or other support persons providing such assistance and when the individual's cognitive level and/or medical conditions suggest that assistance with this planning would be appropriate. Assisting the individual to approach their primary care provider for help in thinking through these issues is an appropriate case management role.

Declaration for Mental Health Treatment

The WVCH CCO Member Handbook and each contracted mental health provider clinic informs Members of their right to assistance in completing a Declaration for Mental Health Treatment, which conveys the individual's preferences for future treatment at times when they are not able to make their own treatment decisions. The Declaration allows the individual to designate a representative to speak for them if a court or two physicians have determined that they are not capable of making decisions for themselves. Detailed instructions and forms are available at: http://www.oregon.gov/oha/amh/forms/declaration.pdf

Credentialing

Contracted licensed providers are required to notify the Credentialing Department of any changes to your practice including:

- Telephone number
- Tax ID number and NPI number
- Billing address
- Physical office address
- Mailing address
- Closing practice
- Name change
- Licensure or DEA actions or status change
- Liability coverage
- Employment change
- Any National Practitioner Databank (NPDB) reportable events

Submit these changes **in writing** to:

WVP Health Authority
Attn: Credentialing
2995 Ryan Dr SE Suite 200
Salem, OR 97301

You may also fax or email these changes to the attention of the Credentialing Department. Please refer to Health Plan Contacts page for fax and email information.

Participating Provider Site Review Criteria
Participating providers agree to participate in a site review, if requested by WVCH CCO, and to abide by the recommendations given to them after the review. A sampling of items that may be reviewed include:

- Wheelchair access which meets ADA standards
- Adequate waiting room space for member volume
- Confidentiality in reception area
- After hours emergency coverage to respond immediately
- After hours urgent coverage to respond within 30 minutes
- Visible documentation that all patients are treated with respect and due consideration for their dignity

Contact WVCH CCO to access policies and procedures for a detailed explanation of the review process and for a sample of the medical records review instrument itself.

Quality Review & Compliance with WVCH CCO Practice Standards

All Participating Providers will cooperate with the requests and requirements of quality review organizations, when such activities pertain to the provision of services for health plan members.

All participating providers are required to comply with WVCH CCO practice guidelines, medical policies, QI program and Medical Management program, as developed by the WVCH CCO Compliance Officer and Quality Committee.

Waivers for Non-Covered Services
HSD General Rule 410-120-1280 outlines the waiver requirements for the Oregon Health Plan. HSD, and therefore WVCH CCO, require that health plan members receive advanced written notification that a specific service is not covered. Provider offices may not require WVCH CCO members to sign waivers on a routine basis. The waiver must meet HSD waiver standards. The current Health Systems Division waiver (Form # 3165) is available on the WVCHealth.org website.

Health Systems Division and WVCH CCO require that the following be included in the waiver:

- The specific service being provided.
- An estimated cost of the service.
- A statement indicating the member or members' family is or may be financially responsible for payment for the specific services.

In addition, a member cannot be billed a "cancelation fee" for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the member or the plan (OAR 410-120-1280(1)(a)).

Note: Services that are not supported by a diagnosis or established coding guidelines (i.e. unbundling) may be denied as provider responsibility even though a waiver may be on file.

WVCH CCO CASE MANAGEMENT PROGRAM

A small but significant portion of the population served will require a greater than usual amount of available resources**.** Case management services are offered as a resource to providers by Nurse Case Managers under the guidance of the Medical Director, to assist in managing the care of members that have presented as having complex medical and social needs, thereby requiring intensive care coordination. All WVCH CCO nurses are designated as Intensive Case Management (ICM). Early identification of these members can significantly impact the cost associated with their care without sacrificing quality or member satisfaction. Under the Oregon Health Authority, these services are referred to as "Intensive Case Management (ICM)."

Intensive Case Management (ICM)
Intensive Case Management (ICM) is defined as "A specialized case management service provided by Fully Capitated Health Plans to Health Systems Division Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405 Oregon Health Plan, Prepaid Health Plan, Intensive Case Management (ICM)".

Identification of members in need of ICM services will occur through surveillance of:

- Referral and authorization requests
- Facility discharge reports
- Physician referrals
- Member requests
- PreManage

ICM care coordination is available for the aged, blind and disabled, and the medically fragile member.

A request for ICM services may come to the ICM coordinator through a provider, provider delegated staff, the member's state case manager or the individual member. A member may also be identified as needing ICM services through the internal pre-authorization process or concurrent review while the member is in a health care facility.

Services

- Assistance to ensure timely access to providers and capitated services.

- Notification to providers that they have a member in need of case management, and coordination of services with providers to facilitate the provision of appropriate services.
- Assistance to providers with coordination of capitated services and discharge planning.
- Coordination of community support and social service systems.
- Facilitating continuity of care, movement of members to various health care settings, evaluation of alternative care, and coordination of care with community resources.

The ICM Coordinator will educate the member on the appropriateness of resources and management of the specific medical needs.

The ICM Coordinator will be available to the client who may have a need for explanation of processes or procedures. For example the client may need explanation of how to obtain services such as pharmacy, medical equipment, home health care, and infusion services. Please refer to Health Plan Contacts page for ICM Coordinator contact information.

WVCH CCO REFERRAL AND PRE-AUTHORIZATION PROGRAM

Referrals and Authorizations

WVCH CCO encourages provider offices to submit all referrals and authorizations into the Community Integration Manager (CIM) system for processing and electronically attach clinical notes to the referral/pre-authorization. The CIM system allows the provider to enter and track the progress of requests. For questions related to a referral or authorization that cannot be obtained from the system or if your office currently does not have CIM, please contact Provider Customer Service. Please refer to the Health Plan Contacts page for contact information.

A request for services is required in order to determine, prior to delivery of care, if the requested service is considered medically appropriate. Authorization requests will be addressed in a timely manner. Urgent/Emergent requests will be processed within 24 hours. Routine requests will be processed within 14 calendar days, once all of the information critical to decision making is available. WVP Medical Management Staff will contact providers if additional information is needed. If requested information is not received within the initial 14 days, a letter will be sent to the member stating that additional time is required because needed information has not been received from the provider to process the request. If no information is received before the 28th day of the request, the request will be processed with the information available.

Authorization does not guarantee payment. The actual claim may be rejected for reasons such as: the care provided differs from the care that was pre-authorized or the

billing is outside of standard billing practices. Payment for care that has been pre-authorized will not be denied on the basis of medical appropriateness unless critical information was not given at the time of authorization (i.e. member was given an experimental or investigational treatment that was not clearly stated in the authorization process.) If the member has lost eligibility, the claim will not be paid regardless of pre-authorization.

For a list of pre-authorization requirements see the current pre-authorization grid at http://www.WVCHealth.org/medicaid-ohp/for-providers.

Procedure/Diagnostic Service Authorization Guidelines
WVCH CCO requires approval for all surgical procedures and select diagnostic services. Please see the current Pre-Authorization grid at www.WVCHealth.org a listing of services requiring approval.

WVCH CCO utilizes the current Health Systems Division Prioritized List of Health Services when considering authorizations. You can find the current prioritized list at: http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx

Reconsiderations for Referrals and Authorizations
The reconsideration process is offered as a courtesy to providers and other professionals by WVCH CCO. A provider or other professional may ask for reconsideration one time before a case is then considered an appeal, see Grievance and Appeals section for more information on filing an appeal. Reconsiderations will not be reviewed if received more than three months after the initial denial, at that point a new request will need to be submitted. This reconsideration process affords the provider or other professional an opportunity to submit new, not previously reviewed clinical information and/or point out areas that may have previously been misinterpreted or overlooked.

WVCH CCO PLAN BENEFITS

All WVCH CCO Health Plan benefits are subject to review for medical appropriateness via written documentation, appropriateness of treatment setting (level of care versus severity of condition) and the Oregon Health Plan (OHP) Prioritized Listing / Treatment Pair Ranking.

Here is an example of what OHP covers:

- Acupuncture
- Substance use disorder and mental health services
- Preventive care (immunizations, regular checkups, family planning)
- Pregnancy care
- Diagnostic services
- Hospital care for urgent, emergent or non-emergent services

- Medical equipment and supplies
- Medical vision care *specific conditions only, as outlined by Health Systems Division
- Hearing services, hearing aids and batteries
- Home health
- Physical, occupational and speech therapy
- Skilled Nursing Facility
- Private duty nursing
- Route vision testing and eyeglasses (Pregnant Women and Children under 21 years old only)
- Transportation to health care services

Prioritized List of Health Services

WVCH CCO utilizes the Prioritized List of Health Services, a listing of diagnosis and treatment pairings, to determine whether a diagnosis and/or service is considered to be part of the Oregon Health Plan (OHP) benefit package. The Health Evidence Review Commission (HERC) shall:

- Develop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served
- Develop or identify and shall disseminate evidence-based health care guidelines for use by providers, consumers and purchasers of health care in Oregon
- Conduct comparative effectiveness research of health technologies

The Health Evidence Review Commission reviews clinical evidence in order to guide the Oregon Health Authority is making benefit-related decisions for its health plans. Its main products are the Prioritized List of Health Services, used by the legislature to guide funding decisions for the Oregon Health Plan, and evidence-based reports on specific topics of interest to Oregon health payers and providers as well as members of the public.

Information regarding the Oregon's legislature approved funding for lines are available at www.Oregon.gov/oha/herc/pages/prioritizedlist.aspx or the CIM website.

Provider offices that are online with CIM and have a user login can access the line finder by going to the main menu of the CIM intranet system, select Provider Services and then select HSD Line Search. If you have any questions regarding the Oregon Health Plan benefit package (covered versus non-covered diagnoses), please contact our Customer Service Department. Please refer to Health Plan Contacts page for contact information.

Preventive Care

Service	Frequency	Age
Breast Exam	Once every 1 year	Women all ages
Cholesterol Screening	Baseline Once every 5 years **or** as recommended by doctor	Baseline 19-23 Screening 24 and older
Colon Cancer Screening	Once every 1 year	All ages as needed
Diabetic/Nutritional Counseling	Once per lifetime	
Pelvic Exam/Pap Test	Once every year	Women onset of sexual activity to age 65
Physical Exams	Unlimited	Birth to 21
	Once every 4 years	21-34
	Once every 2 years	35 and older
Immunizations	In Compliance with APA Vaccination Recommendations	
Mammograms*	One baseline	Women 35-40
	Once every 1 year	Age 40 and older
	No Limit	If ordered by PCP or specialist
Prostate Cancer Screening	Once every 1 year	Men 50 and older
Well-Child Care	Unlimited	Birth – 21 years old

*Mammograms - Women of any age who have a potentially pre-cancerous condition, (includes breast lump or mass) or a significant family history of breast cancer, are eligible for mammography, as ordered by their PCP or Gynecologist.

Coverage includes medically appropriate treatments for conditions that are expected to get better with treatment. Some examples of medical conditions include but are not limited to:

- Appendicitis
- Asthma
- Broken bones
- Heart disease
- Burns
- Infections
- Kidney stones
- Eye diseases
- Diabetes
- Pneumonia
- Ear infections
- Rheumatic fever
- Epilepsy
- Stomach or leg ulcers
- End of Life Care/Hospice

Emergency Room Usage

WVCH CCO members are provided written materials upon enrollment with regard to the use of the emergency room for emergency medical needs only. Members are given examples of appropriate symptoms for presentation to the emergency room, such as broken bones, bleeding that does not stop, suspected heart attack or loss of consciousness.

Members are advised to contact their Primary Care Provider (PCP) prior to going to the emergency room, unless they have a life or limb threatening condition. Members are advised that the plans will not reimburse emergency room charges for care that should take place in their provider's office, such as sore throats, cold, flu, back pain and tension headaches, most particularly during normal clinic office hours. In communities where after hours coverage is provided by the Emergency Room, a provider must be available for telephone consultation and triage. Answering messages and services may not direct a member to present to the Emergency Room as the only option after hours.

Pre-Authorization is not necessary in cases of emergency room visits. WVCH CCO reimburses minimal emergency room screening fees. The final decision regarding reimbursement will be based on the establishment of medical necessity based on review of emergency room chart notes post service.

Immunizations
Immunizations are covered as needed per the Childhood Immunization Schedule. The current Childhood Immunization Schedule approved by the Advisory Committee is located at www.cdc.gov/nip/acip.

Vaccines For Children (VFC)
Vaccines For Children (VFC) is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The CDC buys vaccines at a discount and distributes them to grantees—i.e., state public health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers. See OAR 410-130-0255 for requirements.

Note: WVCH CCO requires that pediatric members needing vaccinations be vaccinated using the VFC program. If the member's PCP is not participating with the VFC program, member must be directed to an eligible provider. Member is not required to change providers and approval is not required for member to obtain vaccination at a non-PCP office.

State VFC:
https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx

Federal VFC site: https://www.cdc.gov/vaccines/programs/vfc/index.html

Flu Vaccination

- Vaccination is available annually to all members.
- Members may get the vaccine at either a contracted pharmacy or a physicians' office.

Pneumococcal Vaccination/Revaccination Policy

The following persons should receive pneumovax injections:

- Persons aged 65 or over, members with functional or anatomic asplenia, and those members under 65 years of age who suffer from conditions which cause them to be considered "medically fragile". Medically fragile members are those who may become seriously ill, or whose health may be seriously compromised by a bout of pneumonia.
- In persons aged 65 years old or older, a second dose of vaccine should be received if their first one is more than five years ago and they were younger than age 65 at that time.
- In persons with functional or anatomic asplenia who are older than age 10 or those persons with compromised immune systems, one additional dose of vaccine at least 5 years after the first is indicated.
- For those members younger than age 10 who meet the criteria above, consider a second dose 3 years after the first.

Pharmacy Services

Refer to WVCHealth.org for current formulary, prior-authorization criteria and formulary change notices.

Specialty Pharmacy

Specialty medications are high-cost agents that are used to treat complex, chronic conditions. These agents currently represent less than 1% of the total pharmacy claims and account for approximately 41% of the total drug spend. Specialty medications can be injectable, infused, oral or inhaled pharmaceuticals. Delivery of specialty medications can be directly to the member or to provider offices for administration. Specialty pharmacies provide medications for many chronic conditions including, but not limited to:

Specialty Disease States	
Allergic Asthma	Lupus (Systemic Lupus Erythematosus)
Ancillary Support Agents for Chemotherapy*	Multiple Sclerosis
Anemia Agents	Neurological Disorders*
Ankylosing Spondylitis	Oncology*
Anticoagulants*	Ophthalmic- Macular degeneration

Chronic Renal Failure	Orphan drugs/orphan disease state
Crohn's Disease	Osteoporosis
Cystic Fibrosis	Pulmonary Arterial Hypertension
Genetic / Metabolic Disorders	Primary Immune Deficiency
Growth Hormone Replacement	Psoriasis
Hemophilia	Respiratory Syncytial Virus Prevention
Hepatitis B / Hepatitis C	Rheumatoid Arthritis
HIV*	Transplant*
Hormonal Therapy	
* Exceptions exist (may also be obtained from retail pharmacies)	

Specialty vendors offer greater convenience when ordering and delivering specialty medications at a cost savings to the plan. The Pharmacy Benefit Manager allows for point of service claims processing, eliminating the need for member billing, and diminishing paperwork for you and your staff. These services can be arranged by contacting the specialty pharmacy directly. Please see Health Plan Contacts page for specialty pharmacy contacts.

Family Planning Benefits

WVCH CCO members may be seen by their PCP, a panel OB/GYN, or a panel urologist (vasectomies only), county health clinic, or family planning clinic for family planning services, without a referral. These claims must be billed with a "Family Planning" or "Contraceptive Management" diagnosis code in order to identify these services as excluded from the standard referral procedures.

WVCH CCO covers a broad range of oral birth control medication, diaphragms, condoms, spermicide, Depo-Provera injections and IUDs without requiring pre-authorization. The removal of Norplant implants is reimbursable, as long as the removal is performed by a participating panel provider and is medically necessary.

Health Systems Division covers abortion services directly, without pre-authorization. WVCH CCO members may self-refer for these services, and providers must bill Health Systems Division to receive reimbursement.

Voluntary Sterilization

Voluntary sterilization is a covered service for WVCH CCO members. The provider performing the sterilization procedure (tubal ligation and vasectomy) is responsible for obtaining a completed and signed Consent to Sterilization Form in accordance with OAR 410-130-0580.

Hysterectomy

WVCH CCO requires physicians to obtain a signed Hysterectomy Consent form prior to surgery in accordance with OAR 410-130-0580. There is no required waiting period between signing a Hysterectomy Consent form and surgery.

Please submit the completed and signed consent form, attached to the claim, to WVCH CCO. The form must be legible and completed in compliance with OAR 410-130-0580

Note: Claims associated with sterilization or hysterectomy will not be reimbursed without the associated consent forms, accurately completed.

Consent to Sterilization and Hysterectomy Consent Forms may be obtained by contacting Health Systems Division or online at https://www.oregon.gov/oha/healthplan/Pages/forms.aspx. See OHP Form 741, 742A, and 742B

Prenatal/Maternity Benefits

- Maternity care should be billed globally, to include pre-natal care, delivery and post-natal care. Office visits for related OB care and routine lab handling fees are included in the global charges (with the exception of venipuncture charges, which may be billed separately).
- An exception to global billing is a situation in which the PCP or OB has not provided all phases of care. In such a situation, the charges must be broken out (using the appropriate CPT codes), and submitted by each provider for reimbursement.
- Routine lab tests provided outside the provider's office (e.g. hospital or independent laboratory) will be reimbursed in addition to the global fee.

Maternity Case Management Fees

Maternity case management fees billed by providers of maternity care are eligible for reimbursement directly from Health Systems Division. Please refer to the current Health Systems Division Medical-Surgical Services Provider Guide for a list of these services. Do not bill WVCH CCO for these services.

Tobacco Cessation Benefits

WVCH CCO covers a broad range of tobacco cessation products. See the WVCH CCO Formulary for the current list of covered medications at www.wvchealth.org.

WVCH CCO also encourages tobacco cessation support groups and classes for members who are attempting to quit smoking. This benefit may be initiated by the member, the member's PCP, or the provider of the smoking cessation group/class. WVCH CCO has contracted with Salem Hospital for Stop Smoking Classes, which require no Pre-Authorization. Members may contact Customer Service for benefit information.

Benefits at County Health Departments

Any participating County Health Department may provide the following services, without requiring a referral from the member's PCP:

- Family Planning Services: Birth control pills, Depo-Provera injections, condoms (with a copy of the prescription attached to the claim).
- Women's Health: Pregnancy tests, and annual women's health exams (with PAP smear). In cases in which a member exhibits symptoms suspicious for UTI, appropriate diagnostic screening may be performed. However, claims for reimbursement must indicate the suspected UTI in order to be eligible for reimbursement. With a referral from the members PCP, county health departments may perform cryotherapy, colposcopies, and cervical biopsies.
- Immunizations: Administrative fees under the WVCH CCO Standard Immunization Schedule.
- Prescriptions: Pre-natal vitamins, children's multi-vitamins and medication for the treatment of lice.
- Screening, Diagnosis and Treatment for: Sexually Transmitted Diseases and HIV. Dual screening for Chlamydia and Gonorrhea may be performed as needed. Screening for UTI may also be performed as outlined above under "Women's Health".
- Tuberculosis Screening and some treatment.
- Substance use disorder and mental health treatment.

Services That Require a Referral:

- County Health Departments administered well-baby and well-child checks.
- EPSDT services can be provided by County Health Departments.
- County Health Departments may provide home visits by county health nurses for enforcement of tuberculosis treatment.

Interpreter Services

WVCH CCO contracts with culturally appropriate interpreter services for provider and member use during medical, mental, and dental service visits. Interpreter services are available to the patient and provider at no charge and are covered by the health plan for WVCH patients who are hearing impaired, or whose primary language is not English, and may consequently experience difficulty communicating with the plan or their providers. Interpreters must be qualified to provide the services they render. Patients cannot be required to provide their own interpreter. Minor children are not to be relied upon for medical or clinical interpreter services, nor are unqualified bilingual or multilingual staff, except in a life threatening emergency where there is no qualified interpreter immediately available.

WVCH has contracts with several interpreter providers as of 01/01/2017, see WVCHealth.org for a current list of all contracted vendors: http://wvchealth.org/find-a-provider**.** Provider offices should contact the interpretation vendor directly to schedule interpreter services.

Non-Emergent Medical Transportation

WVCH CCO members have access to Non-Emergent Medical Transportation (NEMT) to help them travel to covered health care services. WVCH CCO is contracted with LogistiCare to coordinate and supply these services. Members or providers are able to schedule a member's ride by contacting LogistiCare.

A member or provider can call LogistiCare between 24 hours a day. Requests by phone require two business days advance notice. A trip may be scheduled up to 30 days before the appointment. (If a member is going to an urgent care center, leaving a hospital, or needs a ride to or from chemotherapy or dialysis, these time limits are waived.)

Please have the below information ready when scheduling a ride:
- The member's WVCH CCO/Oregon Health Plan (OHP) number
- Time and date of the member's appointment
- Name, address, and phone number for the member and the member's health care provider

LogistiCare can take members to doctor appointments, clinics, hospitals, physical therapy, and any other WVCH CCO-approved health care service.

Please see Health Plan Contacts page for Transportation Provider contact information.

Bus Pass

WVCH CCO members can request bus passes, to allow travel to covered pharmacy, medical, behavioral and dental health services as a least costly option for medical transportation. This request can be made through LogistiCare. Please see Health Plan Contacts page for Customer Service contact information.

Travel, Meals and Lodging Reimbursement for WVCH CCO members (OAR 410-136-3240)

Payment for travel, meals and lodging for covered services is coordinated through LogistiCare.

Mental Health and Substance Use Disorders

WVCH CCO's benefits for mental health and substance use disorder treatment include a range of services. The specific conditions and services must be on the Prioritized List in order to be covered by WVCH CCO.

Mental health services include: assessment/evaluation; counseling; case management; individual, group, and/or family therapy; peer support services; medication management; crisis services; hospital services; and programs to help with daily and community living.

The Marion and Polk County health departments operate several specialty programs. Members must meet program criteria to access these programs:

- MV-Wrap provides wraparound services for youth with intensive mental health needs. This program offers an array of services, from intensive community-based treatment to day treatment to residential treatment.
- The Early Assessment & Support Alliance or EASA is for youth and young adults who may be experiencing early symptoms of psychosis.
- Adult Mental Health Initiative or AMHI is a program to help adults with serious mental illness after they have been discharged from the state psychiatric hospital.

Substance use disorder services include: assessment/evaluation; counseling; case management; individual, group, and/or family therapy; medication-assisted treatment for opioid use/dependence; detoxification services; and residential treatment.

For routine services, usually the first step is for the member to get an assessment from a provider. Information from the assessment helps to identify the member's needs and concerns. Decisions about which services may be helpful are made together by the member and their provider. Members do not need referral or prior authorization for routine services with participating providers.

Access to higher levels of care and specialty programs requires program eligibility, prior authorization, and/or clinical review. Please see Health Plan Contacts page for contact information and assistance.

For a current list of participating providers, please refer to the WVCH CCO website http://www.WVCHealth.org/medicaid-ohp. The list covers provider clinics that offer routine services for mental health and substance use disorders, including medication-assisted treatment.

BILLING AND CLAIMS PAYMENT

Payment of claims is subject to Health Plan Referral and Prior Authorization requirements, billing and coding standards, eligibility on the date of service and covered services.

Timely Filing

First submission of claims which are more than 120 past the date of service will not be accepted. These claims will be denied as the time limit for timely filing has expired in accordance with OAR 410-141-3420.

Claims Submission

WVCH CCO encourages electronic claims submission. Claims submitted electronically produce a quicker response to the provider and a reduction in the length of time to payment for clean claims.

Refer to the following information for the appropriate procedures for both electronic and paper claims submission.

Member ID

WVCH CCO uses the Health Systems Division Prime Number (Recipient ID) for member identification for WVCH CCO claims. This number is located on the identification card from Health Systems Division and ties directly to the eligibility. We require you to put the Health Systems Division prime number (Recipient ID) on all claims. We will return the claim if they are not submitted with the correct Recipient ID.

Electronic Claims

If your office would like to be set up for electronic billing, contact the IS Department for more information. Please see Health Plan Contacts page for IS Department contact information. WVCH CCO will assist you in evaluating the necessary steps and implementation as needed.

Filing Paper Claims

Preparing your claim(s) for submission:

- WVCH accepts the following claim forms:
  - Professional (HCFA) - Health Insurance Claim Form, NUCC, Approved OMB-0938-1197 FORM 1500 (02-12)… submitted on red and white form. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
  - Institutional (UB) - UB04 CMS 1450, NUBC, Approved OMB NO. 0938-0997 … - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf
  - Dental - American Dental Association (ADA) Dental Claim Form 2012 …Black and white form is accepted. http://www.ada.org/~/media/ADA/Member%20Center/FIles/ada_dental_claim_form_completion_instructions_2012.ashx
- Providing a correct and complete Plan/Carrier name on the claim form increases our ability to process the claim without extra handling and delay. Avoid indicating outdated or generic plan name data. PH TECH will open all claim mail addressed to plans that we currently service. In accordance with US Code - Section 1702, all mail addressed to plans we do not service will not be opened and returned to the sender.
- All required fields of the paper claim form must be completed with valid data. It is essential that data entered on the claim aligns in the appropriate boxes.

- To assure our OCR scanning process functions with the highest level of accuracy, all claim forms must be the same size, scale, and alignment, as the standard professionally printed version of the form. Poorly aligned claims may result in unnecessary claims data rejections, or incorrect payments.
- Paper claims that are completely typed/printed are highly recommended.
- Hand written claims are not recommended. Claims that are handwritten decrease the ability of the OCR scanning process to accurately read your submitted data and our ability to process it in a timely manner.

Attaching documentation to claims:

- Print documentation single-sided. OCR scanning systems are limited to single-sided scanning.
- Submit documentation on standard 8.5"x11" pages. Attached documentation that is not standard (8.5"x11") size cannot be scanned and processed until extra handling is performed. This will delay processing of the claim. It is strongly encouraged that providers submit standard size documentation.
- In accordance with HIPAA, attachment documents may not contain information for individuals who are not the member indicated on the claim.

WVCH also recommends these "Tips for Submitting Clean Paper Claims" from Noridian. https://med.noridianmedicare.com/web/jddme/claims-appeals/claim-submission/guidelines

Font and Printing:

- Use "OCR A Extended" or "Courier New" font for computer-generated claims. Do not print in italics, bold or script. Do not mix fonts.
- Use Pica 10 or 12-point typeface for claims typed on a typewriter.
- Do not type in italics or script.
- Use upper case letters for all claim data.
- Ensure none of the characters touch.
- Ensure no lines from the printer cartridge are anywhere on the claim.
- Do not use special characters, (dollar signs, decimals, asterisk, or backslashes) unless otherwise specified.
- Use an ink jet or laser printer to complete the CMS-1500 claim form. Because claims submitted with dot matrix printers have breaks in the letters and numbers, OCR equipment is unable to properly read these claims. Suppliers using dot matrix printers risk slow or incorrect processing of their claims.

Ink Color:

The OCR equipment is sensitive to ink color. Follow these guidelines on ink color:

- Submit the scan able, red-ink version of the professional or institutional claim form.
- Do not use red ink to complete a professional or institutional claim form. OCR scanners "drop out" any red that is on the paper.

- Use true black ink. Do not use any other color ink such as blue, purple, or red.

Avoid using old or worn ink cartridges, toner cartridges, or printer ribbons.

All paper claims should be mailed to:

WVCH CCO
PO Box 5550
Salem, OR 97304

Claims Remittance Advice

A Claims Remittance Advice is provided for all WVCH CCO processed claims. The Claims Remittance Advice may include the following information:

- Vendor (Provider/Facility) name and number
- Check number and payment date
- Member name
- Member ID number
- Claim number
- Invoice/Member Account number
- Service date
- Provider name
- Procedure code and description
- Billed amount
- Contract amount
- Copay amount/Coinsurance amount
- Withhold amount
- Coordination of Benefits amount
- Contractual Write-Off amount
- Net payment amount
- Adjustment EOB Code and Summary
- FFS payment amount
- Deductible amount

Coordination of Benefits

Coordination of Benefits (COB) are rules that establish the order in which health insurers pay claims when more than one insurer provider coverage for a member.

WVCH CCO uses standard Federal and State guidelines to make COB determinations. Current federal regulations require that Medicaid pay for health care only after an individual's other health care resources have been exhausted. Therefore, WVCH CCO (with a few exceptions) is considered the payer of last resort. If the member has coverage with WVCH CCO and another health plan, file the claim with the insurance company, which, to the best of your knowledge, is the primary payer.

If you need assistance in determining the position of more than one payer, please contact Customer Service for assistance with this determination. It is very important to include all coverages on your CMS-1500, and UB04 billing forms. All claims billed for secondary coverage must be reported with a copy of the Explanation of Benefits (EOB) from the primary payer. Be sure to list all group numbers and identification numbers on each claim.

The total claim payment will be paid at the lesser of the WVCH contract allowable or billed charges. For example, if the primary pays part of the claim, WVCH will pay the difference up to the WVCH allowable or billed charges whichever is less.

Third Party Liability
Third Party Liability (TPL) is defined as individuals, entities or programs that may be liable to pay all or part of the expenditures for medical expenses provided under a health plan.

Third parties include private health insurance (i.e., commercial insurers, self-funded plans or profit or non-profit pre-paid plans), Medicare, CHAMPUS, automobile insurance, state workers' compensation and other federal programs as well as liability insurance of any kind and or individuals who are legally responsible for the loss.

In most cases, WVCH CCO will pay for claims only when other means are not available. If you have any questions, or would like to report TPL please contact our Customer Service Department. Please see Health Plan Contacts page for Customer Service contact information.

Claims Processing

In order to receive payment for services rendered for a WVCH CCO member the submitting, rendering and attending providers must be enrolled as an Oregon Medicaid provider. WVCH will apply on behalf of the provider; however, additional *required* information is necessary, which may include, but is not limited, to the following: facility/office mailing address, rendering and submitting provider NPI, taxonomy, provider specific information and licensure information. In addition, a recent signed and dated W9 is required.

WVCH CCO will be unable to process any claim until this information has been received and the NPI(s) have been successfully enrolled with Oregon Medicaid.

Note: ***According to CMS 42 CFR §431.52 and 42 CFR §447.15b, the member may not be billed for these services; an Oregon Medicaid Number must be acquired in order to receive payment for this claim.***

For assistance in obtaining an Oregon Medicaid number please contact Provider Services. Please see the Health Plan Contacts page.

Request for More Information
We may send a claim back to you requesting further information in order to process the claim or to redirect the claim to another payer. A prompt response is necessary in order to pay the claim correctly.

Refund Requests
Refund Request Vouchers will be sent to providers, from which WVCH CCO has refunds due. The Refund Voucher will include all of the information on the claims as well as an explanation of why WVCH CCO is requesting the refund. Overpayments shall be refunded to WVCH CCO within 30 days from the date of notice or discovery.

If you find an error, in which you have been overpaid, you are required to take the necessary steps to return those funds. You may pay the amount at that time by attaching the claim voucher to the check or contact the Refund Department to coordinate a refund request or punch credit.

Should you have questions regarding WVCH CCO Overpayment and Recoupment process please contact Refunds. Please see Health Plan Contacts page for refunds contact information.

Claims Processing Schedule
Claims will be processed and paid within 45 days of our receipt of the claim.
If the claim cannot be processed within 45 days a letter must be sent requesting further information and the claim will be processed 44 days from receipt of the completed information.

Remittance Advice and checks will be issued weekly with some exceptions made to accommodate holidays.

Claim Reprocessing
Claims will not be reprocessed beyond 12 months from the original claims payment date. If reprocessing is requested on a claims past the 12 months from its original payment date it will be denied as a duplicate or will be denied for timely filing.

Proof of timely may be submitted with the paper claim or uploaded to the claim in CIM. CIM users can refer to the CIM Provider Manual in the Provider Service section in CIM for instructions.

- If an authorization/referral is processed after a claim has been denied, Claims must be notified to reprocess the claim. Notification can be made through Provider Customer Service or CIM.

- PLEASE DO NOT REBILL any claims you have already sent unless WVCH CCO could not process them (see Electronic Confirmation Submission Report and Request for More Information).
- Clearly mark corrected bills so that they can be rerouted and reprocessed as corrections not duplicate new bills.
- All resubmissions and/or corrections should be clearly identified as such. Please indicate by using a modifier CC next to the corrected CPT/HCPC's code or note "corrected claim" on the form. This will help to prevent a claim(s) from being denied as a duplicate submission.

Claims Inquiries

SEE HEALTH PLAN CONTACTS PAGE FOR PROVIDER SERVICES

CIM users can upload additional documentation and inquire about claims utilizing the functions in CIM. Please refer to the CIM Provider Manual in the Provider Service section in CIM.

Additionally, on-line reporting tools are available via the CIM. The tools available are claims status, authorization status, authorization requests, eligibility information, and electronic claims submission.

For more information on accessing the private web page, please contact CIM Support with Provider Customer Services.

WVCH MEMBER GRIEVANCE & APPEAL PROCESS

WVCH CCO is responsible for providing a process for timely resolution of all member complaints. These complaints can be grievances/complaints (any expression of dissatisfaction with any aspect of the member's health care, health plan, etc.) or appeals for denied services (claims or authorization denials). WVCH CCO meets any and all guidelines established by Health Systems Division.

All WVCH CCO members receive information about their grievance and appeal rights in their Member Handbook. Members are also individually notified in writing, of their grievance and appeal rights each time a service or request for service is denied. This adverse determination letter informs the member of his/her appeal rights and other information regarding the process including outside review if appropriate.

Once a grievance or appeal has been filed with WVCH CCO the issue is immediately logged and tracked by the Grievance and Appeals Coordinator. The issue is reviewed within the time frames established by state or federal regulations.

In reviewing the grievance or appeal it may be necessary to obtain additional information from the physician or providers office. If this is necessary, the Grievance

and Appeals Coordinator will contact the appropriate office with the request. Because there is an established timeframe to resolve the issue your timely assistance is greatly appreciated.

Once the issue has been re-reviewed the member is notified in writing. If the original denial of service, or request for service is overturned, the authorization or claim will be reprocessed.

The grievance and appeal process is outlined step by step, in the Member Handbook. If a WVCH CCO member is dissatisfied with the actions of the plan or wishes to file a grievance please have them contact Customer Service. See Health Plan Contacts page for customer service contact information.

PROVIDER APPEALS POLICY

Appealing a Claim Denial

Providers may appeal claims decisions, where the provider is being held financially responsible for charges, on the basis of the following issues:

- Provider payment methodology
- Medical necessity denial (if no preauthorization was required)
- Contract/benefit plan limitation

(Providers may also assist members who appeal a claims denial of a service, in which the member is being held financially responsible. That process is addressed in a separate policy.)

Note: All claims appeals submitted by a provider must include additional information which the provider believes was not previously known or considered by WVCH CCO in its decision to deny the claim.

If the provider has submitted a request for reimbursement and a clean claim has been denied on its merits, the provider may appeal that non-payment. Claims denied due to lack of information, improper coding or some other administrative error can be resubmitted using the Claims Reconsideration Process.

Providers may file an appeal request to WVCH CCO within 60 calendar days from the date of the organization's final decision on a clean claim by using the following process: Inform the Appeals Coordinator at WVCH CCO in writing of their intent to appeal the determination. The representative will work with the provider in obtaining a formal letter of appeal and identifying the concern. All appeal requests should include the following:

- Member name and identification number
- Claim number assigned by WVCH CCO to the claim in question
- Provider name
- Service denied

- Issue or reason for the appeal
- Any pertinent clinical information, or related documentation that would be of assistance in reviewing the request, to support the reasons for the reversal of the adverse organization determination.

If a treatment has been denied on the basis that it is experimental or investigational, the request for reconsideration must be accompanied with peer-reviewed literature supporting the effectiveness of the procedure or treatment requested.

The written appeal should be submitted to the following address:

WVCH CCO
2995 Ryan Dr. SE Suite 200
Salem, OR 97301
Attention: Appeals Department

The appeal will be reviewed within 30 calendar days of receipt by WVCH CCO or as required by law. The appeal request will be reviewed by the Appeals Coordinator with assistance from Medical Management as appropriate to the issue presented. If WVCH CCO reverses the previous decision, in whole or in part on any claims denial, the claim shall be paid as soon as possible, not to exceed 60 days from the date the plan received all the information necessary to render a decision. That response will include an explanation of the denial/issue, and if the initial determination is upheld, instructions on additional appeal options. The result of this first appeal shall be forwarded to the Appeals Coordinator for tracking purposes.

If the denial is upheld, the provider may file for a review with Health Systems Division per OAR-410-120-1580.

Appealing a Medical Management Decision
Providers may appeal the following WVCH CCO medical claims decisions:

- Pre-authorization of procedures, hospitalizations or medications
- Hospital length of stay
- Denials of coverage because the treatment/service is not covered under OHP
- Denials of coverage based upon medical necessity of a service

Note: All appeals of medical management decisions submitted by a provider must include additional information which the provider believes was not previously known or considered by WVCH CCO in its decision to deny a requested service. This means there must be new clinical information from the provider if no appeal letter is sent.

If the provider disagrees with an organizational determination by WVCH CCO, he/she may appeal by filing a request for an appeal within 60 calendar days from the date of

the notice of the decision by the plan. The provider may appeal in writing to the Appeals Coordinator. The request for appeal needs to include the following:

- Member name and identification number
- Provider requesting the service
- Service denied
- Issue or reason for the appeal
- In the case of a prior authorization, why the provider believes benefit coverage should be provided.
- Any pertinent clinical information, or related documentation that would be of assistance in reviewing the request, to support the reasons for the reversal of the adverse organization determination (to be submitted in writing)

If a treatment has been denied on the basis that it is experimental or investigational, the request for reconsideration must be accompanied by peer-reviewed literature supporting the effectiveness of the procedure or treatment at issue.

The written appeal should be submitted to the following addresses:

WVCH CCO
2995 Ryan Dr. SE Suite 200
Salem, OR 97301
Attention: Appeals Department

The provider's written appeal request and any other supporting documentation, shall be forwarded to the Medical Director for review. If the issue has already been reviewed by the Medical Director and denied, or if the Medical Director determines that the question or issue requires additional clinical expertise, it shall be sought at that time from appropriate clinical sources. The decision shall also be communicated to the WVCH CCO Grievance and Appeal department for tracking purposes only. If the decision is made to uphold the initial decision, the case will be presented to the WVCH CCO Medical Director for review. Outreach may be made to specialty providers as needed to ensure appropriate review.

If the prior decision is upheld, and the provider continues to disagree with the decision, he/she may request an administrative review through Health Systems Division within 30 days of the denial. The written appeal should be submitted to the following addresses:

DHS
500 Summer St #E49
Salem, OR 97301
Attention: Provider Appeal Coordinator

The decision on the appeal request shall be communicated to the provider from WVCH CCO in writing as soon as possible, but no later than 30 days from the date of receipt.

APPENDIX

Appendix A - WVCH MEMBER RIGHTS AND RESPONSIBILITIES

OAR 410-120-1855

Member Rights

1. To be treated with dignity and respect;
2. To be treated by providers the same as other people seeking health care benefits to which s/he is entitled;
3. To select or change his/her Primary Care Provider (PCP) up to 2 times a year;
4. To obtain mental health, chemical dependency, or family planning services;
5. To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;
6. To be actively involved in the development of his/her treatment plan;
7. To be given information about his/her condition and covered and non-covered services, to allow an informed decision about proposed treatment(s);
8. To consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;
9. To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
10. To have written materials explained in a manner that is understandable;
11. To receive necessary and reasonable services to diagnose the presenting condition;
12. To receive covered services under the Oregon Health Plan, which meets generally accepted standards of practice and is medically appropriate;
13. To obtain covered preventive services;
14. To access urgent and emergency services 24 hours a day, 7 days a week;
15. To receive a referral to specialty practitioners for medically appropriate covered services;
16. To have a clinical record maintained, which documents conditions, services received, and referrals made;
17. To have access to his/her own clinical record, unless restricted by statute;
18. To transfer a copy of his/her clinical record to another provider;
19. To make a statement of wishes for treatment and end of life decisions, and obtain a power of attorney for health care;
20. To receive written notices 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;
21. To know how to file a complaint with, and receive a response from WVCH CCO;
22. To request an administrative hearing with the Department of Human Services (DHS);
23. To receive interpreter services;
24. To receive a notice of an appointment cancellation in a timely manner.

Member Responsibilities

1. To read the plan booklet and benefit material, to make certain s/he understands the plan;
2. To choose his/her provider, once enrolled;
3. To treat all WVCH CCO providers and personnel with respect;
4. To be on time for appointments and to call in advance either to cancel, if s/he can't make the appointment, or is going to be late;
5. To seek periodic health exams and preventive services from his/her PCP or clinic;
6. To obtain services from his/her PCP (except in an emergency) or through WVCH CCO providers upon referral from his/her PCP;
7. To obtain a referral to a specialist from his/her PCP before seeking care from a specialist, unless self-referral to the specialist is allowed;
8. To use urgent and emergency care appropriately, and notify WVCH CCO or his/her PCP within 72 hours of an emergency;
9. To give accurate information to be included in the clinical record;
10. To help the provider or clinic obtain clinical records from other providers, this may include signing a release of information;
11. To ask questions about conditions, treatments, and other issues related to his/her care that is not understood;
12. To use information to make informed decisions about treatment before it is given;
13. To help in the creation of a treatment plan with the provider;
14. To follow prescribed agreed upon treatment plans;
15. To tell his/her provider that health care is covered under OHP before services are given, and if requested, to show the provider his/her Health Systems Division Medical Care Identification form;
16. To tell his/her DHS worker of a change of address or phone number;
17. To tell his/her DHS worker if someone in the family becomes pregnant, and of the birth of a child;
18. To tell his/her DHS worker if any family members move in or out of the household;
19. To tell his/her DHS worker if there is any other insurance available;
20. To pay for non-covered services;
21. To pay the monthly OHP premium on time if so required;
22. To assist WVCH CCO in pursuing any third party resources available and to pay WVCH CCO the amount of benefits it paid for an injury from any recovery received from that injury;
23. To bring issues or complaints to the attention of WVCH CCO;
24. To sign a release so that DHS and WVCH CCO can obtain information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Appendix B - HEALTH PLAN CONTACTS

Monday through Friday 8:00 a.m. – 5:00 p.m.
(excluding New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Day after Thanksgiving, and Christmas)

Reporting Suspected Fraud or Abuse

WVCH Hotline: 1-844-319-9343
or to make an anonymous report online:
http://www.wvchealth.ethicspoint.com/

Oregon Department of Health Services
Phone: Fraud Hotline 1-888-372-8301
Fax: (503) 373-1525 (Attn: HOTLINE)
Mail: Investigations Unit, PO Box 14150, Salem, OR 97309

Reporting to the Office of the Inspector General (OIG) Hotline

- **Phone: (800) HHS-TIPS (800-447-8477)**
- **Fax: (800) 223-8164**
- **E-mail: HHTips@oig.hhs.gov**
- **Mail: Office of the Inspector General**
  Department of Health and Human Services
  Attn: HOTLINE
  PO Box 23489
  Washington, DC 20026

Provider Customer Service

Contact Provider Customer Service for questions related to:

- Benefits and eligibility information on your members
- Status of referral or Pre-Authorization requests
- Primary Care Physician changes
- Claims inquiries or reconsideration of payment on claims already processed as related to claims specific billing and/or coding questions.
  Email: ***edi.support@phtech.com***
- Claims status checks
- Remittance Advice and member hold harmless issues

Voice	Local: 503-584-2150	Toll-free:	866-362-4794
Fax	Local: 503-566-9801	Toll-free:	866-566-4905
		TTY:	800-735-2900

Contracting

Contact Contracting for question regarding the terms of your contract for physical and chemical dependency services:

Voice Local: 503-587-5135
Toll Free: 866-318-5375
Email: contracting@mvipa.org

Credentialing Department

FAX: 503-581-8192
Email: credentialing@mvipa.org

Information Systems Department

Voice Local: 503-584-2150
Toll Free: 866-318-5375

Intensive Case Management Services

Voice Local: 503-581-7010
Toll-free: 866-318-5375

The ICM Coordinators can be reached at:
Voice Local: 503-584-2150

Mental Health and Substance Use Disorder Services

Note: Mental health and substance use disorder services are referred to collectively as "behavioral health services".

For questions related to Access to either mental health or substance use disorder services, contact:
Voice call: 503-361-2778
Fax: 503-585-4989

For questions related to prior authorizations, out of network services, and higher levels of care for all behavioral health services, contact:
Voice Call: 503-361-2647
Fax: 503-585-4989
Email: providerrelations@mvbcn.org

If you have a question about your contract for mental health services, contact MVBCN Contracting:
Voice Local: 503-566-2916
Email: MHcontracting@mvbcn.org

If you have a question about your contract for substance use disorder services, contact WVCH CCO Contracting:
Voice Local: 503-371-7701
Email: contracting@mvipa.org

Pharmacy Services
Voice Local: 503-581-7010
MedImpact Customer Service: 800-788-2949
MedImpact Direct Specialty: 877-391-1103
Email: pharmacytechs@mvipa.org

Provider Relations
Contact Provider Relations for questions such as:

- Explanations on medical, administrative or reimbursement policies
- Call Share Issues
- Updates to current access status for new members

Voice Local: 503-581-7010
Toll Free: 866-318-5375
Email: providerrelations@mvipa.org

Referral/Pre-Authorization
Voice Local: 503-581-7010
Toll-free: 866-318-5375
Faxes: 503-581-7417
Email: referral@mvipa.org

Refunds
Voice Local: 503-584-2150
Email: refunds@phtech.com

Transportation Provider
Call LogistiCare to schedule a ride:
Member Phone: 844-544-1397
Healthcare Facility Phone: 844-287-6698
Oregon Relay Service: 7-1-1

Correspondence Mailing Address:
WVCH
2995 Ryan Dr. SE Suite 200
Salem, OR 97301

Appendix C - HEALTH SYSTEMS DIVISION 3108 PROCESS

Dear Provider,

Performance Health Technology has recently received a claim from your office, billed to one of the plans that we manage. If your office did not bill us directly for primary processing it could be that one of our plans is the secondary insurance and received a claim on your behalf for secondary processing. The NPI(s) number on the claim is not enrolled in Oregon Medicaid. In order to receive payment consideration or credit for an encounter to the State, both submitting and rendering providers must be enrolled in Oregon Medicaid in order to receive payment for services rendered for a Medicaid member. Performance Health Technology will apply on behalf of the provider; however, we will need additional information which is outlined in the form below.

Performance Health Technology will be unable to process any claim until this information has been received and the NPI(s) have been successfully enrolled with Oregon Medicaid. ***According to CMS 42 CFR §431.52 and 42 CFR §447.15b, the member may not be billed for these services; an Oregon Medicaid Number must be acquired in order to receive payment for this claim.***

Please complete the attached form with all necessary information and return it along with your most recent signed and dated W9.

You may also fax this information to 503-315-4138, Attn: PSS or send it via email to provider.contracts@phtech.zendesk.com.

Warmest Regards,

Provider Systems

Plan Information

Plan Name:

Claim Information

Claim Number:	DOS:

Addresses

Facility/Office Street Address:	
Facility/Office City, State, Zip+4:	
Office Phone:	Office Fax:
Financial Mailing Street Address:	
Financial Mailing City, State, Zip+4:	
Financial Mailing Phone:	Financial Mailing Fax:

Identification Numbers

For Rendering Physician(s)

Name:		NPI: Rendering NPI
State Medical License (required):	Effective Date:	Expiration Date:
Taxonomy Code:		
State Medicaid Number:	Effective Date:	Expiration Date:
State Medicare Number:	Effective Date:	Expiration Date:
Social Security Number*:		Date of Birth*:

**** Required by new CMS rule CMS-6028-FC effective March 25, 2011.***

For Submitting Provider

Name:	NPI: Submitting NPI	
Taxonomy Code:		
State Medicaid Number:	Effective Date:	Expiration Date:
State Medicare Number:	Effective Date:	Expiration Date:

Hospitals, Skilled Nursing Facilities, Home Health, and ESRD must fill in your license information below.
Laboratories please fill in your CLIA number information below.

Hospital License Number:	Effective Date:	Expiration Date:

The following information is required in order to acquire a Medicaid number for NPI Group/Submitting NPI.
*The following information must be supplied for all owners and officers with a **controlling interest of 5% or more** in the company. If no one person is an owner or has a controlling interest if 5% of more, the following information will need to be supplied for the CEO, COO, or controlling officer in the company. **
Please include additional sheets if necessary.

Name*	Title*	Date of Birth*	SSN*

**** Required by new CMS rule CMS-6028-FC effective March 25, 2011.***

********** PLEASE INCLUDE YOUR MOST RECENT SIGNED AND DATED W9 AND A COPY OF YOUR BUSINESS LICENSE **********