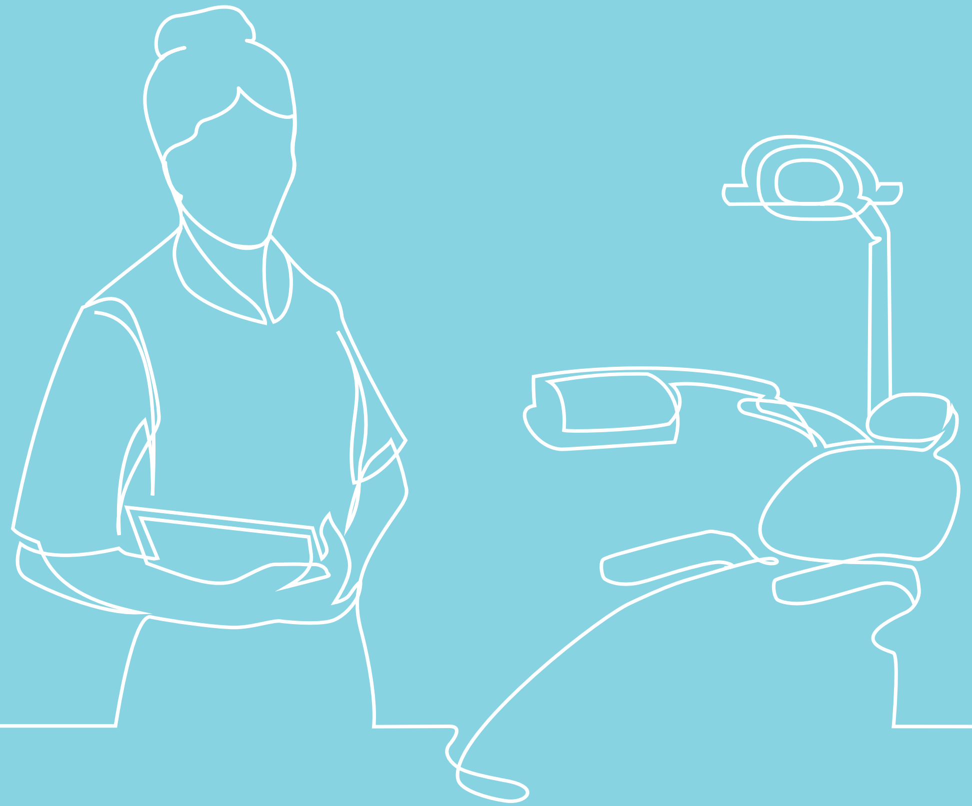

Dental Provider Manual 2024

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Introduction

CareOregon Vision

Healthy communities for all individuals regardless of income or social factors.

CareOregon Mission

To inspire and partner to create quality and equity in individual and community health.

CareOregon Standards of Service

CareOregon's goal is to ensure the greatest possible health benefit to our members through the effective use of state Medicaid funding.

We are equally committed to:

- Providing medically effective health care within State and Federal Medicaid guidelines.
- Promoting the health of every member.
- Providing exceptional and proactive services to our members and providers.
- Treating all contacts with dignity, respect and understanding.
- Working in partnership with our members, their extended health support groups and the providers that help make up their health homes.

CareOregon understands that to accomplish these goals, we must advocate for and on behalf of our members.

Philosophy

From a health services perspective, generally, this means facilitating care that is:

- Safe
- Effective
- Efficient
- Patient-centered (culturally appropriate and linguistically sensitive)
- Timely
- Equitable

Specifically, this means using appropriate clinical judgment in the application of approved criteria and guidelines to evaluate the member's circumstances and medical needs rather than adherence to literal standards. This is especially critical for members with complex medical, dental or social issues, and for those who need additional support in understanding health care issues because of language or literacy barriers. In these cases, appropriately trained staff gather more information to help members make informed decisions that meet their needs within the health care benefit.

From a member and provider service perspective:

- We will be both proactive and responsive in our efforts to resolve member, provider and community concerns.
- In cases where we must decline care or services based on coverage limitations or criteria not being met, we will do so in a polite and courteous manner, seeking alternative solutions in or outside of the organization to assist the member.
- Members and providers will always be informed of their right to appeal an initial decision and CareOregon will have a reasonable and expeditious process to evaluate and respond to this appeal.
- Correspondence regarding denials and appeals will be clear, respectful and informative.

Members

The Oregon Health Plan and Coordinated Care Organizations (CCOs)

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

OHP Bridge is a Medicaid-equivalent benefit package administered by the OHA, which covers adults with higher incomes than those that qualify for OHP Plus. OHP Bridge recipients must meet the following criteria:

- Be 19 to 65 years of age
- Have an income between 139% and 200% of the FPL
- Have an eligible citizenship or immigration status
- Not have access to other affordable health insurance

Coordinated care organizations, or CCOs, were developed by the state to manage and pay for health care at a local community level. Through an integrated model (combining physical, behavioral and dental health), CCOs focus on prevention, chronic disease management and member education.

OHP Eligibility

Applicants who meet eligibility requirements become eligible for OHP. The eligibility effective date for an OHP recipient is retroactive to the recipient's application date.

OHP Plus recipients are eligible for 24 months and must reapply at the end of each 24-month period. OHP Bridge recipients are eligible for OHP for 12 months and must reapply at the end of each 12-month period. If recipients do not reapply before their eligibility ends, their OHP eligibility may terminate until they successfully reapply.

Applying for the Oregon Health Plan

Application for eligibility is coordinated by Oregon Health Authority offices.

People may apply directly at ***one.oregon.gov*** or through the OHP Application Center by calling toll-free 800-699-9075 (TTY 711). Wait times may be long.

Eligibility screeners at federally funded health centers in Oregon are available to help with the application process and answer questions.

Dental Care Organization Enrollment

CareOregon is a dental plan partner of:

- Health Share of Oregon CCO in the tri-county area
- Columbia Pacific CCO in Tillamook county

To CCO members, the appearance is one of CareOregon Dental being a "partner." All material they receive is branded per their CCO. When applying for the OHP in areas with more than one CCO, recipients may choose an available CCO in their area. Those who do not are randomly appointed to a CCO in their area by DMAP, then randomly appointed to a DCO by their new CCO.

DMAP enrolls OHP recipients shortly after they become eligible for the OHP. Recipients can be enrolled with their health plan on the first day of the month or on any Monday.

Counties have either mandatory CCO enrollment, with some exceptions, or voluntary enrollment with a health plan.

If an OHP recipient is not enrolled in a CCO, they receive services through the fee-for-service Medicaid program and may be assigned a DCO by the state. CareOregon Dental is not contracted with the State of Oregon as a Dental Care Organization.

Members' Rights and Responsibilities

CareOregon Dental members receive their rights and responsibilities statement in their CCO member handbook at onboarding and with each subsequent revision of the handbook.

New and existing providers can review the members' rights and responsibilities statement in the members' CCO handbook or online at the CCO's website.

Members' Rights

As an OHP client, you will be:

- Treated with dignity, respect and privacy.
- Free to choose your primary care provider (PCP).
- Urged to tell your PCP about all your health concerns.
- Able to access all care that is covered by OHP, at the level of services you need and deserve; and to get prior authorizations and permission for other services when needed.
- Able to get information on available treatment options and alternatives. These options will be presented in a way that's appropriate for your condition, preferred language and ability to understand.

- Able to have a friend or helper come to your appointments, and an interpreter if you want one.
- Told about all of your OHP-covered and non-covered treatment options.
- Allowed to help make decisions about your health care, including refusing treatment, without being kept away from other people or forced to do something you don't want to do.
- Given a referral or a second opinion, at no cost to you, if you need it.
- Given care when you need it, 24 hours a day and 7 days a week.
- Free to get mental health and family planning services and supplies without a referral.
- Given equal access to the right treatment, services and facilities if you are under 18 years of age. To learn more, read OHP's "Minor Rights: Access and Consent to Health Care" booklet. It tells you the types of services minors can get on their own and how their health records may be shared. Visit OHP.Oregon.gov and click on "Minor rights and access to care."
- Able to get care coordination and be a part of your care planning.
- Free to get help with addiction to tobacco products, alcohol and drugs without a referral.
- Given handbooks and letters that you can understand.
- Able to get a copy of your health records for a reasonable fee.
- Able to have corrections made to your health records.
- Able to limit who can see your health records.
- Sent a Notice of Adverse Benefit Determination (NOABD) letter if you are denied a service.
- Notified 30 days before the change, or as soon as possible, if there is a change in your benefits.
- Given information and help to appeal denials and ask for a hearing.
- Free from any form of restraint or seclusion (isolation) that is not medically necessary or is used by staff to bully 15 or punish you. Staff may not restrain or isolate you for the staff's convenience or retaliation against you. You have the right to report violations to your CCO and/or to the Oregon Health Plan.
- Allowed to make complaints and receive help filing complaints, and to get a response without a bad reaction from your plan or provider.
- Free to ask the Oregon Health Authority Ombudsperson for help with problems at 503-947-2346 or toll-free 877-642-0450, TTY 711.
- Be treated by your providers the same as other people seeking health care benefits they are entitled to; and encouraged to work with the your care team, including providers and community resources that are right for your needs.
- Able to choose a primary care provider (PCP) or service site and to change those choices as allowed by CCO rules.
- Given the right to agree to treatment or refuse services and be told the effects of that decision, except for court ordered services.
- Given written materials describing rights, responsibilities, benefits, how to access services and what to do in an emergency.
- Provided with services and support in a language you understand, and in a way that respects your culture.

- Provided with care coordination and transition planning from your CCO in a language you understand and in a way that respects your culture, to make sure community based care is provided in as natural and integrated an environment as possible, and in a way that keeps you out of the hospital if possible.
- Provided with necessary and reasonable services to diagnose your condition.
- Provided with integrated, person-centered care and services that provide choice, independence, and dignity, and that meet accepted standards of medically appropriate care.
- Able to have a consistent and stable relationship with a care team that is responsible for managing your care.
- Able to receive covered preventive services.
- Provided with a referral to specialty providers for medically appropriate covered coordinated care services following your CCO's referral policy.
- Provided with a clinical record that documents conditions, services received and referrals made.
- Able to transfer a copy of your clinical record to another provider.
- Able to write a statement of your wishes for treatment, including the right to accept or refuse medical, surgical, or mental health treatment.
- Able to write directives and powers of attorney for health care established under ORS 127.
- Given a notice of an appointment cancellation in a timely manner.
- Free to exercise your Member Rights without being treated badly by your CCO, your providers, or the Oregon Health Authority (OHA).
- Able to use electronic methods, if available and at your request, to communicate with your CCO and provide member information.
- Able to work with your CCO's staff who are trained in every part of the Oregon Health Plan (OHP), including benefits, grievances and appeals, enrollment and disenrollment, and more.

Members' Responsibilities

As an OHP client, you agree to:

- Find a doctor or other provider you can work with and tell them all about your health.
- Treat providers and their staff with the same respect you want.
- Bring your medical ID cards to appointments, tell the receptionist that you have OHP and any other health insurance, and let them know if you were hurt in an accident.
- Be on time for appointments.
- Call your provider as soon as possible if you can't make it to an appointment.
- Have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy.
- Follow your providers' and pharmacists' directions or ask for another choice.
- Be honest with your providers to get the best service possible.
- Call OHP Customer Service when you move, are pregnant or are no longer pregnant.
- Use your PCP or clinic for diagnostic and other care except in an emergency.

- Get a referral to a specialist from your PCP or clinic before seeking care from a specialist unless selfreferral to the specialist is allowed.
- Use urgent and emergency services appropriately and notify your PCP or clinic within 72 hours of using emergency services.
- Give accurate information to be put in your clinical record.
- Help your provider or clinic get your clinical records from other providers, which may include signing an authorization for release of information.
- Ask questions about conditions, treatments, and other issues related to your care that you do not understand.
- Use information provided by your CCO's providers or care teams to make informed decisions about treatment before you get it.
- Help your providers make a treatment plan.
- Tell your provider that your health care is covered under OHP before you get services and, if requested, show the provider your CCO Member ID card.
- Call OHP Customer Service to tell them if you change your address or phone number.
- Call OHP Customer Service if you become pregnant and when the baby is born.
- Call OHP Customer Service if you have any other insurance available.
- Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280.
- Let your CCO know about any issues or complaints or grievances you have.

Member Appeals and Grievance Rights

An enrollee has the right to file a grievance or appeal or request a contested case hearing.

Providers may not:

- Discourage a member from using any aspect of the grievance, appeal or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal.
- Encourage the withdrawal of a grievance, appeal or hearing request already filed.
- Use the filing or resolution of a grievance, appeal or hearing request as a reason to retaliate against a member or to request member disenrollment.

Timing

- A member may file a grievance at any time. The CCO will notify the member, within five business days from the date of receipt of the grievance, of one of the following: (a) A decision on the grievance has been made and what that decision is; or (b) That there will be a delay in the contractor's decision, of up to 30 days. The written notice will specify why the additional time is necessary.
- If the CCO denies, stops or reduces a medical service a provider has ordered, the CCO will mail the enrollee a Notice of Adverse Benefit Determination (NOABD) letter explaining why the decision was made. If the member or provider disagrees with this decision, they may file an Appeal within 60 days from the date on the NOABD. The member will receive a Notice of Appeal Resolution (NOAR) letter within 16 days with the CCO's decision.
- If the decision is upheld, the member can file a Contested Case Hearing request with their CCO or OHA, no later than 120 days from the date of the Notice of Appeal Resolution (NOAR). Or, if the CCO fails to adhere to the notice and timing requirements, OHA may deem that the CCO appeals process is exhausted.

Filing Procedures/Requirements

- A member, provider or member representative may file a grievance, a CCO-level appeal and may request a Contested Case Hearing.
- A member may file a grievance, either orally or in writing, with OHA or the CCO.
- A provider acting on behalf of the member, and with the member's written consent, may file an appeal, either orally or in writing.
- If the member and their provider believe that the member has an urgent medical problem that cannot wait for a regular appeal, an expedited appeal can be requested. Members should include a statement from their provider or ask the provider to call the CCO to explain why it is urgent. If the CCO agrees that it is urgent, a decision will be made in 72 hours.
- The CCO can provide assistance to the enrollee with filing grievances and appeals.
- A Contested Case Hearing can be requested by submitting Form MSC 0443. This form will be included with the NOAR or may be requested by calling the CCO or OHA.
- Include as parties to the Contested Case Hearing: The member and the representative; CCO; and the legal representative of a deceased member's estate.
- A member, or provider, who believes that taking the time for a standard resolution of a Contested Case Hearing could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing.
- OHA's toll-free number is 800-273-0557; Health Share of Oregon's toll-free number is 888-519-3845; Columbia Pacific CCO's toll-free number is 855-722-8206.

A member has the right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or state fair hearing filing.

Timing of the request:

- Request must be made within 10 days after the date of the Notice of Adverse Benefit Determination (NOABD).

  OR

- The intended effective date of the action proposed in the notice.

The CCO shall continue the member's benefits if:

- The member or member's representative files the appeal or administrative hearing request timely.
- The appeal or administrative hearing request involves the termination, suspension or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member files timely for continuation of benefits.

If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal is in process, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal or Contested Care Hearing.
- The member does not request a Contested Case Hearing within 10 days from when the CCO mails the Notice of Appeal Resolution (NOAR) to the member's appeal.
- A Contested Case Hearing decision adverse to the member is made.
- OHA issues an appeal decision adverse to the member.
- The authorization expires or authorization service limits are met.

If the final resolution of the appeal or Contested Case Hearing is adverse to the member (upholds the CCO's original decision), the CCO may recover from the member the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

Verifying an OHP Recipient's Dental Plan Enrollment

There are three ways to verify dental plan enrollment:

1. Health Share of Oregon members only: Log on to Clinical Integration Manager (CIM). To register as a new user, contact PH TechProvider Relations Department at 503-584-2169, select Option 2.
2. Columbia Pacific CCO members only: Log on to the CareOregon Provider portal. To register as a new user, contact your agency's Main Office Contact or HealthTrio Customer Service Department at 877-814-9909.
3. Call the CCO of the member:

- Health Share of Oregon: 503-416-8090
- Columbia Pacific CCO: 503-488-2822

Changing DCOs

Oregon Health Plan recipients may change their dental plan based on the DCOs available within their assigned coordinated care organization (CCO).

Changes in dental plan enrollment are made by the member's CCO, not by CareOregon Dental. Members in the tri-county area who wish to change their dental plan should call Health Share's customer service department at 888-519-3845. Columbia Pacific CCO members should call the customer service department at 855-722-8206.

Verifying Eligibility of CareOregon Dental Members

There are four ways to verify dental plan enrollment:

1. Log on to CareOregonConnect at ***careoregondental.org/providers/provider-portal***
2. Log on to Clinical Integration Manager (CIM, Health Share of Oregon members only). To register as a new user, contact PH Tech Provider Relations Department at 503-584-2169, select Option 2.
3. Call CareOregon Dental Customer Service at 503-416-1444.
4. Our batch eligibility (270/271 EDI) service provides a batch eligibility check for providers' practice management systems to check a member's enrollment status and benefits. The service is provided by our vendor, VisibilEDI, and does not replace the individual member eligibility check service available on our CareOregon Connect online portal.

   NOTE: There is no requirement for a provider to use this service. In addition, use of this service does not qualify for incentive payments.

   For information on how to establish the 270/271 EDI real time batch eligibility verification process, please contact us at 800-224-4840 or ***providercustomerservice@careoregon.org***, after reviewing these initial prerequisites:

   - Must be a CareOregon participating/contracted provider
   - Must have ability to establish an SFTP connection: Have FTP solution and provide an SFTP technical contact

PDP Assignment and Selection

Assigning a PDP to CareOregon Dental Members

All CareOregon Dental members have a primary dental provider (PDP) who manages their dental needs. This directory can also be found online at: ***careoregondental.org/members/find-a-dentist***

Members are assigned to PDP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

PDPs are automatically assigned when a member enrolls with CareOregon Dental. Auto assignment is based on claims history, family enrollments, primary care provider colocation and home ZIP code.

Changing PDPs

Newly enrolled CareOregon Dental members receive a welcome packet that includes a directory of CareOregon PDPs. This directory can also be found online at ***careoregondental.org/members/find-a-dentist***

Members can call our Customer Service department at 888-440-9912 to select a new PDP.

PDPs can help a member select their clinic as the PDP by calling the Customer Service department, but the member must make the request.

PDP assignments become effective the day they are requested. However, newly assigned PDPs may not know about their assignments until they receive the next weekly member roster.

Health Share of Oregon and Columbia Pacific CCO members receive an ID card specific to their CCO that includes their PDP name and phone number.

Member Rosters

PDP clinics can access and download their current clinic roster of members assigned to their clinic on their SFTP site at ***ftp.careoregon.org***

PDP assignments are effective the day they are requested. Call CareOregon Dental Customer Service to verify PDP assignment or check the member's assignment using the Provider Portal.

Member Complaints

CareOregon Dental members have the right to file complaints in accordance with Oregon Administrative Rules (OAR) and Centers for Medicare and Medicaid Services (CMS) guidelines. CareOregon Dental encourages members and providers to resolve complaints, problems and concerns directly with those involved.

However, CareOregon Dental provides formal procedures for addressing complaints and problems when they cannot be resolved otherwise.

If they are not resolved, members have the right to request a hearing by the OHA through its hearing process. Members may call CareOregon Dental Customer Service at 503-416-1444 or toll free at 888-440-9912 to file their complaint.

Resolving Complaints at the Provider's Office

Members who have complaints about a specific provider, clinic staff or the provider site in general should contact the clinic manager for help in addressing the issue.

If a member remains dissatisfied with the provider's response to their complaint, or wishes to share their dissatisfaction with CareOregon directly, the member should contact CareOregon Dental Customer Service.

Providers may contact CareOregon Dental Customer Service for help in resolving member complaints.

Resolving Complaints at CareOregon

CareOregon Dental Customer Service staff logs complaints and facilitates the member complaint process. Other CareOregon Dental staff members, such as access coordinators, care coordinators, dental managers and dental directors are involved in the process when appropriate.

CareOregon Quality Assurance monitors and analyzes all complaints documented by Customer Service staff and follows up with appropriate parties until the issue is resolved.

Oregon Health Plan Complaint Forms

If a CareOregon Dental member is uncomfortable contacting CareOregon, they may submit a complaint to the OHA using an Oregon Health Plan Complaint Form (form 3001) or contact OHP Client Services at 800-273-0557 or TTY 711.

OHP Complaint Forms are available online at:
sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3001.pdf

Restraint and Seclusion

In compliance with Federal and State law, CareOregon recognizes that each member has the right to be free from any form of restraint or seclusion as means of coercion, discipline, convenience or retaliation.

Restraint is:

a. Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of the patient to move their arms, legs, body or head freely;

   OR

b. A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage.

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

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

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

CareOregon requires contracted providers to have a policy and procedure regarding use of restraint and seclusion as required under the Code of Federal Regulations and also requires the contracted provider to provide a copy of their policy to CareOregon upon request. If a provider is not required to maintain a policy regarding the use of restraints and seclusion, CareOregon requires that the provider submit a Prohibited Procedure or written statement to that effect.

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

Primary Care and Non-Primary Care

Primary dental care is defined as comprehensive, continuous care that focuses on preventive care and care of common conditions. CareOregon Dental's model of managed care is based on a foundation of primary care services.

Non-primary dental care is defined as services for dental conditions that require specialized treatment or licensure.

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

- Hospital-based dentistry
- Outpatient procedures such as
  - Complex surgical extractions
  - Oral pathology
- Fabrication of dentures and partials

PDPs are responsible for managing all the dental care needs of their assigned CareOregon Dental members. This means PDPs are responsible for either providing or coordinating services that are not considered primary dental services. PDPs can choose to provide non-primary care services to their patients or to refer patients to CareOregon Dental to locate specialists for provision of these services.

Responsibilities of the PDP

Primary dental providers will provide at least the following level of service to those CareOregon Dental members assigned to them:

- Maintain a comprehensive medication list that includes all prescription medications that the member is taking and their medication allergies.
- Provide accessible care within 8-12 weeks for any routine visit (e.g. preventive care).
- Provide accessible care within one to two weeks or as indicated in the initial screening for any member with an urgent problem.
- Provide accessible emergency oral care within 24 hours.
- Provide access to telephone advice for member questions, 24 hours per day.
- Provide preventive services, as recommended by the U.S. Preventive Services Task Force.
- Submit a referral for consultation/specialty services within one week for any member with a non-urgent problem needing such consultation/services.
- Submit a referral for consultation/specialty services within 24 hours for any member with an urgent problem needing such consultation/services.
- Ensure specific written communication including initial diagnosis and procedures requested as part of each referral.
- Provide for interpretation services by staff, telephonically by a qualified interpretation service or onsite by a qualified interpretation service.
- Have a policy and/or procedure to arrange for and provide access to an appropriate back-up practitioner for any leaves of absence.

Benefits

Services covered by the Oregon Health Plan

Prioritized List of Health Services

The Oregon Health Plan (OHP) covers a comprehensive set of medical and dental services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits.

The Division of Medical Assistance Programs (DMAP) sends copies of the Prioritized List to Medicaid providers. It is also available at ***oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx*** In addition, DMAP publishes the Dental Administrative Rules at ***oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx***. These documents can be used to determine if CareOregon Dental covers a service.

- The line on the prioritized list determines whether a treatment is covered by the OHP.
- The OHP and CareOregon Dental cover diagnosis and treatment pairs that appear above the line.
- Diagnosis and treatment pairs that are listed below the line are not covered benefits of either the OHP or CareOregon Dental. Services below the line generally include conditions that improve by themselves, conditions for which no effective treatments are available or cosmetic treatments.

- Additional benefits are available for medically necessary and dentally appropriate services for members under age 21 under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

The Prioritized List can also be accessed by calling DMAP Provider Services at 800-336-6016. If a service is not covered by the OHP and you decide that treatment is essential, send additional information, such as chart notes and related X-rays, to CareOregon's Dental Access staff with the authorization request.

Covered and Non-Covered Dental Services

The OHP covers a comprehensive set of dental services. Many services have periodicity or other restrictions. For the most current Administrative rules and other supplemental information for the OHP Dental Services Program, go to the OHP website at:
oregon.gov/oha/HSD/OHP/Pages/Policies.aspx

Requests for non-covered services are denied if additional information is not included with an authorization request.

You can provide services not covered under the Oregon Health Plan (OHP) to CareOregon Dental members, but arrangements must be negotiated between you and the member.
You are required to:

- Inform the member the service is not covered.
- Provide an estimate of the cost of the service.
- Explain to the member their financial responsibility for the service.
- Complete a waiver with the patient agreeing to be responsible for payment of the non-covered service. The waiver must be signed by the member prior to rendering non-covered services. (See ***Appendix B*** for a sample waiver.)

You may freely communicate with patients about their treatment options regardless of benefit coverage limitations.

IMPORTANT: DMAP prohibits billing Oregon Health Plan recipients for covered services.

Services Covered by Other Managed Care Plans

Medical: The member's coordinated care organization (CCO) or DMAP (open card) covers medical services.

Mental health: The member's mental health organization (MCO) covers mental health services for OHP members. For CareOregon Advantage members, mental health services are coordinated through CareOregon.

Tobacco Cessation

Providers are encouraged to follow the five A's model for treating tobacco use and dependence. No referral is required to provide tobacco cessation treatment and counseling. For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:

a. Ask patients about their tobacco-use status at each visit and record information in the chart.
b. Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and
c. Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco.

Documentation should support all sections listed above if you are using the tobacco cessation code.

For CareOregon Dental patients willing to make a quit attempt, providers may refer patients for counseling or additional behavioral treatment to the Quit for Life Program through Alere Wellbeing (866-784-8454) or your clinic's internal cessation program. You can bill a maximum of two times per member per 12-month period.

You may provide a tobacco cessation counseling session or class to a CareOregon Dental patient. You can bill a maximum of ten times per member per 12-month period.

See the Claims, Billing and Payment section for information on billing for these tobacco cessation services.

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians, 2008 Update:
ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/tobaqrg.pdf

How to Quit: Tobacco Information and Prevention:
cdc.gov/tobacco/quit_smoking/how_to_quit/index.htm

National Quit Line: 800-QUIT NOW National Cancer Institute's Smoking Quit Line (English or Spanish)

For free personalized help with quitting, call 877-44U-QUIT (877-448-7848) toll-free 9 a.m. to 4:30 p.m., Monday through Friday. Oregon Thoracic Society, a medical advisory section of the American Lung Association in Oregon.

E-mail: ***ots@lungoregon.org***, or call 800-586-4872.

For pregnant smokers:

Smokefree.gov is a national program working to help pregnant smokers quit, and publicize effective treatments:
women.smokefree.gov/pregnancy-motherhood/quitting-while-pregnant

Quit Smoking, American Lung Association:
lung.org/quit-smoking/smoking-facts/health-effects/nicotine
Call: 800-LUNG-USA (800-586-4872).

Referrals and Authorizations

CareOregon Dental does not require prior authorization for any service covered in the Oregon Health Plan benefit package when provided by a primary dental provider. If a provider wishes to request a non-covered benefit or needs to confirm benefits, they may submit a referral form or authorization request on behalf of the member. Claims payment for exceptions to the benefit package is not guaranteed without written authorization from CareOregon Dental.

Authorization decisions are strictly made based on relevant benefit plan coverage rules and dentally appropriate determination and are provided at the most cost-effective level (e.g. office, ASC, hospital dentistry) based on the member's need. CareOregon Dental follows all OAR or applicable rules related to the minimum benefit packages and the presenting conditions of the member. CareOregon Dental may choose to provide a higher-level benefit package to all CareOregon Dental members.

Referrals

Referrals are a formal request for the patient to seek a specific services or series of services by another provider, often a specialty or limited practice provider. If these requests include a non-covered benefit or service, they may be denied in accordance with the authorization process.

PDPs submit referrals to CareOregon Dental via the Provider Portal at ***healthtrioconnect.com***. During portal downtime, referrals can be submitted using a PDF fillable form. The form can be found on the ***Provider Forms and Procedures*** page of the CareOregon Dental website. CareOregon Dental staff provides a list of required elements for all referrals needed to process a request based on the OHP benefit requirements for the service. If not included in the initial request, CareOregon Dental staff contact the requestor, specifying information needed, including a due date. CareOregon Dental staff follow up with the requestor if information is not provided and monitor the timeline to ensure a decision is made based on the urgency of the service needs and within the OHP benefit determination processing timelines.

Referrals for specialty services must be submitted to CareOregon Dental within 24 hours for any member with an urgent problem needing such services. For members with a non-urgent problem needing a referral for specialty services, referrals must be submitted to CareOregon Dental within one week.

CareOregon Dental will arrange for non-network specialty dental care when providers are unavailable or inadequate to meet a member's dental needs. Authorizations will be issued to those providers based on the member's benefit package, including applicable rules and policies, as previously stated. If the dental provider requests a "single case agreement" before the service is provided, CareOregon Dental staff notifies the CareOregon Contract Manager, who then secures the agreement based on the urgency of the dental service need and within the authorization processing timelines. CareOregon Dental will cover and coordinate payment for out-of-network services when the CCO is unable to provide covered services that are culturally, linguistically, and medically appropriate.

Authorization Time Frames

If a member or dental provider requests an expedited determination, CareOregon Dental will make a decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

CareOregon Dental will automatically provide an expedited determination to any request made or supported by a dentist, if the dentist indicates, either orally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If CareOregon Dental denies a request to expedite the decision, it will make the determination within 14 calendar days of the request or as timely as the member's dental condition warrants. CareOregon promptly notifies both the member and dental provider verbally of its decision to deny the expedited request and sends a written notification explaining the denial, including appeal rights, within three calendar days of the denial to both the member and dental provider.

For standard prior authorization requests, CareOregon will make the determination as expeditiously as the member's dental condition requires and within 14 calendar days following receipt of the request.

CareOregon Dental may extend the time frame up to an additional 14 calendar days if the member, member's representative or provider requests the extension or if CareOregon Dental justifies a need for additional information and documents how the extension is in the interest of the member. When CareOregon Dental grants itself an extension to the deadline, CareOregon Dental sends a written notification to the member and dental provider of the reason for the delay and informs the member of the right to file a grievance if they disagree with the decision to grant an extension.

Authorization or denial decision notifications occur within two working days of the decision.

Coordination of Benefits

To ensure coordination of benefits (COB) in compliance with CMS requirements and Oregon Health Authority (OHA) guidance, CareOregon Dental has outlined the following guidelines to support the management of primary dental provider (PDP) assignment and referrals to specialty dental services for CareOregon Dental members who have primary dental insurance from a company other than CareOregon Dental.

- If a CareOregon Dental Access Coordinator receives a referral to specialty services for a member with CareOregon Dental secondary, the referral will be processed based on the Oregon Health Plan (OHP) benefit package.
- If the referral results in a denial of any requested service, a Notice of Adverse Benefit Determination (NOABD) letter will be generated and will include a statement to inform the member that they may have additional benefits with their primary carrier.
- If the referral is approved, every attempt will be made to locate a specialist within our network that accepts the member's primary dental insurance so that the Medicaid program is the payer of last resort.

Denials and Appeals of Authorizations

Denials

A CareOregon dental director makes all denials.

Decision-making is based only on appropriate care, coverage guidelines and rules. CareOregon Dental does not reward staff for denying authorization requests and we do not use financial incentives to reward underutilization.

The denial letter documents the service requested, the reason for the denial and the rule/criteria that was used to make the denial determination. The letter includes information on how to obtain a copy of the criteria used to make the denial determination and how to appeal the denial determination. The letter is sent to both the member and the requesting dental provider. The effective date of the denial is the date of the letter. Denial letters are written at or below a sixth-grade reading level. For members who may want an alternate format or language, the denial letter instructs them to contact CareOregon Dental's Customer Service Department.

A notification of the denial is also sent to the requesting dental provider. It includes the service requested and reason for the denial.

Appeals

Medicaid/OHP providers may appeal on behalf of the member with the member's consent. Denial letters tell members that they may contact CareOregon to request an appeal. Appeals must be requested within 60 days after the date on the denial letter.

A CCO dental director reviews all appeal requests. The CCO has 16 days to review and make a determination. The decision to uphold the denial or approve the requested service is sent in writing to the member, PDP or requesting provider and specialist (when applicable). If the decision is upheld, the member can file a Contested Case Hearing request with CareOregon or OHA, no later than 120 days from the date of the Notice of Appeal Resolution (NOAR) letter.

Other Services

Meaningful Language Access

Interpreting

All contracted CareOregon providers must make interpreting services available to CareOregon members.

Services must be available during and after hours for consultation and provision of care. While interpreting services can be scheduled with short notice, to ensure coverage, please schedule as soon as a member makes an appointment.

Interpreting services should be performed by certified and qualified interpreters. The interpreters may be on staff or scheduled through a CareOregon approved vendor. They may operate on site, over the phone or via computer/telephone screen. Interpreting should not be provided by a member of the patient's family. Members should never be asked to bring their own interpreter.

CareOregon's interpretive services cover the following occurences:

- Onsite medical, dental or behavioral health appointments
- Scheduling or rescheduling appointments
- Appointment reminders
- Appointment follow-ups5
- Relaying test results
- Registration for procedures/admissions

Use only our approved vendors

CareOregon pays for interpreting services so that members can access their covered health care services and benefits. We have contractual arrangements with approved vendors. Please use them when serving CareOregon members. (Be sure to verify that your patient is covered by the Oregon Health Plan.) Visit our website at ***careoregondental.org/providersupport*** for a list of contracted interpretation vendors.

A printable document is available for download at: ***link.careoregon.org/interpreter-vendor-handout***

IMPORTANT: If providers choose to coordinate interpreting services themselves rather than through CareOregon, they are responsible for paying for those services. **CareOregon pays only for interpreting services that providers coordinate through our approved vendors.**

Member Transportation

Transportation assistance to medical, dental and mental health appointments is a benefit to OHP members. Depending on the member's needs, they may get transit passes, be provided rides or get help paying for gas.

Health Share of Oregon members call Ride to Care at 503-416-3955 or toll-free 855-321-4899, TTY 711 or visit ***ridetocare.com*** to plan a trip online.

Members must schedule a ride at least two business days in advance of their appointment. Members may schedule a trip up to 90 days before their appointment date.

When calling to schedule, members need to have ready:

1. Their Oregon Health Plan number.
2. Time and date of appointment.
3. Name, complete address and phone number of medical/dental caregiver.
4. Any special accommodations required, such as using a wheelchair.

Short notice trips

If needed, transportation assistance may be available for members even with short notice. Members need to tell the operator if they have urgent transportation needs, for example, a ride to an urgent care clinic.

Prescription pick up

Members can tell their driver they need to get a prescription filled before they return home. The driver will stop and wait for the member to pick up medications or other items prescribed by their provider.

Non-English speaking members

Ride to Care also has interpreters available for non-English speaking members. This service is free. When the call is answered, the member must say the language that they speak and stay on the line. A Ride to Care representative and an interpreter will help them.

Ride to Care LIFT Program (Health Share of Oregon members only)

Phone: 503-416-3955
TTY: 503-802-8058
Hours: 7 a.m. to 7 p.m., Monday through Saturday

LIFT Program riders must have a disability or disabling health condition and their disability or health condition must prevent them from independently using TriMet bus and/or MAX service some or all of the time (without assistance, other than from the bus driver).

LIFT transportation may be provided by bus, taxi, accessible van, secure transport or stretcher car.

LIFT does not provide emergency transportation, but same-day rides may be scheduled with verification from an attending physician or medical facility.

IMPORTANT: All rides must be reserved in advance no later than 5 p.m. the day before the trip.

Columbia Pacific CCO members in Tillamook County

Call NW Rides at 503-861-0657 or
toll-free 888-793-0439, TTY 711.

Members must call NW Rides to schedule a ride at least two business days in advance of their appointment. Members may schedule a trip up to 30 days before their appointment date.

Members can call NW Rides to schedule a ride Monday through Friday 8 a.m. to 5 p.m. The call center is closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

When calling to schedule, members need to have ready:

1. Their Oregon Health Plan number.
2. Time and date of appointment.
3. Name, complete address and phone number of medical/dental caregiver.
4. Any special accommodations required, such as using a wheelchair.

Short notice trips

If needed, NW Rides can help provide transportation for members even with short notice. Members need to tell the operator if they have urgent transportation needs, for example, a ride to an urgent care clinic.

Prescription pick up

Members can tell their driver they need to get a prescription filled before they return home. The driver will stop and wait for the member to pick up medications or other items prescribed by their provider.

Additional information on NW Rides can be found online at ***colpachealth.org/transportation***

Exceptional Needs Dental Services (ENDS)

Exceptional Needs Dental Services provides mobile and hospital dental services statewide for members who are non-ambulatory or who have severe developmental disability or mental impairment and without mobile dental services would otherwise have no access to dental care. Patients must be living in a care facility and be unable to obtain dental care in an office setting to be eligible for an ENDS referral.

Providers may submit a referral on behalf of the member after an office visit. Information should include, if available: radiographs, medical and dental history, diagnosis, treatment plan, and a reason the office visit was not successful.

Members or their advocate can contact CareOregon Dental directly to inquire about a referral to the ENDS program. Dental Access staff will ask a series of questions to determine if a referral is appropriate.

For more information, see ***endsor.com***

Health Promotion Materials

The CareOregon website has health information and links to health education resources at ***careoregon.org/providers/best-practice-guidelines***. The information and links encourage patient self-management, and effective communication with providers.

Community Dental Services

In Clackamas, Multnomah and Washington counties, All Smiles Community Dental (formerly DENTAL3) represents a unique partnership of Medicaid dental plans, coordinated care organizations and community partners to advance the goals of health care transformation by furthering oral health in the Portland Oregon metropolitan community through the provision and coordination of oral health preventive services in alternative care settings. At its core, All Smiles Community Dental functions as a “public health overlay” with a community focus. All Smiles Community Dental pulls together disparate systems of health and safety net structures to align under a common coordinated approach: to meet the needs of Medicaid eligible individuals and other populations in need.

CareOregon Dental is an active partner with All Smiles Community Dental. Coordination and payment of community-based dental services for CareOregon Dental members in Clackamas, Multnomah and Washington counties must be through All Smiles Community Dental.

Dental Access Coordinators

CareOregon dental access coordinators (DACs) are assigned to PDPs and specialists based on geographic territories and health systems. The DACs are designed to meet the service needs of our contracted clinics, facilities and vendors in the tri-county region and in Tillamook County.

The DACs are available by email or phone to providers only. They can be contacted at DentalAccessTeam@careoregon.org, or find a DAC for your provider type, call our Customer Service department at 503-416-1444. They will forward your call to a DAC.

DACs are a link between our provider network and CareOregon staff. They help clinic staff with questions or concerns about our Medicaid (Oregon Health Plan) dental plan.

DACs provide the following information and trainings:

- Orientation to health plan operations, policies and procedures (upon contracting).
- Refresher orientations for new clinic, billing or management staff as needed.
- Training on using our online resources such as Provider Portal (verifies claims/payment detail) and the CareOregon Dental website.

Email or fax updates to DACs about changes such as:

- New and terminated providers or clinic staff.
- Locations, telephone numbers and email addresses.

Timely updates facilitate accurate directory listings, mailings, correct claims payment, system access for your staff and (for primary care clinics) appropriate member assignments.

Contracting

If a provider is interested in contracting with CareOregon Dental, the DACs can be contacted to initiate the process. If it is determined that a contractual relationship is needed, the DAC will request documentation from the provider. Once received, the DAC will begin developing a contract.

Once the contract has been executed, credentialing may be required prior to claims being reimbursed at the contracted amounts.

Access to Care and Member Capacity

It is the policy of CareOregon Dental to ensure all members have access to all covered dental services, delivered in a patient-friendly and culturally competent manner. CareOregon Dental requires practitioners to have policies and procedures that prohibit discrimination in the delivery of health care services. CareOregon Dental also ensures all members have access to appointments according to Oregon Administrative Rules as well as afterhours access 24 hours a day, seven days a week. CareOregon Dental conducts annual audits of after-hours care available with partner clinics.

Primary Care Dental Practices

During the contracting process, CareOregon Dental and primary dental practices agree upon an initial maximum capacity number for the total number of CareOregon Dental members to be assigned to the practice. This number is based on the amount of provider time available for the provision of services to CareOregon Dental members. Any applicable, appropriate practice restrictions are set up at this time.

Members are directly assigned at the clinic level. If a PDP leaves a group practice, the remaining practitioners are expected to absorb members served by the departing PDP. If extenuating circumstances exist, exceptions may be made on a case-by-case basis.

After initial contractual consensus is reached, CareOregon Dental tracks access and capacity monthly, and implements necessary countermeasures to maintain adequate access within primary dental clinics.

- Any time access reports show appointment scheduling out of compliance for three consecutive weeks, the clinic/program must provide CareOregon Dental with a written explanation including strategies to reduce wait times.
- Any time access reports show appointment scheduling out of compliance for two consecutive months, CareOregon Dental may reduce the capacity of the clinic by 10%. Once wait times return to six weeks or less for two consecutive months, and strategies have been implemented to maintain this, CareOregon Dental will reinstate the original capacity limit of the clinic.
- Monthly Collaborative Team meetings: dental directors and program managers from primary dental programs meet with CareOregon Dental staff to discuss emerging access issues, share best practices and problem solve with each other.

Specialty Care Dental Practices

CareOregon Dental staff process all incoming referral requests. CareOregon Dental conducts regular evaluation and implements necessary countermeasures to maintain adequate access within specialty dental clinics.

Appointment Availability and Standard Scheduling Procedures

For children and non-pregnant individuals:

- Routine and follow-up appointments should be scheduled to occur within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

- Urgent dental care should be scheduled within two weeks.
- Dental emergency services should be seen or treated within 24 hours.

For pregnant individuals:

- Routine and follow-up appointments should be scheduled to occur within four weeks, unless there is a documented special clinical reason that makes a period of longer than four weeks appropriate.
- Urgent dental care should be scheduled within one week.
- Dental emergency services should be seen or treated within 24 hours.

Appointments for initial history and assessment should be scheduled in longer appointment slots to allow for preventive care and health education as needed. Members should wait no longer than an average of 20 minutes for scheduled appointments.

Providers should apply the same standards to their CareOregon Dental members (including hours of operation) as they do to their commercially insured or private pay patients.

Non-Scheduled Walk-ins

In accordance with Oregon Administrative Rules, CareOregon Dental has established guidelines for walk-ins. Your procedure for triaging walk-ins should include the following actions:

When a member walks in without an appointment, office staff record the member's demographic information (name, address, etc.) and presenting problem and send this information to the triage provider. The triage provider performs a preliminary assessment of the member's condition:

- Members with emergent dental conditions are seen or treated within 24 hours or referred for transport to the nearest hospital.
- Members with urgent conditions are seen within one week, depending on the severity of the condition, or referred for transport to the nearest hospital.
- Members who present with a non-urgent condition are scheduled for an appointment within the time frames cited above in "Appointment Availability and Standard Scheduling Procedures."

Emergency Services

Emergency care is covered 24 hours a day, seven days a week. CareOregon Dental does not require prior authorization and will pay for emergency services. CareOregon Dental requires contracted entities to make on-call providers available to members 24 hours a day, seven days a week to cover emergency services including prescriptions.

In-Area Emergency Services

CareOregon Dental members can call their PDP 24 hours a day, seven days a week. In the event of a dental concern meeting emergency or urgency guidelines outside normal business hours, an on-call dentist is available through the PDP. If a member cannot reach their PDP or an on-call provider, they can call 911 or go to the nearest hospital emergency room for emergency care.

Out-Of-Area Emergency Services

CareOregon Dental members can access emergency dental services from a provider of their choice. CareOregon Dental:

- Covers and pays for emergency services regardless of whether the entity that furnishes the services has a contract with CareOregon Dental
- Approves payment for treatment obtained by a member who had an emergency dental condition
- Approves payment for treatment obtained by a member under the instruction by a CareOregon Dental representative
- Covers emergency services even if CareOregon Dental was not notified in advance of treatment
- Never holds a member liable for payment of subsequent screening and treatment needed to diagnosis the specific condition

CareOregon Dental approves claims submitted for treatment of conditions defined by the State as emergency conditions. CareOregon tracks and monitors the claim system to ensure there is no payment denial for emergency dental services.

Special Needs Coordination and Continuity of Care

CareOregon Dental works collaboratively with providers to identify and assess member needs. CareOregon Dental coordinates access and services for members with special health care needs.

If a dental provider identifies a member with special health care needs, exhausts treatment options in the primary dental setting, and determines the member to be unable to receive services in the traditional office setting, the provider submits a referral for specialty services to CareOregon Dental. CareOregon Dental staff work with the provider, member and/or caregiver to determine the best treatment setting for the member. This may be in a care facility or foster home, a hospital, or a specialized pediatric or adult setting. CareOregon Dental staff then coordinate the referral for needed oral health treatment and connect the member to the chosen specialty provider. In addition, dental providers coordinate treatment planning with care teams as needed.

If the member has CareOregon for their medical and CareOregon Dental for their dental plan, we can easily share relevant information and closely coordinate care. For other medical plans, we contact the provider (if known) or the CCO, should the need arise to coordinate services.

For non-ambulatory, developmentally delayed or intellectually disabled members, CareOregon Dental refers to ENDS (Exceptional Needs Dental Service). In addition, ENDS accepts referrals directly from care facilities and coordinates with CareOregon Dental for enrollment. Once a member has been enrolled with the ENDS program, they remain with ENDS unless the member's situation has changed and they request a transition back to a traditional clinic setting. ENDS reassesses each member at their recall appointment.

For other special health care needs, CareOregon Dental contracts with a number of dental specialists including pediatric, geriatric and hospital.

Second Opinion

A second opinion by a qualified dental provider is available for members at no cost. A provider within or outside the member's dental home can provide a second opinion upon member and/or provider request.

Either the member or the provider can request a second opinion. Several mechanisms are offered to the member for a second opinion:

1. The member's dental clinic will offer the member a second opinion visit with another provider at the same clinic.
2. If another provider at the same clinic is not available or desired by the member, the clinic will then offer a visit with a provider at a different clinic, but within the same clinic system.
3. If the same clinic system is not available or desired by the member, then the provider shall submit a written request for a second opinion to CareOregon Dental using the CareOregon Dental Referral form. CareOregon Dental staff will then arrange for a second opinion outside of the member's dental home clinic system within 14 days of receiving the request.
4. Second opinions will also be arranged for a member who contacts CareOregon Dental directly requesting a second opinion. Second opinions will be offered to the member by one of the three mechanisms listed above, as preferred by the member.

When the second opinion is conducted within the primary dental clinic system, chart documentation is to include:

- Name of person requesting second opinion
- Arrangements made for second opinion
- Clinical findings and notes
- Resolution

When the second opinion is conducted outside the primary dental clinic system, CareOregon Dental staff will request pertinent chart notes, X-rays, etc. from the PDP and forward to the provider supplying the second opinion. After the secondary provider has made their diagnosis and recommended treatment, the secondary provider will send a report to the member's PDP and CareOregon Dental.

CareOregon Dental pays the secondary provider's fee for the second opinion at the current contracted amount.

If CareOregon Dental does not have a qualified contracted provider, CareOregon Dental shall arrange for the member to see a non-contracted qualified provider at no cost to the member. CareOregon Dental will inform the member that non-CareOregon Dental contracted providers may not completely understand the DMAP Dental Services Rules, and may not be able to inform them what services are covered under the member's plan.

Follow-up of Missed Appointments

To ensure optimum health services and outcomes, CareOregon Dental contracted providers should document and follow up with members who do not keep their scheduled appointments.

Providers should have a procedure for follow-up of missed appointments that includes the following features:

- Documentation on the same day in the member's dental record of the date, type of appointment and failure to keep the appointment.
- Review of the member's dental record by a clinical team member.
- An assessment of the need for and type of follow up to occur (e.g. telephone contact, attempt to reschedule, failed appointment letter) by the clinical team member.
- If telephone contact is required, the provider or clinical team member should call the client. Otherwise, non-clinical support staff can follow up as specified by the provider or clinical team member.

It is important to have written documentation of continually missed appointments if you wish to pursue discharging such members from your care. (See the ***Discharge and Disenrollment Guidelines*** section for more information on the discharge and disenrollment process.)

CareOregon dental access coordinator (DAC) staff are available to help providers who have problems with members missing repeated appointments.

24-Hour Telephone Access

CareOregon Dental has a commitment to its members to provide 24-hour telephone access to health care.

CareOregon Dental primary dental providers must have a telephone triage system with the features below:

During Office Hours

A primary dental provider or dental hygienist triages member calls to determine appropriate care and assist the member with advice, an appointment or a referral.

Calls may be answered by but not screened by support staff. If support staff answers calls, the member should be informed of the estimated response time (not to exceed 30 minutes).

The nature of the call and intervention are documented in the member's dental record.

Interpreter services are available for telephone calls. (See the Meaningful Language Access/ Interpretation section for more information.)

After Hours

The DACs conduct an annual after-hours survey to ensure that the following criteria are met.

After-hours access options for members include:

Answering Service

Urgent situations: The person who answers the phone must offer to either page the doctor on call and call the member back or transfer the member's call directly to doctor on call.

Emergencies: The person who answers tells the member to call 911 or go to the nearest emergency room if the member feels it is too much of an emergency to wait for a doctor to call them.

Answering Machine

Urgent situations: The message gives instructions on how to page a doctor for urgent situations.

Emergencies: The message must provide information on accessing emergency services, i.e., call 911 or go to nearest emergency room if the member feels the situation is an emergency.

Physical Access

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

Quality Assurance Program

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

The Quality Program reflects the imperative of the Triple Aim to improve the member's experience of care, improve the health of populations and reduce the per capita cost of care. CareOregon pursues these aims through the implementation of programs and strategies that have the following objectives:

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

    - Pursuing research on new models of health care design and delivery.
- Seek collaboration within the community to identify and eliminate health care disparities.
- Create and support the capacity development of community providers to facilitate clinical change.

The effectiveness of the Quality Program is monitored through the CareOregon Quality and Health Outcomes Committee (COQHO) and the CareOregon Quality Oversight Subcommittee, which reports directly to the Network and COQHO of the CareOregon Board of Directors. The COQHO is structured to directly support the delivery system in building the infrastructure to support population health, deliver high-risk member interventions, and improve clinical processes and workflows that impact clinical performance metrics. The COQHO includes contracted providers (primary care, specialty care, dental and behavioral health), and CareOregon staff (QI, QA, plan operations, network and clinical support, clinical innovation).

Clinical Practice Guidelines

CareOregon Dental, through its Quality Oversight Subcommittee and Dental Collaborative Team, reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses. CareOregon Dental adopts, reviews and updates practice guidelines:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
- Considering the needs of CareOregon Dental members.
- Consistent with applicable Oregon Administrative Rules and the Oregon Health Plan benefit package.

Practice guidelines are posted on our website, ***careoregondental.org/providers/provider-support***

Every year, approved guidelines are reviewed within the Quality and Health Outcomes Oversight Committee, Dental Collaborative Team and applicable dental specialists.

The CareOregon dental director communicates with the CareOregon Quality and Health Outcomes Oversight Committee on any new or updated clinical practice guidelines implemented by the CareOregon Dental Leadership Workgroup or Collaborative Team.

Dental Records

Records must:

- Contain information for one patient only.
- Have dated legible entries for each patient visit. Entries are identified by author.
- Be signed using full and legible signatures including the writer's title. Acceptable forms of signatures include handwritten, electronic signatures or facsimiles of original written or electronic signatures. Stamped signatures are not acceptable.
- Be reviewed and completed by a responsible provider before it is filed.
- Be organized and stored in a manner that allows easy retrieval and ensures confidentiality.
- Be stored securely, only allowing authorized personnel to have access.

- Identify member information on each page of the provider's dental record by two patient identifiers, such as name, date of birth or provider office dental record number.

Clinic staff receive periodic training in patient information confidentiality.

Each dental record shall contain:

- Patient's name, date of birth, sex, address, telephone number and any other identifying numbers (as applicable).
- Name, address and telephone of legal guardian or other responsible party, if applicable.
- All services delivered directly by any dental provider or under the supervision of a dentist or dental hygienist.
- A current medical-dental history, allergy/adverse reaction information, medication list, appropriate follow up.
- Vital signs.
- Adequate radiographs that are labeled appropriately and of diagnostic quality.
- Documentation of clinical findings and evaluation, including complete periodontal charting if clinically indicated.
- Diagnosis of all conditions, including, but not limited to caries, oral pathology and cancer screening, periodontal status.
- Treatment plan supported by diagnosis and findings.
- Prescribed medications, including dosages and dates of initial/refill prescriptions.
- Medications or anesthetics used during a procedure.
- Adequate detail of each procedure, including a diagnosis, tooth number and surfaces, materials utilized and complications.
- Post-operative instructions.
- All diagnostic and treatment services for which a member was referred.
- Lab results and diagnostic test reports with documented follow up.
- Goods or supplies dispensed or prescribed.
- Advance Directives, guardianship, power of attorney or other legal health care arrangements for general anesthesia procedures for adults, or upon member request.

To correct an entry in a dental record, strike through the error one time with ink. Initial and date the strike-through. Do not write "error."

Dental Record Review

CareOregon Dental requires that all contracted dental providers maintain patient dental records in a manner that is current, detailed and organized for effective and confidential patient care and quality review.

All provider dental records must meet established standards for dental record content, organization, confidentiality and retrievability. CareOregon Dental will request chart submissions from PDP network partners with more than 500 assigned members for review by CareOregon Dental staff. To balance capacity with the need to conduct these reviews, routine audits of PDP network partners will be conducted every two to five years, based on member assignment.

Specialty network providers will be audited every two to five years based on utilization. Newly contracted PDP and specialty network providers will be audited within one year of contracting.

Audit frequency will be modified as needed based on a review of member grievances and potential quality issues. Information from the dental record review is also used for payment integrity purposes. Payment integrity specific audits may be conducted and are separate from clinical quality chart reviews. They may be triggered by:

- Issues identified on clinical chart audits, referrals and authorizations, or grievances.
- Outliers based on claims data, including high dollar claims.
- CDT codes that have extensive OHP rules.
- Certain high dollar codes.
- A pattern of non-compliance.

Information from the dental record review is also used for payment integrity purposes.

Network providers who do not meet 90% compliance in 80% of areas reviewed and/or have received 70% or less in a specific area, require a plan for improvement as well as follow-up action which may include:

- Provider education
- Recoupment/adjustment of services found to be incorrectly paid
- Claims review
- Subsequent chart or payment integrity auditing which may focus on specific areas of deficiencies
- A corrective action plan
- Referral to CareOregon's Peer Review Committee

Aggregate dental record review results reflecting each criterion are presented to the CareOregon Quality and Health Outcomes Committee. Aggregated information can also be shared with the Dental Collaborative Team. Opportunities for improvement identified at the provider or entire network level are outlined. The CareOregon chief dental officer will report updates at least annually to the CareOregon Quality and Health Outcomes Committee.

Confidentiality

Providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Act's (HIPAA) transactions must adhere to the HIPAA Privacy and Security regulations.

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

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

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

Disclose health information in medical or financial records only to the patient or legal guardian unless the patient or legal guardian authorizes the disclosure to another person or organization, or a court order has been sent to the provider.

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

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

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

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

Take extra care not to discuss patient information (financial and clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

Providers' employees (including physicians) must not have unapproved access to their own records or records of anyone known to them who is not under their care. CareOregon staff adheres to the HIPAA-mandated confidentiality standards.

Release of Information

Providers must obtain an authorization to release individually identifiable health information whenever information is released about the patient, unless the release is for payment, treatment of the patient, or the health care operations of another organization that is providing health care or payment for health care for the patient.

- A general release of information form is not necessary for CareOregon Dental and the providers to communicate regarding treatment or payment for treatment of CareOregon Dental members, according to HIPAA privacy regulations.
- The general authorization form is not valid for HIV, STD, genetic, mental health or alcohol and drug treatment information. Do not release this information unless the member signs an authorization specifying that these types of records may be released.

Credentialing

When contracting with CareOregon Dental, the following providers are subject to the credentialing process:

- Dentists
- Denturists
- Expanded Practice Dental Hygienists with a Collaborative Practice Agreement
- Dental Therapists with a Collaborative Practice Agreement

During the credentialing process, the CareOregon Credentialing Committee may deny, suspend or terminate a provider's participation with the plan. The Fair Hearing Policy outlines the process for providers to appeal and/or challenge an adverse action. Fair hearing is offered to both initial and recredentialed providers.

It is the responsibility of the provider to notify CareOregon of any changes in the available

rendering providers and to submit appropriate credentialing information as per contract requirements. Failure to do so will result in reimbursement at non-participating rates.

If you have questions, contact the Dental Access Team.

Initial Credentialing

Prospective CareOregon Dental providers must submit to CareOregon a signed and dated Oregon Practitioner Credentialing Application (OPCA) along with other documentation. The CareOregon Dental and Credentialing Departments will work with new and existing providers to obtain the necessary documents needed to complete the process. **IMPORTANT**: The applicant must inform CareOregon Dental within 30 days if changes occur to any statements on the application.

CareOregon's Credentialing Committee reviews the initial application documents including the provider's application, attached documents, verification of state licensure, National Practitioner Data Bank report, closed claim reports, license action report, Medicare Opt-Out Report, any patient complaints about the provider and site visit reviews (for PDPs only). They may request additional information, if necessary, and will recommend acceptance or rejection of the application. The CareOregon Network and Quality Committee (a subcommittee of the board) grants final approval.

Recredentialing

All credentialed providers are recredentialed at least once every three years. Ninety days before the provider's recredentialing date, the CareOregon Credentialing Department sends a recredentialing packet to the provider.

The CareOregon Credentialing Committee considers this information with the National Practitioner Data Bank inquiry results, closed claim reports, license action report, Medicare Opt-Out Report and member complaints.

Failure to provide recredentialing information in a timely manner may be brought to the attention of the CareOregon Credentialing Committee. Noncompliance may result in a recommendation to send the provider a notice of termination.

Provider Rights

CareOregon Dental considers it essential to maintain a provider panel that has the legal authority, relevant training and experience to provide care for all members. Provider rights ensure that all participants are aware of their rights during the credentialing process. CareOregon Dental advocates for provider rights to be readily accessible and understandable to all providers, available at the time of initial credentialing and at the beginning of each recredentialing cycle. This policy applies to all records maintained on behalf of CareOregon Dental, including the credentials and performance improvement files of individual providers. Peer references, recommendations, or other peer review protected information is excluded from this list of rights. CareOregon Dental's process adheres to standards established by the National Committee for Quality Assurance (NCQA), Medicare Manual, Ch. 6, and Oregon Administrative Rules.

CareOregon has adopted the following Provider Rights that shall apply to all contracted professional providers. It is the right of each participating provider involved in the credentialing/ recredentialing process:

- To be free from discriminatory practices such as discrimination based solely on the applicant's race, ethnicity, gender, gender identity, national identity, age, sexual orientation, or other types of procedures or by the type of patients the provider specializes in. Providers are free from discrimination based on serving high-risk populations or specializing in conditions that require costly treatment.
- To have the right to be notified in writing of any decision that denies participation on the CareOregon panel.
- To be aware of applicable credentialing/recredentialing policies and procedures.
- To review information submitted by the applicant to support the credentialing application.
- To correct erroneous information submitted by third parties that does not fall under the Oregon Peer Review Statute protections (Section 41.675).
- To be informed of the status of the provider's credentialing or recredentialing application on request, and to have that request granted within a reasonable period of time.
- To be notified of these rights via Provider Rights Policy and Procedure and by other means.

Organizational Credentialing

CareOregon credentials institutional providers or suppliers such as hospitals, skilled nursing facilities, home care agencies, behavioral health services, clinical laboratories, outpatient speech and physical therapists, ambulatory surgery centers, end stage renal disease services, outpatient diabetes self-management training, portable X-ray providers, rural health centers and Federally Qualified Health Centers. A standardized application is used for this process.

CareOregon assesses organizations to ensure that each facility is in good standing with state and federal regulatory bodies and/or reviewed and accredited by an approved body. Hospitals, home health agencies, skilled nursing facilities and freestanding surgical centers must also be reviewed and/or approved by an accrediting body.

Claims, Billing and Payment

Please use the standard American Dental Association (ADA) claim form (2006 or newer).
To submit claims electronically, use EDI Payer ID 93975.

Contact your practice management system vendor or clearinghouse to initiate electronic claim submission. CareOregon accepts HIPAA-compliant 837 electronic claims through our clearinghouse, Change Healthcare. Change Healthcare will validate the claims for HIPAA-compliance and send them directly to CareOregon. Change Healthcare offers several solutions for providers without a practice management system or clearinghouse. Contact them at 866-369-8805 for medical claims and 888-255-7293 for dental claims.

When submitting claims to CareOregon Dental, you have two options:

Send claims electronically using our payer ID 93975. Please contact Change Healthcare at 877-363-3666 for more information.

Mail paper claims to:
CareOregon Dental
PO Box 40328
Portland, OR 97240-0328

Submit Claims

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

For claim inquiries, you have several options:

- Send your claims inquiries by email to claimshelp@careoregon.org. Note: All emails containing protected health information (PHI) must be sent securely. We are unable to respond to emails that are not sent securely.
- Call 503-416-1444 or 888-440-9912. Press option 3 for provider.
- Fill out the Provider Claim Appeal form ***careoregondental.org/docs/default-source/providers/behavioral-health/bh-forms/provider-post-service-claim-reconsideration-appeal.pdf?sfvrsn=5b968fb3_3***

The Provider Portal application is a confidential online system that allows clinics and vendors to check the status of their CareOregon Dental claims and verify member eligibility.

To register for The Provider Portal, visit:
healthtrioconnect.com/register/nonmember/SelectPayer?xsesschk=&portal=Provider

Payment

You will receive paper checks unless you sign up with our vendor for Electronic Funds Transfer (EFT) payments. CareOregon contracted with Zelis for ePayments in July 2023. For more information, see the section "Submitting claims and receiving payment" on our website at ***careoregon.org/providersupport***

Authorizations

CareOregon Dental denies claims submitted for services that require a referral if the referral was not obtained. (See the Referrals section for more information on referral requirements.)

If you have any questions, please contact CareOregon Customer Service at 503-416-1444 or toll-free at 888-440-9912.

Timely Filing

Eligible claims for covered services must be received within 120 days after the date of service.

If a claim meets one of the following criteria and proof is submitted, CareOregon may choose to waive the 120-day timely filing rule:

- Newborns
- Other insurance coverage
- Maternity-related expenses

- Claims denied by Workers' Compensation
- Claims processed or adjusted after retroactive eligibility changes (the absence of legal capacity is the only exception to this policy)

Timely Payment

CareOregon pays the provider by the 45th day after a clean claim is received.

A clean claim can be processed accurately without additional information. For example, information is complete and correct and all CDT codes are valid.

Claims Appeals

Contact CareOregon's Claims Department to appeal an action. An action, as applied to the Prepaid Health Plan, includes but is not limited to the denial, in whole or in part, of payment for service.

Reconsideration for Payment

- Denied for missing information/documentation not including authorization related denials
- Duplicate claims
- Timely filing denials

Post-Service Provider Claim Appeal

- Previously upheld reconsiderations for payment
- Authorization related denials
- Contract rate
- Excluded benefits

IMPORTANT: CareOregon must receive appeals no more than 365 days after the date the claim was paid or denied.

Submit provider reconsideration/appeal requests in writing by completing the Provider Post Service Claim Reconsideration/Appeal Form. Include the reason for the dispute and any relevant information and/or documentation related to the dispute. If the claim was denied because of authorization issues, please send current medical documentation with the appeal.

Mail or fax written claim appeals to:
CareOregon Claims Department
Attn: Provider Appeals Coordinator
PO Box 40328
Portland, OR 97240-0328

Fax to Provider Appeals Coordinator at 503-416-8112 or toll-free to 800-874-3916.

CareOregon resolves the appeal and sends a notice of determination to the provider no later than 45 calendar days after the day the appeal is received.

An extension of 14 calendar days may be granted if either the provider or CareOregon requests it and if the extension meets criteria defined in the Oregon Administrative Rules.

Coordination of Benefits

If there is a primary carrier, such as private insurance, and CareOregon Dental is the secondary payor or for any third-party resources paying as primary (i.e., workers' compensation, MVA), submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received. Claims must be received within 120 days from the date the claim was processed on the primary EOB.

For third-party resources, include detailed information documenting payment, allowances and claim denial reason if applicable.

Calculating Coordination of Benefits

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

For clients with other third-party resources, CareOregon Dental compares our payment to the other carrier's payment to determine amount payable.

If CareOregon Dental's payment is equal to or less than the other carrier's payment, the benefit is zero.

If CareOregon Dental's payment is greater than the other carrier's payment, CareOregon Dental pays the difference, but does not exceed the patient's responsibility.

EXAMPLE #1

Total billed	$100
Other plan paid	$40
Patient responsibility	$60
CareOregon normal benefit	$80
CareOregon pays	$40

EXAMPLE #2

Total billed	$100
Other plan paid	$40
Patient responsibility	$60
CareOregon normal benefit	$0
CareOregon pays	$0

EXAMPLE #3

Total billed	$100
Other plan paid	$24
Patient responsibility	$76
CareOregon normal benefit	$65
CareOregon pays	$4

Clinical Editing

CareOregon Dental uses a clinical editing system to ensure the efficiency and accuracy of our claims payment system.

Actions of the clinical editing system include:

- Rebundling lab, X-ray, medicine, anesthesia and surgical procedure codes.
- Denial warning message when surgery is inconsistent with the diagnosis.
- Denial warning message on claims when a patient's age does not fall into the normal age range for the procedure or diagnosis.
- Denial of a procedure considered integral to another billed procedure.
- Denial of procedures not customarily billed on the same day as a surgical procedure.
- Denial of services normally included as follow-up care associated with a surgical procedure.

Valid exceptions to clinical editing exist. CareOregon Dental reviews records for unusual or extraordinary circumstances that may influence the benefit.

Member Billing

State and federal regulations require that a provider accepting Medicaid payment accept it as payment in full. Furthermore, they are prohibited from billing Oregon Health Plan recipients for missed appointments and OHP-covered services, except for coinsurance, copayments and deductibles expressly authorized by the General Rules, OHP Rules and/or federal rules.

As allowed by 42 CFR 447.15 and per Oregon Administrative Rule, members cannot be billed for the following covered services:

- Services that were denied due to lack of an authorization
- Services that were denied because the member was assigned to a PDP other than the one who rendered the services
- "Balance billing" for the amount not paid to the provider by CareOregon Dental

Generally, a provider may legally bill an Oregon Health Plan recipient in the following two circumstances:

1. The service provided is not covered by the OHP and the member signed an OHP Client Agreement to Pay for Health Services form before the member was seen. This form can be found at ***careoregon.org/external-document-links/cod-provider-manual/dhs-form-he3165*** and ***Appendix B***.
   - The form must include the specific service that is not covered under the OHP, the date of the service and the approximate cost of the service. The estimated cost of the covered service, including all related charges, cannot exceed the maximum DMAP reimbursable rate or managed care plan rate.
   - The form must be written in the primary language of the member.

2. The member did not tell the provider that they had Medicaid insurance and the provider tried to obtain insurance information.
   - The provider must document attempts to obtain information on insurance or document a member's statement of non-insurance.
   - Billing or sending a statement to a member does not qualify as an attempt to obtain insurance information.

Community-Based Dental Services

All claims for community-based services in Clackamas, Multnomah and Washington counties (i.e., school-based dental sealant programs and Head Start programs) must be made to All Smiles Community Oral Health. CareOregon Dental will zero-pay any claim received for community-based dental services in the tri-county area and use the remit message 109: "Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor."

Overpayment Recovery

CareOregon Dental uses an auto-debit system to recover identified overpayments.

When an overpayment is identified, the appropriate group of claims is reversed and claims payments are automatically debited until the outstanding overpayment balance is settled.

If there are insufficient funds to recover the overpayment, the debit is carried over to future claims payments until recovery is satisfied.

Locum Tenens Claims and Payments

CareOregon Dental allows licensed providers acting in a Locum Tenens capacity to temporarily submit claims under another licensed provider's NPI number when that provider is on leave from their practice for less than 60 days. The Locum Tenens provider must have the same billing type or specialty as the provider on leave, e.g., a dentist must substitute for another dentist.

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

If the Locum Tenens may work longer than 60 days, the standard CareOregon Dental credentialing process applies.

DMAP ID Number

As a contracted CareOregon provider serving OHP members, providers must have an active DMAP ID in order to maintain contract status and be eligible for payment. Prior to processing a claim, the rendering and billing provider's National Provider Identifier (NPI) must be verified as eligible to receive payment by DMAP and be enrolled with an ID number. The DMAP ID number is considered a minimum requirement for claims processing and must be maintained.

A rendering or billing provider's DMAP ID can be inactivated due to a number of reasons, such as license expiration, returned mail, etc. As a contracted CareOregon Dental provider serving OHP members, you must have an active DMAP ID in order to maintain your contract status and be eligible for payment by DMAP.

To verify your active enrollment status with Oregon Medicaid, click on the following link: ***or-medicaid.gov/ProdPortal/Home/ValidateNPI/tabId/125/Default.aspx***

- Enter the provider NPI and date of inquiry (e.g. date of service).
- Click on **search** button.

If the provider NPI is not actively enrolled for the date of service entered, submit claims to CareOregon and simultaneously complete and submit the Oregon Medicaid ID Application Form located under "Provider forms" on our website.

CareOregon will enroll the NPI and automatically reprocess any previously denied claims received with the dates of service within the previous calendar year for that reason. CareOregon does not enroll out-of-area and non-participating providers without first receiving a claim; it is appropriate to submit both claims and DMAP ID Application Form simultaneously. CareOregon will not enroll providers until a claim has been received. Incomplete Oregon Medicaid ID Application Forms received will not be processed.

Medicare Enrollment

In April 2018, the Centers for Medicare and Medicaid Services rescinded Section 6405 of the Affordable Care Act, in which all physicians and eligible professionals—including dentists and oral surgeons—who prescribe Part D covered drugs were required to enroll in Medicare, or opt-out for those prescriptions to be covered under Part D. CMS removed this requirement to "reduce as much burden as possible for providers." Instead, CMS is compiling a Preclusion List of prescribers, individuals and entities currently revoked from Medicare, or under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program. Part D plan sponsors will be required to reject, or require its pharmacy benefit manager to reject, a pharmacy claim for a Part D drug if the prescribing provider is included on the Preclusion List.

CareOregon Dental wishes to make available the option for providers to enroll in Medicare should they choose. Providers can enroll in Medicare by using the online PECOS (Provider Enrollment, Chain and OwnershipSystem) or by completing a paper 855O application at: ***pecos.cms.hhs.gov/pecos/login.do#headingLv1***

Fraud, Waste and Abuse (FWA)

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

CMS fraud, waste and abuse training can be found on our website at ***careoregondental.org/providersupport***

Discharge and Disenrollment Guidelines

Definitions

- Discharge: A member is removed from the care of their assigned PDP.
- Disenrollment: A member is removed from their dental plan.
- Verbal abuse: Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

Requirements

CareOregon Dental must follow the guidelines established by the Department of Human Services (DHS) regarding disenrolling members from the plan.

Although there are general DHS guidelines for discharging a member from a provider, CareOregon Dental is responsible for establishing specific discharge policies and procedures.

The CareOregon Dental philosophy is to encourage members and their providers to resolve complaints, problems and concerns at the clinic level. However, before discharging a member or requesting that a member be disenrolled from CareOregon Dental, the PDP shall request CareOregon's involvement to help resolve the problem or concern.

If the clinic management decides to discharge the member:

1. Send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number.
2. Fax a copy of the discharge letter to 503-416-8117, Attn: Enrollment Department, or secure email to MedicaidEligibilityServices@careoregon.org. If any of the above information is missing, CareOregon Dental may not process the discharge and the letter will be returned to the clinic.

IMPORTANT: PDPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

Key Points When Considering Discharging a Member

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

- Timely, early communication and collaboration with CareOregon Dental staff to problem solve.
- Thorough documentation of events, problems and behaviors.
- A plan generated by the PDP to attempt to address the problem or concerns.
- Using contracts and case conferences to address problems and concerns.
- Considering mental health diagnoses as part of the discharge and disenrollment process.

Just Causes for Discharging a Member

A member may be discharged from a PDP or disenrolled from CareOregon Dental only with just cause. Just causes identified by DHS include but are not limited to the following:

- Missed appointments (except prenatal care patients)
- Drug-seeking behavior
- The member commits or threatens an act of physical violence directed at a provider or property, clinic or office staff, other patients or CareOregon Dental staff
- Verbal abuse
- Discharge from PDP by mutual agreement between the member and the provider
- Agreement by the provider and CareOregon Dental that adequate, safe and effective care can no longer be provided
- Fraudulent or illegal acts committed by a member, such as permitting someone else to use their medical ID card, altering a prescription or committing theft or another criminal act on any provider's premises

Note: The provider or provider staff must report any illegal acts to law enforcement authorities or to the Oregon Department of Human Services as appropriate. Call the Fraud Hotline at 888-FRAUD01 (888-372-8301).

When a Member Cannot Be Discharged

According to DMAP Administrative Rule 410-141-0080, members cannot be discharged or disenrolled solely because of any of the following reasons:

- The member has a physical or mental disability.
- The member has an adverse change in health.
- The PDP or CareOregon Dental believes the member's utilization of services is either excessive or lacking or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises their option to make decisions regarding their medical care and the provider/plan disagrees with the member's decisions.

Appendix A

Discharging a Member

Follow these procedures to discharge a member from a PDP or to request disenrollment of a member from CareOregon Dental.

Process for discharging a member

MISSED APPOINTMENTS

Responsibilities and actions

PDP or PDP Staff:

1. If a member misses an appointment, consider sending a letter to the member emphasizing the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation.
2. If a member misses two appointments in a row after the initial office visit or three appointments over a six-month period, send a letter informing the patient that they must contact the clinic manager or other designated staff person before the member can receive further care.
3. Meet with the member. Ask the member to sign a completed contract outlining that they must contact the clinic manager or other designated staff person.
4. Fax a copy of the signed contract to the member's caseworker.
5. If the clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.
6. Fax or secure email a copy of the discharge letter and any relevant documentation including chart notes, copies of letter(s) sent to the member, signed contracts and/or documentation of case conferences to **503-416-8117**, Attn: Enrollment Department or: ***MedicaidEligibilityServices@careoregon.org***

IMPORTANT:
PDPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

7. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Process for discharging a member

DRUG-SEEKING BEHAVIOR

Responsibilities and actions

PDP or PDP Staff:

1. Meet with the member to develop a plan to address possible drug-seeking behavior and document meeting. Consider chemical dependency treatment.

CareOregon Pharmacy Staff:

2. At the PDP's request, restrict the member to one or more designated pharmacies and/or one or more designated prescribers.

PDP or PDP Staff:

3. Document any contract violation in member's medical record.
4. If the provider cannot manage the member's care, try to find another provider within the dental clinic to manage the member's care.

   If another provider is not available within that clinic and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, CareOregon may not process the discharge and the letter will be returned to the clinic.
5. Fax or secure email a copy of the discharge letter to CareOregon, **Attn: Enrollment Department, 503-416-8117** or: ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:

   PDPs must provide urgent care for the discharged member for 30 days following notification of the member.

CareOregon Enrollment:

6. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Process for discharging a member

MEMBER COMMITS OR THREATENS ACTS OF PHYSICAL VIOLENCE AND/OR COMMITS FRAUDULENT OR ILLEGAL ACTIVITIES

Responsibilities and actions

PDP or PDP Staff:

1. Immediately contact the police to file an official report.
2. Contact CareOregon care coordinator to describe the incident.
3. Fax chart notes and police report when available to care coordinator.

A member may be discharged in the following situations:

- Member commits act of violence to staff, property or other patients.
- Member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation. This includes but is not limited to acts of theft, vandalism and/or forgery.

CareOregon Care Coordinator:

4. At care coordinator's discretion, contact DMAP Coordinator by phone to request disenrollment of member.
- Fax written documentation to DMAP.
- Inform PDP of DMAP decision regarding disenrollment.
- If DMAP or Care Coordinator decides that disenrollment is not necessary, work with PDP to plan the discharge process and work with CareOregon Customer Services to assign the member to a new PDP.

PDP or PDP Staff:

5. If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.
6. Notify the CareOregon care coordinator and fax or secure email a copy of the discharge letter to CareOregon, Attn: Enrollment Department, 503-416-8117 or ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:
   PDPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

7. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Process for discharging a member

VERBAL ABUSE – MENACING AND/OR VERBAL ASSAULT

Responsibilities and actions

Verbal abuse is abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

PDP or PDP Staff:

1. Document incident(s).
2. At discretion of clinic manager, contact police to file an official report.
3. If police report was filed, fax chart notes and police report to CareOregon care coordinator.
4. If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, CareOregon may not process the discharge and the letter will be returned to the clinic.
5. Fax or secure email a copy of the discharge letter to CareOregon, Attn: Enrollment Department, 503-416-8117 or: ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:
   PDPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

6. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

CareOregon Care Coordinator:

7. At care coordinator's discretion, contact OHA by phone to request disenrollment.
8. Fax documentation to DMAP.
9. Inform PDP of DMAP decision regarding disenrollment.

Process for discharging a member

VERBAL ABUSE – VULGAR LANGUAGE

Responsibilities and actions

PDP or PDP Staff:

1. Document incident(s) in member's chart.
2. Schedule a meeting with the member to negotiate a behavioral contract that clarifies expected behavior and consequences for violations.
3. If contract is repeatedly violated, and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, CareOregon may not process the discharge and the letter will be returned to the clinic.
4. Fax or secure email a copy of the discharge letter to:
   CareOregon, Attn: Enrollment Department, 503-416-8117
   or: ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:
   PDPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

5. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Process for discharging a member

DISCHARGE FROM PDP BY MUTUAL AGREEMENT BETWEEN THE MEMBER AND THE PROVIDER

Responsibilities and actions

PDP or PDP Staff:

1. Document date and reason for mutual decision.
2. Try to find another provider within the dental clinic to manage the member's care.
3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, CareOregon may not process the discharge and the letter will be returned to the clinic.
4. Fax or secure email a copy of the discharge letter to CareOregon, Attn: Enrollment Department, 503-416-8117 or: ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:
   PDPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

5. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Process for discharging a member

PROVIDER AND CAREOREGON AGREE THAT ADEQUATE, SAFE, EFFECTIVE CARE CAN NO LONGER BE PROVIDED FOR A MEMBER

Responsibilities and actions

PDP or PDP Staff:

1. Document date and reason for mutual decision.
2. Try to find another provider within the primary care clinic to manage the member's care.
3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address and client number. If any of the above information is missing, the discharge may not be processed by CareOregon and the letter will be returned to the clinic.
4. Fax or secure email a copy of the discharge letter to CareOregon, Attn: Enrollment Department, 503-416-8117 or: ***MedicaidEligibilityServices@careoregon.org***

   IMPORTANT:
   PDPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

CareOregon Enrollment:

5. Send CareOregon PDP discharge letter to member, terminate clinic assignment 30 days post notification, add discharge attribute to all applicable dental clinics.

Appendix B

OHP Client Agreement to Pay for Health Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, *services* include, but are not limited to, health treatment, equipment, supplies and medications.

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the provider who is providing the service)* ☐ Prescribing provider
☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Services requested:

Service codes *(CDT/CPT/HCPCS/NDC)*:

③ Expected date(s) of service:

④ Condition being treated:

⑤ Estimated fees $ To $. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of this service.
☐ There may be other costs that are part of this service and you may have to pay for them, too. Other procedures that usually are part of this service may include the following (*check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other:

⑥ ☐ As the rendering or prescribing provider:

- I have tried all reasonable covered treatments for your condition.
- I have verified that the proposed services are not covered.
- I have informed you of covered treatments for your condition, and you have selected a treatment that is not covered.

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.
☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: NPI:

Provider signature: Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand:

- That the services listed above are not covered for payment by OHP, my CCO or managed care plan.
- If I get the services above I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- I have read the back of this form and understand my other options.

I have been fully informed by the provider of all available medically appropriate treatment, including services that may be paid for by the Division of Medical Assistance Programs (DMAP) or DMAP-contracted CCOs or managed care plans, and I still choose to get the specified service(s) listed above.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the service is scheduled within 30 days of the member's signature.

Client – Keep a copy of this form for your records.

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Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure the service is not covered by OHP or your coordinated care organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to make sure the service is not covered***

DMAP, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and or Hearing***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html.

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Contact Customer Service:
503-416-1444 or 800-440-9912
TTY: 711
Hours: 8 a.m. to 5 p.m.
Monday-Friday

careoregondental.org

COD-24873221-1115