

February 2018



Provider Manual

Tuality HealthAlliance

**The right care.
Right here.**

THA Contact Information

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| Customer Service (English/Spanish) Fax | 503-844-8104 503-681-1927 |
| Referrals and Prior Authorization Fax | 503-844-8104 503-681-1823 |
| Provider Relations Fax | 503-681-1166 503-681-1981 |
| Contracting Fax | 503-681-1867 503-681-1981 |
| THA Website | http://www.tuality.org/tha/ |
| THA Provider Directory | http://www.tuality.org/tha/index.php/find_a_Provider |
| THA Provider Portal | https://www.tuality.org/tha/ <ul style="list-style-type: none">• Providers & Clinics > Provider Login |
| THA Mailing Address | PO Box 925 Hillsboro, OR 97123 |

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WELCOME TO THA!

THA Mission

THA is committed to improving healthcare outcomes by serving members and Providers within our community.

THA History

THA (hereinafter “THA”) is a physician-hospital community organization (PHCO) dedicated to providing quality, community based care. This partnership is with Tuality Healthcare and includes Tuality Community Hospital, Tuality Forest Grove, Tuality Urgent Care, the local physicians and community members. The Board of Directors is comprised of Providers, community leaders and Tuality Healthcare staff. THA Provider membership includes approximately 100 primary care physicians and 200 specialists.

Formed in 1994, THA is a managed care capitated health plan contracted for Oregon Health Plan (OHP) Western Washington County members. Focused on providing quality care to vulnerable populations, THA provides guidelines for member Providers to maximize community physician participation. Most importantly, THA locally manages care, control utilization through effective referral and authorization process, and develops customized payment arrangements.

In 2008, THA became the Administrator for the Tuality Healthcare employee benefit plan. The plan covers all Tuality employees and their families. While THA pays the claims made under the plan, medical management is provided by Innovative Care Management.

In late 2012, THA partnered with Health Share of Oregon, a Coordinated Care Organization (CCO) certified by the Oregon Health Authority (OHA) to serve OHP (Medicaid) enrollees in Clackamas, Multnomah and Washington Counties.

THA contracts on behalf of the physicians and the hospital with many of the Insurers operating in our service area including:

- Aetna
- Cigna
- First Choice Health Network
- Health Net Health Plan of Oregon
- MODA
- Humana
- Pacific Source
- PHCS/Multiplan
- Providence Medicare
- Regence Blue Cross Blue Shield of Oregon
- United Healthcare

The THA network, available to our OHP and Employee Plans include over 1,000 referral specialists and four hospital systems in our immediate service area.

THA administrative staff supports our Providers with medical case management, delegated credentialing, and quality improvement services to a variety of these contracted plans.

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

- improve the member’s experience of care
- improve the health of populations
- reduce the per capita cost of care

More information about IHI's Triple Aim Initiative can be found at <http://www.ihl.org/Engage/Initiatives/TripleAim>. THA adopted the initiative in ____ after recognizing the need to streamline our processes to provide consistently high quality care and reduce administrative burdens on Providers.

MEMBERS

How to become a THA Member

Individuals become members of THA by enrolling in the Health Share of Oregon CCO and choosing THA Health Plan or stating their Provider preference.

Coordinated Care Organizations (CCOs)

The Oregon Health Plan (OHP) is the Oregon Medicaid program administered by the Division of Medical Assistance Programs (DMAP) at the State of Oregon. DMAP extended Medicaid eligibility to all state residents with incomes up to 138% of the federal poverty level (FPL), as well as children whose family income is up to 300% of the FPL.

CCOs were developed by the State to provide better health and better care at lower costs for all Oregonians. Through an integrated model, CCOs provide locally managed care emphasizing prevention, chronic disease management, and educating members who may be high utilizers in need of additional assistance. THA administers OHP benefits through Health Share of Oregon. More information about Health Share of Oregon can be found at www.healthshareoregon.org.

Oregon Health Plan (OHP) Eligibility

OHP Eligibility is determined by a simple screening and application process managed by Oregon Health Authority. OHP members must meet income and residency requirements, but may also qualify based upon age and disability status. OHP members eligibility effective dates are retroactively granted to the recipient's application date. Adult recipients are eligible for six months and must reapply prior to the conclusion of each six-month period. Children must reapply every 12 months. If recipients do not reapply before their eligibility ends, their OHP eligibility terminates until they reapply. Member eligibility effective dates and application renewal dates are available in the CIM6 portal.

Applying for the Oregon Health Plan

OHP Application can be completed online (<https://one.oregon.gov>); on paper (<http://www.oregon.gov/oha/HSD/OHP/Pages/apply.aspx#apps>); or in person at a trained community partner facility (<http://healthcare.oregon.gov/Pages/find-help.aspx>). Additional assistance can be provided by calling toll free 1-800-633-9075 or 711 (TTY).

Oregon Health Plan Member's Rights and Responsibilities

THA CCO members receive their rights and responsibilities statement in their member handbook at onboarding and with each revision of the handbook. Members and participating Providers can access the handbook via the Health Share of Oregon website www.healthshareoregon.org and the THA website www.tualityhealthalliance.org.

Member Rights:

- Be treated with dignity, respect and privacy
- Be treated by participating Providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with your care team, including Providers and community resources appropriate to your needs
- To be free from discrimination in receiving benefits and services to which you are entitled
- To receive equal access for both males and females under 18 years of age to appropriate treatment, services and facilities. This includes homeless youth and those in gangs, as required by ORS 417.270
- Choose a Primary Care Provider (PCP), Primary Care Dentist (PCD), mental health Provider or service site, and to make changes to these as permitted in the Health Share's administrative policies
- Get behavioral health or family planning services without a referral from a PCP or other participating Provider
- Have a friend, family member, or advocate with you during appointments and other times as needed within clinical guidelines
- Be actively involved in the development of your treatment plan; to talk honestly with your Provider about appropriate or medically necessary treatment choices for your conditions, regardless of the cost or benefit coverage
- Be told information about your condition and covered and non-covered services in a way that you can understand, to allow an informed decision about proposed treatments
- Consent to treatment or refuse services, and be told the consequences of that decision, except for court-ordered services
- Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- Have written materials explained in a manner that is understandable to you, including the coordinated care approach and how to get services in the coordinated health care system
- Receive services and support in a language you understand, and in a way that respects your culture, as close to home as possible
- To choose Providers, if available within the network, that are in non-traditional settings and accessible to families, diverse communities, and underserved populations
- Receive care coordination and transition planning from THA in a language you understand and in a way that respects your culture, to ensure that community-based care is provided in as natural and integrated an environment as possible, and in a way that keeps you out of the hospital
- Receive necessary and reasonable services to diagnose your condition
- Receive integrated, person-centered care and services that provide choice, independence and dignity, and that meet generally accepted standards of medically appropriate practice
- Receive the level of service that you expect and deserve, as approved by your Providers
- Have a consistent and stable relationship with a care team that is responsible for comprehensive care management
- Receive assistance using the health care delivery system and accessing community and social support services and statewide resources, including but not limited to certified or qualified health care interpreters, advocates, community healthworkers, peer wellness specialists and personal health navigators who are part of your care team. This is to provide cultural and language assistance appropriate to your need to participate in making decisions about your care and services
- Obtain covered preventive services
- Have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization

- Receive a referral to specialty Providers for medically appropriate covered services, following the CCO's referral policy
- Have a clinical record that documents conditions, services received, and referrals made
- To have access to your own clinical record unless restricted by statute, and to receive a copy and have corrections made to your health information
- To know that information in your medical record is confidential, with exceptions determined by law; to receive a notice that tells you how your health information may be used and shared; to decide if you want to give your permission before your health information can be used or shared for certain purposes and to get a report on when and why your health information was shared for certain purposes
- Transfer of a copy of the clinical record to another Provider
- Write a statement of wishes for treatment, including the right to accept or refuse medical, surgical, dental or behavioral health treatment
- Write advance directives and powers of attorney for health care established under ORS 127
- To be free from any form of restraint or seclusion (isolation) that is not medically necessary or is used by staff to bully or punish you. Staff may not restrain or isolate you for the staff's convenience. You have the right to report violations to THA, Health Share and to the Oregon Health Plan
- Receive written notices before denials or changes in benefits or service levels if a notice is required by federal or state regulations
- Be able to make a complaint or appeal with the THA or Health Share and receive a response
- Request a contested case hearing
- Receive qualified health care interpreter services; and to have information provided in a way that works for you. For example, you can get it in other languages, in Braille, in large print or other format such as electronic. If you have a disability, we must give you information about the plan's benefits in a way that is best for you
- Receive notice of an appointment cancellation in a timely manner
- The right to obtain a second opinion
- To receive information about THA, Health Share, our Providers and services
- To make recommendations about Health Share's member rights and responsibilities policy
- To request and receive information on the structure and operation of THA or any physician incentive plan
- To know that if you believe your rights are being denied or your health information isn't being protected, you can do either or both of the following: File a complaint with your Provider or health insurer, File a complaint with the Client Services Unit for the Oregon Health Plan

Member Responsibilities:

- Help choose a PCP or clinic, a primary care dentist (PCD), and a Primary Mental Health Provider if needed
- Treat THA, Health Share, Providers, and clinic staff members with respect
- Be on time for appointments, and call in advance to cancel if unable to keep the appointment or if you expect to be late
- Seek periodic health exams and preventive services from your PCP, PCD or clinic
- Use your PCP or clinic for diagnostic and other care except in an emergency
- Obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed
- Use urgent and emergency services appropriately, and tell your PCP or clinic within 3 days of using emergency services
- Give accurate information that may be included in the clinical record

- Help the Provider or clinic obtain clinical records from other Providers which may include signing an authorization for release of information
- Ask questions about conditions, treatments, and other issues related to your care that you do not understand
- Use information provided by THA Providers or care teams to make informed decisions about a treatment before you receive it
- Help your Providers make a treatment plan
- Follow treatment plans as agreed and take active part in your health care
- Tell your Providers that your health care is covered under the OHP before you receive services and, if requested, show the Provider your Oregon Health ID card
- Call OHP Customer Service to tell them of a change of address or phone number
- Call THA, Health Share and OHP Customer Service if you become pregnant, and when the baby is born
- Tell OHP Customer Service if any family members move in or out of the household
- Call Health Share Customer Service if there is any other insurance available
- Assist your health plan in pursuing any third party resources available, and reimburse the health plan the amount of benefits it paid for an injury if you receive a settlement for that injury
- Bring issues, complaints and grievances to the attention of THA or Health Share

Verifying Plan Enrollment for Oregon Health Plan

Health Share of Oregon issues a medical care identification card when the participant enrolls with the CCO. Eligibility may be verified through the THA Provider portal at www.tualityhealthalliance.org.

PCP ASSIGNMENT AND SELECTION

Assigning a PCP to THA Members

THA encourages members to choose their own PCP which allows members to establish care with Providers who best meet their cultural and personal preferences. If a THA member does not choose a PCP within 30 calendar days from enrollment, THA will formally assign a PCP keeping in mind any cultural, language or special needs of the member.

Changing PCP

Members are allowed to change their PCP at any time by calling the THA Customer Service line at 503-844-8104. New PCP assignments become effective the day they are requested; Providers may not be notified of the new member assignment until they receive their member roster.

Members will receive an updated ID card from Health Share reflecting their new PCP choice.

Member Rosters

PCP clinics receive a roster of members sent by THA Provider Relations on a monthly basis. Use the THA portal to verify PCP assignment. Should you have any questions regarding member assignment, you may also reach out to Provider Relations or Customer Service.

MEMBER COMPLAINTS

Resolving Complaints with a Provider or Facility

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

THA will review, research and resolve all concerns within five (5) business days. If the complaint requires additional follow up, a letter will be issued to the member within five (5) business days. A final answer will be provided within 30 calendar days. Complaints are monitored by the THA Complaints and Grievances Committee as well as reviewed quarterly by the THA Quality Management Committee. Additional information about the THA Complaint and Grievance process can be found in THA Policy VI-2, Member Complaints and Grievances.

If a THA member is uncomfortable contacting THA for assistance with their complaint they may contact Health Share of Oregon Customer Service at 503-416-8090. They may also contact OHP Client Services by calling 800-273-0557 or the Oregon Health Authority's Ombudsman at 503-947-2346.

Restraint and Seclusion

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

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move their arms, legs, body or head freely. Restraint is also a drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage.

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

OHA requires Providers to have a policy and procedure regarding use of restraint and seclusion in compliance with the Code of Federal Regulations Title 42 Public Health. Providers are required to provide this policy to THA upon request. If a Provider and/or clinic does not use restraint and seclusion, they are not required to maintain a policy. In these cases, THA requires that the Provider and/or clinic submit a written statement and complete a restraint and seclusion waiver.

BENEFITS

Oregon Health Plan Covered Services

The Oregon Health Plan covers a comprehensive set of medical services defined by a list of diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Evidence Review Commission (HERC). Known as the “Prioritized List of Health Services”, the list is regularly updated by OHA. To determine if a service is covered under the Oregon Health Plan, Providers may search via:

- OHA List Inquiry <http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Searchable-List.aspx>
- Provider Web Portal <https://www.or-medicaid.gov/>
- OHP Code Pairing and Prioritized List Hotline 800-393-9855

Updates to the Prioritized List can be automatically sent to you by subscribing to updates at https://public.govdelivery.com/accounts/ORDHS/subscriber/new?topic_id=ORDHS_378.

OHP coverage is determined based upon the lines of the Prioritized List of Health Services. Covered lines are updated regularly. Diagnosis and treatment pairs that rank below the line are not covered benefits under OHP, and therefore not covered by THA. If a service is not covered by OHP and a Provider has determined the treatment is necessary, an authorization request may be submitted with the proper documentation to the THA’s Prior Authorization department. Requests for non-covered services are denied automatically if additional information is not included with an authorization request.

Sterilizations and Hysterectomies

Oregon law requires that informed consent be obtained from any individual seeking voluntary sterilization (tubal ligation or vasectomy) or a hysterectomy (ORS 677.097). It is prohibited to use state or federal money to pay for voluntary sterilizations or hysterectomies that are performed without the proper informed consent. THA cannot reimburse primary or secondary payments to Providers for these procedures without proof of informed consent.

For a tubal ligation or vasectomy, the patient must sign the Consent to Sterilization form (DMAP form 741, available in English and Spanish) at least 30 days but not more than 180 days prior to the sterilization procedure. The person obtaining the consent must sign and date the form. The date should be the date the patient signs. It cannot be on the date of service or later. The person obtaining consent must provide the address of the facility where consent was obtained. (OAR 410-130-0580). If an interpreter assists the patient in completing the form, the interpreter must also sign and date the form. The physician must sign and date the form either on or after the date the sterilization was performed.

Fully and accurately completed consent forms, including the physician’s signature, should be submitted with all sterilization claims. Incomplete forms are invalid and will be returned to the Provider for correction. Should a claim without a proper consent form be mistakenly paid, a recoupment shall be initiated.

Hysterectomies performed for the sole purpose of sterilization are not a covered benefit. Patients who are not already sterile must sign the Hysterectomy Consent form (available in English and Spanish).

Physicians must complete Part I including the portion “medical reasons for recommending a hysterectomy for this patient”. THA will return the form to the Provider if this portion is omitted.

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

The following are exceptions to this policy:

Premature delivery: sterilization may be performed fewer than 30 days but more than 72 hours after the date that the member signs the Consent form. The member's expected date of delivery must be included.

Emergency abdominal surgery: sterilization may be performed fewer than 30 days but more than 72 hours after the date of the individual's signature on the consent form. The circumstances of the emergency must be described and the physician must complete Part II including the nature of the emergency that made prior acknowledgement impossible.

Skilled Nursing Facility Care

The Oregon Health Plan members have a 20-day Skilled Nursing Facility (SNF) benefit. Continued stay is determined based on clinical review and member need.

When a THA member is being discharged from the hospital and must be placed in a skilled nursing facility, the hospital discharge planner and the THA Nurse Case Manager will coordinate placement. Skilled nursing care does require prior authorization.

PCP's will be sent a copy of the SNF authorization, notifying them that their patient will be admitted to an SNF.

PCP's can choose whether or not to manage the care of their patients who are placed in an SNF. PCP's can choose to provide medical management to these patients or PCP's can have the nursing facility's house physician provide medical management. Members remain assigned to their existing PCP during a temporary stay in an SNF.

Palliative and Hospice Care

THA covers palliative and hospice care with prior authorization.

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

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

Mental Health and Substance Use Services

THA members receive their mental health and substance use services through Washington County. They can be contacted at 503-291-1155. The Crisis Line is 503-291-9111.

www.co.washington.or.us/hhs/mentalhealth

Local Resources for Mental Health Crisis:

- Hawthorn Walk-in Center: urgent care services for mental health and addiction concerns.

- Unity center for behavioral health: immediate psychiatric care and a path to recovery for people experiencing a mental health crisis.

Tobacco Cessation

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

THA is contracted with the Quit for Life Program which offers telephonic counseling, resources and additional treatment. Those resources can be accessed by calling **1-866-QUIT-4-LIFE** or online at **www.quitnow.net**.

Flexible Services

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

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

Flexible Services funds for Health Share/THA members are allocated from OHP state funds and they are subject to all applicable rules and regulations for Medicaid expenditures.

Requesting Funds for Flexible Services:

- i. Funds can be requested by any participating Health Share/THA Provider, Nurse Case Manager or staff, or THA member.
- ii. Requests must be submitted via a completed Flexible Services Request Form which can be obtained through Health Share/THA website at www.tualityhealthalliance.org; at THA Provider offices; or by calling THA Customer Service at 503-844-8104.
- iii. Completed Flexible Services Request forms must be submitted to the Health Share/THA Referral & Authorizations department via fax at 503-681-1823. Health Share/THA Referral Coordinators will review request for completion and forward request to Health Share/THA Nurse Case Managers.
- iv. Health Share/THA Nurse Case Managers will review request and make a final determination. Services requested may require additional documentation prior to final determination.
- v. THA will provide the written determination outcome to the requesting Provider/member.

Oregon Health Plan Non-Covered Services

Providers can provide services not covered under OHP to THA members, but arrangements for reimbursement must be negotiated between you and the member. The member must sign an OHP Client Agreement to Pay for Health Services form before services are performed. This form may be found at <http://www.oregon.gov/oha/healthplan/pages/forms.aspx>. DMAP prohibits billing Oregon Health Plan recipients for covered services.

MEMBER CARE AND SUPPORT SERVICES

Primary Care and Non-Primary Care

Primary Care Services

THA's primary care Providers are responsible for providing primary care services to their assigned patients. General categories of primary care services are:

- Preventive services, health maintenance and disease screening such as:
 - Well child care
 - Immunizations
 - Blood pressure screening
 - Physical exams, including annual gynecological exams
- Managing common chronic primary care problems such as:
 - Diabetes
 - Hypertension
 - Chronic lung disease
 - Asthma
 - Arthritis
 - Seizure disorders
 - Peptic ulcer disease
 - Ischemic heart disease
 - Other similar conditions managed in the office
- Managing common acute primary care problems such as:
 - Respiratory infections
 - Urinary infection
 - Gastroenteritis
 - Acute musculoskeletal strains, sprains and contusions
 - Vaginitis
 - Hemorrhoids
 - Depression
 - Anxiety disorders
 - Other similar conditions managed in the office and minor outpatient procedures
- Coordinating care including such services as:
 - Referring patients for specialty care needs, communicating with specialists and managing the ongoing referral process
 - Coordinating hospital care and discharge planning, including planning done by a consultant

Non-Primary Care Services

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

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

The following are examples of services considered non-primary care services:

- Inpatient physician care
- Obstetric care
- Prenatal care
- Non-primary laboratory including all lab tests not waived by the CLIA regulations
- Mental health treatment not provided in a primary care setting
- Radiology services including X-ray interpretation
- Consultant care
- Home and nursing home visits including hospice care
- Prescription drugs including medications dispensed from the office
- Outpatient procedures such as:
 - ECG tracing and interpretation
 - Spirometry
 - Fracture care including casting
 - Colposcopy
 - Endometrial Biopsy
 - Sigmoidoscopy
- Family planning including:
 - IUD Insertion
 - Birth Control Pills
 - Vasectomy
 - Emergency Contraception

Responsibilities of the PCP

PCP's will provide **at least** the following level of service to THA members assigned to them:

- Maintain in the member's record a comprehensive problem list which lists all medical, surgical and psycho-social problems for each patient
- Maintain a comprehensive medication list that includes all prescription medications that the member is taking and their medication allergies. This includes medications prescribed by specialists
- Information to members on where to receive appropriate urgent care services (Do not refer to Emergency Department for non-life threatening medical needs.)
- Accessible outpatient care within 72 hours for any member with an urgent problem
- Accessible outpatient care within four weeks for any routine visit
- US Preventive Services Task Force Preventative Services recommended preventative services or all age appropriate immunization recommendations by the Centers for Disease Control
- Arrange and/or request authorization for specialty consultation with a network consultant within 72 hours for any member with an urgent problem needing such consultation
- Arrange and/or request authorization for specialty consultation with a network consultant within two weeks for any member with a non-urgent problem needing such consultation
- Ensure appropriate and complete medical records including but not limited to initial diagnosis and procedures requested as part of each referral
- Arrange for hospitalization in a network institution when required
- Coordinate hospital care for every hospitalized member including participation in planning for post discharge care
- Coordinate nursing home care for each member in a nursing home
- Arrange interpretation services, telephonically or onsite by a qualified interpretation service
- A policy and/or procedure to arrange for and provide access to an appropriate back-up physician or practitioner for any leave of absence

Access to Care

It is the policy of THA to ensure that our members have access to timely, appropriate health services that are delivered in a patient centered and culturally competent manner. THA requires Providers to have policies and procedures that prohibit discrimination and adhere to enrollee rights in the delivery of health care services.

Physical Access

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

Appointment Availability and Standard Schedule Procedures

Routine and follow up appointments should be scheduled to occur as medically appropriate within four weeks. Urgent cases should be scheduled to be seen within 72 hours or as indicated in initial screening

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

Providers should apply the same standards to their THA members as they do their commercially insured or private pay patients.

In support of the Institute for Healthcare Improvement Triple Aim, THA strongly encourages Provider offices to consider alternative scheduling, such as:

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

Follow Up on Missed Appointments

THA participating Providers should document and follow up with members who do not keep their scheduled appointments.

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

It is important to have written documentation of continually missed appointments if you wish to pursue discharging such members from your care. THA Medical Management and Customer Service staff are available to help Providers having problems with members missing repeated appointments.

If members are missing appointments due to transportation issues, please see Medical Transportation Services. If members do not qualify for Medical Transportation Services, please see Flexible Spending section.

24 Hour Telephone Access

Providers are required to provide 24 hour telephone access to THA members.

THA Providers must have a telephone triage system with the following features:

- **Office Hours Access Criteria:** A clinic must have a triage process for member calls to determine appropriate care and assists the member with advice, an appointment, or a referral. Calls may be answered by, but not screened by, non-clinical support staff. If calls are answered by non-clinical support staff, the member should be informed of the estimated response time from a clinician. The nature of the call and intervention are documented in the member's medical record. Interpreter services are available for telephone calls.
- **After Hours Access Criteria:**
 - **Answering Service Urgent:** Person who answers the phone must offer to either page the Provider on call and call the member back OR transfer the member directly to the Provider on call.
 - **Answering Service Emergency:** Person who answers the phone must tell the member to call 911 or go to the nearest emergency room if the member feels it is too emergent to wait for the Provider to call them.
 - **Voice Mail Urgent:** Message must give instructions on how to page the Provider for urgent situations or tell the member to go to the hospital emergency room or urgent care if they cannot wait until the next business day.
 - **Voice Mail Emergency:** Message must provide information on accessing emergency services such as calling 911 or go to the nearest emergency room if the member feels the situation is emergent.

Quality Management Program

Participation in Quality Management Program

Participation in the Quality Management (QM) program is a requirement for all Providers. Participation includes providing data for various QM activities and adhering to established standards of care.

Provider and member input into the delivery system is encouraged and made available thorough participation in appropriate committees. For information on the committees or if there is interest in participation, please contact THA Provider Relations at 503-681-1166

Quality Management Program

THA's Quality Management Program (QMP) is the structure and processes to ensure that care provided to members is accessible, cost effective, and improves health outcomes. QMP is designed to support achievement of clinical and operational performance goals and to ensure that THA meets its regulatory and contractual deliverables to Health Share of Oregon (THA's CCO), the Oregon Health Authority (OHA), the Centers for Medicare and Medicaid Services (CMS), and other relevant accrediting bodies.

The QMP reflects the imperative of the Institute for Healthcare Improvement Triple Aim to improve the member's experience of care, improve the health of populations, and reduce the per capita cost of care. THA pursues these aims through the implementation of programs and strategies that have the following objectives:

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

The effectiveness of the QMP is monitored through THA's Quality Management Committee (QMC), which reports directly to THA's Board of Directors. The QMC is structured to directly support the delivery system in building the infrastructure to support population health, deliver high-risk member interventions, and improve clinical processes and workflows that impact clinical performance metrics. The QMC consists of at least five physician members, including primary care and specialist Providers. The Committee also includes the THA Executive Director, THA Medical Director, THA Operations Manager, THA Medical Management Manager, THA Quality Improvement Coordinator(s), and Representative(s) of the THA Board of Directors. The board president is ex-officio and, thereby, can attend any Quality Management Committee meeting.

Medical Records

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

Criteria for what constitutes a complete medical record:

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

Each medical record should contain the following information:

- Patient's name, date of birth, sex, address, telephone number and any other identifying numbers as applicable

- Name, address and telephone number of patient’s next of kin, legal guardian or responsible party
- Advance Directives, guardianship, power of attorney or other legal healthcare arrangements when applicable
- A problem list with significant illness and medical conditions
- A comprehensive and reconciled medication list including an indication of allergies and adverse reactions to medications and documentation if no allergies are identified as well
- History of presenting problems and a record of a physical exam for the presenting problem(s)
- Diagnoses for presenting problems
- Treatment plan consistent with diagnoses
- Vital signs, height, weight, BMI
- Laboratory and other studies ordered, as appropriate, and initialed by the primary care Provider
- Documentation of referrals to and consultations with other Providers
- Documentation of appropriate follow-up
- Emergency room and other reports
- Baseline and current documentation of tobacco and alcohol use
- Documentation of past and present use or misuse of illegal, prescribed and over the counter drugs
- Documentation of behavioral health status assessments
- Copies of signed release of information forms
- Copies of medical and/or mental health directives
- Age appropriate screenings and developmental assessments

THA Access to Records

On a periodic basis, THA staff may require access to member medical records for the purpose of quality assessment, investigating grievances and appeals, monitoring of fraud and abuse, and review of credentialing issues. On an annual basis, THA staff may require Provider assistance in collecting medical record information for Division of Medical Assistance Program (DMAP) reporting.

Third Party Access to Records

Member records must be disclosed to contracted health plans or their representatives for quality and utilization review, payment or medical management.

A THA Provider who refuses to cooperate with the medical record review process, Peer Review requirements, and corrective action plans, or who is unable to meet Provider qualifications and requirements may have their contract terminated with cause.

Confidentiality

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

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

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

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

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

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

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

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

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

Providers, Clinical and Non-Clinical staff including physicians and THA staff must not have unapproved access to their own records or records of anyone known to them who is not under their care.

Interpreter Services

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

Here is a list of THA's contracted interpreter services:

- Passport to Languages – provide all languages including American Sign Language. In person interpreting is available. 503-297-2707 or 1-877-722-2090
- Certified Language Interpreters (CLI) – provide all languages including American Sign Language. In person interpreting is available. 1-800-225-5254 Access Code: TUALIT
- Pacific Interpreters – provide all languages by phone only. 1-800-264-1552

Access to qualified Interpreter Services shall be provided by telephone or in person.

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

After normal business hours, and on weekends and holidays, Interpreter Services will be available for emergency and urgent care needs.

The utilized Interpreter Services shall demonstrate both awareness for and sensitivity to sociodemographic and cultural differences and similarities among members.

A minor child is not to be used as an interpreter. Family members or friends should only be used as adjunctive interpreters if this is the member's preference.

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

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

Special Healthcare Needs Members

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

Special Healthcare Needs member services include:

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

Members with Special Healthcare Needs are identified through Division of Medical Assistance Program (DMAP) enrollment files and medical screening criteria.

Members may also be identified for services through self-referral, high utilization, from their Primary Care Provider (PCP), agency caseworker, their representative or other health care or social service agencies.

Special Healthcare Needs members will be identified on PCP's monthly rosters.

Medical Transportation for OHP Members

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

Ride To Care

Scheduling: 503-416-3955

TTY: 503-802-8058

Toll-free: 855-321-4899

Website: www.ridetocare.com

Hours: 7am – 7pm Monday through Saturday

Ride To Care provides free rides to covered medical appointments for OHP members who have no other transportation options.

- THA members must call Ride To Care to schedule a ride at least two business days in advance of their appointment. Members may schedule a trip up to 90 days before their appointment date.
- THA members need to have available their OHP number, time and date of their appointment and name, complete address and phone number of their medical caregiver.
- Ride To Care can help provide transportation for members with short notice. Members need to tell the operator if they have urgent transportation needs. For example, a ride to an urgent care clinic, or if the member requires transportation to and from dialysis or chemotherapy.
- Ride To Care has interpreters available for non-English speaking members. This service is free. Members can call Ride To Care and say the language they speak and stay on the line. A Ride To Care representative and interpreter will help them.
- THA members may call Ride To Care to obtain bus tickets.
- Ride To Care operators are there in person to answer calls 24 hours a day, 7 days a week, 365 days a year

Health Promotion Materials

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

DOING BUSINESS WITH THA

Provider Relations & Contracting

THA Provider Relations and Contracting is a link between our Provider network, THA staff and the health plans that THA contracts with on their behalf. They provide valuable resources to the Provider offices through direct contracting with health plans as well as credentialing and other key Provider relations services. In addition, the Provider Relations and Contracting staffs assist the Provider offices with questions or needs regarding Oregon Health Plan, Employee Health Plan, or contracted Health Plans issues.

Provider Relations

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

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

To contact Provider Relations you may call 503-681-1166 or email providerRelations@tuality.org.

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

If a Provider is interested in participating in network with THA, Provider Relations can be contacted to initiate the process. If it is determined that participation is needed, Provider Relations will help to coordinate the credentialing process.

Contracting

In addition to our direct participation for the Medicaid program, THA contracts on behalf of our THA member Providers with several commercial and Medicare Advantage Plans that provide coverage in our service area. THA staff negotiates these contracts on behalf of our member Providers. As a member of THA, you are required to participate in all contracted health plans.

Our Provider network is made up THA member physicians and associated clinicians; Tuality Community Hospital & Tuality Forest Grove Hospital; ancillary Providers including OHSU Providers and facilities; DME; SNFs. This network of Providers insures adequate access and quality care to our Oregon Health Plan and Tuality Employee members.

THA's contracts with commercial and Medicare Advantage plans, expands the opportunity for our THA member Providers to provide services to patients throughout Washington County and the surrounding area.

To contact Contracting you may call 503-681-1050 or email tyler.gunn@tuality.org.

Credentialing

THA credentials Providers to be part of the THA panel and members of THA. In addition, THA is delegated the credentialing responsibilities for all the commercial and Medicare Advantage plans that THA contracts with. This means Providers must only credential once with THA rather than credentialing separately with every health plan within the network.

THA credentials Doctors of Medicine (MD), Doctors of Osteopathic Medicine (DO), Nurse Practitioners (NP), Physicians Assistants (PA), and Nurse Anesthetists (CRNA). Additional Ancillary Providers may be accepted to the THA panel.

Criteria for Credentialing/Participation with THA

- Current, valid, unrestricted license by the appropriate Board to practice in the state of Oregon
- Completion of the Oregon Practitioner Credentialing Application
- Completion of the THA Membership Documents
- Clinical privileges in good standing at TCH, as confirmed by the THC Medical Staff Coordinators or Inpatient Covering Plan or Inpatient Covering Plan utilizing Hospitalists. Member Provider applicants must be an active, courtesy, or affiliate member of the TCH medical staff.
- Current, valid, DEA certificate in the state of Oregon, if applicable
- For physicians, graduation from the appropriate Medical School and completion of residency
- For nurse practitioners and anesthetists, graduation from the appropriate nursing school
- Board certification for Member and Contracted Providers within four years of residency completion by a Board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Naturopathic Medical Certification Board of the American Board of Podiatric Medicine.
- Complete employment history for the most recent five years.
- Current Professional Liability Insurance with a minimum of \$1 million/\$3 million
- A history of fewer than three malpractice claims in the past five years for initial credentialing, or in the most recent review period for re-credentialing; no evidence of recurring types of claims and total judgement or settlement greater than \$500,000.
- NPDB queries with no adverse findings
- Opt Out list, OIG, and SAM queries with no adverse findings
- Adequate physical and mental health status
- Absence of felony convictions
- Absence of current illegal drug use
- Satisfactory history with respect to State and Federal licensing agencies, medical staff membership and/or clinical privileges; disciplinary actions, Medicare/Medicaid sanctions, or any other actions reasonably related to professional judgement, competence and clinical/technical performance

THA's Quality Management Committee (a subcommittee of the Board) grants final credentialing approval.

Re-Credentialing

All credentialed Providers are re-credentialed at least every three years. A re-credentialing packet will be sent to the Provider with all necessary requirements for re-credentialing

The following information is needed to complete the re-credentialing process:

- Oregon Practitioner Re-Credentialing Application
- Copy of state license
- Current DEA registration and proof of prescriptive privileges, if applicable
- Current professional liability insurance coverage in the amount of \$1 million/\$3 million
- THA release of information
- THA Practitioner's Right to Review

The THA Quality Management Committee considers this information with the NPDB inquiry results, closed claim reports, license action report, Medicare Opt-Out report, and member complaints.

Failure to provide re-credentialing information in a timely manner may be brought to the attention of the THA Quality Management Committee. Noncompliance may result in additional actions that may include a recommendation to send the Provider a notice of termination.

Provider Rights

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

THA has adopted the following Provider Rights that shall apply to all contracted medical professional Providers. It is the right of each participating Provider involved in the credentialing/re-credentialing process:

- To be free from discriminatory practices such as discrimination based solely on the applicant's race, ethnicity, gender, national identity, age, sexual orientation, or there types of procedures or by the type of patients the Provider specializes in. Providers are free from discrimination based on serving high-risk populations or specializing in conditions that require costly treatment.
- To have the right to be notified in writing of any decision that denies participation on the THA panel
- To be aware of applicable credentialing/re-credentialing policies and procedures
- To review information submitted by the applicant to support the credentialing application
- To correct erroneous information submitted by third parties that does not fall under the Oregon Peer Review Statute protections
- To be informed of the status of the Provider's credentialing or re-credentialing application on request, and to have that request granted within a reasonable period of time

Provider Termination of Member Care

The Provider-Member relationship may be terminated through:

- Mutual consent
- The member's dismissal of the Provider
- The Provider's dismissal
- It is not necessary to indicate to the member why the relationship is being terminated

When a Provider intends to withdraw from or terminate care of a member who is in need of continuing care at that time, the Provider must take the following steps:

- Give reasonable notice of the intent to withdraw by notifying the member's THA Case Manager, thus allowing time to develop an action plan for Provider-Member relationship alterations as agreeable to both the Provider and the member
- When there isn't compliance to an action plan, the Provider-Member relationship may be terminated with a thirty (30) day written notice

The Provider is required to send a written and signed notification to the member upon termination of the patient's care. THA suggests that Providers give written notice of the termination via mail by a certified, return receipt letter.

- Members residing in nursing homes or otherwise incapacitated must have letters sent to the person acting on their behalf to make medical decisions.
- Written notification of member termination must also be submitted to THA, either to the appropriate Case Manager or to the THA Member Outreach Coordinator who will notify the Case Manager

Providers should continue to meet the member's medical needs during the 30 day time period following termination. If the basis for termination is a threat of dangerous behavior to other patients or staff, the period may be shortened to as little as one day, depending upon the seriousness of the threat. The Provider must work with THA to ensure appropriate documentation is received to member's mental state and any or all attempts to coordinate behavioral needs with their mental health Provider. In this situation, emergent care may be provided in the TCH Emergency Department.

CLAIMS

Submitting Claims

THA has three clearing houses to use for electronic primary and secondary claims:

Change Healthcare Payer ID – 93112
Payer Connection Payer ID – OHP – THA01, Employee Benefit – THASC
Relay Health Payer ID – THA2012

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

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

Incomplete claims are denied for resubmission with the missing information.

Claims must include the member's diagnostic codes to the highest level of specificity and the appropriate procedure codes.

For specific claims questions you can visit the THA portal at www.tualityhealthalliance.org or contact the THA customer service at 503-844-8104.

Timely Filing

Eligible claims for covered services must be received within 120 days from the date of service or from primary payment. Claim appeals or submissions for reconsideration must be received within 90 days of denial date.

DMAP ID Number

As a Provider of THA serving OHP members, **Providers must have an active DMAP ID in order to maintain participating status and be eligible for payment.** In order to process a claim, the rendering, attending and billing Provider's National Provider Identifier (NPI) is verified as eligible to receive payment by DMAP and enrolled with an ID number. The DMAP ID number is considered a minimum requirement for claims processing and must be maintained.

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

To verify active enrollment status with DMAP:

- Go to www.or-medicaid.gov/ProdPortal/Home/ValidateNPI/tabId/125/Default.aspx
- Enter the Provider NPI and date of inquiry
- Click on the search button

If the Provider NPI is not actively enrolled for the date of service entered, submit claims to THA and simultaneously complete and submit the Oregon Medicaid ID Application Form.

National Correct Coding Initiative (NCCI) Edits

THA adheres to all applicable edits under NCCI.

Claims Appeals

All requests for claims appeals must be submitted in writing. You must include a copy of the original claim, any supporting documents such as clinical notes, system reports or screen shots to support your request. Claim appeals must be received within 90 days of the original denial date.

Member Billing

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

Members cannot be billed for the following covered services:

- Services that were denied due to lack of an authorization
- Balance billing for the amount not paid to the Provider by THA

THA does not withhold payment due to Provider assignment.

A Provider may legally bill an OHP recipient in the following circumstances:

- The service provided is not covered by OHP and the member signed an OHP Client Agreement to Pay for Health Services form before the member was seen. The form must include the specific service that is not covered under OHP, the date of service and the approximate cost of the service. The estimated cost of the covered service, including all related charges, cannot exceed the maximum DMAP reimbursable rate or managed care plan rate. The form must be written in the primary language of the member.
- The member did not tell the Provider they had Medicaid insurance and the Provider tried to obtain insurance information. The Provider must document attempt to obtain information on insurance or document a member's statement of non-insurance.

Billing or sending a statement to a member does not qualify as an attempt to obtain insurance information. A member's eligibility can be verified by accessing the THA Provider Portal at www.tualityhealthalliance.org.

Coordination of Benefits

If there is a primary carrier, such as Medicare or private insurance, or third party resource such as worker's compensation, and THA is the secondary payer, submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received. Claims must be received within 120 days from the date the claim was processed on the primary EOB. THA can accept secondary claims electronically.

Calculating Coordination of Benefits

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

Hysterectomy and Sterilization

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

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

Be sure the member signs the correct sterilization consent form.

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

Vaccines For Children (VFC) Billing

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

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

Locum Tenens Claims and Payments

THA allows licensed Providers acting in a Locum Tenens capacity to temporarily submit claims under another licensed Provider's NPI number when that Provider is on leave from their practice. The Locum Tenens Provider must have the same billing type or specialty as the Provider on leave.

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

Overpayment Recovery

THA uses an auto-debit method to recover identified overpayments. When an overpayment is identified, the appropriate group of claims is reversed and future claims payments are automatically debited until the outstanding overpayment balance is settled.

Fraud, Waste and Abuse

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

Referral and Authorizations

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

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

- All members are required to be seen by a PCP during the previous year and there must be some type of written communication that demonstrates medical necessity for the request
- The THA PCP/Specialist Communication/Referral Form must be used and filled out completely for those services that require a referral
- Providers should submit requests for “urgent” or “expedited” referrals or preauthorization to the THA Referral office on the referral form, by checking “expedite”, via fax or phone. The THA Referral Specialist or THA Nurse Case manager will approve the request or immediately contact the THA Medical Director for a determination
- The THA Pre Authorization list is utilized for THA OHP members. InterQual Criteria is utilized for establishing medical necessity and standards for length of stay. Specific health plan criteria may also be used as a reference
- Pre Authorization requests must be current and complete in order to provide timely responses to Providers and members. A summary of pertinent clinical history and other data is required. Copies of legible office notes, lab or radiology reports, consults, etc. may be used. The patient’s name and health plan identification number must be clear on all papers.

The current Referral and Authorization guidelines can be found on the THA website at www.tualityhealthalliance.org/Provider_clinics

When THA does not have appropriate contracted specialists, certain out of plan specialists may be authorized when necessary. Nurse Case Managers will authorize these referrals according to established Referral Guidelines. The specialist must have authorization numbers in order for THA to consider reimbursement for services rendered.

Monitoring Appropriate Utilization

THA monitors utilization data for OHP members and analyzes all data collected to detect under and over utilization. Analysis is performed at least annually and includes:

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

Under or over utilization thresholds

- Health Share Quality Incentive Measures and CAHPS
- Length of Stay Data
- Member complaints and appeals

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

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

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

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

PHARMACY PROGRAM

Using the Formulary

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

The formulary is available on the THA website at www.tualityhealthalliance.org/Providers&Clinics/Formulary.

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

Contracted Pharmacies

THA Contracts with the majority of the chain pharmacies as well as other local pharmacies. You may obtain a list of contracted pharmacies by visiting our website at www.tualityhealthalliance.org.

Prior Authorization Process

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

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

For drugs listed in the formulary with quantity limited (QL), a prior authorization is required once the limit has been reached for quantities over the monthly allowable.

- Fax a completed Medication Request Form to 503-681-1823. This form is located on the website at www.tualityhealthalliance.org/Provider.

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

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

Injectables and High Cost Medication through Specialty Pharmacies

THA in conjunction with Specialty Pharmacies has a program in place for High Cost/Self Injectable medications.

Providers may administer a one-time dose of the patient's medication in their office for the purposes of educating the member and/or family on administration of the medicine. The medication and supplies necessary to administer the drug will be labeled specifically for each member and delivered to the Providers office or their residence.

Prior authorization is required for Specialty medications through this program and may be requested from THA at 503-844-8104.

Specialty medications can be ordered in several different ways:

Phone prescription to: 503-418-8228 or
Fax prescription to: 503-494-5470 or
Electronic prescribing to: OHSU Specialty Pharmacy

OHSU Specialty Pharmacy Program offers:

- Refill reminders
- Easy home delivery of your medications
- Care coordination and medication support
- Call center Mon-Fri, 6am-6pm PST at 503-494-1459
- 24 hour access to a pharmacist
- Insurance benefit review
- Prior authorization help
- Financial assistance screening

Further questions can be directed to THA at 503-844-8104 for more information.