Samaritan Health Plans

Provider Manual

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Welcome

It is our pleasure to welcome you as a contracted provider for Samaritan Health Plans (SHP) and/or InterCommunity Health Network Coordinated Care Organization (IHN-CCO). We value your commitment to our members and appreciate your service.

We are an organization dedicated to meeting the health care needs of each of our members. Our mission is to coordinate the management of quality integrated health care services for individuals and the communities we serve. We ensure this coordination through our values of Leadership, Respect, Customer Experience, and Collaboration.

We look forward to working in partnership with you to improve the health care system and to provide a positive experience for your patients who have health care coverage through one of our health insurance plans.

About this Manual

The Provider Manual has been developed exclusively for our contracted providers. Please note that the content herein is subject to change at SHP's discretion.

We developed The Provider Manual as a guide to help you find and access resources that aid in delivering quality health care to your patients (our members!). This manual should be used in conjunction with your contract with SHP or IHN-CCO.

Contact Us

We hope that you find this manual helpful and welcome your feedback. If you have any suggestions, questions, or concerns, please contact us**.**

Samaritan Health Plans

2300 NW Walnut Blvd.
Corvallis, OR 97330
Monday – Friday, 8 a.m. to 5 p.m. PT

By mail:
P.O. Box 1310
Corvallis, OR 97339

Provider Services
Monday – Friday, 8 a.m. to 6 p.m. PT
Corvallis: (541) 768-5207
Toll-free: 1-888-435-2396
SHPprovider@samhealth.org

Resources

We view health care as a team effort, with you as our partners in improving the health of our members. To support this collaboration and help you in your success, we have developed a variety of resources just for providers, listed below.

Provider Website

SHP's provider website, providers.samhealthplans.org, is accurate and frequently updated and will serve as your greatest resource. We encourage you to get to know our website and use it regularly to ensure that you have the most up to date information on:

- **Benefits and Eligibility** – Conveniently access information on benefits, formularies, eligibility, appeals, news, prior authorizations, and more when you visit providers.samhealthplans.org/billing/benefits-and-eligibility.
- **Claims and Billing** – Submit claims, enroll in Electronic Funds Transfer, and access reimbursement guidelines at providers.samhealthplans.org/billing.
- **Authorizations** – To access prior authorization lists and forms, visit providers.samhealthplans.org/care-management/authorizations.
- **Provider Directories** – To view provider directories for Samaritan Advantage, Samaritan Choice, Employer Group and IHN-CCO, visit samhealthplans.org.
- **Pharmacy and Formularies** — View and search all of our plans' formularies at providers.samhealthplans.org/care-management/pharmacy.
- **Appeals** — Learn about appeal requirements, access guidelines, and review timeframes to appeal at providers.samhealthplans.org/working-with-samaritan-health-plans/appeals.
- **Medical Policies and Clinical Guidelines** — Review clinical practice guidelines, access case management services, and view medical record documentation standards by visiting providers.samhealthplans.org/care-management/clinical-resources.
- **News and Articles** — Get the latest news on policy changes, guidelines, new provider tools, authorization criteria, metrics, billing and more at providers.samhealthplans.org/support/news-and-articles-for-providers.

Provider E-News

Stay in the know: Subscribe to our monthly Provider E-News at providers.samhealthplans.org/support/subscribe-to-provider-news. Provider E-News offers timely information about plan changes, education and training, quality metrics and other industry-related topics.

Provider Connect (Provider Portal)

Log in to your provider portal at providers.samhealthplans.org/support/provider-portal to:

- See payment details for all of your claims.
- Search claims information by provider, member or date of service.
- Submit your prior authorization requests online and check their status.
- Get the details you need for coordination of benefits (COB) for your patients.
- Update Primary Care Provider (PCP) assignments.

Glossary of Terms

Affiliate: A company in which SHP or any parent or subsidiary corporation of SHP owns 51% or more of the voting stock or other ownership interest.

Clean Claim: A clean claim shall be one that is (a) submitted within the time frames set forth in the provider agreement and *The Provider Manual*, (b) contains appropriate and sufficient medical and patient data to allow SHP to pay the claim, (c) does not involve a coordination of benefits issue or subrogation, (d) is submitted electronically in accordance with the formatting and submission requirements that may be established by SHP from time to time, and (e) has no defect, error, impropriety or other circumstance that would prevent the timely processing of the claim.

Coordination of Benefits: The allocation of financial responsibility for payment of covered services between two or more payers.

Coinsurance: Coinsurance refers to the percentage cost of a covered service that a member is required to pay for covered services under the member's plan.

Copayment: Copayment shall refer to a charge required under the member's plan that must be paid by the member at the time they receive covered services.

Covered Services: Covered services refers to medically necessary health care services and supplies that are (a) within the scope of a provider's license and practice, (b) routinely provided to patients by a provider, (c) covered under the terms of the member's plan, and (d) provided in accordance with the terms and conditions of the provider agreement.

Credentialing: This refers to a process of screening, selecting and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status, and judgment.

Deductible: A deductible is the amount that a member must pay for covered services for a specified period in accordance with the member's plan before benefits will pay. A deductible is not coinsurance or copayment.

Emergency or Emergency Medical Condition: An emergency or emergency medical condition refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) that would lead a prudent layperson to believe that the absence of immediate medical attention would result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or unborn child), (b) serious impairment of bodily functions, or (c) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions: (a) there is inadequate time to affect a safe transfer to another hospital before delivery, or (b) a transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services: Emergency services are those provided to treat an emergency or emergency medical condition, as covered by the terms of the member's plan.

Experimental or Investigational Procedures: These procedures are also known as unproven therapies. As determined by SHP, experimental or investigational procedures are services, supplies, drugs or devices that are not recognized as standard medical care for the condition, disease, illness or injury being treated, including non-FDA approved drugs or therapies.

Formulary: A list of medications that are eligible for coverage under the terms of a member's plan.

IHN-CCO: InterCommunity Health Network Coordinated Care Organization

Medically Necessary/Medical Necessity: Medically necessary and medical necessity refers to health care services and supplies that SHP determines are required to treat a member's condition and are authorized by the terms of the member's plan. All determinations of medically necessary and/or medical necessity shall be made in accordance with SHP policies, the Provider Agreement and *The Provider Manual*. Any service that is determined to be not medically necessary is considered to be a non-covered service.

Member: A member is a person who is eligible to receive covered services under his or her plan at the time the provider renders services pursuant to the Provider Agreement.

Member Encounter Data: Member encounter data refers to the specific data collected during a patient encounter, or a series of patient encounters, that substantiates a member's health condition or disease.

Non-Covered Services: Non-covered services are services that are determined by SHP to be not medically necessary. They are not covered by the member's plan. SHP is not required to reimburse providers or pay any claims related to a non-covered service.

Non-Participating Provider: A Non-participating provider is any person or entity that provides otherwise covered services, but who has not entered into an agreement with SHP.

Participating Provider: A participating provider is any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into an agreement with SHP to provide covered services to SHP's members, and who has been credentialed by SHP or its designee.

Payer: Payer shall mean an employer, insurer, health maintenance organization, labor union, SHP, IHN-CCO, and/or any other person or entity which has agreed to be responsible for funding benefit payments under the terms of the plan.

Plan: "Plan" refers to any health benefit product or plan issued, administered, or serviced by SHP or any of its subsidiaries or affiliates, including, but not limited to, commercial health insurance products, Medicare Advantage, and Medicaid.

Plan Allowable: This refers to the lessor of (1) billed charges or (2) total allowed amount as determined in the applicable rate exhibits and any plan limitations relating to covered services, such as prior authorization requirements. In consideration of medically necessary covered services that a provider renders to members, SHP shall reimburse the provider for timely filed clean claims up to a maximum amount of the plan allowable.

Primary Care Physician or Primary Care Provider: A primary care provider, also known as primary care physician (PCP), refers to a participating provider who is duly licensed to practice medicine and who has the primary responsibility for providing primary care services to members. A PCP may be a general practitioner, internist, pediatrician, obstetrician, gynecologist, family practitioner, or any other specialty that has been approved to act as a PCP pursuant to the Oregon Revised Statutes.

Prior Authorization: Prior approval obtained by a provider from SHP for covered services defined by SHP requiring authorization for payment.

Provider: This refers to the person or entity that has executed the Provider Agreement, as indicated on the signature page, and who has met all credentialing and/or re-credentialing requirements. In the event the provider is a group of health care service providers, the term shall encompass all the providers associated with the provider executing the Provider Agreement.

Proprietary Information: Proprietary information refers to information that has been developed or belongs to SHP or a related payer, which is intended to remain confidential. This information includes, but is not limited to, the Provider Agreement, mailing lists, patient lists, employer lists, payer rates and procedures, product related information and structure, utilization review processes and procedures, quality improvement processes and procedures, and any other information which SHP marks as proprietary or confidential, or which SHP reasonably believes is proprietary or confidential.

Quality Improvement Program: The Quality Improvement Program (QIP) is a program designed by SHP to monitor the quality of care and services that are received by SHP members as covered services.

Regional Health Information Collaborative (RHIC): RHIC refers to the electronic health information exchange infrastructure that has been developed by IHN-CCO in conjunction with community stakeholders and medical service providers.

SHP: Samaritan Health Plans

Subrogation: The process by which SHP may recover from another insurance carrier benefits paid on behalf of a member, where the legal obligation to pay benefits with regard to a claim rests with the other carrier.

Samaritan Health Plans

Samaritan Choice Plans

Samaritan Health Services (SHS) offers Samaritan Choice Plans (SCP) to its own employees and their dependents. SCP is the self-funded health benefit plan that provides coverage to over 12,000 SHS employees and their dependents.

Samaritan Choice Plans offers a standard medical plan, a high-deductible medical plan option, and a vision plan option. A pharmacy plan is included with the medical plans. View all SCP plan benefits and access our provider directory at choice.samhealthplans.org .

InterCommunity Health Network (Medicaid)

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (OHP) members in Linn, Benton and Lincoln Counties. Although IHN-CCO's contract with the State of Oregon is not exclusive, it is currently the only CCO in these three counties that administers OHP, which provides access to health insurance for Medicaid-eligible, low-income residents. IHN-CCO currently serves more than 54,000 OHP members.

View all contracted providers in the provider directory at IHNtogether.org/find-care.

IHN-CCO offers three packages for members depending on the level of care individual members need: comprehensive (medical, mental health, and dental), mental health and dental, and mental health only. Find out more about plan benefits at IHNtogether.org/your-benefits.

Providers serving our IHN members are required to verify that the member is eligible on the date of service before rendering services, and that the service to be rendered is covered under the OHP Prioritized List of Health Services. The provider is also required to obtain any necessary pre-authorizations or authorizations. Finally, providers must inform IHN members of any non-covered services prior to the services being delivered and must inform members of their responsibility for payment of these services. When non-covered services are performed, the member must complete an OHP Client Agreement to Pay for Health Services, in advance, as defined in OAR 410-120-0000. If a member disagrees with the provider regarding services, the provider is responsible for issuing the member his or her appeal rights.

IHN-CCO uses the OHP Prioritized List of Health Services, a listing of diagnosis and treatment pairings, to determine whether a diagnosis and/or service are considered to be part of the OHP benefit package. The Oregon Health Services Commission (HSC) designs and maintains the prioritized list under the direction of the Oregon Legislature, who determines the level to which the List will be funded in essence, diagnoses and/or treatments that are considered **below the line** are not funded by the available budget set forth by the Oregon Legislature and are therefore not considered part of the OHP benefit package. IHN-CCO plan benefits are subject to review for medical necessity via written documentation, appropriateness of treatment setting (level of care versus severity of condition) and the OHP Prioritized List condition/treatment pair ranking. For **above and below the line** diagnoses, please refer to the OHP Prioritized List of Health Services at oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx

Samaritan Advantage Health Plan HMO (Medicare)

Samaritan Advantage Health Plan HMO (SAHP) offers four plans to eligible members: Premier Plan, Premier Plan Plus, Conventional Plan and Special Needs Plan (SNP). The medical benefit is congruent across all Samaritan Advantage Health Plans.

Providers are required to verify that the client is eligible on the date of service before rendering services, and that the service to be rendered is covered under the Samaritan Advantage Health Plan. The provider is also required to confirm that the patient is enrolled in SAHP prior to rendering the service and seek any necessary pre-authorizations or authorizations. Finally, providers must inform SAHP members of any non-covered services prior to the services being delivered and must inform members of their responsibility for payment of these services. If a member disagrees with the provider, the provider is responsible for issuing the member his or her appeal rights.

Premier Plan offers the prescription benefit (Medicare Part D) in conjunction with the medical benefit.

Premier Plan Plus offers all the benefit of the Premier Plan, and also includes: dental benefit, coverage during the Medicare Rx drug coverage gap, hearing aid coverage and a DME benefit.

Conventional Plan is for eligible members who have decided not to participate in Medicare Part D. These members may not enroll in a standalone Prescription Drug Plan (PDP).

Special Needs Plan is for Medicaid eligible members who are also eligible for Medicare Part A and Part B. These members are dually enrolled and referred to as "duals." Duals have both medical benefits and prescription drug benefits. All SAHP Plan benefits are subject to review for medical necessity via written documentation or appropriateness of treatment setting (level of care versus severity of condition).

Samaritan Employer Group Plans

Samaritan Health Plans (SHP) offers employer group health plans to employers domiciled in the state of Oregon. View benefits for Small, Large and Association groups at samhealthplans.org/employers.

You can view all preferred providers in the provider directory by visiting our web site at samhealthplans.org.

Member Rights and Responsibilities

Member Rights

Members have the right to:

- Receive information about the organization, its services, its practitioners, and provider and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy.
- Participate with their healthcare provider in making decisions regarding their care.
- Candidly discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Confidential protection of their medical information and records.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Continue care from an individual provider for a limited period of time after the medical services contract terminates.
- Emergent needs are immediately assessed/referred/treated.
- Urgent, acute care is available within 24 hours.
- Non-urgent care (symptomatic) is available within 7 calendar days.
- Routine visits for chronic or ongoing medical problems are available within ten working days.
- The average wait to see a provider is less than 45 minutes.
- If a provider must cancel an appointment, the provider must make a good-faith effort to contact the member and reschedule for a later time.
- InterCommunity Health Network Coordinated Care Organization (IHN—CCO) provides members with opportunities to seek a second opinion from a qualified health care provider within the network or arranges for a second opinion outside of the network, at no cost to the member.

Member Responsibilities

Members have a responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Pay their co-pays at the time of service and to be on time for that service.
- Read and understand all materials about their health plan benefits and ensure that family members covered under their plan also understand.

Physicians and Providers

For your review, the following list of physicians and practitioners are considered eligible providers with the contingency that they meet credentialing requirements for the plan in which they seek to become in-network providers, i.e., SAHP, IHN-CCO, Samaritan Choice and Employer Groups.

Some of the providers listed below may not be eligible for certain plans. To confirm your eligibility, please contact Provider Service at providers.samhealthplans.org/contact-us.

Eligible Providers

- Acupuncturists
- Ambulatory Surgery Center
- Audiologist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Laboratories
- Dialysis Facility
- Doctor of Osteopathy
- Durable Medical Equipment
- Home Health
- Home Infusion Therapy
- Hospice
- Hospital
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Medical Doctor
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Oral Surgeon
- Physical Therapist
- Physician Assistant
- Podiatrist
- Psychiatric Nurse Practitioners
- Psychologist

- Registered Dietician
- Skilled Nursing Facility
- Speech Therapist

Contract Management

SHP provides tools and resources to support providers and ensure that we are all able to work effectively and efficiently, together. In-network providers can access and benefit from:

- Direct support for all contracting, claims and operational inquiries
- Provider trainings and educational materials
- *The Provider Manual*, which includes our policies and procedures
- Provider Directories listing all contracted providers
- Quality programs and initiatives

Credentialing

Practitioner Credentialing

Contracting is contingent on credentialing approval. SHP follows the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) requirements for credentialing providers. In order to credential practitioners and other health care professionals, SHP requires:

- Oregon Practitioners Credentialing Application
- Completed and signed Attestation and Release
- Completed and signed **Attachment A** (mark N/A if not applicable, sign and date)
- Copy of current Oregon State **license and/or registration**
- Current **DEA certificate(s)** (if applicable)
- Copy of your current liability certificate
- List of all medical **malpractice carriers** for the past 5 years, including carrier name, address, policy number, limits, and any claims history information
- Copy of board certificate(s) – preferred
- Copy of PA practice description, and Oregon Medical Board (OMB) supervising physician approval letter (if applicable)
- Copies of **medical school diploma**, and/or completion certificates from medical training – Preferred
- Copies of internship and residency **completion certificates** – Preferred

Please Note: Your credentialing application will only be processed once all required documents are received and your application is considered complete.

Exceptions: Providers are not required to be credentialed by SHP if they practice exclusively in an inpatient setting and provide care to the Plan's members as a result of the member being directed to the hospital or other inpatient setting.

Review our credentialing requirements at providers.samhealthplans.org/working-with-samaritan-health-plans/join-our-network.

Locum Tenens

A Locum Tenens arrangement is made when a participating provider must leave their practice temporarily due to illness, vacation or leave of absence. Locum Tenens is a temporary replacement for that Provider, for a specified amount of time, not to exceed 60 days. If the Locum Tenens Provider will be covering for more than 60 days, the Locum Tenens Provider is required to be credentialed.

When a participating Provider requires coverage by a Locum Tenens Provider, the practice should notify Provider Services by completing the New Provider Form located at providers.samhealthplans.org/working-with-samaritan-health-plans/update-your-information.

Facility Credentialing

In order to credential facilities, SHP requires:

- Facility Credentialing Application
- Completed and signed Attestation and Release
- W9 form (download at irs.gov/forms-pubs/about-form-w9)
- Current DEA certificate(s) (if applicable)
- Copy of Medicare and/or Medicaid certification – (if applicable)
- Copy of current state license
- Copy of your current liability certificate
- Copy of **certification** from an accredited agency

Participating Provider Identification

Update your Information

Provider and demographic changes must be reported to Samaritan Health Plans within 30 days. Visit providers.samhealthplans.org/working-with-samaritan-health-plans/update-your-

information to change your practice information, add a new practitioner, or alert us that a practitioner has left your group.

Update your Taxpayer Identification Number (TIN)

Providers must immediately notify SHP if their TIN changes. To ensure accurate IRS reporting, the TIN must match the business name reported to both SHP and the Federal government.

When you need to notify us of a change to your TIN, please complete the following steps:

- Download the IRS form W-9 at irs.gov/forms-pubs/about-form-w9.
- Complete and sign the W-9 form, following instructions exactly as outlined on the form; include the effective date.
- On a separate sheet of paper, please tell us the date SHP should begin using the new number (this is the effective date).
- Submit the completed form to SHP via fax, email or mail.

Fax: 541-768-9364

Email: SHSSHPOProviderRelationsTeam@samhealth.org

Mail: Attn: Provider Services
Samaritan Health Plans
P.O. Box 1310
Corvallis, OR 97339

Primary Care Providers (PCPs)

Responsibilities

The PCP is responsible for providing or facilitating authorizations to specialists so they can provide for the complete health care needs of the member, as applicable, based on the member's benefits. Members may select a PCP from the following providers:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics for children or Medicare eligible children
- Physician Assistant
- Nurse Practitioner

Additionally, a specialist may consider being a PCP for an established patient if the specialist is willing to assume all of the responsibilities of a PCP for that patient. Examples of this include an obstetrician becoming the PCP for their pregnant patient and an oncologist becoming the PCP

for their patient during the patient's cancer treatment program. Occasionally, SHP will allow its members to select a specialist as the member's PCP. This happens when a member has a long-standing relationship due to a particular health condition.

On-Call Policy

Participating Primary Care Providers (PCP) and Primary Care Dentists agree to accept new Samaritan Advantage Health Plan or InterCommunity Health Network patients unless the practice has closed to new patients. Participating providers agree to provide 24-hour, 7-day-a-week coverage for IHN and SAHP's members in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care or to direct members to the setting most appropriate for treatment.

Participating Primary Care Providers have the ability to monitor and track their current PCP assignment list by accessing Samaritan's provider portal, Provider Connect at https://Providerconnect.samhealth.org

Hours of Operation

Participating Health Providers shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services as accessible to InterCommunity Health Network patients in terms of timeliness, amount, duration and scope as those services provided to non-members within the same service area.

Access to Care

InterCommunity Health Plan providers must adhere to the timeliness of access to care standards related to primary care, emergent/urgent care and behavioral healthcare.

Monitoring of adherence will be conducted by the Network Strategy and Contracting Department on an annual basis via telephonic surveys, on-site visits or member complaints. Non-compliance will be reviewed by the Network Strategy and Contracting Department to identify opportunities for improvement and/or corrective action if necessary.

Primary Care Providers:

- **Preventative Primary Care Appointments** (annual visits, pediatric/adult immunizations and annual GYN exams) – Within four weeks.

- **Urgent Care Appointments** (high fever, vomiting etc.) – Within seventy-two (72) hours or as indicated in the initial screening for urgent care.
- **Emergency Care** – Same day.
- **After-Hours Care** – Provider offices must maintain 24-hour phone availability (call share, answering machine or answering service) advising members on access options.

Behavioral Health Services:

- All InterCommunity Health Plan members will have direct access to behavioral health services by contacting their primary care provider office or by going to the Emergency department.

Specialty Care Services:

- **Urgent Care Appointments** – Within seventy-two (72) hours or as indicated in the initial screening for urgent care.
- **After-Hours Care** – Provider offices must maintain 24-hour phone availability (call share, answering machine or answering service) advising members on access options.

Primary Care Dental Services:

- **Routine Care** – Within 12 weeks
- **Urgent Care** – Within two weeks or as indicated in initial exam in accordance with OAR 410-123-1060
- **Emergency Care** – Within 24 hours

Advance Directives

An Advance Directive, also called a Living Will, explains the specific medical decisions the Member wants if they have a terminal illness or injury and are incapable of making decisions about their own care, including refusing treatment. Most hospitals, nursing homes, home health agencies and HMOs routinely provide information on advance directives at the time of admission. SHP delegates its requirement as specified in 42 CFR 422.128 and OAR 410-120-1380 to ensure members receive proper communication and instruction for completing Advance Directives to its contracted providers. You have agreed to this responsibility by contracting with SHP. For more information visit providers.samhealthplans.org/support/resources.

Mental Health Advance Directives

A Mental Health Advance Directive is a legal document that allows individuals to state their mental health care wishes in advance for occasions when they may become unable to communicate heir wishes or to make their wishes known. The goals of completing the Declaration for Mental Health Treatment (DMHT) or MMental Health Advance Directives is to ensure patients are treated according to their wishes and to encourage more open dialogue between patients and their treatment providers. SHP delegates its requirement as specified in 42 CFR 422.128 and OAR 410-120-1380 to ensure members receive proper communication and instruction for completing Mental Health Advance Directives to its contracted providers. You have agreed to this responsibility by contracting with SHP. For more information visit providers.samhealthplans.org/support/resources.

Notice of Privacy Practices and HIPAA

Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) providers are responsible for safeguarding their Member's personal health information (PHI). Disclosure of any PHI is limited to the minimum necessary and a disclosure form is required prior to any release of PHI. All participating Providers are required to comply with HIPAA Privacy and Security rules and regulations.

Billing and Payment

Providers are responsible for submitting itemized claims for services provided to members in a complete and timely manner, in accordance with your provider agreement, this manual and applicable law. Providers are also responsible for ensuring that all codes submitted to SHP for payment are current and accurate, that the codes reflect the services provided, and are compliant with all industry and governmental standards. Incorrect or invalid coding may result in delays in payment, denial of payment, a post payment provider refund request or a post payment recoupment of overpaid amounts from later payments.

SHP reserves the right to review all claims submitted for accuracy and appropriateness. This review may include review of supporting documentation. Improper data submission may cause claims to pend and/or be returned for correction or documentation.

Electronic Data Interchange (EDI)

We recommend that providers submit claims via EDI for quicker claims reimbursement, improved accuracy, and to reduce or eliminate costs associated with mailing, such as envelopes and postage. To sign up for EDI, visit our billing and claims page at providers.samhealthplans.org/billing/submit-claims.

Submitting Paper Claims

For providers that submit paper claims please refer to the following standards to produce clean and legible claims, which will reduce claim rejection, speed up processing, and prevent payment delays:

- Review CMS guidelines for form **CMS 1500** at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html.
- Review CMS guidelines for form **CMS 1450** at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html.
- Submit only claim forms that are typed or printed.
- Correctly align text in the form boxes and do not allow text to overlap lines.
- All claims and attachments should be printed single sided. Do not duplex print, even on primary Explanation of Benefits (EOBs) or attachments.
- Send full page attachments only.
- Do not staple claims or attachments together.
- Mark multipage claims with either a page number, i.e., page 2 of 3, or a "continued".
- Ensure that each secondary claim has the primary EOB submitted with it.
- Do not write or stamp over top of the body of the claim form.
- Do not use white-out or cross out and correct any fields that affect the payment of the claim.
- Use black ink — the scanning process filters out red ink.
- Use the "Remarks" field for messages.
- Send the original claim form to Samaritan Health Plans and retain a copy for your records.
- Remove all perforated sides from the form; to help our equipment scan accurately, leave a quarter-inch border on the left and right sides of the form after removing perforated sides.
- Do not highlight any fields on the claim forms or attachments as highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- Print with dark font, i.e., ensure your toner or ink is fresh and do not print in "draft" mode.

Where to Mail Paper Claims

Please see providers.samhealthplans.org/billing/submit-claims to access our current mailing addresses by line of business.

If you submit paper claims, the following information must be included:

- Provider name
- Rendering provider group or billing provider
- Federal provider TIN
- NPI (excluding atypical providers)
- Medicare number (if applicable)
- DMAP number (if applicable)

Some claims may require additional attachments. When submitting a paper claim, please include all supporting documentation. Claims with attachments should be submitted on paper and attachments should be printed single sided. Claims with duplex printed attachments may be sent back for correction and resubmission.

Form Details

Full claim form details can be referenced at:

CMS 1500 - providers.samhealthplans.org/-/media/SHP/Documents/Providers/CMS1500-Requirements.pdf

CMS 1450 - providers.samhealthplans.org/-/media/SHP/Documents/Providers/CMS-1450-Instructions.pdf

Monitoring Submitted Claims

After filing a clean claim, the claim status should be available in our claims adjudication system within 10-14 business days after receipt. After filing a clean EDI claim, the claim status should be available in our claims adjudication system within two business days of receipt.

After submitting paper or electronic claims, you can monitor them by:

- Checking claim status on our secure provider portal at providerconnect.samhealth.org. Users must be subscribers of OneHealthPort in order to login. If you are not yet

subscribed to OneHealthPort, please register your organization at http://www.onehealthport.com/sso/register-your-organization. Providers that are not subscribed should click on "I'm not an OneHealthPort Subscriber but would like information on subscribing".
- Contacting Customer Service at providers.samhealthplans.org/contact-us.
- Confirming receipt of plan batch status reports from your vendor or clearinghouse to ensure your claims have been accepted by Samaritan Health Plans.
- Correcting and resubmitting plan batch status reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.

Payment

Payments are processed on a weekly basis, at the end of the week.

Electronic Funds Transfer (EFT)

SHP recommends that providers receive payment via Electronic Funds Transfer for quicker payment and to avoid lost checks (yes, it does happen).

Electronic Remittance Advice

Providers can also choose to receive ERAs, which are received through an electronic mailbox set up between Samaritan Health Plans and the provider's clearinghouse.

This option is independent of EFT. You can still receive ERAs even if you are not enrolled in EFT.

If you would prefer to receive an ERA, but do not have a billing system that can automatically load the electronic files, CMS offers Medicare Remit Easy Print (MREP) software that can be used to access and print remittance advice information from an electronic remittance advice file. You can download this software at cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html.

EFT/ERA sign up is quick and easy — enroll at providers.samhealthplans.org/billing/eft-era-enrollment. For more information, contact Samaritan Health Plans' Provider Service team.

Paper Checks

If you prefer, you can receive a paper remittance advice, which will be mailed two business days after the Thursday by which the claim is completely processed. Providers that receive both paper checks and paper remittance advices will receive them in separate envelopes.

Claims Editing and Pricing

SHP uses claims editing software developed internally and from third party vendors to assist in determining the appropriate handling and reimbursement of claims. From time to time, SHP may change this coding editor or the specific rules that it uses in analyzing claims submissions. SHP's goal is to make sure claims are accurate, and to ensure compliance with all state and federal rules and regulations, including those claims payment methodologies required for Medicare Advantage and OHP administration.

Samaritan Health Plans utilizes both the Optum EASYGroup prospective payment systems (PPS) and the Claims Editing System (CES) software to assure accuracy and consistency in claims processing for all of our product lines for both professional and facility-based claims.

This system applies all of the existing industry standard criteria and protocols for Diagnosis Related Groups (DRG), Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS) and the Internal Classification of Diseases (ICD-10_CM) manuals.

These are the three most prevalent coding irregularities that we find:

- **Unbundling:** Two or more individual CPT or HCPCS codes that should be combined under a single code or charge.
- **Mutually Exclusive:** Two or more procedures that by practice standards would not be billed to the same patient on the same day.
- **Inclusive Procedures:** Procedures that are considered part of a primary procedure and not paid as separate services.

Consistent application of these rules improves the accuracy and fairness of our payment of benefits.

The software also applies the National Correct Coding Initiative (NCCI) edits for the processing of both facility and professional claims. Our updates of the NCCI are implemented as soon as possible after receipt from Optum. However, these updates will not align with CMS; we will always be one version behind.

Prompt Pay Policy

SHP follows CMS and OHA guidance to determine claims payment timeliness for Medicare and Medicaid lines of business. These guidelines can be found in the following documents for Medicare:

- Review this at cms.gov in the Managed Care Manual Chapter 13, Section 40.1.
- Medicare Claims Processing Manual Chapter 1, Sections 80.2 and 80.3.
- OHA guidelines can be found at oregon.gov/oha/hsd/ohp/pages/index.aspx.

COB and TPL

SHP follows the National Association of Insurance Commissioners (NAIC) model regulations for coordinating benefits, except in instances where the NAIC model regulations differ from Oregon State law or from CMS regulations.

Claim Payment Appeals

If you have a question or concern about the way a particular claim was processed by SHP, please contact our Provider Service staff. If your issue cannot be resolved through this initial contact, you can submit your question as a claim payment appeal. Providers can access appeals information specific to each line of business at providers.samhealthplans.org/working-with-samaritan-health-plans/appeals.

Medical Management

Medical Management coordinates population health management, oversees and monitors care management and utilization management programs and services to coordinate, manage and evaluate the delivery of health care. The scope of the medical management program includes all behavioral health, physical and oral health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities and skilled nursing facilities (SNF), home care services, outpatient care and office visits.

Medical Coverage Policies

Medical Coverage Policies provide clinical criteria for decision-making and are developed when no appropriate external guidelines exist. Medical Coverage Policies do not determine covered benefits or whether a prior authorization is required. Medical Coverage Policies are made available to providers upon request.

Utilization Management

Prospective, concurrent and retrospective reviews are performed on a case by case basis to determine the appropriateness of care. Utilization management (UM) decisions are made by qualified licensed healthcare professionals, who have the knowledge and skills to assess clinical information, evaluate working diagnoses and proposed treatment plans. Medical Management is supported by board certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Inter-rater reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria.

Authorizations

Medical Management ensures accurate and timely processing of prior authorization related to DME, medical procedures and services including mental health and substance use disorder services. Medical Management ensures that appropriate clinical information is obtained, documents, and reviewed for all utilization management decisions. This process may include consulting with the requesting provider when appropriate. Authorizations may be submitted via fax or through the Authorization Wizard located on our online portal accessed through Provider Connect. To submit any type of authorization other than a standard request, the following conditions must be met:

- **Expedited:** Submission must indicate that waiting for a decision within the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.

- **Retroactive:** Medical Management follows state and federal regulations and contract language for review of retroactive authorization requests. As of May 1, 2019, retroactive requests will be reviewed for the extenuating circumstances listed below. If the exceptions are met, retroactive requests are processed according to the specific line of business authorization request policy. If the exceptions are not met the request will be denied. Contracted providers are not penalized for failure of a facility to provide the required inpatient admission and discharge notification. Retroactive authorization requests submitted by non-contracted providers and facilities will be accepted and processed in accordance to the line of business specific authorization request policy.

    - **Exceptions –** Retroactive authorization requests will be reviewed for medical necessity from contracted providers and facilities if:

        - The member indicated at the time of service that they were self-pay or no coverage was in place.
        - A natural disaster prevented the provider or facility from securing prior authorization or providing hospital admission notification.
        - Provider presents compelling evidence of attempt to obtain prior authorization in advance of the service. The evidence shall support the provider followed SHP policy and that the required information was entered correctly by the provider office into the appropriate system.
        - Member enrollment was entered retroactively in Facets and was not available at the time of service for the provider to obtain prior authorization from SHP.
        - Requested within 7 calendar days of service for detoxification related to substance use, an initial outpatient mental health evaluation, day treatment, psychiatric residential treatment and subacute care.
        - Requested within 7 calendar days of the date dispensed for DME items provided at an office visit.
        - Requested within 30 calendar days for DME items that require a Certificate of Medical Necessity.

For more information regarding authorizations, please visit providers.samhealthplans.org/care-management/authorizations.

Second Opinions

InterCommunity Health Network Coordinated Care Organization (IHN—CCO) provides members with opportunities to seek a second opinion from a qualified health care provider within the network or arranges for a second opinion outside of the network, at no cost to the member.

Utilization Management Disclaimer

SHP's physicians, staff and contracted dental providers make decisions about the care and services that are provided based on a member's clinical needs, the appropriateness of care and service, and the member's coverage. SHP does not make decisions regarding hiring, promoting or terminating its physicians or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. SHP does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. In order to maintain and improve the health of our members, all physicians and health care professionals should be especially diligent in identifying any potential underutilization of care or services.

Clinical Criteria

The Plan's Evidence of Coverage (EOC) or plan document, federal and state guidelines are used to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines, and company developed clinical standards are used to determine clinical and medical appropriateness of services.

The criteria are selected, developed, approved, and overseen by the Clinical Department. The Clinical Department will ensure clinical consistency and appropriateness of all criteria utilized by the Medical Management department.

Complete criteria sets are maintained electronically, and are available for reference to authorized entities, providers and members upon request.

The criteria utilized include:

- MCG CareWebQI 10.2 – assessment tools, review criteria and reporting.
- Centers for Medicaid and Medicare Services (CMS) - Coverage guidelines, a compendium of regulations, operation policy letters and manuals that are based on

medical appropriateness criteria and clinical status of the patient to support decision-making: Medicare Coverage Database.

- Samaritan Health Plans Medical Coverage Policies based on **local, regional and national practice standards**, literature, research and consensus-based policy.
- The Oregon Health Plan (OHP) Oregon Administrative Rules (**OAR**) and Oregon Revised Statutes (**ORS**) provide guidance for interpreting IHN Medicaid benefits. Oregon Health Authority (OHA) Prioritized List of HealthCare Services along with Guideline Notes as published on State of Oregon website.
- American Society of Addiction Medicine Criteria.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity, complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria.

The organization gives practitioners with clinical expertise in the area being reviewed, the opportunity to advise or comment on the development or adoption of criteria.

Peer-to-Peer Consultation

Treating providers may request a peer-to-peer conversation with SHP Medical Review to discuss reason(s) for a specific denial or adverse benefit determination of services/items. Peer-to-peer conversations may be requested via phone, email, fax or by visiting the SHP storefront.

Out-of-Network Services

When providers make a request or referral for a member to use an out-of-network provider or service, the request must indicate the reason for the medical necessity and the reason for the out-of-network referral request, e.g., no available contracted in-network provider, full provider panel, wait time to contracted provider exceeds the medical necessity of the service.

Case Management Services

Case management services are designed to promote continuity of care and effective use of resources. Case management services are voluntary and provided at no cost to the member.

Case management provides intensive, personalized management services and goal setting for members who have complex medical needs and require a wide variety of resources to manage health and improve quality of life. Services are provided in a collaborative process that assess, plan, implement, coordinate, monitor and evaluate options and services required to meet an individual's health needs using communication and available resources to promote quality, cost-effective outcomes.

Special Needs Plan Model of Care (SNP-MOC)

The Special Needs Plan Model of Care (SNP-MOC) provides a framework for quality improvement and method to ensure the unique needs of our members enrolled in our SNP are identified and addressed. SHP also contracts with the Oregon Health Authority to operate the Medicare Advantage Dual Special Needs Plan (D-SNP) for members dually eligible for Medicare and Medicaid. The goal is to ensure effective coordination of care and payment to effectively support the special health care needs of this vulnerable population. The MOC provides care coordination and case management services for all SNP members. Case Managers talk with members by phone and work on identifying problems, goals and opportunities as well as capturing potential gaps or barriers to care. Individualized Care Plans (ICP) are created with the member in an effort to positively impact health outcomes. Interdisciplinary Care Teams (ICT) consisting of the member, providers, community partners and a case manager meet regularly to review member conditions and status, goals, progress, gaps in care, and needs for additional resources. Care coordination is provided for those members needing additional support through transitions, such as discharge from hospitalization or moving from their own home into a community-based facility.

Appeals and Grievances for Samaritan Advantage Health Plan (SAHP)

Special circumstances allow a provider to appeal for a medical, pharmacy or durable medical equipment (DME) authorization or payment denial on behalf of a patient. SHP follows strict rules and regulations set forth by Medicaid, Medicare and the federal government. These rules and regulations are subject to change.

For further information about appeal rights, time frames to submit appeals, and to download appeals forms for each plan, please visit providers.samhealthplans.org/working-with-samaritan-health-plans/appeals.

Urgent Situations: Pre-Service Denials

Medical Appeal

Any treating physician can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to SHP **without** filling out a CMS-1696 form. This applies when the patient has not received the service and the physician believes that applying the standard appeal time frame could seriously jeopardize the patient's life, health or ability to regain maximum function.

Pharmacy Appeal

Any provider/prescriber can appeal a pre-service denial on their patient's behalf by submitting an oral or written request directly to Samaritan Health Plans **without** filling out the CMS-1696 form. This applies when the patient has not received the medication and the provider or prescriber believes that applying the standard appeal time frame could seriously jeopardize the patient's life, health or ability to regain maximum function.

Standard Pre-Service Denials

Medical Appeal

Only the treating physician can appeal on the patient's behalf **without** filling out a CMS-1696 form. This applies when the patient has not received the service. Medicare assumes the treating physician has documented a conversation with the patient regarding the intent to appeal on their behalf.

Pharmacy Appeal

Any provider/prescriber can appeal on the patient's behalf **without** filling out a CMS-1696 form. This applies when the patient has not received the medication. Medicare assumes the provider/prescriber has documented a conversation with the patient regarding the intent to appeal on their behalf.

Payment Denials

A contracted provider does not have appeal rights. If a contracted provider wants to appeal on the patient's behalf, only after completing an Appointment of Representative form. With your appeal, please include Medicare's **CMS-1696 form** (cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf), a legal court appointed representative document, or the equivalent. Both the patient or legal representative, and the contracted provider must complete their applicable sections of the form before the appeal will be processed.

- Please fill out, print and sign the Medicare Appointment of Representative form, **CMS-1696 Form**, and include this with your appeal. Send the form, the appeal request and any supporting documentation to SHP to the attention of the Appeal Team.
- Any non-contracted provider can appeal a denied payment but only after completing a **Waiver of Liability** (providers.samhealthplans.org/-/media/SHP/Documents/Providers/Waiver-Of-Liability-Statement.pdf). Send the waiver, appeal request form, and any supporting documentation to SHPO to the attention of the Appeal Team.

Please submit your completed form(s), appeal letter and supporting documents to:

Fax: 541-768-9765

Email: SHPOAppealsTeam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Timeframe to Appeal:

SAHP	To request appeal timeframe	Appeal Time
Medical	60 days from the initial decision	Expedited=72 hour Standard Pre-Service=30 calendar days Standard Post-Service=60 calendar days
Pharmacy	60 days from the initial decision	Expedited=72 hours Standard=7 calendar days

Appeals for InterCommunity Health Network Coordinated Care Organization (IHN-CCO)

For Urgent Situations

Any provider can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to IHN-CCO. To submit a verbal request, please call **541-768-5207**, or **1-888-435-2396**, Monday – Friday, 8 a.m. – 6 p.m. Please send written requests to SHPOAppealsTeam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the physician believes that applying the standard appeal time frame could seriously jeopardize the patient's life, health or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

For Standard Pre-Service and Payment Denials

A provider can appeal on the patient's behalf with written permission from the patient or patient's authorized representative. A copy of the written permission, signed and dated by the patient or their authorized representative, must be received by IHN-CCO before the appeal will be processed.

Please submit your completed appeal letter with the member's (or member's authorized representative) written consent to:

Fax: 541-768-9765

Email: SHPOAppealsTeam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Timeframe to Appeal:

IHN-CCO	To request appeal timeframe	Appeal Time
Medical	60 days from the initial decision	Expedited=72 hours Standard Pre-Service=16 calendar days Standard Post-Service=16 calendar days
Pharmacy	60 days from the initial decision	Expedited=72 hours Standard=16 calendar days

Appeals for Samaritan Choice Plans (SCP)

For Urgent Situations

Any provider can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to SCP. To submit a verbal request, please call **541-768-5207**, or **1-888-435-2396**, Monday – Friday, 8 a.m. – 6 p.m. Please send written requests to SHPOAppealsTeam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the physician believes that applying the standard appeal time frame could seriously jeopardize the patient's life, health or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

For Standard Pre-Service and Payment Denials

A provider can appeal on the patient's behalf with written permission from the patient or authorized representative. A copy of the written permission, signed and dated by the patient or authorized representative, must be received by SCP before the appeal will be processed.

Please submit your completed appeal letter with the member's (or member's authorized representative) written consent to:

Fax: 541-768-9765

Email: SHPOAppealsTeam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Timeframe to Appeal:

SCP	To request appeal timeframe	Appeal Time
Medical	180 days from the initial decision	Expedited=72 hours Standard Pre-Service=30 calendar days Standard Post-Service=60 calendar days
Pharmacy	180 days from the initial decision	Expedited=72 hours Standard=30 calendar days

Appeals for Employer Group Plans

For Urgent Situations

Any provider can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to Commercial Employer Group Plans. To submit a verbal request, please call **541-768-5207**, or **1-888-435-2396**, **Monday – Friday, 8 a.m. – 6 p.m.** Please send written requests to SHPOAppealsTeam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the physician believes that applying the standard appeal time frame could seriously jeopardize the patient's life, health or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

For Standard Pre-Service and Payment Denials

A provider can appeal on the patient's behalf with written permission from the patient or authorized representative. A copy of the written permission, signed and dated by the patient or authorized representative, must be received by SHP before the provider's appeal will be processed.

Please submit your completed appeal letter with the member's (or member's authorized representative) written consent to:

Fax: 541-768-9765

Email: SHPOAppealsteam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Timeframe to Appeal:

Employer Group	To request appeal timeframe	Appeal Time
Medical	180 days from the initial decision	Expedited=3 days Standard Pre-Service=30 calendar days Standard Post-Service=30 calendar days
Pharmacy	180 days from the initial decision	Expedited=3 days Standard=30calendar days

Pharmacy

Formulary

SHP maintains drug formularies for its members in accordance with state and federal regulations. Drug formularies are developed and maintained by SHP Pharmacy Programs with direction from the SHP Pharmacy and Therapeutics Committee. SHP may add, delete or modify the drug formulary to ensure that the formulary maintains an evidence-based formulary on an ongoing basis. The most up to date formularies can be located on the SHP provider website at providers.samhealthplans.org/care-management/pharmacy.

SHP contracts with a pharmacy benefit manager (PBM) for administration of the outpatient prescription benefit. This does not apply to injectable medications administered in an inpatient setting, i.e. skilled nursing facilities (SNF), group homes, hospitals, or skilled care. Exceptions may apply for Samaritan Advantage Health Plan.

SHP utilizes a formulary in order to better manage the prescription benefit. Covered prescriptions can be filled at any participating pharmacy for each individual plan, within the formulary restrictions.

Generic medications are strongly recommended unless a therapeutically equivalent generic is not available, or the member has a contraindication to the generic product. Prescriptions are dispensed

for up to a 34-day supply (90 days for some plans on certain drugs) with a 75% utilization required prior to refill.

Some prescriptions require pre-authorization (this may not apply when administered in an inpatient hospital or SNF setting). Most medications that require pre-authorization can be authorized for up to one (1) year at a time once the specific pre-authorization criteria has been met and documented.

Non-Formulary Drugs

If it is medically necessary for a member to have a drug that is not a formulary medication of the Health Plan of which he or she is enrolled, the provider or the member can submit a medication exception form to Health Plans' Pharmacy Programs Department. This form can be found at providers.samhealthplans.org/care-management/pharmacy/medication-exceptions-and-redeterminations.

Quantity Limits

For certain drugs, there are limits to the amount of the drug that the plan will cover over a period of time, depending on each plan benefit. These requirements are developed using evidence-based, community standards, cost conscience, and the latest pharmaceutical compendia. These limitations are reviewed and approved by the SHP Pharmacy and Therapeutics Committee. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits. The member or member's physician can ask for an exception to these restrictions and/or limits.

Step Therapy

SHP uses step therapy for medications that are not first line treatment. SHP enforces step therapy for medications as determined by the SHP P&T Committee. SHP requires the use of a less expensive medication when there is a cost difference between therapeutically equivalent medications. SHP approves the next step in therapy when members are unable to tolerate the first line medications or have adverse outcomes when taking the first line medications. Medicare's Part D claims system may automatically start this process. When a claim is adjudicated, the claims payment system looks for any instance of a first line medication and if found, will automatically approve the claim. If, however, the first line medication is not found, the claims payment system denies the claim and gives a rejection notice to follow step therapy. The member or member's physician can ask for an exception to these restrictions and/or limits.

Specialty Drugs

Medications are considered for the specialty tier if they meet certain conditions:

1. The drug must have at least three of the following characteristics:
   - Biotechnology products
   - FDA-designated orphan drugs or ultra-orphan drugs
   - Any formulation of drug that is high cost as defined by cost greater than $600 per month for either a medical or prescription claim
   - Requires special storage control and/or other specific shipping/handling requirements
   - Therapy requires management and/or care coordination by a healthcare provider specializing in treating the member's condition
   - Requires focused, in-depth member education and/or adherence monitoring and/or side effect management and/or injection preparation/administration education. The medication may have REMS programs requiring this level of clinical oversight beyond the standard REMS program medication guide requirements.
   - Managed as part of an existing specialty therapeutic program

2. Medication does not meet any of the following characteristics:
   - Requires nuclear pharmacy sourcing
   - Preventive immunizations (e.g., influenza, DTP)
   - Administration is only in the inpatient setting

Quality Management Plan

SHP's Quality Management Plan is developed annually as a guide to the Quality Management Program. It includes the goals, objectives, scope, principles, authority, organizational model, oversight, reporting requirements and evaluation requirements of the Quality Management Program. Providers may find information about our current quality management plan at providers.samhealthplans.org/care-management/quality-management-programs.

Quality Management Work Plan

Our work plan is developed annually, updated periodically throughout the year and serves as a guide to prioritize our Quality Management Program activities. It includes all anticipated regulatory site visits or oversight activities, such as required document submissions, data submissions, etc.

Quality Management Committee (QMC)

Our Quality Management Committee membership consists of practicing physicians within our service area that oversee the Quality Management Program. The Quality Management Committee provides guidance in quality planning, oversees the quality monitoring and improvement activities, and evaluates the effectiveness of key services provided to members, providers, and regulatory agencies.

Quality Improvement Projects

The Quality Management Program includes numerous quality improvement projects designed to improve the health outcomes of our members. Some quality improvement projects are specific to a certain line of business. However, projects overlap lines of business as appropriate. We encourage providers to review a list of current quality improvement projects at providers.samhealthplans.org/care-management/quality-management-programs.

Evidence-based Clinical Practice Guidelines

Evidence-based clinical practice guidelines are designed to improve the quality and consistency of care provided at the provider level, and to assist providers and members in making decisions about appropriate health care for specific clinical circumstances including "self-management" of chronic diseases. View our current Clinical Practice Guidelines at providers.samhealthplans.org/care-management/clinical-resources/clinical-guidelines.

Behavioral Health Guidelines

Samaritan Health Plans' partners in Behavioral Health and Substance Use Disorder follow evidence-based clinical practice guidelines that are in alignment with the American Psychiatric Association (APA) and the American Society of Addiction Medicine (ASAM) guidelines.

APA's clinical practice guidelines can be found at:
https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines.

ASAM's guidelines and consensus documents can be found at:
https://www.asam.org/resources/guidelines-and-consensus-documents.

Dental Health Guidelines

Samaritan Health Plans' Dental Care Organization (DCO) partners follow evidence-based clinical practice guidelines that are in alignment with American Dental Associations (ADA) clinical practice guidelines list.

ADA's clinical practice guidelines can be found at: https://ebd.ada.org/en/evidence/guidelines .

HEDIS/HOS/CAHPS

Healthcare Effectiveness Data and Information Set (HEDIS) is performed and reported annually as required by The Centers for Medicare and Medicaid Services (CMS). HEDIS data is used to monitor plan performance and identify opportunities for improvement in the care and services provided to our members.

The Health Outcomes Survey (HOS) is used to gather health status data from our members. This data is used in quality improvement activities to improve health. HOS is administered to a cohort of Medicare Advantage members each year. The same cohort of members is surveyed again two years later.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that focuses on how members experienced or perceived key aspects of their care. This information is particularly useful in identifying opportunities for improvement in delivering health care and services to our members.

Provider Education

Samaritan Health Plans offers Provider Education materials and other information resources at providers.samhealthplans.org.

Educational and Compliance training content is offered to meet CMS requirements for Fraud, Waste and Abuse, Special Needs Plan-Model of Care (SNP-MOC) requirements, as well as other topics that enhance provider knowledge and improve member care.

Annual Education Requirements for SNP Providers

Samaritan Health Services (SHS) through Samaritan Health Plans (SHP) operates a Medicare Advantage Special Needs Plan for the dual eligible population residing in Linn, Benton and Lincoln Counties of Oregon. Samaritan Health Plans also operates a Medicaid managed care plan for the region, InterCommunity Health Network Coordinated Care Organization (IHN-CCO.) Samaritan Health Plans ensures that all physicians and providers permitted to practice

independently under state law are properly credentialed per CMS, the Oregon Medicaid Program, and SHP policies prior to providing health care services to our SNP members.

The SNP-MOC annual training is offered to meet the CMS regulatory requirements for Model of Care Training for our SNP-MOC providers. This training also ensures all contracted network providers and out-of-network providers who regularly see our SNP members have the specialized training this unique population requires. Training should be completed on an annual basis and can be located on the SHP website at providers.samhealthplans.org/working-with-samaritan-health-plans/required-attestations.

Annual Compliance and Integrity Trainings per CMS Requirements

Our Corporate Integrity Program is our commitment to comply with laws and regulations relating to health care operations. The program was designed to assist in the prevention and detection of legal violations and to promote the highest standard of professional ethics in the delivery of health care services and education for everyone.

Access FAQs and more information on First Tier, Downstream and Related Entities (FDR) training and education at providers.samhealthplans.org/working-with-samaritan-health-plans/compliance-and-integrity/compliance-program.

What are the CMS First Tier, Downstream and Related Entities (FDR) requirements?

- The FDR has a process in place to confirm its employees, contractors, board members, or any shareholders (interest of 5% or more) that work directly or indirectly on any federal health care program do not appear in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General, nor in the List of Debarred Contractors as published by the General Services Administration.

- The FDR, its employees, board members, agents and contractors that provide administrative services or health care services for or to Medicare Advantage members, participate in Medicare fraud, waste and abuse (FWA) training that meets CMS requirements. The FDR agrees to comply with SHPO Group (SHPO) conflict of interest policy or a conflict of interest policy developed by FDR that meets CMS requirements.

- The FDR agrees to comply with SHPO's Code of Business Conduct (COBC) and the COBC Guide (which includes SHPO's disciplinary standards) and policies and procedures, or to adopt and comply with its own code of conduct, disciplinary standards and policies and procedures that reflect a commitment to detecting, preventing and

correcting non-compliance with Medicare requirements in the delivery of Medicare services, including detecting, preventing and correcting fraud, waste and abuse.

- The FDR is required to publish disciplinary standards which include its expectation that employees ask Medicare compliance questions and report potential and actual instances of non-compliance with Medicare requirements to SHPO through its anonymous hotline or through other means. Disciplinary standards must also state that any violation of these standards will result in appropriate disciplinary action, up to and including termination of employment. They also must include a non-retaliation policy for good-faith reporting.

- The FDR will report compliance or FWA concerns and will publicize to its employees the methods for reporting potential and actual instances of Medicare fraud, waste and abuse to SHPO through its anonymous hotline or through other means. Federal law prohibits SHPO from retaliating against FDRs or their employees for reporting a fraud, waste and abuse issue.

What actions do FDRs need to perform to be in compliance with the FDR requirements?

- FDRs will check the federal exclusion lists prior to hire and monthly thereafter.

- If an employee, contractor, board member or shareholder (interest of 5% or more) is on either exclusion list, the FDR shall immediately remove the person or entity from any work related directly or indirectly to all federal health care programs and will take appropriate corrective actions, including preventing payment to excluded entity. The FDR will notify SHPO of the finding and action.

- CMS FWA training will be conducted within ninety (90) days of hire and annually thereafter and there will be documentation attesting to the completion of this annually. Please note that you must use either the free CMS online FWA training or SHPO FWA training to meet this requirement.

- The FDR will contact the Medicare hotlines with compliance questions and to report potential and actual instances of non-compliance.

- Standards of Conduct and policies and procedures will be distributed to all employees who provide administrative services or health care services for SHPO's Medicare Advantage program at time of hire and annually thereafter.

- Conflict of interest disclosure forms will be distributed at time of hire and annually thereafter to governing body, officers and senior leadership, as applicable, certifying that they are free from any conflict of interest related to Medicare.

- Disciplinary standards must be publicized and include:
    - Requirement to ask compliance questions and report potential and actual instances of noncompliance and Medicare FWA
    - Violation of standards will result in appropriate disciplinary action up to and including termination
    - Non-retaliation policy

Are FDRs required to use SHPO compliance program to meet the requirements?

No, FDRs may use a compliance program that meets CMS requirements as long as documentation is maintained.

Can FDRs develop and use their own fraud, waste and abuse training?

No, FDRs are required to use only CMS FWA training, SHPO FWA training or FWA training provided by another Medicare Advantage and Part D Sponsor.

What records do FDRs need to keep and how will FDRs be audited for compliance?

- The FDR will keep a record that confirms reviews of the two federal exclusion lists have been completed. This generally includes a copy of each exclusion list with confirmations for initial hires and monthly verifications thereafter, along with employee names and verification dates.
- A copy of fraud, waste and abuse training materials will be maintained and proof that such training has been completed by its employees, board members, agents and contractors (e.g. attestations). FWA training must be provided by CMS, SHPO or another Medicare Advantage and Part D Sponsor.
- Copies of conflict of interest certifications for governing body, officers, and senior leadership, as applicable, directly or indirectly with the federal health care program will be maintained and made available for audit purposes.
- Copies of Standards of Conduct attestations will be maintained and made available for audit purposes.
- Copies of compliance program policies and procedures, including non-retaliation policy and disciplinary standards will be reviewed.

How will FDRs be monitored for compliance?

FDRs may be asked to provide documentation that demonstrates compliance with the FDR requirements.

Requirements for First Tier, Downstream, and Related Entities

Starting January 1, 2016, to comply with training requirements, sponsors must accept from FDRs certificates of completion of CMS' training located on the Medicare Learning Network (MLN).

View the CMS update Compliance Program Training memo available at providers.samhealthplans.org/-/media/SHP/Documents/Providers/Fraud-Waste-Abuse-Training-2016.pdf.

CMS requires First Tier, Downstream, and Related Entities (FDR) employees to complete its Medicare Fraud, Waste, and Abuse (FWA) training within 90 days of hire and annually thereafter. Required FWA training is developed and provided by CMS and is available through the CMS Medicare Learning Network (MLN) at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts. CMS has provided two training modules to fulfill this requirement:

- Medicare Parts C and D General Compliance Training
- Combating Medicare Parts C and D Fraud, Waste and Abuse Training

Once an individual completes the training, the system will generate a certificate of completion.

Copies of your completed training attendance logs and completion certificates must be made available for audit upon request by Samaritan Health Plans or CMS.

Integrity Program and Disciplinary Standards

SHP strives to ensure compliance with federal, state and local laws and regulations that apply to the health insurance industry and to each contract. We are committed to comprehensive compliance with contractual, legal, and ethical expectations. Our policies and procedures reflect the organization's goal to meet or exceed compliance standards. CMS expects us to share our standards of conduct with our FDRs and ensure that these entities adhere to our standards, or that these entities adopt and follow their own standards of conduct. These standards reflect a commitment to detecting, preventing and correcting noncompliance with regulatory requirements, including detecting, preventing and correcting fraud, waste and abuse.

Review our Corporate Integrity Program policies and procedures at providers.samhealthplans.org/-/media/SHP/Documents/Providers/Corporate-Integrity-Program.pdf.

Access Samaritan Health Plans' Disciplinary Standards at providers.samhealthplans.org/-/media/SHP/Documents/Providers/Disciplinary-Standards.pdf.

Conflict of Interest

Disclosure and Attestation

CMS expects SHP to regularly audit conflict of interest attestations from our FDRs. We require annual completion of these certifications because it ensures that each FDR has effectively screened managers, officers, and directors responsible for the administration or delivery of Medicare Advantage and Part D benefits. A conflict of interest statement that is signed annually or upon hire, attests that the manager, officer or director is free from any conflict of interest in administering or delivering these benefits. Conflicts must be reported to our Compliance Department immediately upon discovery.

Our conflict of interest policy documents and attestation are available for download on our provider website:

Review our Conflict of Interest Policy:
providers.samhealthplans.org//media/SHP/Documents/Providers/Conflict-Of-Interest-Policy.pdf

Download the Conflict of Interest Attestation:
providers.samhealthplans.org/-/media/SHP/Documents/Providers/FDR-Conflict-Of-Interest-Attestation.pdf

Review Exclusion Databases Pre- and Post-Hire

We ask that FDRs review the exclusion databases listed below before hire and continue to review them on a monthly basis for current employees, officers and directors, board members, subcontractors, consultants and vendors as applicable. If you identify any exclusion, please notify SHP's Compliance Department immediately; excluded persons or entities are prohibited from receiving payment.

Access the Office of Inspector General (OIG) exclusion database at oig.hhs.gov/exclusions.

Search the General Services Administration (GSA) exclusion list at sam.gov.

Providers are responsible for ensuring that they record exclusion logs with employee name, the date each database was checked and whether or not exclusion was found. These logs must be made available for review upon request. Please report these logs directly to SHP.

If you have a member who indicates dissatisfaction to you or your employee(s) regarding any aspect of their experience, please direct this issue to SHP immediately. If you are dealing directly with our members and receive a grievance and/or appeal request, send the member's name, member ID, date, time of contact and description of issue to SHP.

To report member dissatisfaction, please contact us:

Fax: 541-768-9765

Email: SHPOAppealsTeam@samhealth.org

Phone: Corvallis **541-768-4550**, Toll-free **1-800-832-4580**, Monday - Friday, 8 a.m. to 6 p.m.

Mail: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Ethics, Compliance and Fraud

Samaritan Health Plans is committed to ethical business practices; complying with all Medicare requirements; and detecting, preventing and correcting fraud, waste and abuse.

If you suspect fraud, waste or abuse, please report it immediately through any of the following channels:

- Call the SHP Compliance Officer, Denise Severson, at **541-768-5670**
- Complete a Special Investigations Referral Form, available at providers.samhealthplans.org/support/corporate-compliance under Ethics, Compliance and Fraud
- Mail the form to Compliance Department, Samaritan Health Plans, 2300 Walnut Blvd., Corvallis, OR 97330
- Fax the form to **541-768-9791**
- Email the SHP Compliance Department at SHPOCompliance@samhealth.org
- Call the Ethics Point Hotline at **1-866-297-0489** (anonymous)
- File a report through EthicsPoint online at secure.ethicspoint.com

See more ways to report on our fraud, waste and abuse page at providers.samhealthplans.org/working-with-samaritan-health-plans/compliance-and-integrity/reporting-fraud-waste-abuse.

Stark Law: Physician Self-Referrals

The Stark law prohibits certain physician referrals for designated health services that may be paid for by Medicare, Medicaid or other state healthcare plans. The Stark law provides that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician (or immediate family member) and the entity.

The Stark law includes many exceptions, which may apply to ownership interests, compensation arrangements or both. Unlike the Anti-Kickback Statute, which recognizes that arrangements falling outside of the safe harbors may still be permitted, the Stark law is a strict prohibition against self-referrals; accordingly, if a referral arrangement does not meet one of the exceptions, it will be considered unlawful.

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000, and in certain cases not to exceed $100,000, per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute or investment interest in any entity providing the designated health service. A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

More information on the "Stark Law" can be found in Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn).

Requirement for Interpretation Services

In order to meet Federal and State regulations, providers are responsible for ensuring that their practice or clinic offers timely and free interpretation services to all members with Limited English Proficiency (LEP). Members that may be considered "LEP," are individuals who do not speak English as their primary language, and have a limited ability to read, speak, write or understand English.

Providers and provider clinics that receive federal funding, such as Medicare and Medicaid dollars, are required to provide these services in accordance with the Section 1557 of the Affordable Care Act, viewable at gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf and Oregon State law, which you can access at oregonlegislature.gov/bills_laws/ors/ors413.html.

Interpretation services are crucial in supporting access to health care for underserved populations, reducing communication barriers, developing positive patient-provider relationships, and improving efficiency of health care services.

Suggestions?

We take your feedback seriously. If you have suggestions or comments about how SHP can better support you, email SHPprovider@samhealth.org or contact our Provider Service team at 541-768-5207, 1-888-435-2396, Mon. – Fri., 8 a.m. to 6 p.m. PT.