



2010

Provider

MANUAL

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FamilyCare, Inc. Provider Reference Manual

Creating Healthy Individuals ~ *Through Innovative Systems*

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Section 1: Introduction

1.1 General Information

Welcome to the FamilyCare, Inc. Practitioners' and Organizational Providers' Reference Manual. This document has been written with you, our practitioners, in mind.

The purpose of the manual is to provide you and your office with the basic information that you may need when working with FamilyCare. In addition to this hardbound reference manual, you can access this information on our webpage at www.familycareinc.org.

As part of your agreement with FamilyCare you are asked to comply with all of the services and processes outlined in this manual. This manual may impose obligations beyond those listed in your agreement. In the case of conflicts, your agreement takes precedence unless the manual specifically overrides the agreement.

Keep in mind that this is a dynamic resource and will be updated regularly. We will post updates to the manual contents on the FamilyCare website and provide written notification 30 days prior to implementation. In addition, we ask that you reference the website as a current resource for FamilyCare policies and procedures. If at any time you feel uncertain about a particular policy or procedure, please contact the Provider Relations department for more information at (503) 471-2149 or (800) 335-3205 ext. 2149.

We value the partnership with our participating providers and appreciate the important role that each of you play.

1.2 History of FamilyCare, Inc.

Three physicians and our current President, Jeff Heatherington, founded FamilyCare, Inc. in 1984. FamilyCare was originally designed as a managed care organization to provide healthcare to the Medicaid population under the 1983 Medicaid Managed Care Act. With the exception of Kaiser Permanente, FamilyCare is the oldest Medicaid Managed Care program in Oregon.

FamilyCare had two major operational objectives at its inception. The first objective was to provide an opportunity for physicians to successfully practice under a capitated payment system. The second objective was to create a management system that left physicians and providers in control of managing their patients. While FamilyCare was not the first to capitate Primary Care Physicians, it was the first to capitate Specialists in Oregon. In addition to the capitated payment system, FamilyCare also created a program to educate physicians with a regard to their utilization patterns so that they could more effectively manage their own practices. Overall, FamilyCare has maintained a very successful operation that relies on a streamlined management system, compensation for providers at an extremely attractive rate, and autonomy for the provider and patients to make treatment decisions for themselves.

In 1988, FamilyCare, Inc. purchased Evergreen Medical Systems, a Medicaid Managed Care program operated in Portland. In 1994, with the advent of the Oregon Health Plan (OHP), FamilyCare became a fully capitated health plan operating as an HMO. This completed the seamless medical system in most of FamilyCare geographical areas, allowing providers to manage utilization among themselves without the case-by-case oversight of the health plan.

In 1997, the State of Oregon invited managed care organizations to submit proposals to manage the mental healthcare of OHP members. Since FamilyCare already managed the physical and chemical dependency services for members, there existed an opportunity for an integrated health plan approach. We have been in HMO since 1997. In 2005 we brought the administration of the MHO (Mental Health Organization) in house and became the first to pair both the physical and

mental health in Oregon. This was also the year that we initiated having Medicare Advantage plans.

FamilyCare, Inc. relocated and opened the doors to their new office space in the Lloyd Center Tower in 2008.

1.3 Mission

Creating Healthy Individuals ~ Through Innovative Systems

Our Declared Values:

- Integrity, innovation, and leadership are fundamental to everything we do;
- Family physicians are the foundation in building a caring and efficient healthcare system in cooperation with specialists and other providers;
- Quality relationships between Patient, Provider, and Plan based on Commitment, Trust, Respect and Communication;
- Evidence based information and education empower both the patient and physician to make responsible healthcare decisions;
- Medical decisions are best made between the patient and provider;
- Osteopathic medicine creates opportunities for innovation in healthcare;
- Our employees' well being and professional development are essential to our success.

1.4 FamilyCare, Inc. Provider Relationship Tenets

FamilyCare, Inc. is committed to creating a positive working relationship with your office and providing quality healthcare for our members. This commitment is conveyed through our mission of "Creating Healthy Individuals through Innovative Systems" and from our value of "Quality Relationships between Patient, Provider, and Plan based on Commitment, Trust, Respect and Communication".

Towards that goal, FamilyCare, Inc. will:

- Strive for innovation in being the most user friendly health plan;
- Be available to answer questions in a prompt and courteous manner during business hours;
- Provide contracted providers with timely, accurate, and eligible data;
- Provide timely and useful financial and utilization reports to the appropriate provider management personnel;
- Maintain a strong communication link through newsletters, updates, web access, office visits and community workshops.

As our partner in healthcare delivery we expect you to:

- Follow the terms of your contract;
- Notify FamilyCare when you feel we are not meeting our stated goals.

1.5 FamilyCare, Inc. Products

FamilyCare is a non-profit Oregon organization providing health benefits administration. Please refer to your provider contract for information on the populations you are eligible to serve.

We maintain and monitor a network of participating providers including physicians (both medical and psychiatric), nurse practitioners, psychologists, hospitals, skilled nursing facilities, ancillary providers and other healthcare providers through which our members obtain covered services.

FamilyCare administers various product lines:

Oregon Health Plan (OHP) – OHP is Oregon’s Medicaid benefit. FamilyCare provides physical health and chemical dependency treatment services for OHP eligible’s in Clackamas, Clatsop, Morrow, Multnomah, Jackson, Josephine, Umatilla and Washington counties.

FamilyCare MHO (mental health organization) – FamilyCare operates as an MHO for FamilyCare OHP members in Clackamas, Multnomah and Washington counties.

PremierCare – A Commercial Medicare product maintained by FamilyCare Health Plans, Inc. This Medicare Advantage product is available to Medicare eligibles in Clackamas, Clatsop, Columbia, Morrow, Umatilla, Multnomah, and Washington counties. FamilyCare offers five commercial products with varying level of benefits: PremierCare Advantage Rx, PremierCare Value Rx, PremierCare Select RX (Diabetic plan), PremierCare Choice RX and PremierCare Choice.

PremierCare Plus – A Medicare Advantage plan for the special needs population. Special needs beneficiaries have Medicare as their primary insurance and Medicaid as their secondary insurance. PremierCare Plus is offered in Clackamas, Columbia, Clatsop, Morrow, Multnomah, Washington and Umatilla counties.

FamilyCare OHP and PremierCare members must choose a contracted Primary Care Provider (PCP). For members on both FamilyCare OHP and FamilyCare MHO, a Mental Health Primary Care Provider (MHPCP) is paired with the members’ PCP. To ensure continuity of care, members must coordinate with their PCP or MHPCP before seeking care from a specialist, except in the case of specified services (e.g. women’s health, preventive care services or emergency services).

FamilyCare furnishes each member with a Member Handbook that explains their benefits, resources and references. Our PremierCare members are provided an *Evidence of Coverage* tool which outlines the details of payment responsibility and coverage.

Providers are given a copy of the handbook(s) as well as education on the handbook’s location on the FamilyCare website.

1.6 Coordination of Care

Individuals eligible for Medicaid and Medicare benefits are often involved with a network of social service agencies. FamilyCare offers special assistance to this group, as well as any other member identified with special needs, to help in coordinating their care. Care Coordinators and Service Coordinators are available to assist members and providers in meeting treatment goals. FamilyCare providers are required to provide coordination of services including, but not limited to, coordination with Mental Health Providers, Primary Care Physicians, Medical Service Providers, Chemical Dependency Service Providers, Allied Agencies, Educational Providers, and Emergency Services.

Addiction, Physical and Behavioral Health Care Coordination continues to be a focus for improvement in the Medicaid Demonstration Project. To further advance this initiative, FamilyCare expects that members actively receiving treatment are being treated by providers in a joint manner.

This includes but is not limited to:

Primary Care Providers/Practitioners (PCP) - working with members Addiction, Physical and Behavioral Health Providers, to ensure members are informed of changes in medication and/or medical conditions that may affect their healthcare. Such medical conditions may include chronic pain, head trauma, diabetes, cardiovascular disease and other diseases.

Mental Health Primary Care Providers (MHPCP) - working with the PCP to ensure they are informed of a patient's progress at regular intervals, termination of treatment and initiation/change in medication.

Medical Specialists - informing the PCP of a patient's progress at regular intervals, termination of treatment, and prescribe/change in medication.

Documentation of this interaction is expected to be noted in the medical record and will be reviewed as part of FamilyCare Chart Audit process.

1.7 Exceptional Needs Care Coordination

FamilyCare provides Care and Service Coordination for special needs eligibles and all members as needed. These services are provided while ensuring that dignity, confidentiality, and specific disability issues related to the members medical, social, and quality of life issues are respected.

Case Management services include:

- Assisting members as a patient advocate;
- Assisting all members in obtaining care and services;
- Assisting providers with patients who are non-compliant or disruptive.

The Care Coordinator will:

- Work with the member and provider to identify and assess barriers to compliance;
- Initiate the appropriate intervention such as provider and/or member education and provide active listening;
- Be available to facilitate care conferences and initiate patient behavior contracts;
- Document activity, follow through and proceed with member disenrollment from FamilyCare as appropriate;
- Maternity case management will be followed by the Maternity Care Coordinator where appropriate intervention is needed due to concerns such as past adverse prenatal conditions, diabetes, substance abuse or psycho-social issues affecting prenatal health.

The Service Coordinator will:

- Facilitate best care outcomes between member and the member's assigned primary care clinic;
- Establish contact with newly assigned members via phone;
- Complete baseline assessment which includes physical health, mental health and psycho-social needs;
- Review care plan with patient and actively assist to ensure successful implementation and monitoring;
- Facilitate referrals to specialists and other required services as directed by the care plan or baseline assessment;
- Provide patients with tools to be actively involved in all aspects of their care plan.

For care coordination assistance providers are welcome to call FamilyCare Customer Service and request to speak with a Care Coordinator.

1.8 Members' Rights and Responsibilities

Getting treatment is a private matter. At FamilyCare we respect our members' right to privacy. We seek to create a health plan that has the highest quality of care and is honest and dependable. We can only reach this goal by working with our members, partners and with you, our providers. We also know that a quality health plan acts on new ideas and the changing needs of its members. Our members have, at the very least, the rights and responsibilities listed below.

1.8.1 FamilyCare, Inc. members have the right to:

- Be treated with respect and consideration for their dignity and privacy by FamilyCare, and by all providers and staff;
- To choose a PCP (Primary Care Provider) or MHPCP (Mental Health Primary Care Provider) and to change those choices as per OAR 410-141-0080 and as per FamilyCare policies;
- Participate in healthcare decisions;
- Self refer to mental health, chemical dependency or family planning services without a referral from a PCP or other participating provider;
- To have a friend, family member or advocate present during appointments and at other times as needed within clinical guidelines;
- Receive information on available treatment options and alternatives; including the benefits and detriments of opting for treatment or not;
- Receive necessary and reasonable services to diagnose the presenting condition;
- Receive covered services under their respective health plan that meet generally accepted standards of practice and is medically appropriate;
- Obtain covered preventive services;
- Have access to urgent and emergent service 24 hours a day, 7 days a week;
- Receive a referral to specialty practitioners for medically appropriate covered services
- Receive a second opinion from a different therapist or doctor;
- Receive information about their respective health plan; Medicare and Oregon Health Plan as well as information about FamilyCare;
- Have a clinical record maintained which documents conditions, services received and referrals made;
- Have treatment information and records of their services kept private;
- Allow or refuse the release of healthcare information, except when the release of information is required by law;
- Request and receive a copy of medical records and request that they be amended or corrected and to transfer a copy of his/her clinical record to another provider;
- Receive counseling or treatment without regard to race, color, religion, sex, sexual orientation, age or cultural background;
- Execute a statement of wishes for treatment or refusal of treatment, and the right to execute directives and powers of attorney for health care in accordance with the Patient Self-Determination Act;
- Refuse counseling or treatment, unless court ordered (*the possible results of refusing treatment may be against their best interest*);
- Be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- File a grievance (complaint) about the Oregon Health Plan, FamilyCare, a provider, or the care provided and receive a timely answer;
- File an appeal about a FamilyCare action or decision with FamilyCare and/or Oregon Department of Human Services (DHS) and Medicare. Members can request an additional review consistent with state and federal regulations if they are not satisfied with the outcome of their appeal;
- Receive interpreter services;
- Receive a notice of an appointment cancellation in a timely manner.

1.8.2 FamilyCare, Inc. members have the responsibility to:

- Seek care before they are in a crisis situation;
- Treat those providing them with services with the same respect and kindness they expect to receive;
- Tell the provider that his/her health care is covered under OHP or Medicare before services are received and present their Medical Care Identification card. Talk openly and honestly with the provider they choose;
- Seek periodic health exams and preventive services from his/her PCP or clinic;
- Use his/her PCP or clinic for diagnostic and other care except in an emergency;
- Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
- Use urgent and emergency services appropriately and notify the PCP within 72 hours of an emergency;
- Ask their provider questions and listen to their input, so they better understand the care and instructions they are given;
- Take the lead in developing their recovery and/or treatment plan;
- Keep their appointments and be on time and call ahead if they must cancel a visit;
- Help providers to obtain clinic records which may include signing and authorization for release of information;
- Notify the health plan and the provider if there is third party coverage resource available
- Follow the grievance and appeal steps if they are unhappy with their care, their provider, or FamilyCare;
- Call FamilyCare if they have any questions.

Section 2: Code of Conduct

2.1 Introduction

This Code of Conduct has been adopted by the FamilyCare, Inc. and FamilyCare Health Plans, Inc. Board of Directors in order to set forth the general principles and standards to which our Board of Directors, employees and sales agents (collectively, "FamilyCare, Inc. Personnel"), as well as our outside Contractors, are expected to adhere. All FamilyCare Personnel and Contractors are expected to perform their responsibilities in compliance with this Code of Conduct, applicable laws, company policies and contractual requirements. In addition, if at any time you believe that a legal or ethical violation has occurred, we ask that you report it to FamilyCare's Compliance Officer or the Compliance hotline.

Compliance Officer 503-734-3113

Compliance Hotline 503-345-5777

The Code of Conduct is the framework for FamilyCare's Corporate Compliance Program along with the written policies and procedures that are maintained by the operational departments. Each Contractor is responsible for ensuring that they understand the standards of conduct contained herein and comply with them, as well as all related policies and procedures.

2.1.1 Raising Concerns and Seeking Advice

If you are ever in doubt about the right thing to do in conducting FamilyCare's business, please ask for help. You may contact any member of our Executive team, the Compliance Officer or one of our managers to raise issues and get guidance. You can also ask for help or report a violation or problem by calling the Compliance Hotline at 503-345-5777. You can call anonymously but remember if you want follow-up, you will need to provide your name and number.

2.2 Conflict of Interest

All of FamilyCare's Contractors need to understand that we take conflicts of interest very seriously. A conflict of interest may occur if any FamilyCare Personnel's outside activities, personal interest or relationships might influence, or appear to influence, their ability to make objective decisions in the course of their job responsibilities or may be prejudicial to the legitimate interests of FamilyCare. A conflict of interest may also exist if the demands of any outside activities might hinder or distract them from the performance of their job or cause them to use FamilyCare resources for other than FamilyCare business.

FamilyCare Personnel must avoid actual and apparent conflicts of interest. They must avoid any situation where a conflict of interest exists or might appear to exist between their personal interests and those of FamilyCare. The *appearance* of a conflict of interest may be as serious as an *actual* conflict of interest because it reflects poorly on FamilyCare. We expect our Contractors to honor our Conflict of Interest Policy.

FamilyCare Personnel may not use their positions to profit personally or to assist relatives or members of their households in profiting in any way at the expense of the organization. FamilyCare Personnel who are also Participating Providers may serve under a potential conflict of interest. However, FamilyCare must expressly acknowledge and waives such conflict of interest. Any conflict of interest must be disclosed and reviewed in accordance with FamilyCare Conflict of Interest Policy and Procedure.

2.2.1 Business Courtesies / Gifts

Gifts or gratuities are generally prohibited. FamilyCare Personnel may not accept or encourage gifts of money under any circumstances, nor may they solicit non-monetary gifts, gratuities, or any other personal benefit or favor of any kind from Contractors or customers. FamilyCare Personnel, their relatives, and members of their households may accept unsolicited, non-monetary gifts from a Contractor doing or seeking to do business with FamilyCare only if the gift is primarily of an advertising or promotional nature. Such gifts must be of the type which the giver customarily provides to a wide spectrum of existing and potential customers or business associates, and shall not exceed the value of **\$20 per gift or \$100 per calendar year** in the aggregate, unless the Compliance Officer grants an exception based on the circumstances.

Similarly, FamilyCare Personnel must not give gifts or gratuities to Contractors exceeding the value of \$20 per gift or \$100 per calendar year in the aggregate, unless the Compliance Officer grants an exception based on the circumstances. All exceptions will be tracked by the Compliance Officer and reported to the Compliance & Utilization Committee.

Contactors having any doubts about the value or effect of a gift, favor, travel, or entertainment should not offer or accept it without the permission of FamilyCare's Compliance Officer.

Marketing materials such as pens, coffee mugs, or calendars, employee appreciation gifts and business meetings over lunch or dinner where the primary purpose is to facilitate business and the meal is incidental, are not considered gifts and will not be tracked.

Offering or taking bribes, kickbacks, payoffs or other unusual payments to obtain or keep business is unethical, illegal, and strictly forbidden.

2.3 Proper Accounting and Keeping of Records

FamilyCare needs correct information and reliable records in order to make sound business decisions and to submit reports to customers and governmental agencies. We expect all Contractors to record, report, and retain all information in a full, accurate, complete, and honest manner to comply with applicable legal requirements.

2.3.1 Financial Reporting

All financial books, records, and accounts must correctly reflect transactions and events. Additionally, all must conform to generally accepted accounting principles.

FamilyCare requests its Contractors to follow these guidelines:

- Do not make false or misleading entries or omit information;
- Fill out expense reports and attendance reports correctly and completely;
- Do not create or keep secret unrecorded funds, assets or accounts;
- Never purposely pay or approve an invoice, expense report or other document that is not correct, not accurate, or is misleading;
- Properly and consistently follow cost accounting standards and principles of cost allowability, as well as relevant policies, procedures, and contractual obligations;
- All invoices to customers (and others) should correctly note the products sold or services performed, the true sales price, and the terms of the sale.

Improper or fraudulent accounting, documentation, or financial reporting is not only contrary to FamilyCare's policy, but it is in violation of the law. Adequate documentary evidence must support all cost reports.

2.3.2 Member Protected Health Information

FamilyCare Personnel and Contractors are expected to comply with the Health Insurance Portability and Accountability Act (HIPAA) legal requirements regarding Protected Health Information (PHI). PHI includes medical diagnosis and treatments, personal data, billing, and contract information. FamilyCare policies regarding handling and use of PHI will be adhered to by all FamilyCare Personnel and any Contractors who become our Business Associates pursuant to HIPAA in order to receive or process our Members' PHI. The policies conform to federal and state laws and are designed to safeguard patient privacy.

To maintain confidentiality of Member information, all Contractors that receive PHI must:

- Encrypt any FamilyCare member's PHI sent or received through e-mail;
- Comply with FamilyCare security safeguards;
- Never share member PHI with third parties unless it is for business operations approved by FamilyCare;
- Follow all requirements in your Business Associate Agreement.

2.3.3 Record Retention

Disposal or destruction of all records is governed by law and policy. The retention of records will be in accordance with legal and regulatory requirements and your contract with FamilyCare. Records pertaining to litigation or a government investigation or audit shall not be destroyed. Records that are subject to audit or current/threatened litigation shall not be destroyed, unless there is written notification of the conclusion of the litigation.

Records will be maintained in appropriate format (paper, microfilm, microfiche, electronic copies and images) and available within a reasonable timeframe. When FamilyCare no longer needs you to keep information, you must dispose of it in a way that makes certain it is kept safe and private until properly destroyed.

2.4 Fraud and Abuse

FamilyCare requires compliance with the requirements of federal and state laws that prohibit fraud and abuse in connections with federal health care programs, including Medicare and Medicaid.

It is also our policy to provide detailed information to all Contractors about laws that are designed to prevent and detect fraud, waste, and abuse.

Those laws include:

- The federal False Claims Act;
- Administrative remedies for false claims and statements under federal law;
- State laws pertaining to civil or criminal penalties for fraud and abuse;
- "Whistleblower" protections under such laws.

2.5 The Federal False Claims Act

The False Claims Act prohibits any person or entity from making a false or fraudulent Claim to the U.S. Government. A Claim includes any request for money or property, if the Government provides any portion of it.

A false Claim can result from (among other things):

- Presenting a false or fraudulent claim for payment or approval;
- Using a false record or statement to get a false or fraudulent claim paid or approved;
- Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid;
- Using a false record or statement to conceal, avoid, or decrease an obligation to pay money to the Government.

The penalties for making a false Claim can be as much as \$5,500 to \$11,000 per claim, plus 3 times the amount of any damages the Government sustains.

For a Claim to be false, the entity must:

- Know the information on the Claim to be false;
- Act in deliberate ignorance;
- Act in reckless disregard of the truth or falsity of the information.

A private citizen may file suit under the False Claims Act on behalf of the Government. The citizen must have direct and independent knowledge of the submission of a false claim. The government will then decide whether to take over the case, or let the private individual pursue the case on his or her own.

If the Government takes over the case, then the person who initially filed the case may receive between 15 and 25 percent of any amount recovered in either litigation or settlement of the claim. If the Government does not step in, then the person who initially filed the case may receive between 25 and 30 percent of amount recovered (plus reimbursement of reasonable expenses and attorney's fees).

2.6 Employee Protections

We may not and will not retaliate or discriminate against an employee who, acting in good faith, investigates reports or assists in uncovering a false claim or statement. An employee who suffers discrimination or retaliation based on protected activities has the right to sue under the Federal False Claims Act. If the employee proves that we retaliated against him or her for engaging in protected activity, the employee is entitled to be "made whole".

The remedies include:

- reinstatement of the employee to his/her position;
- two times the amount of back pay;
- interest on the back pay;
- compensation for any special damages (including litigation cost and reasonable attorney fees).

2.7 Administrative Remedies for False Claims/Statements

There is also an administrative process the federal government can initiate against a person or entity for submitting false claims or making false statements in connection with claims. This administrative process is initiated and controlled by regulators, but the information about the false statement or false claim could come from private citizens.

A false statement exists when a person asserts a material fact that is false, fictitious, or fraudulent. Something is material if it is important to a decision.

A statement may also be false if a person has:

- A duty to disclose a material fact;
- Does not disclose that fact;
- Certifies that the statement is true;
- The omission makes the statement that is made false, fictitious or fraudulent.

The sanction for making a false claim or statement is a penalty of not more than \$5,000 for each such claim or statement.

2.8 Oregon State Laws

2.8.1 Wrongful Claims (ORS 411.670 – 411.690)

Any person who submits a claim or accepts a payment from the Department of Human Services for services that were not provided is liable to refund or credit the amount of such payment, and if found to have violated this prohibition after an administrative hearing pursuant ORS chapter 183, shall be liable for triple the amount of the payment wrongfully received.

2.8.2 Unlawful Trade Practices (ORS 646.605 – 646.656)

Any person who wrongfully collects or attempts to collect any debt in excess of what is owed, or by unfair means, may be held liable for the debtor's actual damages or \$200, whichever is greater, plus reasonable attorneys' fees. Any person who violates a court injunction or assurance of voluntary compliance under these provisions may be liable to the state for up to \$25,000 per violation.

2.8.3 Perjury and Falsification (ORS Chapter 162)

A person commits the crimes of perjury (if the falsehood is material) and false swearing by making false sworn statements, and can be convicted of a Class C felony or Class A misdemeanor. A person commits the crime of unsworn falsification by knowingly making any false written statement to a public servant in connection with an application for any benefit, and can be convicted of a Class B misdemeanor.

2.8.4 Theft (ORS Chapter 164)

A person commits the crime of theft by obtaining or withholding another person's property (by various means) and can be convicted of various crimes, up to and including a Class B felony, depending on the circumstances and the value of the property wrongfully taken.

2.8.5 Falsification of Business Records (ORS 165.080)

A person commits the crime of falsifying business records with intent to defraud if the person makes a false entry in business records, alters, deletes or prevents a true entry, or fails to make a true entry in violation of a known legal duty, and thereby commits a Class A misdemeanor.

2.8.6 False Claim for Health Care Payment (ORS 165.690 – 165.698)

A person (or entity) commits the crime of submitting a false claim for health care payment by knowingly making or causing a claim, for any health care payment, to contain any false statement or false representation of material fact in order to receive the payment. It is also a crime for any person or entity to conceal from or fail to disclose to a health care payer the existence of any information with intent to obtain any health care payment to which the person or entity is not entitled.

In addition, it is a crime for any person (or entity) to obtain or attempt to attain any state-funded medical assistance payment by submitting, or causing to be submitted, any false claim for payment or accepting any such payment for any duplicate claim for payment not clearly labeled as such, or any claim for which payment has already been received from any source, unless clearly labeled as such.

These crimes are Class C felonies and may be punishable by up to five years imprisonment and/or a fine not to exceed \$125,000.00.

2.8.7 Racketeering (ORS 166.715 – 166.735)

A person commits the crime of racketeering by engaging in a pattern of activity to collect or receive the proceeds of unlawful debts, or conspire or attempt to do so, and may be held liable for up to three times the amount three times the gross value gained or the gross loss caused, whichever is greater, plus reasonable attorneys' fees and costs.

2.8.8 Whistle Blowing Protections (ORS 659A.200 – 659A.233)

It is an unlawful employment practice for an employer to discharge, demote, suspend or in any manner discriminate or retaliate against an employee for doing any of the following in good faith: reporting criminal activity, causing a complaint to be filed, cooperating with any law enforcement agency, bringing a civil proceeding against an employer or testifying in any proceeding trial. It is also an unlawful employment practice for the state or any subdivision to prohibit any employee from discussing with any member of the Legislative Assembly or committee staff, in response to a request for information, any reasonable belief regarding the violation of any law or regulation, mismanagement, gross waste of funds, abuse of authority or substantial danger to public health and safety resulting from action of the state or any subdivision.

2.8.9 State Regulatory Protections (OAR 410-125-1395 – 410-120-1510)

The Oregon Department of Human Services (DHS) pursues a variety of activities to assure the integrity of the Medicaid program. This includes, but is not limited to: medical review, prior authorization, onsite visits, improving accuracy and timeliness of claims processing, provider credentialing, quality improvement activities, audits, and fraud investigations. DHS requires all providers to submit true, accurate, and complete claims for reimbursement, and may review claims either before or after payment for compliance with its rules and policies, and deny payment or seek overpayment recovery if they don't. DHS may suspend or permanently terminate any provider's right to participate in the Medicaid program as a result of failing to obey DHS rules. As a result of provider audits, DHS may pursue reimbursement of overpayments and investigative costs, and withhold payments otherwise due. All providers are required to promptly report any suspected fraud or abuse to DHS and the Medicaid Fraud Control Unit of the Oregon Department of Justice, and to cooperate fully with any resulting investigation.

2.8.10 Other State Claims

There are also other civil claims that DHS may pursue against any provider who wrongfully receives any payment, including common law fraud, money paid by mistake, and money paid by false pretenses.

2.9 Employment Practices and Conduct in the Workplace

FamilyCare believes that each employee and agent should be able to work in a professional atmosphere without fear of retribution. To that end, FamilyCare is committed to complying with all the laws and regulations affecting employment, safety, health and the environment.

FamilyCare is an Equal Opportunity Employer (EOE) that strives to create a workplace that is inclusive and safe for our employees and business partners. Our policies and programs are designed to promote fairness and respect for all individuals. Behaviors that put FamilyCare employees or business partners at risk are not allowed.

2.9.1 Equal Employment

FamilyCare believes in hiring, promoting and compensating employees without regard to race, color, national origin, age, gender, religious preference, marital status, sexual orientation, handicap or disability. We base employment decisions, including selection, development and compensation decisions, on an individual's qualifications, skills and performance. We are committed to Equal Employment Opportunity Commission (EEOC) practices and comply with all laws, regulations and policies related to non-discrimination.

2.9.2 Freedom from Harassment

FamilyCare does not condone any form of harassment. We do not tolerate inappropriate behavior or harassment by employees or business partners, including Contractors.

Under our anti-harassment policy, harassment is any behavior that:

- Creates a workplace that is intimidating, hostile or offensive;
- Unreasonable interference with a person's job performance.

We fully expect employees to report violations to their supervisors or the Director of Administrative Services (HR). Any employee who engages in harassment is subject to disciplinary action, up to and including termination. Any discrimination or adverse action, such as intimidation, threats or coercion, taken against an employee because the individual complains of harassment or assists in an investigation of harassment will also result in disciplinary action, up to and including termination. We expect our Contractors to honor our harassment policies and to have similar policies in place.

2.9.3 Personal Relationships

FamilyCare wants to avoid even the appearance of favoritism in the workplace. An employee who is involved in a personal relationship with another employee must not be in supervisory/subordinate reporting relationships or other positions of authority that can influence employment decisions for one another. We expect our Contractors to honor this policy. In addition, a personal relationship between a Contractor and any FamilyCare Personnel may violate our Conflict of Interest Policy.

2.9.4 Safe Environment, Drug, and Alcohol Use

FamilyCare promotes and protects the health and safety of our employees, members and business partners, including Contractors. That is why we require a drug and alcohol free workplace and prohibit intimidating behavior, threats and acts of violence. The alcohol and drug policy applies while you are on company property and while you are doing company business elsewhere.

Violence has no place in the work environment and will not be tolerated. This includes intimidation, violent acts and threats of violence.

2.10 Framework of Compliance

2.10.1 Commitment to Integrity

Honesty and integrity are core values for FamilyCare. Employees and Contractors are expected to lead with sound, ethical decisions as they interact with members, regulators, providers, supplier, colleagues and customers at large. Integrity is critical to FamilyCare's success today and in the future. As part of our ethics and integrity focus, FamilyCare has adopted this Code of Conduct that describes ethical and legal responsibilities of all employees, officers and directors of FamilyCare, its subsidiaries and any Contractors acting on the company's behalf.

2.10.2 Antitrust and Unfair Competition

Antitrust laws make sure competition between companies is fair. These laws also protect the public against business competitors who band together or "collude" to unfairly set prices. You could be breaking these laws if you do things as simple as discuss competitors pricing, terms and conditions of sales; or dealings with customers, suppliers, or other competitors. Our competitors include managed care organizations, health care delivery companies, and insurance companies that operate in our markets.

2.10.3 Federal Contracts and Federal Procurement

FamilyCare is subject to the Federal Procurement Integrity Act when bidding on Federal contracts. All employees and contractors must comply with these federal statutes: 41 USC §423 and 18 USC §§207 and 208. In general, these laws prohibit certain business conduct for companies seeking to obtain work from the federal government.

More specifically, these laws place restrictions or prohibitions on FamilyCare personnel and contractors from engaging in the following activities:

- Offering or discussing employment or business opportunities at FamilyCare with current or former agency procurement officials;
- Offering or giving gratuities or anything of value to any agency procurement official;
- Seeking or obtaining any confidential information about the selection criteria before the

contract is awarded.

2.10.4 Sales, Marketing and Advertising Standards

We are committed to growing our membership through a well-trained, highly professional sales staff, which is comprised of our employees and independent brokers. All FamilyCare sales representatives are committed to fair, forthright and legally compliant sales and marketing practices. We adhere to any state regulations that require sales representatives to be licensed.

When advertising our products and services, we will present only truthful, non-deceptive information. In many cases, advertising and marketing material require approval from regulatory agencies prior to distribution. When required, FamilyCare will submit material to agencies and ensure they are in full compliance with applicable regulations.

2.10.5 Resources, Seeking Guidance and Reporting Violations

Each contractor should feel free to contact either of the following about any questions regarding this Code of Conduct:

Compliance Officer 503-734-3113

Compliance Hotline 503-345-5777

2.10.6 Cooperating with Internal Investigations

If FamilyCare initiates an investigation to determine whether there has been illegal or unethical conduct, we expect our Contractors to cooperate with the investigation and disclose all information and records that are relevant to the investigation. Failure to cooperate with an internal investigation is a violation of this Code of Conduct and can lead to contract termination.

2.10.7 Resolution, Communication, and Non-Retaliation

Once a problem or suspected violation has been reported, FamilyCare pledges to investigate and resolve the problem in a timely manner. FamilyCare will not retaliate against Contractors for reporting ethics or compliance violations in good faith. As much as possible, FamilyCare will take reasonable precautions to maintain the confidentiality of those who report compliance concerns. Complete confidentiality cannot be guaranteed.

Any retaliation against a contractor, who in good faith, reports a suspected violation of this Code of Conduct, the law, company policies, or contractual obligations, is not permitted and should be immediately reported to the Compliance Officer.

Any contractor, who makes malicious (or purposely false) reports, also violates this Code of Conduct.

2.10.8 Violations and Consequences

Failure to follow this Code of Conduct and any other company policies, applicable laws and contractual obligations will compromise FamilyCare's integrity and reputation. No contractor is ever authorized to commit or direct another person to commit an unethical and illegal act. In addition, no person can use a contractor, agent, consultant, distributor or other third party to perform any act not allowed by law, this Code of Conduct, FamilyCare policies or any applicable contractual obligation.

Section 3: Provider Requirements

3.1 24-Hour Coverage

Primary Care Providers and Mental Health Primary Care Providers

Primary Care Providers (PCP) and Mental Health Primary Care Providers (MHPCP) are expected to provide coverage for FamilyCare members 24 hours a day, 7 days a week. When a PCP/MHPCP is unavailable to provide services, the PCP/MHPCP must ensure that he or she has coverage from another participating provider.

Please note the following:

- Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers;
- Participating providers can consult the FamilyCare Provider Directory or contact the FamilyCare Provider Relations Department with questions regarding which providers participate in the FamilyCare network.

A 24-hour, 7 days a week nurse triage service, through FoneMed, is also available to assist our Medicare members with questions and identifying resources at 1-800-FONEMED.

3.2 Emergency and Urgent Care

3.2.1 An Emergency Condition

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

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

3.2.2 Emergency services

Emergency services are covered by FamilyCare if they are:

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

3.2.3 Members with an Emergency Condition

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

3.2.4 Members Who Need Urgent Care

Members who need urgent care, not emergent, are advised to call their Primary Care Provider/Mental Health Provider, prior to obtaining urgently needed services at another provider.

3.2.5 Covered Urgently Needed Services

Urgently Needed Services are covered when they are not emergency services and provided when:

- The member is temporarily absent from the FamilyCare Service Area **and** services are medically necessary (and immediately required);
- As a result of an unforeseen illness, injury, or condition **and** it is not reasonable given the circumstances, to obtain the services through a FamilyCare network provider.

3.2.6 Under Unusual and Extraordinary Circumstances

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but FamilyCare's provider network is temporarily unavailable or inaccessible.

3.3 Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified provider the member selects when he/she is temporarily absent from FamilyCare's service area and cannot reasonably access contracted dialysis providers. No prior authorization or notification is required. However, it is encouraged that a member voluntarily advises FamilyCare if he/she will temporarily be out of the service area and FamilyCare will assist in identifying a qualified dialysis provider.

3.4 Direct Access Services

There are a number of services that FamilyCare members may access without a referral from their Primary Care Provider or prior authorization from FamilyCare, as long as the member obtains these services from a participating provider. Those services are outlined in the member's benefits and are discussed below.

3.5 Preventive Services

Members may access the following services from any participating provider without a referral from a PCP:

- Diagnostic testing;
- Screening mammography;
- Influenza and Pneumococcal vaccinations (can be obtained at participating pharmacies at no cost to members);
- Routine and preventive women's health services (such as pap smears).

In addition, members may not be charged a co-payment for influenza or pneumococcal vaccinations.

3.6 Dental Benefits

Dental services, if covered, will be accessed directly by members without a Primary Care Provider referral through the services of contracted dental providers unless they are covered as emergency services. FamilyCare managed care programs and dental health benefits naturally complement one another because both emphasize prevention and cost-effectiveness.

3.7 Mental Health Benefits

Mental Health services, if covered, will be accessed without a Primary Care Provider (PCP) referral through a designated Primary Care Mental Health Provider (MHPCP). FamilyCare managed care programs and mental health benefits are managed jointly for members residing in Multnomah, Clackamas and Washington Counties for Medicaid only.

3.8 Substance Abuse Benefits

Substance abuse services (with the exception of Methadone covered treatments) are provided to all FamilyCare members in need of services through any participating provider without the requirement of prior authorization for the initial *90 days*. Treatment beyond 90 days requires authorization. Claims should be submitted within thirty (30) days of the date of service. All Utilization Review activities will be conducted retro-actively based on the claims received.

Methadone Treatment FamilyCare contracts exclusively with CRC Health to provide Methadone treatment for our members in Clackamas, Jackson, Josephine, Multnomah and Washington counties. Members in the Portland-Metro area can call (503) 226-2203. Members in Southern

Oregon can call (541) 774-8240. For Clatsop, Morrow and Umatilla members, please contact FamilyCare Customer Service at (800) 458-9518, TTY (800) 735-2900.

3.9 Vision Care

Vision care, if covered, will be accessed directly by members without a Primary Care Provider (PCP) referral through the services of contracted vision care providers. These providers, with assistance from FamilyCare, will coordinate routine vision benefits for exams and lenses according to the benefit defined in the benefit structure.

3.10 Hospital Services

Non-emergent inpatient admissions require authorization from FamilyCare. If you are a Primary Care Provider (PCP) or Primary Care Mental Health Provider (MHPCP), please contact FamilyCare as soon as you are aware of a planned admission of a member. Notifications of urgent or unscheduled admissions are often carried out by hospital personnel working with FamilyCare's Care Coordinators. These are Registered Nurses/Qualified Mental Health Professionals (RN/QMHP) who work with admitting providers and hospital based physicians (hospitalists) to ensure members are receiving appropriate care and discharge planning. Our Care Coordinators will be of assistance in coordinating all services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding PCPs/MHPCPs.

Certain services do/do not require authorizations:

- Diagnostic outpatient services at hospitals or other facilities do not require authorization;
- Therapeutic outpatient services require authorization.

3.11 Member Access

FamilyCare's intent is that members will have access to healthcare services 24 hours a day, 7 days a week.

Adequacy of member access will be monitored and evaluated through use of encounter/eligibility data, criteria-based reviews, issues identified on a case-by-case basis and trends or patterns identified in our ongoing grievance monitoring. FamilyCare's Quality Management Committees and Manager of Network Development will monitor the adequacy of the provider network and access to providers by monitoring utilization statistics such as out-of-network referrals, access surveys, and member complaints. Analysis will include data by county, Primary Care Provider (PCP), Primary Care Mental Health Provider (MHPCP), specialties, special services, and age-sensitive groups such as geriatrics, pediatrics or specific ethnic populations, disability services, hospital, support services and other categories identified through data sorts.

Elements of this analysis will include:

- Physical Access (including accommodation under the ADA);
- Triage;
- Travel;
- After-hours access for PCPs, MHPCPs and specialty care;
- Interpretive services;
- Telephone access;
- Appointment scheduling/waiting times.

3.12 Appointment Scheduling

The intent of FamilyCare is to ensure that members have access to a Primary Care Provider (PCP)/Mental Health Primary Care Provider (MHPCP) and, when appropriate, specialty care.

The designated FamilyCare procedure for appointment scheduling is as follows:

- Members call the provider office directly to schedule appointments;
- Office staff will schedule member appointments based on urgency;
- Urgent visits will be scheduled within 24 hours for physical health and 48 hours for mental health;
- Non-urgent visits will be scheduled within 48 hours, or two business days;
- Routine, preventive care, visits will be scheduled within 6 weeks for physical health, 14 days for Mental Health/Behavioral Health, and 10 days for chemical dependency and methadone;
- Outpatient Mental Health visits will be scheduled within 7 days following hospital discharge.

3.13 Urgent Care

Urgent care patients will be seen as soon as possible. Non-urgent patients will be seen as the schedule allows but no longer than two days.

3.14 Missed Appointments

When a member fails to keep an appointment the provider may implement his/her office procedure for missed appointments. If the provider chooses to implement his/her own office procedure, a copy of the procedure must be on file with FamilyCare Provider Services.

The following process guidelines apply:

- Provider mails or faxes missed appointment letter;
- Provider documents the missed appointment and recall efforts in the patient's medical record;
- Provider attempts to reschedule appointment as medically appropriate;
- Prior to disenrollment, provider contacts a FamilyCare Care Coordinator for assistance with difficult members or members with repeating disruptive behavior.

If the provider requests that a member be reassigned, notification must be sent to a FamilyCare Care Coordinator along with documentation that supports the reason for the request. The member must be mailed a letter of notification along with provisions for emergent medical care for the next thirty days.

3.15 Access for Special Needs Members

Providers must be aware and comply with the American's With Disabilities Act and ensure the availability of the following types of facility support that may be required for access by the population served:

- Wheelchair access;
- Ramp or street level access;
- Corridor railings;
- Elevators that are operable for a wheelchair;
- Restrooms and exam rooms that are wheelchair accessible.

In addition, the provider and office staff needs to be prepared to meet the needs of non-English speaking, visually impaired, or hearing impaired individuals.

3.16 Interpretive Services

Interpretive services are a covered benefit for all of FamilyCare's members. For assistance in obtaining interpretive services please contact FamilyCare's Customer Service Department at **(503) 222-2880** or **(800) 458-9518** or TTY (800) 735-2900

Section 4: Referrals and Authorizations

4.1 Prior Authorization Information

Prior authorization prospectively reviews eligibility of services, procedures, and equipment for payment under the health plan.

To initiate the prior authorization process you can access more information by calling our Provider Relations Department or by going to FamilyCare's website at www.familycareinc.org. You may also use a fax referral form and fax to the attention of the Referral/Authorization Coordinator or call our Referral/Authorization Department.

Specific referral and authorization policies, procedures, and guidelines can be provided on request. Call the Referral/Authorization line for assistance.

For Physical and Behavioral Health Call: (503) 228-8228 or (800) 684-3799

4.2 Provider Responsibilities

When the Primary Care Provider (PCP) is making a referral to a specialist, the PCP should check the FamilyCare Provider Directory to ensure the specialist is a participating provider in the FamilyCare network.

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

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

If required, the PCP should notify FamilyCare regarding the specialist referral. The notification should include the following information:

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

Section 5: Medical Management Program

5.1 Overview

FamilyCare is a risk-based managed care health plan which seeks to provide its members with vertically and horizontally integrated health services that are built on high quality, cost effective and comprehensive medical care. The Medical Management (MM) Program is comprised of Utilization Management, Financial Management, Quality Assessment & Improvement, Compliance, and Education Activities that link together to ensure efficient and effective utilization of FamilyCare's resources and compliance with applicable federal and state laws and contracts.

For specific aspects of the program, see the Medical Management Program posted at www.familycareinc.org or contact Customer Service for a hardcopy at (800)458-9518.

5.2 Participation in the Quality Management Program

Participation in the Quality Management (QM) program is a requirement for all practitioners, delegated medical groups, and organizational providers. Participation includes providing data for various QM activities and adhering to established standards of care.

Provider and member input into the delivery system is encouraged and made available through participation in appropriate committees. For information on the committees and interest in participation, please contact FamilyCare's **Contracting and Provider Relations** at **503-471-2149**.

5.3 Intensive Case Management Program

An Intensive Case Management (ICM) Program is available to members with multiple psychiatric admissions within a rolling ninety (90) day cycle and to members who have co-occurring behavioral and medical needs requiring an intensive integration of services. As an ICM member, FamilyCare will contact the member on a routine basis to assess their progress and provide assistance determined by the Behavioral Health Care Coordinator and the member.

Remember, Care Coordination assistance may be either one time or ongoing. If you have a member or an issue that you believe would benefit from a Clinical Coordinator's assistance, please contact FamilyCare **Customer Service** at **800-458-9518** and ask to speak to the Behavioral Health Clinical Coordinator.

Section 6: Clinical Records Overview

FamilyCare's providers are required to fully document the member's condition, clinical encounters, and medically appropriate service provisions in their clinical records. The minimum requirements for the clinical records are established by the State of Oregon and pertinent federal regulations.

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

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

Section 7: Initial Determination Overview

The “initial determination” is the first decision FamilyCare makes regarding coverage or payment for care. In some instances, a participating provider, acting on behalf of FamilyCare may make an initial determination regarding whether a service will be covered.

Other examples of “initial determination” are:

- A member asks FamilyCare to pay for medical care the member has already received; this is a request for an “initial determination” about payment for care.
- A member or participating provider acting on behalf of a member asks for preauthorization for treatment, this is a request for an “initial determination” about whether the treatment is a covered benefit.
- A member asks for a specific type of medical treatment from a participating provider, this is a request for an “initial determination” about whether the treatment the member wants is a covered benefit.

Section 8: Grievance and Appeals Overview

FamilyCare has established policies and procedures to address the following issues:

- Grievances (complaints)
- Appeals
- Notice of Medicare Non-Coverage (NOMNC)
- Notice of Discharge and Medicare Appeals Rights (NODMAR), appeals and/or grievance, and the Notice of Medicare Non-Coverage.

Please go to www.familycareinc.org to view the policies & procedure documents or call FamilyCare's Customer Service at - (800) 458-9518 for hard copies.

Section 9: Pharmacy Management

9.1 Introduction

The following information is for physical health providers only.

The FamilyCare Formulary promotes cost effective prescribing for conditions covered under the Oregon Health Plan and PremierCare Plans. The formulary is not intended to replace clinical judgment. If the formulary impedes your ability to make good clinical judgment, please contact FamilyCare's Pharmacy department. The FamilyCare Pharmacy department will work with you to learn what your needs are and will make suggestions on how those needs can best be met. This may include the override of existing guidelines.

To reach the Pharmacy Department:

Call - (503) 471-2126 or (800) 335-3205 ext. 2126

Fax - (503) 471-2176

The Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutic (P&T) Committee is comprised of practicing providers and pharmacists throughout FamilyCare's service areas. The P&T Committee uses evidence-based data concerning efficacy, safety, compliance, side effects, cost, and provider input in the selection of drugs to include in the formulary.

9.2 Using the Formulary

The drug formulary is a list of drugs that are covered under FamilyCare benefits for eligible members in both Medicaid and Medicare.

Both the PremierCare and FamilyCare OHP formularies are available at:

www.familycareinc.org and www.ePocrates.com.

These two resources enable you and 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.

9.3 Giving Feedback on the Formulary

Providers are encouraged to give suggestions, comments or concerns to the Medical Director at FamilyCare. All input must be received in writing to ensure clarity of communication. The Pharmacy and Therapeutics (P&T) Committee will review inputs.

Please address your comments to:

Pharmacist
FamilyCare, Inc.
825 NE Multnomah, Suite 300
Portland, Oregon 97232

9.4 Coverage Limitations

The drug formulary applies to outpatient drugs provided to members, and does not apply to medications given in an inpatient setting.

The following general exclusions and guidelines pertain to all covered members:

- Mandatory generic dispensing, with some exclusion (see below);
- Drug coverage directly relating to treatment of diagnoses which are a covered benefit;

- 75% of the prescription must be utilized before a refill will be authorized;
- Drug products used for cosmetic purposes are not covered;
- Narcotic prescriptions filled without prior health plan authorization will be dispensed with a 90/56 policy (90-tablet quantity/56 day supply);
- Over-the-counter drugs listed on the *FamilyCare “Over the Counter” Formulary* will be approved for diagnoses covered by the Oregon Health Plan;
- Replacement of lost or stolen medication will be considered on a case specific basis (Narcotics and muscle relaxants **are not** covered without a valid police report);
- Experimental drug products, or any drug product used in an experimental manner, are not covered;
- Off label use of medication or those used where the FDA has not reviewed scientific studies to conclude that a medication is safe and effective treatment for that disorder.

Off label uses are based on small antidotal papers and may not be supported by large evidence based reviews. FamilyCare will cover off label use of formulary medications only when that use has been found through evidence based review to be of greater efficacy than other, less expensive, formulary agents.

9.5 Generic Drugs

When available, FDA approved and equivalent generic drugs are mandatory to use. A few exclusions have been identified where there is defined narrow therapeutic efficacy or where blood level maintenance is crucial.

If a provider determines that there is a documented medical need for the specific brand product to be used, a request can be made by notifying FamilyCare’s Pharmacy Manager for clinical review. If approved, the provider will need to indicate to the member’s pharmacy that the medication needs to be “Dispensed as Written.” Requests are made by submitting a FamilyCare Medication Request form.

9.6 Medication Request

For medication requiring prior authorization or non-formulary drugs for which there is no suitable alternative available, participating providers may fax a completed FamilyCare, Inc. Letter of Necessity/Coverage Determination Form, to FamilyCare at **(503) 471-2176** or **(800) 270-7737**.

The Coverage Determination Form is available online at www.familycareinc.org. For questions regarding this process, please contact FamilyCare **Customer Service at (503) 222-2880** or **800-458-9518**.

9.7 Prior Authorization

Medications listed on the formulary as “Prior Authorization (PA)” required, must have an approval before the prescription can be dispensed by a network pharmacy. If the criteria for ordering the medication are not met, the prescribing provider will be contacted 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. Step Therapy Guidelines are available online at www.familycareinc.org. These guidelines are located in two sections: “Step Therapy Guidelines” and “FamilyCare Guidelines.”

Drugs listed in the formulary with *quantity limited* (QTY) require a prior authorization once the limit has been reached.

To prevent delays in filling the prescription, the provider can:

- Fax a completed FamilyCare Letter of Necessity/Medication Request Form to FamilyCare at **(503) 471-2176** or **(800) 270-7737**;
- Contact the **Pharmacy Department** at **(503) 471-2126** or **(800) 335-3205 ext. 2126**.

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

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

Emergencies - In an emergent situation, CVS Caremark provides 24 hour authorization coverage. Pharmacies can call CVS Caremark Help Desk at (800) 770-8014

Section 10: Fraud and Abuse Overview

It is FamilyCare's responsibility to monitor all billing practices to prevent any fraudulent or abusive conduct. Fraud/Abuse involves a provider, or someone who is paid with state or federal funds, who intentionally or recklessly submits inappropriate claims for services to be paid with state or federal funds.

The following are examples of fraud and abuse:

- Providers who demonstrate a pattern of reporting encounters, services, or the provision of goods which did not occur;
- Providers who demonstrate a pattern of reporting overstated or up-coded levels of services;
- Providers who falsify diagnoses in order to obtain additional reimbursement;
- Providers who make false statements about the credentials of persons rendering care to members, e.g. unlicensed personnel or providers excluded from participating in Medicaid/Medicare services;
- Providers who change dates of services or otherwise falsify records to justify reimbursements or payments;
- Provider or their employees who attempt to bill recipients for services that are covered by Medicare or Medicaid;
- Providers or their employees who obtain additional reimbursement by any improper means, including setting up false provider or recipient numbers, duplicating billings for services, etc.;
- Providers who fail to render the care they are obligated to provide;
- Providers who bill for unnecessary services or bill at a cost beyond the provider's usual charge;
- Providers who perform drug up coding and/or drug diversion.

Section 11: Health Care Directives

A Health Care Directive or Advanced Directive is a set of instructions that explain the specific healthcare measures a person wants if he or she should have a terminal illness or injury and become incapable of indicating whether to continue curative and life-sustaining treatment or to remove life support systems. The person must develop the Health Care Directive while he or she is able to clearly and definitively express him or herself verbally, in writing, or in sign language. It must express the person's own free will regarding their health care, not the will of anyone else. It does not affect routine care for cleanliness and comfort, which must be given whether or not there is a Health Care Directive.

In Oregon, the Health Care Decisions Act (ORS 127.570) allows an individual to preauthorize healthcare representatives to allow the natural dying process if he or she is medically confirmed to be in one of the conditions described in his or her healthcare instructions. This Act does not authorize euthanasia, assisted suicide, or any overt action to end the person's life.

11.1 Requirements:

Witnesses: Two adults, at least one of them not related to the person by blood or marriage nor entitled to any portion of the person's estate, must witness or acknowledge the person signing the advance directive. The person's attending physician, attorney-in-fact, and healthcare or residential staff may not serve as witnesses.

Health Care Instructions: These may either be general, or relate to the four specific conditions outlined below. However, general instructions (such as the person never wishes to be placed on life support) may be too vague and not provide for a situation in which an accident or emergency requires that the person be placed on life support temporarily. Specific instructions regarding the person's wishes in each of the four scenarios listed below are preferred. Some hospitals' social workers or chaplains will provide instructions and forms for advance directives.

The patient's physician can determine whether any of these four conditions apply:

1. **Close to death:** Terminal illness in which death is imminent with or without treatment, and where life support will only postpone the moment of death.
2. **Permanently unconscious:** Completely lacking an awareness of self and external environment, with no reasonable possibility of a return to a conscious state.
3. **Advanced progressive illness:** Advanced stage of a progressive illness that will be fatal and is unlikely to improve.
4. **Extraordinary suffering:** Illness or condition in which life support will not improve the person's medical condition and would cause the person permanent and severe pain.

Health Care Representative: A Health Care Directive can appoint someone who is at least 18 years of age to make medical decisions for the person when that individual is not able to do so. Among the decisions made, by the healthcare representative, is whether or not to withhold or remove life support, food, or hydration. The Health Care Representative and an alternate must sign the document accepting their appointment. The patient should appoint a Health Care Representative that he or she trusts completely. A patient can voluntarily revoke their appointment of a Health Care Representative at any time. A general *Durable Power of Attorney*, which is for financial affairs, does not include authority to make healthcare decisions.

Copies of the Advanced Directive can be obtained through Oregon Department of Human Services, or from FamilyCare. You may also download a copy at http://www.oregon.gov/DCBS/SHIBA/docs/advance_directive_form.pdf.

Section 12: Declaration for Mental Health Treatment

12.1 Introduction

As required by the State contract, our providers must supply our members with information about the *Declaration for Mental Health Treatment*, and a copy of the form, when services begin. At the member's request, the provider must also provide the name and phone number of a person who can provide further information or assistance in filling out the form. This is in accordance with ORS 127.700 through 127.735.

The *Declaration of Mental Health Treatment* allows the individual to make some choices about treatment to be provided at *some future time* when the individual is not capable of giving consent.

The Declaration covers three areas:

- Medications;
- Electro-convulsive treatment;
- Hospitalization.

Every individual in the State of Oregon has the choice to make a *Declaration of Mental Health Treatment*. It is a personal choice. No individual can be forced or coerced into completing a Declaration. It is a legal document.

Providers should be aware that the state law requires that information about the Declaration be made available to all "capable adults who are receiving mental health treatment by or through the organization." Furthermore, agencies should have written policies and procedures relating to the Declaration.

12.2 Completing the Declaration of Mental Health Treatment

To complete the Declaration, the member fills out the form, signs it and has two witnesses attest to it by signature.

The following individuals **cannot** be a witness:

- The individual's doctor or mental health provider;
- The provider's relatives;
- The owner or operator of a facility of which the person is a resident;
- Relatives of the owner or operator;
- Any relatives of the individual.

When the form is completed, signed, and witnessed, state law requires that the form be made part of the member's clinical record. The form should also be given to the individual's doctor and/or any other mental health provider or caregiver. In addition, the member should be given a copy so that it can be shown to anyone providing treatment. As appropriately agreed upon, family members should be given copies as well.

12.3 Duration of Declaration Validity and Revocation Rights

The Declaration is valid for three years unless changed or revoked by the member. After three years the member must prepare a new Declaration unless they are incapable of making that decision. In that case, the Declaration remains in effect until the person is capable of making a change in the Declaration.

To make changes in the Declaration, the member simply tells their doctor, mental health provider or anyone else with a copy of the Declaration that they want to revoke or change the conditions. Although not necessary, it is preferable that this change be noted in writing. All copies of the revoked or un-amended Declaration (the original Declaration) should be destroyed.

The purpose of the Declaration is to:

- **Obtain the wishes** of the individual when they are not experiencing disabling symptoms of their illness;
- **Comply with those wishes** at such times when they are unable to understand and make decisions about treatment.

To make the determination that the member meets the latter criteria, it requires either the court or two physicians.

Providers are required to provide the declaration at the start of services. However, if the member is unable to enter a Declaration at the beginning of services, providers should inform the member of the Declaration when they are able.

You may acquire copies of the *Declaration of Mental Health Treatment* from FamilyCare, the **Office of Mental Health and Addictive Services (503) 945-9700** or the **Oregon Advocacy Center (503) 243-2081**.

Section 13: Claims Process



13.1 Identification Cards and Verification of Coverage



Each FamilyCare member will receive a FamilyCare Identification (ID) Card containing the member's name, member number, and information about their benefits (only the FamilyCare OHP card includes the member's PCP name and phone number).



At each office visit, your office staff should:

- Ask for the member's ID card and have a copy of both sides in the member's office file;
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes;
- **Verify eligibility for OHP members using DMAP's MMIS web portal;**
- Refer to the member's ID card for the appropriate telephone number to verify eligibility, any deductibles or coinsurance amounts, co-payments, and other benefit information;
- Verify PCP assignment using FamilyCare's web-based provider interface.

13.1.1 Sample FamilyCare member card fronts for all plans

 <small>Incorporated</small>	Familycare OHP Plus	 <small>Incorporated</small>	Familycare OHP Std
Enrollee: JOHN Q PUBLIC	DOB: 08/01/2009	Enrollee: JOHN Q PUBLIC	DOB: 08/01/2009
I.D. NO: AA999A9A	Eff 08/01/2009	I.D. NO: AA999A9A	Eff 08/01/2009
PCP: DR. JOHN FEELWEEL		PCP: DR. JOHN FEELWEEL	
Pharmacy Benefit RxAmerica	RxPCN: 0635 RxBin: 610473	Pharmacy Benefit RxAmerica	RxPCN: 0635 RxBin: 610473
Eligibility verification required. Special benefits and exclusions apply. Attention Physician: Pre-authorization Required (see reverse)		Eligibility verification required. Special benefits and exclusions apply. Attention Physician: Pre-authorization Required (see reverse)	

 <small>HEALTH PLANS</small>	MedicareR <small>Prescription Drug Coverage</small>	 <small>HEALTH PLANS</small>	MedicareR <small>Prescription Drug Coverage</small>
PREMIERCARE ADVANTAGE Rx		PREMIERCARE CHOICE Rx	
RxBin: 012189		RxBin: 012189	
RxPCN: 5006	Office Visits: \$15	RxPCN: 5006	Office Visits: \$15
RxGrp: 5006	Specialty Visits: \$25	RxGrp: 5006	Specialty Visits: \$30
Issuer: 1508842527	Emergency Room: \$50	Issuer: 1508842527	Emergency Room: \$50
ID No: C090100001	Hospital: \$100	ID No: C090100001	Hospital: \$250
Member: JOHN Q PUBLIC	CMS H3818/001	Member: JOHN Q PUBLIC	CMS H3818/003

 <small>HEALTH PLANS</small>	MedicareR <small>Prescription Drug Coverage</small>	 <small>HEALTH PLANS</small>	MedicareR <small>Prescription Drug Coverage</small>
PREMIERCARE PLUS		PREMIERCARE CHOICE	
RxBin: 012189			
RxPCN: 5006		Office Visits: \$15	
RxGrp: 5006		Specialty Visits: \$30	
Issuer: 1508842527		Emergency Room: \$50	
ID No: C090100001		Hospital: \$250	
Member: JOHN Q PUBLIC	CMS H3818/002	Member: JOHN Q PUBLIC	CMS H3818/004

13.1.2 Sample FamilyCare member card back for all plans



13.2 Participating Providers

FamilyCare's policy is to pay all clean claims within the first thirty (14) business days of receipt. Other claims requiring additional review and/or information are to be paid within thirty (30) days after the completion of review, or receipt of additional information.

FamilyCare can process and receive professional claims electronically or by mail. For electronic submission specifics or problems contact FamilyCare Customer Service at 503-222-2880 or 800-458-9518.

If you have EDI, you must submit electronic claims. FamilyCare will not accept paper claims if there is an electronic option.

Participating Providers should submit claims to FamilyCare Health Plans via EDI or to the claims address as soon as possible but not longer than ninety (90) days after service is rendered, using the standard red CMS-1500 Claim Form for professional claims and the UB-04 from for facility and/or hospital claims or electronically as discussed below. Claims should be submitted within ninety (90) days of service.

Exceptions would include the following:

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

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

- Referral number (on specialists' referral claims). However, if the service is available without a referral, (e.g., routine and preventive women's healthcare services) no referral number is necessary;
- Member name;
- Member address;
- Member's social security number;
- Member's date of birth and sex;
- Member's FamilyCare ID number;
- Group policy number if available;
- Indication of a job-related injury or illness, or an accident-related illness or injury, including pertinent details.

FamilyCare's Health Plan claims review procedures are as follows:

1. Claims submitted by non-participating providers without authorization numbers are reviewed.
2. Any claim submitted without complete information will be reviewed.
3. Both the Medical Director and Clinical Care Coordinator review questions of medical necessity.
4. Questionable services, which should be covered, require more information.
5. A periodic review of the status of claims and services in review is made to ensure the process is timely.

FamilyCare will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to FamilyCare should comply with those requirements.

13.3 Claims Disputes & Requirements

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the FamilyCare Customer Service Department at 503-222-2880 or 800-458-9518 or TTY: 800-735-2900, Monday through Friday 9:00 am to 5:00 pm.

13.3.1. Requirements Necessary When Submitting a Claim

Claims submitted must have the following information:

- Correct zip codes listed
- Federal Tax Identification Number listed (TIN)
- National Provider Identification Number listed (NPI)
- Accurate Insured's ID Number
- Current diagnosis codes
- Include admission date for inpatient hospitalization (Place of Service 21)
- Providers appealing denied claims on behalf of members should include supporting documentation

Please be aware that we cannot accept claims with correction fluid on them. The more neatly the claims are typed, with information in the correct fields, the faster the claims will be processed.

13.4 Clinical Review of Claims and Services Procedure

A goal of FamilyCare is to ensure that claims will be paid according to the clinical guidelines outlined in the plan policies and within the time frames stated in FamilyCare standards.

- A. Claims submitted by a non-contracted provider which do not have an authorization number assigned are reviewed by the clinical staff.
- B. Emergent claims at contracted and non-contracted facilities may be reviewed by health services staff for emergent/non-emergent status based on presenting diagnosis.
- C. Claims which have an authorization number, but the information provided is incomplete or does not match the authorization, are reviewed by the health services clinical staff.
- D. Health Services clinical staff reviews questions of medical necessity, requests for exceptions to benefits, and other exceptional claims or authorization requests which significantly fall outside the benefit guidelines. All appeals are reviewed by the Medical Director or Adjunct Medical Director.
- E. Additional clinical information is requested from the provider, and in some cases, a letter is requested from the provider to address medical necessity as needed.

- F. If a decision continues to be problematic, despite further clinical information and/or a letter of medical necessity, a request is made for independent medical review is considered final in determining medical necessity.

13.5 Explanation of Denial Codes

FamilyCare follows HIPAA guidelines for transaction codes and data sets. Denial codes can be found in Appendix B. You may also want to refer to: <http://www.wpc-edi.com/codes> for more details.

13.6 Adjustment-Overpayment Process

If a claim is determined to be overpaid, a letter will be sent to the provider indicating that a claim was processed in error and a refund is requested. The provider will have thirty (30) days to reimburse FamilyCare. If reimbursement is not received within thirty (30) days, the requested amount will be deducted from the provider's next payment. Reimbursement will be waived or delayed if the provider's office contacts FamilyCare, either in writing or by phone, regarding the dispute of the refund, or receipt of the requested amount. If the refund is not disputed, and no refund has been received, the overpayment will be deducted.

13.7 Billing Members

You may not bill a member for a non-covered service unless:

- You have informed the member in advance that the service is not covered;
- The member has agreed **in writing** to pay for the services if they are not covered.

Providers may not balance bill for these services:

- Providers may not balance bill FamilyCare OHP members for covered services over and above FamilyCare allowable;
- Providers may not balance bill PremierCare members for covered services over and above applicable copays and plan allowable (limited exceptions for buy-up option pertaining to vision hardware for members with PremierCare Advantage RX and PremierCare Select RX).

Providers should contact our **Customer Service Department, 503-222-2880** or **800-458-9518** to verify if the service is covered or not before charging members for health services.

Section 14: Provider Performance, Standards, & Compliance Obligations

14.1 Performance

When evaluating the performance of a participating provider FamilyCare will review, at a minimum, the following areas:

- **Quality of Care:** Measured by clinical data related to the appropriateness of a member's care and member's outcomes;
- **Efficiency of Care:** Measured by clinical and financial data related to a member's healthcare costs
- **Member Satisfaction:** Measured by plans and member reports regarding accessibility, quality of healthcare, member-participating provider relations, and the comfort of the practice setting;
- **Administrative Requirements:** Measured by the Participating Provider methods and systems for servicing members, keeping records, and transmitting information;
- **Participation in Clinical Standards:** Measured by the Participating Provider's involvement with panels used to monitor quality of care standards;
- **Provider Compliance to Standards of Care:** FamilyCare participating providers must comply with all applicable federal and state laws and licensing requirements. In addition, participating providers must furnish covered services in a manner consistent with FamilyCare's Code of Conduct and standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment.

Participating Providers must also comply with FamilyCare's standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity);
- All federal, state, and local laws regarding the conduct of their profession;
- Support of committee and clinical task forces to improve the quality and cost of care
- Provider participation on the quality review committees ;
- Pre-notification requirements and timeframes;
- Participating provider credentialing requirements;
- Referral policies;
- Care Management Program referrals;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of member medical record information to fulfill the business and clinical needs of FamilyCare;
- Cooperating with efforts to assure appropriate levels of care;
- Maintaining a collegial and professional relationship with FamilyCare personnel and fellow participating providers;
- Providing equal access and treatment to all members.

14.2 Compliance Process

The following types of non-compliance issues are key areas of concern:

- Out of network referrals/utilization;
- Failure to pre-notify the plan of admissions;
- Member complaints/grievances that identify provider concern or non-compliance trends or patterns;
- Underutilization, over utilization, or inappropriate referrals;
- Inappropriate billing practices;
- Non-supportive actions and/or attitude;
- Non-compliance with FamilyCare's Code of Conduct.

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

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

14.3 Laws Regarding Federal Funds

Payments that participating providers receive for furnishing services to FamilyCare members are, in whole or part, from Federal funds. Therefore, participating providers and any of their subcontractors must comply with laws that are applicable to individuals and entities receiving Federal funds.

This includes, but is not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84;
- The Age Discrimination Act of 1975 as implemented by 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act.

14.4 Marketing

Participating providers may not develop and use any materials that market FamilyCare without the prior approval of FamilyCare.

14.5 Sanctions under Federal Health Programs and State Law

Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other Federal Health Care Programs are employed or subcontracted by the participating provider.

Participating providers must disclose to FamilyCare whether the participating provider, any staff member, or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of Oregon or any other island, the federal government, or any public insurer. Participating providers must notify FamilyCare immediately if any such sanction is imposed on the participating provider, a staff member, or subcontractor.

14.6 Initial Credentialing

Providers requesting participation with FamilyCare should contact our Provider Relations (PR) department at 503-471-2149. If appropriate to network capacity and needs, and if provider is not on the Medicare/Medicaid sanctioned or excluded list, the PR representative will request for a completed and signed credentialing application.

The provider's credentialing application must include the following:

- Completed and signed Oregon or Washington Initial Practitioner Credentialing Application (**Effective October 2009, FamilyCare will only accept the approved, updated Oregon Practitioner Credentialing Application dated 7/16/2009**);
- Signed and dated attestation questions (within 180 days of credentialing decision);
- Any attestation questions answered "yes" must be accompanied by attachment A explanation;
- Signed and dated Authorization and Release of Information form;
- Current, unrestricted, Medical License in state of practice;
- Current Drug Enforcement Agency (DEA) certificate, if applicable;
- Evidence of current professional liability insurance coverage in the amount of no less than one million dollars (\$1,000,000) per incident, three million (\$3,000,000) aggregate or equivalent protection. Exceptions may be made for county clinics that are protected under the Tort Claims Acts (ORS 30.282) and may have the professional liability limits of \$500,000 per occurrence;
- Copies of board certifications, if applicable;
- Call coverage and hospital admission coverage, if applicable;
- Documentation of the past five years of work history.

Providers should notify FamilyCare of any changes within 30 days of any statements on the application.

The initial application is reviewed for completeness before undergoing primary source verification. FamilyCare's Credentialing staff verifies status of state licensure, including any actions or active restrictions, the National Practitioner Data Bank report, and Medicare/Medicaid sanction list including the Office of Inspector General (OIG) and the List of Excluded individuals/Entities (LEIE) database as a part of the credentialing process.

14.7 Credentialing & Recredentialing

14.7.1 Credentialing and Re-credentialing of Panel Providers

FamilyCare, Inc. verifies directly and/or through a delegated credentialing entity the skills, training, and licensing of Providers to ensure the validity of their qualifications and so that we can demonstrate the qualifications of our panel of providers to members, purchasers and regulators. Only providers who demonstrate sufficient qualifications verified through the credentialing process will be appointed and granted membership on FamilyCare's Provider Panel.

14.7.2 Nondiscrimination Disclosure

FamilyCare does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patient's the practitioner specializes in. Any complaints of discrimination from practitioners will be researched to ensure that practitioners are not discriminated against.

14.7.3. FamilyCare Contractual and Policy Stipulations

Providers accepted for panel membership agree to comply with FamilyCare contractual and policy stipulations.

Providers subject to credentialing and recredentialing processes include, but are not limited to:

- Certified Nurse Midwives;
- Medical Doctors;
- Naturopaths;
- Doctors of Osteopathy;
- Podiatrists;
- Nurse Practitioners;
- Psychologists;
- State Certified or State Licensed Clinical Social Workers;
- Audiologists;
- Physician assistants with expanded licensure for remote delivery systems;
- Behavioral Health/Chemical Dependency Specialists.

FamilyCare may or may not credential providers that are:

- Hospitalists or Emergency Department providers;
- Providers practicing in free-standing facility (e.g., mammography centers, urgent care centers, surgicenters);
- Physician assistants working on a dependent basis;
- PT, OT and Speech Therapists;
- Bachelor and master level behavioral health providers;
- Licensed professional counselors for behavioral health;
- Out of Network providers added for payment of limited services.

14.7.4. Recredentialing

FamilyCare formally recredentials its providers every three (3) years. Exceptions may occur when a QMC determination requires that a provider's credentialing period is approved for a one (1) or two (2) year period. FamilyCare will notify by mail providers subject to recredentialing within ninety (90) days before the provider's recredentialing date. Notification will include a Practitioner Recredentialing Application.

Providers recredentialing application must include the following:

- Completed and signed Oregon or Washington Practitioner Re-Credentialing Application (**Effective October 2009, FamilyCare will only accept the approved, updated Oregon Practitioner Re-Credentialing Application dated 7/16/2009**);
- Signed and dated attestation questions (within 180 days of credentialing decision);
- Any attestation questions answered "yes" must be accompanied by attachment A explanation;
- Signed and dated Authorization and Release of Information form;
- Current, unrestricted Medical License in state of practice;
- Current Drug Enforcement Agency (DEA) certificate, if applicable;
- Evidence of current professional liability insurance coverage in the amount of no less than one million dollars (\$1,000,000) per incident, three million (\$3,000,000) aggregate or equivalent protections. Exceptions may be made for county clinics that are protected under the Tort Claims Acts (ORS 30.282) and may have the professional liability limits of \$500,000 per occurrence;
- Copies of board certifications, if applicable;
- Call coverage and hospital admission coverage, if applicable.

In addition the following quality review information is tracked and trended by provider to include in the recredentialing decision-making process:

- Complaints/Concerns, including adverse incidents;
- After hour and appointment access;
- Information from QI activities;
- Utilization management;
- Member satisfaction;
- Medical record reviews;
- Site visits.

Credentialing staff will review recredentialing application for completeness before undergoing primary source verification. Credentialing staff verifies the status of state licensure including any actions or active restrictions, the National Practitioner Data Bank report and Medicare/Medicaid sanction list (Office of Inspector General (OIG) list of Excluded individuals/Entities (LEIE) database) as part of the recredentialing process.

14.8 Facility/Organization and Ancillary Provider Credentialing

Credentialing criteria are designed to assess a facility/organization or Ancillary Provider's ability to delivery appropriate care.

Facility/Organization and Ancillary Providers include but are not limited to:

- Hospitals;
- Skilled nursing facilities;
- Home care agencies;
- Clinical laboratories;
- Diagnostic radiology facilities;
- Ambulatory surgery centers;
- Rural health centers;
- Durable Medical Equipment suppliers
- Mental Health Organizations.

FamilyCare will not contract with facilities/organizations, or Ancillary Providers that have active license, accreditation or certification restrictions which affect or may affect their ability to provide contracted services to FamilyCare members.

The credentialing criteria include:

- Evidence of current licensure;
- Accreditations;
- Certifications;
- Liability Declaration;
- No Medicare/Medicaid Sanctions or Exclusions;
- For Medicare, no opt out report.

Credentialing staff will review the standardized application for completeness before undergoing primary source verification. Credentialing staff verifies the licensure, certification or accreditation, Medicare/Medicaid sanction list including the Office of Inspector General (OIG) and the List of Excluded individuals/Entities (LEIE) database as part of the credentialing process.

14.9 Review and Notification

The Quality Management Committee (QMC) oversees all credentialing and recredentialing of providers. The QMC is responsible for developing credentialing criteria based on applicable standards and applying criteria in a fair and impartial manner.

Providers will be notified in writing regarding the decision on their request to be credentialed, including the effective beginning and end dates of the approved credentialing period from a minimum of one (1) year to the maximum of three (3) years.

The QMC may choose not to credential a provider based on adverse information found during the credentialing discovery process.

Please note:

- The Medical Director will attempt to verbally notify any provider that does not receive credentialing approval, prior to the provider receiving the written notification;
- Written notification includes the provider's right to review appropriate information submitted to support his or her credentialing application as well as the provider's right to appeal and the appeal process.

14.10 Site Visits

FamilyCare will conduct on-site visits, for purposes of credentialing, recredentialing and quality of care monitoring, at most every three (3) years. In addition, FamilyCare may schedule and perform on-site visits for independent quality review or monitoring of delegated responsibilities. The purpose of on-site visits is to assess the quality, safety and accessibility provided by providers and to ensure that practitioners meet FamilyCare's standards for the physical environment.

FamilyCare and its Quality Management Committee (QMC) will review, as needed, any data gathered regarding practitioners who fall outside acceptable quality standards. Repeated failure to meet acceptable quality standards may result in termination from panel participation.

14.11 Termination of Participating Provider without Cause

Notwithstanding the terms of any contract, FamilyCare shall not terminate a provider's participation in the FamilyCare without cause upon less than ninety (90) days prior written notice.

14.12 Appeal Process for Provider Participation Decision

If FamilyCare decides to suspend, terminate, or deny a provider's participation status, FamilyCare will give the affected provider written notice of the reasons for the action. If relevant, this will include the standards and profiling data used to evaluate the provider and the numbers and mix of providers needed. FamilyCare will allow the provider to appeal the action to a hearing panel and give the provider written notice of his/her right to a hearing and the process and timing for requesting a hearing. FamilyCare will ensure that the majority of the hearing panel members are peers of the affected provider.

If a suspension or termination is the result of quality of care deficiencies, FamilyCare will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted provider groups must provide that these procedures apply equally to providers within those subcontracted groups.

14.13 Notification to Members of Provider Termination

FamilyCare will make a good faith effort to provide written notice of a termination of a participating provider to all members who are patients seen on a regular basis by that provider at least thirty (30) calendar days before the termination effective date, regardless of the reason for the termination. When a contract termination involves a Primary Care Provider (PCP) or Mental Health Primary Care Provider (MHPCP), FamilyCare will notify all members who are patients of that PCP or MHPCP of the termination and assist with identifying a new PCP or MHPCP.

14.14 Medical Records Review

A FamilyCare representative may visit the participating provider's office to review the medical records of FamilyCare members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the *Standards for Medical Records* listed below. The Quality Management Committee (QMC) will review the medical record reviews quarterly.

Standards for Medical Records:

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in a member's medical chart.

Each medical record chart must have documented (at a minimum):

- Member name;
- Member identification number;
- Member age;
- Member sex;
- Member date of birth;
- Date of service;
- Allergies and any adverse reaction;
- Chief complaint/purpose of visit;
- Subjective findings;
- Objective findings, including diagnostic test results;
- Diagnosis/assessment/ impression;
- Plan including: services, treatments, procedures and/or medications ordered, recommendation and rationale;
- Name of Participating Provider including signature and initials;
- Instructions to Member;
- Evidence of a follow-up with indication that test results and/or consultation was reviewed by PCP and abnormal findings discussed with Member/legal guardian;
- Health risk assessment and preventative measures.

In addition, participating providers must document in a prominent part of the member's current medical record whether or not the member has executed an *Advance Directive*.

Advance Directives are written instructions, such as *Living Wills* or *Durable Powers of Attorney* for healthcare, recognized under the law of the state of Oregon and signed by a patient, that explain the patient's wishes concerning the provision of healthcare if the patient becomes incapacitated and is unable to make those wishes known.

To acquire further information about Health Care Directives refer to Section 11: Health Care Directives Overview.

14.15 Confidentiality of Member Information

FamilyCare strives to exceed all Federal and State requirements in maintaining the privacy of patients' Protected Health Information and all medical records.

FamilyCare will maintain the confidentiality of medical record information and release such information only in accordance with Federal Regulation 42 CFR 431 Subpart F, by Oregon Revised Statute or by Oregon Administrative Rules.

Patient Information- Information about a patient's condition, care, treatment, personal affairs, or records may not be discussed with anyone (except those responsible for patient care and treatment) without full written consent of the patient, unless compelled to do so by law. Discussion of patient information shall be confined to appropriate areas.

Monitoring and Enforcement - Breach of confidentiality is considered a major offense and will require immediate disciplinary action in the form of suspension from work or termination.

Confidentiality issues involving providers and/or provider office staff will be managed through the Quality Management Committee (QMC) and may result in the provider's removal from the provider panel.

Reporting Obligations- FamilyCare must provide to the Centers for Medicare & Medicaid Services (CMS) information that is necessary for CMS to administer and evaluate any federal programs FamilyCare contracts with CMS for provision of services to beneficiaries. FamilyCare must establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Information such as plan quality and performance indicators includes: disenrollment rates, information on member satisfaction, and information on health outcomes. Participating providers must cooperate with FamilyCare in its data reporting obligations by providing to FamilyCare any information that it needs to meet its obligations.

14.16 Certification of Diagnostic Data

FamilyCare is specifically required to submit to the Centers for Medicare & Medicaid Services (CMS) data necessary to characterize the context and purposes of each encounter between a Member and a provider, supplier, physician, or other practitioner (encounter data). Participating providers that furnish diagnostic data to assist FamilyCare in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Section 15: Medicaid Information Only

FamilyCare Incorporated

15.1 Referral & Authorization

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

FamilyCare's Quality Management Committee (QMC) reviews, develops, and updates guidelines as determined necessary. These guidelines provide specific criteria used to review and authorize acute and chronic care services with the following goals:

- Expedite access to the appropriate level of care;
- Increase uniformity of care;
- Maximize cost effectiveness of care;
- Improve healthcare outcomes and status through total care integration.

15.2 General Guidelines

FamilyCare must be contacted for:

15.2.1. Additions to Existing Referrals and Authorizations

Additions may consist of adding office visits, procedures, items, new diagnosis, second opinions, transfer of care, or extending dates of existing referrals/authorizations.

15.2.2. Alternative Care Settings

Alternative Care Settings (hospice, home health, and skilled nursing) **must be prior authorized**. Once a request for authorization is received a Care Coordinator will assist with all coordination and arrangements.

15.2.3. Referral to Specialists

All inpatient and outpatient surgery, physical therapy, occupational therapy, and speech therapy **require authorization**. With the exception of women's health, chemical dependency and outpatient mental health, specialist referrals **require authorization**. Our Customer Service Department can assist you with identifying specialists.

15.2.4. Consults/Additional Visits/Medical Records Request

Family Care allows one consult with diagnostic testing and two follow up visits for a covered benefit. Medical records will be requested from the provider of care if the Health Services staff needs clinical information to determine if services being requested meet medically appropriate guidelines and are a covered benefit. Below the line diagnosis for FamilyCare may approve one visit. If additional visits are requested, chart notes will be required for review.

15.2.5. Circumcisions

Male members up to 3 months old are allowed to have circumcisions in the hospital or the physician's office without a referral.

If the male member is above the age of 3 months, a prior authorization is required and medical records must be provided to document medical justification.

15.2.6. Dental Hospital Authorizations

FamilyCare covers the *hospital* and *anesthesia* for dental procedures that are done in a hospital setting. FamilyCare covers the facility and anesthesia costs and coordinates with our member's Dental coverage for the actual procedures performed according to the member's covered benefits.

FamilyCare may allow authorization for the following reasons:

- Patient is a child with extensive dental care needed and treatment has been tried in dental setting;
- Patient has physical, mental, or medically compromising conditions;
- Patient with dental needs for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- Patient has acute situational anxiety, fearfulness, or is extremely uncooperative.

15.2.7. Detoxification

Inpatient detoxification treatments require prior authorization.

15.2.8. Durable Medical Equipment (DME) Authorizations

FamilyCare requires authorization for covered services over \$300 that are listed on the DMAP DME Guide.

At a **minimum**, DME authorizations require:

- A valid provider's prescription;
- Member must be eligible with FamilyCare;
- The request is medically necessary.

Rental or Purchase of the following items requires prior-authorization:

- Hospital Beds;
- Wheelchairs;
- Light Therapy;
- All Oxygen Supplies;
- Pressure Pads with HCPC codes E0179-82;
- All Incontinence Supplies (Covered with ICD-9-CM 788.30);
- All Miscellaneous Code Items (E1399 or K0108);
- All Items/Sets Over \$200 Billed *and/or* Totaling Over \$200;
- All Orthotics and Prosthetics.

OHP Standard Plan has limited DME benefits. Please refer to DMAP DME Guide for coverage information for Standard Plan members or contact our Referral/Authorization Department at 503-228-8228 or 800-684-3799.

15.2.9. Multiple Electroconvulsive Therapy (MECT)

Inpatient MECT treatments require prior authorization.

15.2.10. Emergent vs. Non-Emergent ER Visits

FamilyCare does not require prior authorization for emergency room services. If a member is in doubt that their condition is an emergency, we encourage our members to check with their Primary Care Provider first. Members may self refer in such cases where a prudent layperson (person who possesses an average knowledge of health and medicine) determines the absence of immediate medical attention will result in: serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ, or harm to an unborn child. FamilyCare performs 100% concurrent review of all ER claims with follow up member education for identified non-emergent use.

15.2.11. Home Health Authorizations

FamilyCare covers Home Health services for members that are homebound, have medical needs and are unable to be seen on an outpatient basis. All Home Health requests need to be reviewed and authorized by FamilyCare's Care Coordinators.

15.2.12. Hospice Authorizations

Hospice benefits are provided for members. Each hospice request needs to be reviewed and authorized by FamilyCare's Care Coordinators.

15.2.13. Hospital Admissions and Authorizations

All admissions must be faxed or called in to FamilyCare by the hospital within three (3) business days. Any request after three business days require medical review of hospital notes prior to authorization being considered.

Scheduled Admissions:

- Scheduled hospital admissions require FamilyCare prior notification;
- Scheduled admissions must be done at contracted facilities unless the required services are not provided at those facilities or there are no contracted facilities in the service area;
- Scheduled admissions are initially authorized using Millman™ standard length of stay guidelines;
- Extended hospital stays can be authorized by faxing calling the **Utilization Review line** at **503-345-5786** or **800-707-7880**.

Emergency Admissions:

If admitted to a non-contracted facility, FamilyCare may request a transfer to a contracted facility to be arranged when the patient is stabilized. Members with OHP Standard Plan benefits have limited hospital benefits. Please contact FamilyCare for coverage questions pertaining to non-emergent admissions for Standard Plan members.

15.2.14. Medicare Primary Payer

If a member has Medicare as their primary insurance, authorization is required per their Medicare benefits administrator guidelines.

15.2.15. Mental Health Evaluation

Prior Authorization is not required if the member is seen by their Mental Health Primary Care Provider (MHPCP). Evaluation by a non-contracted provider does require prior authorization (authorization is the responsibility of the provider).

15.2.16. Mental Health Services

Prior authorization is not required if the services are performed by the member's Mental Health Primary Care Provider (MHPCP). All services provided by a non-contracted provider require prior authorization.

15.2.17. Newborn Referrals – For Medicaid Only

Newborns are automatically covered under their mother's ID Number for the first 30 days when referrals/authorizations are needed. The parents are responsible for enrolling them in that time period. Should the baby require a referral within that time frame, the referral will be generated under the mother's ID, as deferred, until the newborn is issued their own unique ID number. It is important to know that *claims can only be paid under the baby's ID and NOT the mother's ID*.

15.2.18. Family Planning and Women's Health Services

FamilyCare has a panel of participating OB/GYN providers. This list is included with the new member packet and is available through our Customer Services department.

15.2.19. Outpatient Hospital Services

Diagnostic testing *does not* require prior authorization and can be ordered by any PCP or specialist with a valid referral from FamilyCare.

Any surgical procedure that needs to be arranged at contracted or non-contracted facilities *require* prior authorization. Fax to the Authorization and Referral Department prior to proceeding with surgical procedures at those facilities.

15.2.20. Pharmacy Management

FamilyCare works with CVS Caremark as our Pharmacy Benefits Manager. Prior authorization is performed by the plan during regular business hours and by CVS Caremark during non-business hours. Please refer to the member's individual plan coverage for pharmacy benefits.

FAMILYCARE PHARMACY: 503-471-2126

CVS CAREMARK: 800-770-8014

15.2.21. Provider Referrals

- PCP's and Contracted Specialists can initiate referrals to another provider;
- Members may self refer to a contracted OB/GYN, Mental Health and chemical dependency provider only.

15.2.22. Physical/Occupational/Speech Therapy

Refer to the member's benefit package for specific benefit limitations or give FamilyCare Customer Service a call for assistance. PT/OT/ST require authorization. The initial authorization will be for an evaluation visit only. Once the initial evaluation is completed, the therapist must submit evaluation notes and plan of treatment, including CPT codes for services for medical review prior to authorization of additional visits. Standard Plan members *do not* have PT, OT, and ST benefits.

15.2.23. Psychological Testing

Pre-surgical testing and testing of children outside of a mental health assessment require prior authorization.

15.2.24. Referrals and Authorization Denials

Every denied request for referrals or authorizations is entered into the FamilyCare system. Denial letters are always sent to the member with copies faxed to the ordering provider and PCP if different.

15.2.25. Referrals for Second Opinion or Transfer of Care

FamilyCare allows second opinions or transfer of care for diagnoses that are covered benefits. If contracted providers are available, members need to be referred to contracted providers. Second opinion referrals only allow one initial visit, and if care is going to be transferred additional visits can be added per policy.

15.2.26. Retroactive Referrals

Retroactive referrals are not the policy of FamilyCare. Exceptions can be made but will require medical review for appropriateness of care and operational approval. Retroactive referrals will not be done for a member who self refers.

15.2.27. Skilled Nursing Facility (SNF) Authorizations

FamilyCare's Care Coordinators review Skilled Nursing Facility (SNF) requests and authorize, or deny, the SNF request based upon the medical need. Prior authorization for Medicaid and Medicare members is required before being transferred to a SNF. The daily rate for Medicaid members will need to be negotiated. Medicare members will be reimbursed at the RUG Rate (Resource Utilization Group Rate). Weekly reviews and updates will be required by all SNF admissions.

15.2.28. Special Procedures Requiring Prior Authorization

In All Cases:

- Organ Transplant services, including evaluation for transplant;
- Chemotherapy and Radiation Treatments;
- Dialysis;
- Multiple Electroconvulsive Therapy (MECT).

15.2.29. Sterilizations/Hysterectomy

Sterilizations, other than hysterectomies, do not require a referral/authorization. If the member is covered under Medicaid, the provider will need to complete a *Consent to Sterilization* (DMAP 742-A or 742-B) and forward it with the claim. With exceptions for life-threatening treatment, sterilization procedure must take place during a minimum of 30 days after the date of member's signature to a maximum of 180 days from date of signature for the form to be valid. For emergent sterilization procedures done prior to 30 days from date of signature, provider must complete "Physicians Statement" section of the Consent Form with explanation of emergent circumstance(s). Invalid or unsigned consent forms will cause claim to be denied. DMAP reserves the right to final review and approval of Consent Forms. If DMAP denies the validity of a Consent Form, any related claims that FamilyCare has paid for the sterilization service will be processed for refund from provider.

Reference: <http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html> under Hysterectomy and Sterilization Procedures Manual.

Hysterectomies require referral, authorization, and a signed Hysterectomy Consent form. Specialists can contact FamilyCare with CPT and ICD 9 codes to obtain authorization. Copies of appropriate consent forms must be completed and forwarded with claim to ensure processing of the claim.

15.2.30. Surgical Authorizations

A valid referral from a PCP to a Specialist needs to be initiated prior to FamilyCare authorizing surgery, unless the Specialist is contracted.

15.3 Abuse Review

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

Medicaid only:

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

15.4 Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicaid, please submit a claim for payment to that plan first. The amount payable by FamilyCare will be governed by the amount paid by the primary plan and OHP secondary payer law and policies.

Section 16: Medicare Advantage Information Only

FamilyCare Health Plans

16.1 Referral & Authorization

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

Participating Providers with FamilyCare Health Plans do not require authorization or referrals for office visits. When referring members out to specialists, please refer to participating providers. If a request for a non-participating provider is received, FamilyCare Health Plans will try to have the provider direct to a participating provider.

FamilyCare's Quality Management Committee reviews, develops, and updates guidelines as determined necessary. These guidelines provide specific criteria used to review and authorize acute and chronic care services with the following goals:

- Expedite access to the appropriate level of care;
- Increase uniformity of care;
- Maximize cost effectiveness of care;
- Improve healthcare outcomes and status through total care integration.

16.2 General Guidelines

FamilyCare must be contacted for:

16.2.1. Additions to Existing Referrals and Authorizations

For Medicare members no referral is needed for office visits for Medicare covered services. Additions may consist of adding office visits, procedures, items, new diagnosis, second opinions, transfer of care, or extending dates of existing referrals/authorizations.

16.2.2. Alternative Care Settings

Alternative Care Settings (home health, skilled nursing) **must be prior authorized**. Once a request for authorization is received a Care Coordinator will assist with all coordination and arrangements.

16.2.3. Referral to Specialists

No authorizations are required for covered services provided by contracted specialists. All inpatient procedures **require authorization**. Our Customer Service Department can assist you with identifying specialists.

16.2.4. Consults/Additional Visits/Medical Records Request

For Medicare members, no referral is needed for office visits for Medicare covered services. Medical records will be requested from the provider of care if the Health Services staff needs clinical information to determine if services being requested meet medically appropriate guidelines and are a covered benefit.

16.2.5. Circumcisions

If the male member is above the age of 3 months, a prior authorization is required and medical records must be provided to document medical justification.

16.2.6. Dental Hospital Authorizations

The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires the patient to be admitted to the hospital for the performance of the dental procedure and

to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered.

Hospital inpatient services, which are necessary because of the patient's underlying medical condition and clinical status or the severity of the **non-covered** dental procedure, are **covered**.

16.2.7. Detoxification

Inpatient detoxification treatments require prior authorization.

16.2.8. Durable Medical Equipment (DME) Authorizations

Please refer to the individual member's Evidence of Coverage for Durable Medical Equipment Benefits.

At a minimum, DME authorizations require:

- A valid provider's prescription;
- Member must be eligible with FamilyCare;
- DME must be a Medicare covered benefit;
- The request is medically appropriate.

Through FamilyCare Health Plans coverage, no prior authorizations are required for Medicare covered DME through a participating DME supplier if under \$1,500 billed and/or totaling under \$1,500 a month.

16.2.9. Multiple Electroconvulsive Therapy (MECT)

Inpatient MECT treatments require prior authorization.

16.2.10. Emergent vs. Non-Emergent ER Visits

FamilyCare does not require prior authorization for emergency room services. If the member is in doubt that their health condition is considered to be an emergency, we encourage our members to check with their Primary Care Provider first. Members may self refer in such cases where a prudent layperson (person who possesses an average knowledge of health and medicine) determines the absence of immediate medical attention will result in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or harm to an unborn child. FamilyCare performs 100% concurrent review of all ER claims with follow up member education for identified non-emergent use.

16.2.11 Home Health Authorizations

FamilyCare covers Home Health services for members that are homebound, have medical needs and are unable to be seen on an outpatient basis. All Home Health requests need to be reviewed and authorized by a FamilyCare Care Coordinator.

16.2.12 Hospice

PremierCare does not cover hospice services. Providers can contact Medicare directly for authorization and billing questions. For dual members, FamilyCare will process claims as secondary.

16.2.13 Hospital Admissions and Authorizations

All admissions must be called in or faxed to FamilyCare by the hospital within three (3) business days. Any request after three business days require medical review of hospital notes prior to authorization being considered.

Scheduled Admissions:

- Scheduled hospital admissions require FamilyCare prior notification;
- Scheduled admissions must be done at contracted facilities unless the required services are not provided at those facilities or there are no contracted facilities in the service area;

- Scheduled admissions are initially authorized using Millman's standard length of stay guidelines.

Extended hospital stays can be authorized by calling the Utilization Review line at: **(503) 345-5786** or **(800) 707-7880** 24 hours a day/7 days a week.

Emergency Admissions:

If admitted to a non-contracted facility, FamilyCare may request a transfer to a contracted facility to be arranged when the patient is stabilized.

16.2.14. Mental Health Services

Prior authorization is not required if the services are emergent.

16.2.15. Family Planning and Women's Health

FamilyCare has a panel of participating OB/GYN providers. This list is included with the new member packet and is available through our Customer Service department.

16.2.16. Outpatient Hospital Services

Medicare covered outpatient surgical procedures do not require prior authorization.

16.2.17. Pharmacy Management

FamilyCare works with CVS Caremark as our Pharmacy Benefits Manager. Prior authorization is performed by the plan during regular business hours and by CVS Caremark during non-business hours. Please refer to the member's individual plan coverage for pharmacy benefits.

16.2.18. Provider Referrals

PCP's and Contracted Specialists can initiate referrals to another provider for Medicare covered services.

16.2.19. Physical/Occupational/Speech Therapy

Refer to the member's evidence of coverage for specific benefit limitations or give FamilyCare Customer Service a call for assistance. PremierCare covers PT, OT and ST without authorizations as long as they are referred to a Participating FamilyCare Provider.

16.2.20. Referrals and Authorization Denials

Every denied request for referrals or authorizations is entered into the FamilyCare system. Denial letters are always sent to the member with copies faxed to the ordering provider and PCP if different.

16.2.21. Retroactive Referrals

Retroactive referrals are not the policy of FamilyCare. Exceptions can be made but will require medical review for appropriateness of care and operational approval. Retroactive referrals will not be done for a member who self refers for a service that requires prior authorization.

16.2.22. Skilled Nursing Facility Authorizations

FamilyCare's Care Coordinators review and authorize or deny Skilled Nursing Facility requests.

16.2.23. Special Procedures Requiring Prior Authorization

In All Cases:

- Organ Transplant services, including evaluation for transplant.

16.2.24. Surgical Authorizations

Inpatient and outpatient surgeries require prior authorizations.

Section 17: Glossary of Terms

Appeal: A process that allows an individual, or provider, to appeal an adverse benefit or claim decision.

Basic Benefits: Medically necessary healthcare services and supplies rendered by providers for enrollees which qualify for payment, pursuant to the terms of the applicable Benefits Plan.

Behavioral Health: An all inclusive term for mental health and substance abuse services.

Care Coordination: Collaborative process to coordinate, assist, implement, monitor, and evaluate options and services to meet individual member health needs. This process includes, but is not limited to, prior authorization and medical appropriateness review, discharge review, facilitating medical service, encouraging and educating members (and/or their representatives), communication with members and providers, identifying resources, Exceptional Needs Care Coordination (ENCC), and coordinating care conferences.

Center for Health Dispute Resolution (CHDR): An independent contractor for Centers for Medicare & Medicaid Services (CMS) that reviews appeals submitted by members of Medicare Managed Care Plans, including FamilyCare.

CMS: The Centers for Medicare & Medicaid Services.

Concurrent Review: Concurrent review is a process that allows FamilyCare to receive clinical information needed to evaluate the medical necessity/appropriateness of extending the existing authorization for members who are:

- Inpatients;
- Residing at a mental health facility;
- Continuing to utilize outpatient services beyond initial authorization period;
- Out of Network Services.

Contracted Hospital: A Hospital that has a contract to provide services and/or supplies to FamilyCare members.

Contracted Medical Group: Providers organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement to provide medical services to FamilyCare members.

Contracted Pharmacy: A pharmacy with an agreement to provide FamilyCare members with medication(s) prescribed by a participating provider in accordance with FamilyCare's formulary.

Covered Services:

Those benefits, services or supplies which are:

- Provided or furnished by Participating Providers or authorized by FamilyCare or its Participating Providers;
- Emergency Services and Urgently Needed Services that may be provided by non-Participating Providers;
- Renal dialysis services provided while you are temporarily outside the Service Area.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) Serious jeopardy to the health of the individual or, in the case of a

pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient or outpatient services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Experimental Procedures and Items: Items and procedures determined by FamilyCare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, FamilyCare will follow relevant state or federal guidelines.

Encounter Data: The information obtained by a participating provider as a result of a contact with an enrollee for the delivery of healthcare services or supplies.

Grievance: Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are waiting times in physician offices and rudeness or unresponsiveness of Customer Service Staff.

Home Health Agency: An agency which provides intermittent Skilled Nursing Care and other Therapeutic Services in your home when: medically necessary, when members are confined to their home, and when services have been authorized by their Primary Care Physician.

Hospice: An organization or agency, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital: An institution which provides inpatient, outpatient, emergency, diagnostic, and therapeutic services.

Hospitalist: A Member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key Member of the healthcare team, and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's Primary Care Physician.

Independent Physicians Association (IPA): A group of providers who function as a Contracting Medical Provider/Group, yet work out of their own independent medical offices.

Medically Appropriate: Services that are a covered benefit appropriate in order to treat or care for symptoms of an illness or injury, to diagnose an illness or conditions that is harmful to life or health, and which are:

- Consistent with the Member's medical condition;
- Appropriate and customarily recognized treatment of the condition, illness or injury, and provided in accordance with standards of good medical practice at the most appropriate level of service;
- Not furnished primarily for the convenience of the member, the attending participating provider, or other provider of service.

FamilyCare will make determinations of medical necessity based on clinical appropriateness by utilizing peer review, federal and/or state regulations, Millman guidelines, community standard of practice, FamilyCare's formulary, and other authoritative medical sources as deemed necessary by FamilyCare.

Medicare: The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A: Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility Care, Home Health Agency Care, and Hospice care offered through Medicare.

Medicare Part A Premium: Medicare Part A Premium is financed by part of the Social Security payroll withholding tax paid by workers and their employers, or by part of the Self-Employment Tax paid by self-employed persons.

Medicare Part B: Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs (that cannot be self-administered), certain self-administered anti-cancer drugs, and blood not covered under Part A.

Medicare Part B Premium: A monthly premium paid to Medicare (usually deducted from a Member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive Covered Services whether Members are covered by an MA Plan or by original Medicare.

Medicare Advantage (MA) Plan: A policy or benefit package offered by a Medicare Advantage Organization (MAO) under which a specific set of benefits are offered, with uniform premium and uniform level of cost-sharing in specific service areas. A MAO may offer more than one benefit Plan in the same Service Area.

Medicare Advantage Member:

A beneficiary entitled to receive covered services, who have voluntarily elected to enroll in FamilyCare (Medicare only), and whose enrollment has been confirmed by CMS.

Mental Health Practitioner (MHP): The participating provider assigned to serve as an entrance into the mental health continuum of care. This practitioner can be any Qualified Mental Health Professional (or Qualified mental Health Associate as appropriately overseen by a QMHP) chosen by the member to provide mental health services.

Non-Contracting Medical Provider or Facility: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of Oregon or Medicare to deliver or furnish healthcare services; and who is neither employed, owned, operated by, nor under contract to deliver covered services to FamilyCare Members.

Non-Covered Services: Any service or supplies that do not qualify for payment under the relevant benefit plan.

Participating Provider: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of Oregon (and if applicable), Medicare, to deliver or furnish healthcare services. This individual or institution has a written agreement to provide services directly or indirectly to FamilyCare Members pursuant to the terms of the Agreement.

Pre-admission Review: Pre-admission review is the process for obtaining prior authorization from the health plan for all non-emergent hospital admissions. In addition, pre-admission review is also required for admission to a Skilled Nursing Facility, Inpatient Rehabilitation, and Home Health and Hospice. Pre-admission review includes appropriateness review using medical criteria and assignment of length of stay per established guidelines. Failure to obtain pre-admission review will delay payment and may result in no reimbursement.

Prior Authorization: Prior authorization prospectively reviews eligibility of services, procedures and equipment for payment under the health plan. Decisions are based on medically appropriate guidelines.

Mental Health Primary Care Provider (MHPCP): The participating provider has the responsibility for supervising, coordinating and providing initial and primary Mental Health Treatment Services for members, for initiating referrals for specialist care, or for maintaining the continuity of member treatment within the Mental Health service delivery system. MHP's are generally Participating Providers of Mental Health Services including: Psychologists, Psychiatrists, and Psychiatric Nurse Practitioners.

Primary Care Provider (PCP): The Participating Provider who has the responsibility for supervising, coordinating and providing initial and primary care for members, for initiating referrals for specialist care, or for maintaining the continuity of patient care. PCPs are generally Participating Providers of Internal Medicine, Family or General Practice, or Pediatrics.

Service Area: A defined geographic area identified by zip codes, provider groupings or county boundaries, approved by the appropriate regulatory agency, within which an eligible individual may enroll in a health plan.

Medicaid:

- Clackamas County
- Clatsop County
- Josephine County
- Morrow County
- Multnomah County
- Portions of Jackson County
- Umatilla County
- Washington County

PremierCare (Medicare Advantage) Plan:

- Clackamas County
- Clatsop County
- Morrow County
- Multnomah County
- Umatilla County
- Washington County

PremierCare Plus (Medicare Advantage/Medicaid) Plan:

- Clackamas County
- Clatsop County
- Morrow County
- Multnomah County
- Umatilla County
- Washington

Mental Health Organization:

- Clackamas County
- Multnomah County
- Washington County

Retrospective Review

A process that determines whether documentation supports medical necessity of services or supplies, including the appropriateness of codes selected for billing. Retrospective review is used to evaluate the appropriate use of resources according to healthcare guidelines after the care or service has been provided.

Urgently Needed Services

Covered Services provided when the member is:

- Temporarily absent from the FamilyCare Service Area;
- Under unusual and extraordinary circumstances, services provided when the Member is in the service area but their PCP is temporarily unavailable or inaccessible;
- Such services are medically necessary and immediately required

Section 18: Contact Information

Department	For Questions Regarding:
Customer Service	
<p>(503) 222-2880 (800) 458-9518 TTY (800) 735-2900 Fax (503) 345-5720 or (877) 558-1556 E-mail: member-services@familycareinc.org Hours: 8am to 8pm Monday – Friday, except holidays</p> <p>Medicare Customer Service: (866) 798-2273 TTY (800) 735-2900 Hours: 8am to 8pm 7 days a week</p> <p>Behavioral Health Customer Service: (866) 798-2330 TTY (800) 735-2900 Hours: 9am to 5pm Monday – Friday, except holidays</p>	<p>Eligibility Member ID cards Member address changes FamilyCare OHP benefits Interpreter services Claims status Participating providers Pharmacies Formulary Member EOB PCP changes Authorization status Grievance & Appeals Third party resources including MVA</p> <p>PremierCare Medicare Advantage benefits</p> <p>FamilyCare Mental Health benefits</p>
Health Services	
<p>Referrals & Authorizations (503) 228-8228 (800) 684-3799 Fax (503) 345-5770 Fax (800) 270-7737 E-mail: authorizations@familycareinc.org Hours: 8am to 5pm Monday – Friday, except holidays</p> <p>Utilization Review (503) 345-5786 (800) 707-7880 E-mail: utilizationreview@familycareinc.org Hours: phone messages 24 hours, 7 days a week UR nurse hours: 8am to 5pm Monday – Friday, except holidays</p> <p>Care & Service Coordination (calls routed through Customer Service)</p>	<p>Referrals, including out of network Prior Authorizations Behavioral Health Authorizations Chemical Dependency Authorizations</p> <p>Utilization Review</p>

<p>E-mail: carecoordinators@familycareinc.org Hours: 8am to 5pm Monday – Friday, except holidays</p>	<p>Case management</p>
<p>Behavioral Health</p>	
<p>Behavioral Health Care Coordination (calls routed through Customer Service) E-mail: behavioral-health@familycareinc.org Hours: 8am to 5pm Monday – Friday, except holidays</p>	<p>Behavioral Health Case Management</p>
<p>Pharmacy</p>	
<p>(503) 471-2126 (800) 335-3205 ext 2126 Fax (503) 471-2176 Fax (800) 270-7737 E-mail: rxsupp@familycareinc.org Hours: 8am to 5pm Monday – Friday, except holidays</p> <p>Pharmacy Benefits Manager (PBM): CVS Caremark (800) 770-8014 ext 8 Hours: After hours, weekends and holidays</p>	<p>Provider/Pharmacist inquiries Prior Authorization</p> <p>PBM: CVS Caremark- after hours inquiries</p>
<p>Provider Relations</p>	
<p>(503) 471-2149 (800) 335-3205 (Option 3) Fax: (503) 734-3188 E-mail: provider-relations@familycareinc.org</p> <p>Provider Relations Representatives By County:</p> <p><i>Clatsop, Columbia, Washington, NW/SW Multnomah</i> Rosa Conlon.....(503) 471-2128 Fax (503) 471-2178 E-mail: rosac@familycareinc.org</p> <p><i>Morrow, Umatilla, East Multnomah</i> Joshua Corsen.....(503) 734-3146 Fax (503) 734-3196 E-mail: joshuac@familycareinc.org</p> <p><i>Clackamas, Marion, Josephine, Jackson</i> Adam Hundis.....(503) 734-3102 Fax (503) 734-3152 E-mail: adamh@familycareinc.org</p> <p>Provider Services Representative: Lynn Sullivan.....(503) 471-2107</p>	<p>Contracting PR/Contract issues/concerns Provider utilization reporting Panel information Practice demographic changes, TIN changes Practice access changes Web Portal inquiries</p>

<p>Fax (503) 471-2157 E-mail: lynns@familycareinc.org</p> <p>Network Development & Provider Relations Manager: TBD (503) 734-3107 Fax (503) 734-3157 E-mail:</p>	
Credentialing	
<p>Alethea Johnson..(503) 471-2129 Fax (503) 734-3156 E-mail: aletheaj@familycareinc.org</p>	<p>Credentialing/Re-credentialing application</p> <p>Credentialing status</p>
Medicare Sales	
<p>(866) 225-2273 TTY (800) 735-2900 Hours: 8am to 8pm 7 days a week</p>	<p>Medicare Advantage enrollment</p> <p>Special Needs Plan enrollment (Medicare/Medicaid, Diabetic)</p>
FamilyCare Web Portal	
<p>FamilyCare Website: www.familycareinc.org</p> <p>PremierCare Website: www.familycarehealthplans.org</p>	<p>Member Handbooks</p> <p>Member Rights and Responsibilities</p> <p>Link to PremierCare website</p> <p>Provider Directories</p> <p>Provider Manual</p> <p>Provider Newsletters</p> <p>Provider Web Portal (eligibility, claims status)</p> <p>EDI instructions</p> <p>Formulary/Step Therapy guidelines/Medication Request form (prior authorization)</p> <p>Release of information forms</p> <p>DME list of items requiring prior authorization</p> <p>Prior Authorization forms</p>
Web Resources	
<p>ePocrates: www.epocrates.com</p> <p>Milliman Care Guidelines: www.careguidelines.com</p> <p>Oregon Administrative Rules: www.dhs.state.or.us/policy/healthplan/guid</p>	<p>FamilyCare & PremierCare Formularies, free online or download service</p> <p>Care guidelines</p> <p>OHP Policy and Regulations</p>

<p><u>es/main.html</u></p> <p>Electronic Code of Federal Regulations: <u>http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl</u></p> <p>DMAP “MMIS” provider web portal: <u>https://www.or-medicaid.gov/ProdPortal/Home/tabId/36/Default.aspx</u></p>	<p>Medicare Code of Federal Regulations</p> <p>OHP member eligibility portal</p>
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FamilyCare Health Plans

825 NE Multnomah, Suite 300
Portland, Oregon 97232

800-458-9518

www.familycareinc.org

