Heraya Health
Provider Operations Manual

Table of Contents

Section One – Introduction 3
Welcome from Heraya Health! 3
1.00 What is Heraya Health? 4
2.00 Heraya Contact Information 4
3.00 Overview of This Manual 4
4.00 Heraya Health Management Committees 5
5.00 Heraya Committee Members Code of Conduct 6
Section Two – Provider Participation and Compliance 8
1.00 General Information 8
2.00 Heraya Clinical Record Quality Standards 23
3.00 Provider Office Information 32
4.00 Member/Patient Information 39
5.00 Network Consideration 48
6.00 Complaints/Appeals 51
7.00 Adverse Events 58
Section Three – Heraya Utilization Management Policies & Procedures 69
UM Program Overview 70
1.00 Utilization Management Structure and Function 73
2.00 Clinical Criteria for Utilization Management 76
3.00 Communication Services 79
4.00 UM Reviews Performed by Appropriate Professionals 80
5.00 Timeliness of UM Decisions 81
6.00 Clinical Information for UM Decisions 85
7.00 Denial Notices 86
8.00 UM Appeals 89
9.00 Technology Assessment 95
10.00 Experience with UM Process 95
11.00 Appropriate Utilization 96
12.00 Affirmation Statements 102
Section Four – Radiographic Guidelines 103
Heraya Radiographic Guidelines 103
Section Five – Heraya Forms 104
Vacation / Leave of Absence / Sabbatical Request Form 105
Associate Request Form 106
Association Authorization and Release of Information Form 108
Call Coverage Application Form 109
Confidentiality Statement 112
AUTHORIZATION AND RELEASE OF INFORMATION FORM 113
Heraya Philosophy of Care 114
Addendum to Attestation 116

Section One – Introduction

Welcome from Heraya Health!

We welcome you as a provider to Heraya Health. We are pleased to have you participate as one of our network providers in the creation of an accessible delivery system of health care, which provides excellent integrative healthcare (IH) services at an affordable cost in an effort to preserve private IH.

It is our strategy to select only providers who have demonstrated a reputation of excellence, as well as concern for cost in providing necessary care. Our goal is to keep you informed and to receive clinician input at every opportunity. We encourage you to participate in one of our free Continuing Education Events and to become familiar with Heraya's policies and expectations. Please contact us if we can answer any questions you may have.

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1.00 What is Heraya Health?

Since 1989, Heraya Health has partnered with leading health plans, employers, and IH providers to empower members to invest in their health and well-being. We design, implement, and manage flexible, cost-effective IH products and programs which give our customers seamless access to high quality, effective, and affordable care.

Heraya is a provider-founded, provider-focused network of chiropractors, acupuncturists, naturopathic physicians, and massage therapists that provides patients with seamless access to high-quality IH. Our ongoing commitment to quality care is reflected throughout our operations, clinical policies, and practice guidelines.

2.00 Heraya Contact Information

General Contact Information:

- General Number: 503-203-8333 or 800-449-9479
- General Fax Number: 877-482-2856 (toll free, 24/7) or 503-644-0442
- Mailing Address: 6600 SW 105th Avenue, Suite 115, Beaverton OR 97008
- General Email: info@herayahealth.com

Claims Department

- Claims Telephone Number: 503-203-8333 ext. 235
- Claims Mailing Address: PO Box 278, Beaverton, Oregon 97075-0278
- Claims Fax Number: 503-203-8522

Provider Relations Department

- Provider Relations Number: 503-203-8333 ext. 234
- Provider Relations Fax Number: 877-482-2856 (toll free, 24/7)
- Provider Relations Email: ps@herayahealth.com

Utilization Management/Clinical Services Department

- General Utilization Management Number: 503-203-8333 or 800-449-9479 ext. 106
- Heraya Medical Directors: 503-203-8333 or 800-449-9479 ext. 114 or 122
- Utilization Management Fax Number: 877-252-8452 (toll free, 24/7)
- Utilization Management/Clinical Services Email: cs@herayahealth.com

3.00 Overview of This Manual

Knowing the contents of this manual and adhering to its guidelines and recommendations will help to assure your success with Heraya Health. The information provided throughout this manual will facilitate your understanding of policies and procedures referenced in your Professional Services Agreement and answer questions that may arise as you provide care and are reimbursed for services rendered to Heraya patients. Please refer to your Heraya Billing Manual for information regarding all billing matters. If you have questions relating to this manual, please contact the Provider Relations Department.

Amendments to This Manual

Please refer to Heraya's website for the most current versions of Heraya's Provider Operations Manual and Billing Manual, which can be found behind the Provider Hub login at herayahealth.com. A paper copy of the Provider Operations Manual will be distributed upon provider request.

Proprietary Information

The information in this manual is proprietary and may not be distributed, shared, or copied for use outside the office of a Heraya participating provider's practice or for purposes other than rendering services to Heraya members.

4.00 Heraya Health Management Committees

Clinical Management Committee (CMC)

Meets:	Quarterly or as necessary.
Members on Committee:	The Clinical Management Committee consists of six providers, the President & CEO, the Chief Clinical Officer, and at least one Provider Relations staff.
Functions:	The Clinical Management Committee (CMC) is responsible for reviewing the quarterly and annual business operations reports and serving in an advisory capacity to the CEO. The responsibilities of the CMC include: ensuring the strategic goals of the Utilization Program are met; reviewing quarterly and annual reports from the Clinical Services and Provider Relations Departments; overseeing member complaints and grievance processes to improve quality of care and services provided; overseeing the activities of the Combined Medical Directors Committee (CMD), the ad hoc Advisory Committee(s) and the Credentialing Committee; ratifying program policies and procedures recommended by the CMD and Credentialing Committee; monitoring and ensuring detected clinical management deficits are corrected; and monitoring Heraya clinical policies.

Combined Medical Directors Committee (CMD)

Meets:	Quarterly.
Members on Committee:	Members of the Committee consist of the Chief Clinical Officer, Regional Medical Directors, Associate Medical Directors from each discipline and the Clinical Services Supervisor.
Functions:	This Committee is responsible for guiding the organization in all relevant aspects of clinical utilization management performance and measurements; coordinating and overseeing the effectiveness of monitoring, evaluation, and improvement of utilization management systems and providers; managing the Clinical Records Quality Improvement Program; coordinating UM activities with risk management, analyzing UM findings, making recommendations to the CEO and appropriate committees based on results, and assessing improvements; monitoring compliance with regulatory requirements, including health plan delegation policies and procedures for UM and Claims Processing; making recommendations to the CEO and the CMC on policies, procedures, and guidelines; and reporting to the CMC regarding program performance.

Quality Management Team (QMT)

Meets:	Quarterly or as necessary.
Members on Committee:	Members of this committee include the Chief Clinical Officer, Regional Medical Director, and other staff as assigned.
Functions:	This Committee develops and monitors the annual Quality Work Plan activities, assigns tasks, and obtains and coordinates the goals of the related committees providing input into quality management performance goals.

Network Advisory Team (NAT)

Meets:	Monthly or as necessary.
Members on Committee:	Members include the President & CEO, Chief Clinical Officer, Director of Business Development, Director of IT, Senior Marketing Manager, and Director of Provider Relations and Engagement.
Functions:	This Committee is responsible for monitoring provider access in compliance with health plan contracts and strategic business planning of Heraya.

Focus Groups

Meets:	Periodically, as scheduled.
Members on Committee:	Ten providers at each meeting held.
Functions:	Previous focus groups have assisted Heraya in developing polices that directly affect the business of Heraya providers. Providers are invited through various mediums. Providers may contact Heraya to add their name to a Focus Group list. Topics vary as the healthcare environment changes.

If you are interested in serving on one of Heraya's committees, please contact the Provider Relations Department.

5.00 Heraya Committee Members Code of Conduct

The following Code of Conduct guidelines incorporate the characteristics and values most people associate with ethical behavior. The expectation is that all Heraya employees and committee members conduct themselves in an ethical manner as described below:

(1) **HONESTY.** Heraya Employees and Committee members are expected to be honest and truthful in all their actions and to not deliberately mislead or deceive others by misrepresentations, overstatements, partial truths, selective omissions, or any other means.

(2) **INTEGRITY.** Heraya Employees and Committee members are expected to demonstrate personal integrity and the courage of their convictions by doing what they believe is right even when there is great pressure to do otherwise and by not sacrificing their principles for expediency.

(3) **TRUSTWORTHINESS.** Heraya Employees and Committee members are expected to be worthy of trust, to be candid and forthcoming in supplying relevant information and correcting erroneous information, and to make every reasonable effort to fulfill the letter and spirit of their promises and commitments. They are expected not to interpret agreements in

an unreasonably technical or legalistic manner to rationalize non-compliance or create justifications for escaping their commitments.

(4) **LOYALTY.** Heraya Employees and Committee members are expected to demonstrate loyalty to co-workers, Heraya, its employees, and business associates by not using or disclosing information learned in confidence and by safeguarding the rights and ability to make independent professional judgments by avoiding undue influences and conflicts of interest.

(5) **FAIRNESS.** Heraya Employees and Committee members are expected to be fair and just in all interactions with others; they are not to exercise power arbitrarily or take undue advantage of another's mistakes or difficulties.

(6) **CONCERN FOR OTHERS.** Heraya Employees and Committee members are expected to assist those in need and seek to accomplish assigned objectives in a manner that benefits all those involved and produces the greatest positive good.

(7) **RESPECT FOR OTHERS.** Heraya Employees and Committee members are expected to demonstrate respect for the human dignity, autonomy, privacy, rights, confidentiality, and interests of all those who have a stake in their decisions; they are to be courteous and treat all Customers, Providers, Committee Members, Staff and co-workers with equal and non-discriminatory respect and dignity.

(8) **LAW-ABIDING.** Heraya Employees and Committee members are expected to abide by all laws, rules and regulations relating to their business/professional responsibilities.

(9) **COMMITMENT TO EXCELLENCE.** Heraya Employees and Committee members are expected to pursue excellence in performing their duties, to never be satisfied with mediocrity, to be well informed and prepared, and to continually endeavor to increase their proficiency in all areas of responsibility.

(10) **LEADERSHIP.** Heraya Employees and Committee members are expected to be conscious of the responsibilities and opportunities of their position and strive to be positive ethical role models by their own conduct, helping to promote an environment in which principled reasoning and ethical decision-making are highly prized.

(11) **REPUTATION AND MORALE.** Heraya Employees and Committee members are expected to protect and build Heraya Health reputation and the morale of those they do business with (other Heraya employees, committee members, providers, and customers) by not engaging in any conduct that might undermine respect and by addressing inappropriate conduct of others within the organization in an ethical manner.

(12) **ACCOUNTABILITY.** Heraya Employees and Committee members are expected to acknowledge and accept personal accountability for the ethical quality of their decisions.

Section Two – Provider Participation and Compliance

1.00 General Information

1.01 Guidelines for Participation

Heraya Guidelines for Provider Participation are applied to both initial applicants and participating providers for use in making credentialing decisions. These guidelines are provided in the initial application packet for new applicants and posted on Heraya's website for participating providers. Heraya requires all providers meet the guidelines established prior to contracting and remain in compliance with the guidelines at all times.

Heraya is committed to the development of a network of providers who have demonstrated background and experience consistent with the delivery of high quality, cost-effective health care. Heraya has established guidelines for the evaluation, appointment, and reappointment of providers to its network. Heraya reserves the right to accept or deny a provider's request for initial or ongoing participation based upon the following: The Guidelines for Provider Participation, business strategy, membership obligations, and other legitimate business interests of Heraya.

To be eligible for participation, providers must meet and maintain the following guidelines adopted by Heraya for chiropractic physicians, naturopathic physicians, licensed acupuncturists, medical doctors and doctors of osteopathy providing acupuncture services, and licensed massage therapists recognized through licensure by the appropriate licensing boards in the applicable state where the provider is providing professional health care.

Clinical Practice

Heraya is committed to assisting providers to achieve the highest levels of competency with respect to clinical record keeping. Heraya's clinical record requirements may be required prior to acceptance on the network. The initial application process may require a redacted clinical record sample which is reviewed against Heraya's quality standards. Clinical records not meeting or exceeding established thresholds may result in provider enrollment in the Clinical Records Quality Improvement Program (see section 2.02).

Clinical/Billing Practice

- Clinical records are required to be maintained in English.
- Compliance with Heraya's Utilization and Quality Management Programs is required.
- Providers rendering acupuncture services are required to use:
    - FDA-approved disposable needles only (no autoclaved re-useable needles) and
    - Attest to proper hazard waste removal and use of the clean needle technique.
- Heraya providers are responsible for the accuracy of billed services rendered to Heraya members, to include:
    - Billing functions that are outsourced or performed by other office staff.
    - Electronic submission of claims is required.
- Providers are required to have a National Provider Identifier (NPI) Type I number.
- If billing under any number other than the provider's Social Security number, a NPI Type II number is typically required.

Board Certifications

Medical Doctors and Doctors of Osteopathy (MD/DO) who provide acupuncture services must have and maintain board certification by the American Board of Medical Acupuncture when applying to the network.

Insurance (Professional Liability and Office Liability)

In geographic locations where Heraya has no current business contracts, professional and office liability limits are not required until such time as contracts become active. At that time, insurance liability limits, as required by Heraya's Professional Services Agreement, must be raised to meet Heraya requirements.

- Professional liability insurance must be in amounts not less than $1 million per incident and $3 million in aggregate individually.
- Office liability insurance limits must be not less than $500,000 combined single limit.

The provider's history of medical malpractice claims or professional liability claims must not reflect what, at Heraya's discretion, is a pattern of questionable or inadequate treatment or contains any gross and/or flagrant incidents of malpractice.

Work History

In addition to NCQA requirements of a 5-year review of work history, Heraya typically reviews and considers the provider's entire professional work history in any healthcare field for the following:

- Licensure issues, disciplinary actions, or current sanctions of any nature taken against the provider;
- Denial, resignation, limitation, suspension, or termination of participation by any health care institution, plan, facility, or clinic;
- Unstable professional work history;
- Incomplete or multiple discrepancies relating to professional work history, i.e. confusing work history explanations and unexplained gaps in work history;
- Prior work history with Heraya; and
- Other relevant issues.

Office Location

Heraya providers are expected to render services in a professional health care setting and for medical necessity. Services provided to Heraya members must be performed only at the approved/credentialed location which must meet Heraya's Office Facility Questionnaire threshold and standards.

The following are general requirements:

- Office Setting/Home Offices
  - Heraya and our contracted clients expect that professional services to Heraya members are rendered in a permanent, fixed professional office setting located in a traditional commercial office site.
  - Home offices are generally not accepted unless as allowed by exception due to a Heraya business need. The home office must meet the site visit policies and threshold requirements.
- Patient Privacy
  - A room with floor to ceiling walls to provide for patient confidentiality and privacy.
- Other Office Personnel

Unless covered under state laws governing otherwise, a provider should not request Heraya participation if:

- He or she is an employee of a provider of concern, an associate of, or otherwise affiliated within the same office or practice as a provider where services being rendered are incongruent with Heraya's Philosophy of Care, and
- In an office where a provider whose participation with Heraya was/is:
  - Terminated by Heraya,
  - Terminated as a result of a resignation at Heraya's request,
  - Denied participation on Heraya's network, or
  - Currently in the internal provider appeals process.

Terminations

Heraya has the right to terminate a provider pursuant to the terms of the Professional Services Agreement between Heraya and the provider. Terminations may be made for "cause" or "without cause." Heraya is not required to consider a reapplication, or request of reapplication, of a previously terminated provider for a period of five (5) years from the termination date. Providers who have been terminated from participation with Heraya or denied initial network participation more than once are not eligible for reapplication.

1.02 Credentialing and Provider Rights

General Requirements

Heraya is delegated by our contracted health plans to perform credentialing in full compliance with National Committee for Quality Assurance (NCQA) Standards. NCQA Standards require all providers providing care to members to be fully credentialed before ever treating a health plan member (specific exclusions may be stipulated). Heraya is audited annually by all contracted health plans to ensure credentialing and re-credentialing meet NCQA standards.

Initial Credentialing

All providers applying for participation with Heraya are required to complete Heraya's initial credentialing process meeting NCQA and Heraya Standards. Heraya uses standard credentialing applications as determined by State law. Providers will not be granted acceptance to any Heraya contracted network prior to the successful completion of the credentialing process and approval by either the Heraya Credentialing Committee or a Regional Medical Director's Clean file approval.

Re-credentialing

All Heraya participating providers who have completed the initial credentialing process are subject to re-credentialing every three years or less. Providers must return the re-credentialing package in the time frame provided to ensure Heraya compliance with NCQA standards and contracted delegation agreements. Failure to comply with required credentialing standards jeopardizes Heraya's delegation status and may result in the provider experiencing an interruption in their network participation or termination.

Credentialing Review Process

All credentialing and re-credentialing files are reviewed by the Regional Medical Directors, Chief Clinical Officer, Associate Medical Directors, and/or the Credentialing Committee. Heraya does not make

credentialing or recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the provider specializes. Credentialing Committee members are required to sign an annual attestation statement assuring decisions are not discriminatory.

Quality File Information

The re-credentialing process includes a review of the provider's current professional credentialing information. A further review is conducted on all quality related activities concerning the provider's care since last being credentialed. Such quality activities include, but are not limited to, complaints, malpractice claims, licensing board issues, sanctions, terminations, criminal investigations, and compliance with Heraya's utilization and quality management programs. The Credentialing Committee or Regional Medical Directors are presented with an aggregate report of previous activities when new concerns are identified.

Participating Provider's Credentialing Rights to Appeal

The provider's rights to appeal are made available in the following manner:

- The Professional Services Agreement signed by the provider at the time of submitting an application to Heraya,
- The Credentialing Committee's adverse determination notification letter to the participating provider, if the adverse determination is based upon quality of care or treatment concerns, and
- Continuous access to the latest revisions of the Provider Operations Manual which is available on Heraya's website.

Communicating Provider's Credentialing Rights

The Provider Credentialing Rights are included in the application packet for all initial credentialing applicants. All participating providers are sent a document containing the Provider's Credentialing Rights with the recredentialing application. All Heraya participating providers have continuous access to the Provider Credentialing Rights via the Heraya website.

Right to Review Credentialing Information

The provider has a right to review the information* obtained by Heraya or its representatives to evaluate their credentialing application. This includes information from any outside primary source, contracted entity, professional liability carriers, and state licensing boards permitting the release of such information. If copies of information are prohibited by the agency providing such information, the provider will be given the name and address of the agency to obtain a copy of the information provided to Heraya.

This policy does not require Heraya to allow a provider to review references, recommendations or other information that is peer-review protected.

Right to Correct Erroneous Information

The provider has the right to be notified of information obtained during the credentialing process which varies substantially from the information shared by the provider, as well as the right to correct erroneous information. The policy is intended to ensure providers attest to the accuracy of information they submit, while allowing providers to correct information obtained from another party that is incorrect.

All credentialing applications contain a statement indicating errors and/or omissions of information may result in denial by the Credentialing Committee. The applicant is advised to carefully review his or her application prior to submission.

Procedure for Notifying Provider of Erroneous Information or Information that Varies

Applications determined to contain conflicting information will be addressed with the applicant by the Provider Relations staff via telephone, e-mail, fax or letter. Conflicting information may result in the applicant's file being presented to the Credentialing Committee. Please refer to the File Review and Credentialing Committee Presentation Process policy 2.04.

1) The Provider Relations staff will contact the applicant in the following manner:
    a) ***By*** telephone, e-mail, fax, or letter to clarify such information as gaps in work history less than one year, malpractice, or office liability coverage. All conversations will be documented by printing of emails or written memo to the file.
    b) ***By*** e-mail, fax, or letter to clarify gaps in work history of one year or greater, discrepancies specific to the attestation, or any other major discrepancy. This letter must contain the following:
        i) An inquiry as to the reason the error or omission was made on the application,
        ii) A request for an explanation of the circumstances, e.g., with a malpractice claim, the applicant would be asked to provide a written statement regarding the history of the claim, and
        iii) Notification of to whom to address the written reply and notification of the 10 business day requirement to comply with the request.

    The above processes will provide for the following: a timeframe to provide changes, the format for submitting changes, and the person to whom corrections must be submitted. Provider Relations staff will date stamp the received date on the corrected information.

2) The applicant's documented response will be reviewed by the Director of Provider Relations and Engagement, the Regional Medical Directors, Chief Clinical Officer or Associate Medical Directors.

3) Depending on the degree of conflicting information, the Regional Medical Directors, Chief Clinical Officer, or an Associate Medical Director may directly contact the applicant for further discussion. All contact made with the applicant will be documented and placed in the applicant's credential file.

4) The Credentialing Committee may deny the applicant participation if the conflicting information and/or omission of the information is determined to be substantive or raises concerns regarding the moral or ethical conduct of the applicant. The decision of the Credentialing Committee will be based on a review of the applicant's credentialing or recredential file and an evaluation of the discrepancy or falsification of the misinformation given.

Rights of Confidentiality

The provider has the right to expect confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. This right covers Credentialing Committee procedures, access, and the storage of all credentialing documents concerning the provider.

Right to an Impartial, Non-Discriminatory Review of Credentials and Related Activity

All Heraya providers have a right to an impartial, non-discriminatory, and confidential selection and review process. Heraya monitors for and prevents discriminatory credentialing in the following manner:

- Heraya does not collect information on an applicant's race, ethnic/national identity, sexual orientation, or the types of procedures or patients in which the provider specializes as a credentialing element.
- Credentialing Committee members are required to sign an annual attestation statement assuring credentialing and recredentialing decisions are not discriminatory or based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the provider specializes.
- Provider complaints are monitored quarterly for concerning trends.

The Heraya Credentialing Attestation Statement is communicated to all providers on the Heraya website, https://www.herayahealth.com/.

Right to know Status of Application

All providers have the right to contact the Provider Relations Department at any time to request the status of their applications for initial credentialing or recredentialing in any of the following methods:

Mail:	Heraya Health, Attn: Provider Relations Dept. 6600 SW 105th Avenue, Suite 115 Beaverton, OR 97008
Phone:	503-203-8333 or 800-449-9479
Fax:	877-482-2856
E-mail:	ps@herayahealth.com

The provider will be advised of any outstanding information, reasons for any delay in the credentialing process, and an approximate Credentialing Committee date for review of the provider's file.

Timely Notification of Credentialing Committee Decision

All providers have the right and will be notified of the decisions made by the Credentialing Committee within 10 business days of the meeting. Providers having Clean files approved by the Regional Medical Directors, Chief Clinical Officer, or Associate Medical Director will also be notified of their approval within 10 business days.

1.03 Heraya Philosophy of Care

Heraya provides access to members and enrollees to quality health care services through insured benefits and access plans. Regardless of the financial arrangement, Heraya and its providers adhere to a philosophy of care that is patient-centered and evidence-based. Heraya believes:

- Patients deserve care that is accessible, appropriate for their condition, considerate of their values and preferences and respectful of their autonomy, time, and resources.
- Providers must have the latitude to advocate for quality care for their patients and be able to provide that care without intrusion.
- Those who pay for the care deserve assurance that the resources they are paying for are used in ways consistent with contracted arrangements and expectations for appropriate care.

Access to Heraya providers is of primary importance to patients. Heraya policies set explicit targets for wait times, expectations for follow up of test results, missed appointments and referrals. Treatment plans and care recommendations are expected to adhere to community standards of practice and be consistent with best practices benchmarks established by Heraya clinicians, advisory groups, and Regional and Associate Medical Directors.

Under contracts for insured benefits Heraya providers have an obligation to provide "medically necessary" health care services to health plan members. Medical necessity implies that the care is appropriate for the condition, is being provided for that condition, is within the community standards of good care, and is for the benefit of the patient, not the caregiver. In practical terms, our philosophy of care can be summarized as:

"Treat and release." Care is rendered to correct the presenting condition, bring it to maximum improvement, and lead to discharging the patient with appropriate instruction for follow-up, self-care, and prevention of future occurrences.

- The condition itself is one that is generally recognized throughout the health care community. While there may be discipline-specific clinical assessments (for example, subluxation or dysfunction in chiropractic or stagnation of blood and chi in acupuncture), these must also be characterized in diagnostic terms relevant and comprehensible to all clinicians.
- ***"Maintenance" or "wellness" care is not a covered benefit in insured health plans***. While these modes of care are of value, they are not part of the insurance benefit that the payer is obligated to provide in most instances. Maintenance and wellness care are usually the financial responsibility of the patient. Maintenance care, wellness care and other non-covered services are featured in all-access plans (such as the Heraya CAMplus program).

These expectations and values are shared with each provider and held by all. We enable and encourage providers continuously to evaluate and enhance their own practices, philosophies, and goals.

1.04 Participation and Contracting Options

Heraya contracts with various health plans, employer groups, and associations to provide coverage and access for their enrolled members and employees. Contracts include: capitated/Heraya discounted fee for service contracts, direct pay/discounted fee for services contracts, Worker's Compensation (MCO) contracts, Administrative Services Only (ASO) contracts, Preferred Provider Organization (PPO) contracts, and the Affinity Program.

This policy will outline Heraya's expectations in providing care to contracted members and serves as a guideline to providers making business/contracting decisions.

The service contracts with individual payers vary by product. For example, one health plan may contract with Heraya to provide only chiropractic services with a specific product line and offer another product that includes all disciplines. The same health plan may have various fee schedules depending on the products. Heraya is expected to provide a fully credentialed, qualified, and available network of participating providers to meet a variety of needs, regardless of the type of product.

Most health plans require a network, such as Heraya's, to provide services for all lines of business rather than allowing individual providers to select which types of service agreements they will accept. Heraya providers must provide services to any enrolled members/patients covered under a plan in which the provider has contracted through Heraya.

Heraya providers may opt out of one contract or another but must provide services for all lines of business within a specific health plan or contract unless otherwise prohibited by State Rules and Regulations. This requirement does not apply to Heraya's CAMplus program.

Providers should refer to their Professional Services Agreement Attachment "A" to verify which plans are effective within their signed contract with Heraya.

1.05 Provider Obligations

Adverse Event Notifications

Participating providers are required to provide notification to Heraya immediately upon notice of any adverse actions or investigations initiated against the provider as outlined in the Professional Services Agreement Section 2: *Early notification allows us to monitor quality related activity and may possibly avoid Heraya having to take further adverse actions when we later are informed by outside sources*.

Examples of reportable adverse events to Heraya

- License Board complaints or investigations.
- License Board actions.
- Malpractice claims filed or settled.
- Any action that restricts, prohibits, or terminates your activity with a health plan, payer, or professional health care institution.

- Civil actions taken which result in legal charges, criminal investigation, lawsuits, incarceration etc.

Other Common Provider Obligations

- Timely notification for vacations, leave of absence or sabbatical requests. See Vacation/Leave of Absence/Sabbatical Policy.
- Strict compliance with Heraya Policies relating to relocating office practice. See Relocation Policy.
- Compliance with Heraya policies relating to Call Coverage. See Coverage in Providers Absence policy.
- Maintain current, active professional license at all times.
- Maintain current professional liability insurance at all times and provide timely proof of such coverage to Heraya upon request.
- Maintain current, active email address, submit to Heraya for official communication (e.g., credentialing, contracting) and provide any changes to this email address in a timely manner. The provider cannot unsubscribe or opt-out.
- Signing, completing, and returning or furnishing documents requested by Heraya staff for purposes of contracting, credentialing and utilization reviews.
- Compliance by participating in Heraya's Patient Satisfaction Surveys in a timely manner. The provider cannot unsubscribe or opt-out.

Professional Obligations/Courtesy

Participating providers and their office staff are requested to do their part in respecting Heraya's business reputation with health plans, health plan members and in the IH community. Heraya providers and/or office staff with complaints or experiencing dissatisfaction with Heraya are encouraged to contact the Provider Relations Department to address or resolve those matters in a positive and collaborative manner.

Disparaging remarks regarding satisfaction with contracted health plan carriers or with Heraya made to health plan members, in meetings, or other public forums is counter-productive and negatively affects both the professional reputation and the business opportunities of the IH profession. At Heraya, we strive to always speak with respect to our providers and affiliates and we request the same courtesy of all our participating providers. We are always happy to speak with our providers and their office staff.

Contractual

To be as transparent as possible Heraya would like to draw the attention of our participating providers to the following excerpts taken from the Professional Services Agreement. These excerpts relate directly to all participating providers' contractual obligations. Please review your Professional Services Agreement for complete details on Provider Obligations.

Professional Services Agreement: Section 2 Provider Obligations: *"Provider agrees:*

2.8 To comply with all Heraya Policies of which Provider knows or reasonably should have known. Policies may be revised and updated from time to time pursuant to Section 7, but no Policy change will be retroactive without the express consent of the Provider. In the event of any inconsistency between a Policy and this Agreement, this Agreement shall prevail.

2.12 To notify Heraya within ten (10) days after the occurrence of any changes in the information or statements contained in Provider's Heraya Participation Application ("Application"). A copy of Provider's Heraya Application, as completed and signed by Provider, is available upon request, and Provider represents and warrants that the information and all statements in the Application remain true, correct, and complete.

2.13 To notify Heraya immediately in the event of any of the following:

- *(a) The proposed or actual suspension, restriction, revocation, or non-renewal of Provider's license to provide health care services or the imposition or proposed imposition of probation or limitations on Provider's privilege to practice;*
- *(b) The proposed or actual suspension, restriction, revocation, non-renewal or other limitation or termination of Provider's privileges or credentials by any entity, network, or payer;*
- *(c) The (i) issuance of any formal allegation to Provider (including any complaint, indictment or other initiation of a proceeding) before a court of law, state licensing authority or professional society regardless of the content of the allegation, or (ii) commencement of an investigation by, or the filing of a complaint before, a governmental authority or professional society, of which Provider has been notified and which relates adversely to Provider's practice or fitness to practice, involves a claim of alleged malpractice by Provider or involves person(s) under Provider's supervision;*
- *(d) The filing of a report concerning Provider with the National Provider Data Bank, or the Healthcare Integrity and Protection Data Bank; or the filing of a complaint of any nature with a state licensing authority or similar organization (if and when made known to Provider), together with copies of any reports or complaints to Heraya;*
- *(e) The initiation of any investigation, audit, review, or other administrative proceeding, or the issuance of any subpoena, warrant, or civil or criminal investigative demand, relating to compliance with state or federal fraud and abuse laws, including but not limited to 42 USC §§ 1320a-7, 1395nn, and applicable state laws and regulations;*
- *(f) Provider's arrest, charge or conviction of any misdemeanor or felony (excluding parking tickets and minor traffic infractions); or*
- *(g) Provider's expulsion or suspension from Medicare or Medicaid programs.*

Failure to provide immediate written notification of the occurrence of any of the events identified in (a) – (g) above shall constitute a material breach of this Agreement and may result in immediate termination of the Agreement. In the event of the occurrence of any of (a) - (g) above, Provider shall cooperate fully with Heraya's investigation, including the timely provision to Heraya of all information in Provider's possession, or to which Provider has or can gain access, related to the events of (a)-(g).

Further, if Provider is under licensure probation in any state in which the Provider practices, then the Provider must comply with all requirements of that process and proceeding. If the Provider is not in

compliance, Heraya's remedies shall include, but not be limited to, immediate termination of this Agreement and recoupment of payment for any services rendered by the Provider outside of the probationary ruling, subject to Provider's right of appeal under Section 8.5."

1.06 Heraya Provider Code of Ethics*

The following Code of Ethics incorporates the characteristics and values that most people associate with ethical behavior. The expectation of Heraya is that all Heraya participating providers conduct themselves in an ethical manner as described below:

(1) **HONESTY.** Heraya providers are expected to be honest and truthful in all their interactions and to not deliberately mislead or deceive others by misrepresentations, overstatements, partial truths, selective omissions, or any other means.

(2) **INTEGRITY.** Heraya providers are expected to demonstrate personal integrity and the courage of their convictions by doing what they believe is right even when there is great pressure to do otherwise and by not sacrificing their principles for expediency.

(3) **TRUSTWORTHINESS.** Heraya providers are expected to be worthy of trust, to be candid and forthcoming in supplying relevant information and correcting erroneous information, and to make every reasonable effort to fulfill the letter and spirit of their promises and commitments. They are not expected to interpret agreements in an unreasonably technical or legalistic manner to rationalize non-compliance or create justifications for escaping their commitments.

(4) **LOYALTY.** Heraya providers are expected to demonstrate fidelity and loyalty to members and business affiliates by devotion to their professional standards; they are not to use or disclose information learned in confidence for personal advantage; they are to safeguard their ability to make independent professional judgments by carefully avoiding undue influences and conflict of interest.

(5) **FAIRNESS.** Heraya providers are expected to be fair and just in all their interactions with other; they are not to exercise power arbitrarily, nor take undue advantage of another's mistakes or difficulties.

(6) **CONCERN FOR OTHERS.** Heraya providers are expected to be caring, compassionate, benevolent, kind, helpful to those in need, and seeking to accomplish their healthcare objectives in a manner that causes the least harm and the greatest positive good.

(7) **RESPECT FOR OTHERS.** Heraya providers are expected to demonstrate respect for the human dignity, autonomy, privacy, rights, confidentiality, and interests of all those who have a stake in their decisions; they are to be courteous and treat all people with equal and non-discriminatory respect and dignity.

(8) **LAW-ABIDING**. Heraya providers are expected to abide by laws, rules and regulations relating to their health care practice.

(9) **COMMITMENT TO EXCELLENCE**. Heraya providers are expected to pursue excellence in performing their duties, to be well informed and prepared, and to constantly endeavor to increase their proficiency in all areas of responsibility.

(10) **LEADERSHIP**. Heraya providers are expected to be conscious of the responsibilities and opportunities of their position and strive to be positive ethical role models by their own conduct and by helping to create an environment in which principled reasoning and ethical decision-making are highly prized.

(11) **REPUTATION AND MORALE**. Heraya providers are expected to seek to protect and build the profession's reputation and the morale of those employed in the profession by engaging in no conduct that might undermine respect and by taking whatever actions are necessary to correct or prevent inappropriate conduct of others.

(12) **ACCOUNTABILITY.** Heraya providers are expected to acknowledge and accept personal accountability for the ethical quality of their decisions and omissions to themselves, their colleagues, their patients, and their communities.

*Adapted from Ethics in Business, Training program for Ethics Education, Copyright © 1991 Josephson Institute.

1.07 Advertising by Providers

Restriction from Advertising Using Health Plan Names

As with any registered name, the company using that name has the right to restrict its usage. This applies to Heraya Health trademarks and to our contracted health plans. **Heraya's contracted health plans have prohibited the use of their names in any advertising by Heraya or its providers.** Heraya asks all Heraya providers to respect the rights of the health plans and comply with this stipulation in all advertising. Refusal to immediately comply with advertising guidelines, as well as those for the Heraya trademarks, may result in termination from the network. Random website audits are performed to ensure our contracted health plans of compliance with this policy.

Heraya no longer uses the business names: AcuMedNet, ChiroNet, NatureNet, or Heraya Massage and only markets or advertises using the **Heraya Health** name and trademark and Heraya's new name/trademark: Heraya Health®.

Providers contracted with Heraya may not use the Heraya or CAMplus name and logo or any of the names listed above for advertising their services without the express written approval of Heraya. To request permission the provider must:

- Submit a letter of request to Heraya, attention ProviderRelations, and
- Identify the specific media being used and attach a final copy of the advertisement.

The request may either be mailed or faxed to Heraya, allowing one week for processing.

Permission may be granted for use of the registered trademark name under the following restrictions:

- Heraya Health℠, Heraya Health℠ and/or CAMplus cannot be used immediately adjacent to other complementary health plan payer names.
- If using a series of payer names, Heraya Health℠, Heraya Health℠ and/or CAMplus must be the first name(s) in the series.
- If using a series of payer names, the font size used for Heraya Health℠, Heraya Health℠ and/or CAMplus shall be equal to or greater than the font size used for other payer names.
- The Heraya Health℠, Heraya Health℠ and CAMplus names cannot be altered in any manner.
- The Heraya Health℠ or Heraya Health℠ name must be followed by the registered trademark or service mark as appropriate: ® and ℠.

Avoiding Non-Compliance with Advertising

- Advertising, for the sake of this policy, is defined as any form of communication from the provider, the provider's office, or a representative of the provider to Heraya's contracted health plan members which offer IH services specifically identifying an affiliation with the health plan;
- The provider may not place a sign in the office window advertising they are a Heraya provider or that they are authorized to treat specific health plan members;
- The provider may not send out announcement letters to former members, current members, or potential future members announcing the provider is "now on the Heraya network";
- The provider may not advertise on a website without prior authorization using the names of Heraya or a Heraya contracted health plan, other contracted entity, i.e., an association or TPA, or indicate they are a participating provider on any of these plans; and
- A provider may not advertise or offer discounts to Heraya contracted health plan members for services provided under their insurance benefits.

1.08 Anti-Trust Guidelines

Heraya was formed in part to provide a network of participating providers to contract with organizations responsible for paying for health care services and to make known the availability of its providers to provide services to the public.

The Antitrust Laws

The antitrust laws of the United States and the State of Oregon are designed to promote competition. Section 1 of the Federal Sherman Act prohibits agreements, whether express or implied that restrain competition. Section 2 of the Sherman Act prohibits efforts by a single person (or single entity) to monopolize, attempt to monopolize, or conspire to monopolize. Violations of the antitrust laws can be prosecuted as a felony by the U.S. Department of Justice. Both the Department of Justice and the Federal Trade Commission can file civil lawsuits to enjoin violations and to assess civil penalties. The State of Oregon also may file suit to enforce the state and federal antitrust laws. Private persons who have been harmed because of an antitrust violation can file civil lawsuits seeking treble damages and attorneys' fees.

To ensure compliance with the antitrust laws, Heraya has adopted the following guidelines for its dealings with health plans.

Fee-for-Service Contracting

No Price Fixing or Other Agreements Limiting Competition

Otherwise, independent providers who are not sharing substantial risk in connection with a managed care contract must make independent decisions whether or not to contract with particular health plans and must set their fees and prices independently.

Heraya will not undertake directly to provide or negotiate for the provision of health care services pursuant to contracts under which the health plan pays on a negotiated fee-for-service or other basis that does not expose Heraya and/or its providers to substantial risk for the cost of the services. Rather, Heraya's function is to facilitate arrangements between its participating providers and health plans. In furtherance of this role, Heraya will not:

1. Agree or disagree on behalf of its participating providers, individually or collectively, to enter into negotiated fee for service contracts;
2. Advise its participating providers whether they should or should not enter contracts with health plans; or
3. Share information among its participating providers as to the price or other bases on which they contract or do business individually, or as to whether they are prepared individually to do business with any health plan.

Risk Contracts

Forms of Risk Contracts

If Heraya and its participating providers enter risk contracts with health plans, these provisions of the guidelines shall govern. "Risk contracts" means any one of the following arrangements.

1. *Capitated Contracts*
   Heraya and its participating providers may contract with health plans to provide services in consideration of a prepaid or periodic payment, in return for which Heraya and/or the participating providers assume substantial risk for the cost of services provided.
2. *Percent of Premium Contracts*
   Heraya and its participating providers may contract with health plans to provide services in consideration of a predetermined percentage of premium or revenue from the health plan.

Other

Notification: This policy will be provided to each participating provider.

Non-Exclusivity

Heraya's participating provider network is non-exclusive. Participating providers are free to contract directly with a health plan that is free to approach the participating providers directly.

1.09 Provider Resignation

Any provider wishing to resign from Heraya Health network should notify the Provider Relations Department in writing. All resignations are handled in accordance with Heraya's Professional Services Agreement, Section 8.00.

Provider Notification

Provider notifications contain the following:

- Reason for or acknowledgement of resignation,
- Date of resignation,
- Responsibility to notify active Heraya members,
- Responsibility to notify active Heraya members of any charges for which the member will be responsible if the member continues in provider's care following the provider's inactivation or the completion of the member's approved plan of treatment as set forth in the Professional Services Agreement Section 8.6,
- A list of active Heraya members identified, and
- Copy of a sample Heraya member letter.

Member Notification

Heraya will send written notice of the discontinuance of a provider's contract with Heraya to all active members, in accordance with State Laws, as noted below:

- ***Oregon***: Heraya will notify all active members of a Heraya provider's inactivation no later than 10 days from the termination effective date, irrespective of whether the termination was for cause or without cause.
- ***Washington***: Heraya will notify all active members of a Heraya provider's inactivation within 15 business days from the date of notification to the Heraya provider, irrespective of whether the termination was for cause or without cause.

In addition, participating providers are required by contract to provide timely and appropriate notification to Heraya members under the provider's care within fifteen (15) calendar days from the resignation notification made to or from Heraya.

Contracted Entity Notification

Heraya contracted entities relevant to the inactivated provider are notified through the established reporting process by Heraya which occurs at least monthly. All resignations are handled by Heraya in a discreet and professional manner.

1.10 Provider Termination

Heraya has the right to terminate a provider pursuant to the terms of the Professional Services Agreement between Heraya and the provider, Section 8.00. Terminations may be made for "cause" or "without cause." Providers terminated from the Heraya network may not request reapplication for a period of five (5) years. Providers are requested to maintain their professional integrity when leaving the network, or in matters of termination, by not involving members in disputes.

Provider Notification

Provider notifications contain the following:

- Reason for the termination,
- Date of termination,
- Responsibility to notify active Heraya members,
- Responsibility to notify active Heraya members of any charges for which the member will be responsible if the member continues in provider's care following the provider's inactivation or the completion of the member's approved plan of treatment as set forth in the Professional Services Agreement Section 8.6,
- A list of active Heraya members identified, and
- A sample of the Heraya member letter.
- Appeals rights if applicable, see below.

Member Notification

In the event of a provider's immediate termination resulting from death, health issues, professional conduct, or criminal investigation issues, members will be provided immediate notification no later than ten (10) calendar days from the date of termination. Notifications will not provide information pertaining to the reasons for termination and will state only that the provider "will no longer be participating on the network effective (date)."

Appeals Process

Heraya is not required to provide an appeal process when a provider's contract is terminated pursuant to a "without cause" contract provision. Appeal rights are only granted when quality of care is the reason sited for the termination.

A two-level appeal process is available to participating providers who do not agree with the Credentialing Committee's decision concerning quality of care terminations. The procedure for a participating provider to appeal the decision of the Credentialing Committee is outlined in the Appeals policy 7.04.

Contracted Entity Notification

In the event of a provider's immediate suspension or termination resulting from death, health issues, quality of care, professional conduct, or criminal investigation issues, contracted entities will be notified within one (1) business day of termination.

2.00 Heraya Clinical Record Quality Standards

High quality clinical care is reflected in high quality clinical documentation. Heraya is committed to assisting providers to achieve the highest levels of competency with respect to clinical record keeping. These standards establish Heraya's performance expectations for record keeping and processes to improve record keeping competency. In compliance with the National Committee on Quality Assurance, Heraya requires all network providers to ensure that a contemporaneous clinical record is established and maintained for each member who receives services from a Heraya provider. Clinical records must be maintained in accordance with all applicable professional, state, and federal standards, as well as the Heraya standards outlined in this section. These best practices facilitate record keeping to ensure clinical documentation is current, detailed, and organized to promote communication, maintain member confidentiality, deliver effective member care, permit quality improvement, and document medical necessity.

Definitions

Clinical Records:
The term "clinical record" means a record created by or on behalf of a provider of health care for services provided to a member. This record includes information that the member may provide concerning personal identification, demographics, social and family history, symptoms, and medical history. Information entered into the medical record by the provider includes the history reported by the member, the results of examinations, reports of tests and consultations, diagnoses, clinical assessments, treatment plans, treatments rendered including modalities, instructions, and advice, and recommended follow-up.

Protected Health Information (PHI):
Under HIPAA, protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

Health information such as diagnosis, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information. PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically.

PHI is only considered PHI when an individual could be identified from the information. If all identifiers are stripped from health data, it ceases to be protected health information and the HIPAA Privacy Rule's restrictions on uses and disclosures no longer apply.

Other examples of where PHI may be documented include completed health care claim forms, detailed claim reports, explanations of benefits (EOB), and notes documenting discussions with members.

Occasionally Heraya requires you to submit clinical records for various purposes. When responding to these requests, it is imperative that you comply with Federal rules that protect member confidentiality. **Note: These rules do not apply to clinical records submitted to support billing, for Treatment Extension Requests, appeals, and other aspects of payment.**

The following are the 18 identifiers that create the definition of "individually identifiable" and can be used to identify a specific individual.

1. Names of members, spouses, relatives.
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes. The exceptions are for the initial three digits of a ZIP code if, according to the current publicly available data from the Bureau of the Census (a) the geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (b) the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. Day and month elements of dates directly related to an individual, such as birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of "age 90 or older." **Note: this does not apply to dates of service in the chart notes.**
4. Telephone numbers.
5. Fax numbers.
6. Email addresses.
7. Social Security numbers.
8. Medical record numbers.
9. Health plan beneficiary numbers.
10. Account numbers.
11. Certificate/license numbers.
12. Vehicle identifiers and serial numbers, including license plate numbers.
13. Device identifiers and serial numbers.
14. Web Universal Resource Locators (URLs).
15. Internet Protocol (IP) addresses.
16. Biometric identifiers, including finger and voice prints.
17. Full-face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code.

2.01 Heraya Clinical Record Criteria

Confidentiality of Clinical Records

PHI is legally protected and must be handled in a confidential manner. Unless otherwise required by law, including those laws that apply to minors, disclosure of member-specific health information can be only to:

1. The individual to whom the information relates.
2. Heraya and/or a health plan contracted with Heraya to perform health care delivery, payment, administration and/or management functions on their behalf.
3. A third party only if specific authorization is obtained from the individual to whom the information relates.

Heraya providers will make available to member's (and members' minor children's eligible dependents) member-specific health information for inspection and copying, except as otherwise provided by law.

Clinical Record Keeping System and Standards for Availability

1. Clinical records must be organized and stored in a manner that allows easy retrieval.
2. Clinical records must be stored in a secure manner that allows access by authorized personnel only.
3. Each member will have a centralized clinical record containing all clinical records for that member. Records are organized in date-order.
4. This record will be opened at the time of a member's first visit. Entries into the record will be contemporaneous with the encounter.
5. The provider will store, retain, and maintain such records for a period consistent with applicable state and federal law.
6. The obligations of the provider regarding clinical records will survive the termination of Heraya's Professional Services Agreement, regardless of the cause giving rise to such termination.
7. There is evidence of continuity and coordination of care. Records from other providers and outside consultants will be maintained in the member's record.
8. Consultation, laboratory, and diagnostic imaging reports filed in the records will be initialed by the provider to signify review.
9. Abnormal lab and imaging results will have an explicit notation in the record of follow-up plans for notifying the member as well as the clinical intervention.
10. Records will be maintained in ink or appropriate Electronic Health Record (EHR) system.

Clinical Records Documentation Standards: "Best Practices" in Record Keeping

1. Legibility
    a. The record is legible to someone other than the writer.
    b. Type written is preferred.
    c. Abbreviations used are standard and comprehensible by a peer or are accompanied by a key that explains their meaning.
2. Identification

a. The record contains identifying personal biographic and demographic data of the member including address, home and work telephone number, marital status, employer, and alternate/emergency contact person.
b. Each side of each page of the record contains the member's name and date of birth (or unique identifier), the provider's name and clinic of origin by name, physical address, and telephone number.
c. Each entry is dated by month, day, and year.
d. The author of each entry is identified by name. Services that are provided or ordered must be authenticated for each entry by the provider of or ordering provider using a valid signature. Signatures are to be handwritten, electronic, or stamped (only permitted where the author has a physical disability and who can provide proof of an inability to sign due to the disability).
    - **Handwritten Clinical Record**: For a signature to be valid it must be legible. Alternatives include an illegible signature or initials next to a typed/printed legible identification of the author; illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory; where multiple providers are listed the author of record is specifically identified; illegible signature or initials accompanied by a signature log or attestation statement.
    - **Electronic Clinical Record**: For a signature to be valid, systems and software products must include protections against modification (e.g., time and date stamp), and administrative safeguards should be applied that correspond to standards and laws, e.g., using signature and secure login functions appropriately. Best practice would include the following elements:
        - Full printed name of the author at the end of the entry.
        - Date.
        - Time.
        - Digitized signature or signature statement, e.g., electronically signed by, signed by, authenticated by, reviewed by, etc.

3. Clinical Information
    a. The complaint prompting the member to seek care is noted. The mode of onset, location, nature, duration, aggravating/palliating factors (OPQRST) are documented.
    b. Prior interventions and outcomes of previous treatment of the presenting condition are indicated.
    c. Other pertinent current medical history, system review, past medical history, family, and socioeconomic history are noted.
    d. Notations of all significant illnesses, surgeries, and injuries. For children and adolescents, pre-natal care, birth, operations, and childhood illnesses are documented.
    e. Clinical indications for laboratory and diagnostic imaging studies are documented.
4. Member Safety
    a. Current and significant past medication (including Rx, OTC, and natural medicines) use is documented.
    b. Allergies, medication allergies, intolerances, adverse reactions, and contraindications to potential treatments are clearly noted.
    c. Informed consent is obtained and properly documented and included in the clinical record. This process includes a verbal discussion to include the following elements often referred to as the "PARQ" conference:

- (P) explanation of proposed examination, procedure, or treatment in general terms,
- (A) viable alternatives,
- (R) material risks,
- (Q) ask if the member has any questions.

This can be documented in the clinical record as PARQ. If the member requests further information or has specific questions the provider can underline PARQ and should note the question and the more detailed information provided. It is also recommended that the member sign a document acknowledging they have been part of the informed consent process, that the material risks have been disclosed, including a description of those risks, and that the member has agreed to the procedures, understands the risks, understands the alternatives, and the opportunity to ask questions has been provided. This could be accomplished using a prepared written consent form or other format that must be signed by the member and should be signed by the provider. It is important that providers have a discussion directly with the member and not rely exclusively on these forms.

5. Preventive Health Care
   a. There is documentation and advice when appropriate for routine preventive health measures, such as:
      - Tobacco use.
      - Alcohol use.
      - Exercise habits.
      - Diet.
      - Screening for obesity.
      - Hypertension.
      - Cholesterol.
      - Sleep habits.
      - Known allergies.
      - Mammography.
      - PAP.
      - Stress.
      - Assessment of behavioral health status.
   b. Inquiry about and referral for significant chronic conditions (CAD, heart failure, diabetes, asthma, etc.) is noted.
6. Integrated Care
   a. Member's other health care providers (PCP, specialists, IH) are identified.
   b. Permission to contact member's other care providers is documented.
   c. Contact with other care providers (written, telephone, etc.) is documented.
7. Evaluation
   a. Vital signs are recorded.
   b. Findings of abnormal and pertinent negative physical and laboratory examinations and diagnostic imaging are documented. The examinations are appropriate for the presenting condition. The test results are clearly documented in the record by being adequately described and results properly qualified and quantified.
   c. Appropriate outcomes assessments are used, such as functional (ADL) assessment, physiologic measurements, and outcome assessment tools (VAS, pain drawing, etc.).
8. Assessment

a. The provider's initial assessment of the member's condition, whether a working diagnosis, clinical assessment or impression is clearly indicated.
b. Progress of the members' condition is noted in every chart note.
c. The initial and ongoing assessments are consistent with the history, complaints, and examination findings.

9. Treatment Plan
    a. The treatment plan is documented.
    b. Expected visit frequency, duration, and interventions are noted.
    c. Goals/expected outcomes of treatment are identified.
    d. Obstacles to recovery and strategies to overcome them are documented.
10. Follow-up Visits
    a. Each entry in the clinical record is visit specific where all components of a routine visit with an established member are documented.
    b. Review of chief complaint, effect of the prior treatments, changes since the last visit and pertinent interim history are documented.
    c. Relevant examination findings are noted.
    d. Current clinical assessment of the member's condition and the member's progress are noted.
    e. The treatment rendered, recommendations and instructions to the member at the visits are documented.
    f. Follow-up is documented.
11. The patient record should never be backdated, erased, deleted, or altered in any way. If corrections need to be made or addendums added to a written record, a line should be drawn through the correction, or the addendum inserted and the change initialed and dated. In the case of electronic patient records, corrections or amendments should be made using an addendum that is signed or initialed and dated. In both cases, the original record should be preserved.

2.02 Performance Goals for Clinical Record Quality Improvement and the Clinical Record Quality Improvement Program (CRQIP)

Performance Goals

Assessing the Quality of Clinical Records

Clinical record keeping quality is measured by discipline-specific scoring tools that were developed by provider focus groups. A minimum quality threshold has been established for each discipline and noted on the applicable scoring tool.

Initial Applicants

Initial applicants are required to submit clinical records at the time of application for initial credentialing and are required to meet the minimum quality threshold prior to acceptance on the network. Initial applicants are notified of this requirement and provided a copy of the scoring tool in the credentialing application for awareness of the scored elements.

Heraya Contracted Providers

For contracted providers, clinical records are routinely monitored for quality improvement purposes, in concert with record reviews related to claims submissions and Heraya's Utilization Management Program. Heraya contracted providers who do not meet threshold will be allowed to enroll and participate in the CRQIP twice. Failure to pass CRQIP or maintain clinical record quality standards may result in Heraya offering the contracted provider the opportunity to resign. Otherwise, Heraya will terminate their participation for breach of contract in accordance with the Professional Services Agreement.

All Heraya contracted providers who meet threshold are assigned to one of three categories below and are notified in writing of their status.

1. ***Audit Pool***: This pool is comprised of 1) contracted providers who have met or exceeded the scoring tool threshold specific to their discipline and 2) initial applicants who met the threshold are automatically placed in this pool since only one clinical record review has occurred. The providers in this pool will be required to submit clinical records periodically at Heraya's request.
2. ***Exempt Status***: Heraya providers who have consistently demonstrated the ability to keep quality clinical records by scoring at least 85% twice consecutively, without being enrolled in CRQIP, may be exempted from further clinical record quality reviews. This status requires approval by a clinician reviewer or a Heraya Medical Director. All exempt providers may be subject to periodic random clinical record quality reviews if deemed necessary by a Heraya Medical Director.
3. ***Exception Status***: Exceptions to meeting the minimum quality threshold may be granted by the Heraya Chief Clinical Officer. Criteria for determining an exception include:
    a. Number of current active members.
    b. Geographical location.
    c. Number of other providers in the geographic area meeting threshold standards.
    d. Tenure on network.
    e. Business needs.

Change of Status

A clinician reviewer or a Heraya Medical Director has the right to change a provider's status. This change will be communicated to the provider by letter. Medical necessity reviews performed by Heraya or its contracted health plans or related activities which indicate non-compliance with maintaining threshold standards will result in auditing of the providers' clinical records. This policy will apply to all contracted providers, including those who may have been previously exempt from clinical record audits.

Initial applicants and Heraya contracted providers whose clinical records do not meet the established minimum thresholds are enrolled in and must successfully complete the CRQIP which is described below.

CRQIP Process

Clinical records not meeting the established thresholds will result in provider enrollment in the CRQIP. The following process applies to both initial applicants and contracted providers:

1. Heraya notifies the provider in writing of the CRQIP enrollment. This notification will contain the following:

a. Instructions on when and how to submit a new set of clinical records. All enrollees are provided 60 days to finish the program from the initial date of notification.
b. A copy of completed scoring tool and notes scored.
c. Quality Improvement Guide to Clinical Record Keeping containing information relating to areas where the applicant scored low.
d. A copy of the blank applicable scoring tool and guidelines.

2. Clinical records are submitted to Heraya by the provider within 45 days of enrollment.
3. Clinician reviewers audit clinical record quality utilizing scoring tools based on the discipline specific performance criteria.
4. Heraya notifies the provider in writing of scored results. The course of action for those providers whose scores pass threshold and for those who do not is outlined below.
5. Heraya scans all relevant CRQIP information to the provider database.

Scores At or Above Threshold

Initial Applicants: Clinical records meeting the minimum quality threshold for initial applicants will result in the continuation of the credentialing process. The provider is notified of the passing score, provided a copy of the scoring tool, notified of placement in the Audit Pool for future periodic clinical record reviews and that the credentialing process will be completed.

Contracted Providers: Clinical records meeting the minimum quality threshold for contracted providers will result in notification of the passing score. The provider will be given a copy of the scoring tool and, if applicable, notified of a status change.

Scores Below Threshold

Initial applicants or contracted providers whose clinical records do not meet the minimum quality threshold after the CRQIP review will be given the following two options:

1. The provider will be given the opportunity to work with a mentor to meet Heraya's minimum threshold requirements.
2. If the provider should choose not to work with a mentor, Heraya may proceed to terminate their participation for breach of contract in accordance with the Professional Services Agreement or for initial applicants, may proceed with application closure.

Clinical Record Mentors

If the initial applicant or contracted provider chooses the option to work with a mentor to meet Heraya's minimum quality threshold, the provider will be contacted by the assigned mentor and repeat the CRQIP process described above.

2.03 Clinical Record Quality Improvement: Visit Specific Clinical Records Program

Clinical records not meeting the visit specific requirement will result in provider enrollment in the Clinical Record Quality Improvement: Visit Specific Clinical Records Program.

Performance Goals for Clinical Record Quality Improvement: Visit Specific Clinical Records Program

Assessing the Quality of Clinical Records

Requirements have been established for all Heraya providers to document visit specific entries in the clinical record. This is noted on the applicable scoring tool and scoring guidelines.

Initial Applicants

Initial applicants are required to submit clinical records at the time of application for initial credentialing and are required to meet the visit specific requirement in their clinical record keeping. Initial applicants are notified of this requirement and provided with a copy of the scoring tool and scoring guidelines in the credentialing application for awareness of the scored elements.

Heraya Contracted Providers

Contracted providers are required to meet the visit specific requirement in their clinical record keeping in concert with record reviews related to claims submissions and Heraya's Utilization Management Program.

Initial applicants and Heraya contracted providers whose clinical records do not meet the visit specific requirement are enrolled in and must successfully complete the Visit Specific Clinical Records Program which is described below.

Visit Specific Clinical Records Program Process

The following process applies to both initial applicants and Heraya contracted providers:

1. Heraya notifies the provider in writing of their enrollment in the Visit Specific Clinical Records Program. This notification will contain the following:
    a. A memo detailing the visit specific requirements and instructions on the next step. All enrollees are provided six (6) months to finish the program from the initial date of notification.
    b. A copy of the completed scoring tool and notes scored.
    c. A copy of Best Practices in Clinical Record Keeping: Visit Specific Chart/Progress/Encounter Notes.
2. A follow up memo is sent six (6) months from the initial date of notification to request a new set of clinical records.
3. Clinical records are submitted to Heraya by the provider.
4. The Regional Medical Director or clinical reviewer of the same discipline will audit clinical record quality on the explicit discipline specific performance criteria.
5. Heraya notifies the provider in writing of the results. The course of action for those providers who meet the visit specific requirement and for those who do not is outlined below.
6. Heraya scans all relevant information to the provider database.

Providers meeting the requirements

Clinical records meeting the visit specific requirements will result in notification of successful completion of the program.

Providers not meeting the requirements
Clinical records that do not meet the visit specific requirements will be given the following two options:

1. The provider will be given the opportunity to work with a mentor to meet Heraya's requirements for visit specificity.
2. If the provider should choose not to work with a mentor, Heraya may proceed to terminate their participation for breach of contract in accordance with the Professional Services Agreement or for initial applicants, may proceed with application closure.

3.00 Provider Office Information

3.01 Office Location

Heraya providers agree to provide professional services to Heraya members in a permanent, fixed professional office setting located in a traditional commercial office site. Services provided to members must be performed only at the approved location which must meet Heraya's site visit requirements. In addition, prior authorization is required before relocation. Please reference the Office Relocation policy 3.03 if further clarification is needed.

A traditional commercial office site includes a medical office building, and freestanding office or clinic, or a house converted entirely to a professional office, but does not include health clubs, other athletic facilities, gymnasiums, salons/spas, mobile, out-call, or house-call practices.

Exceptions
Heraya may consider a location other than a traditional commercial office site, such as a home office. Such exceptions may be granted when necessitated by Heraya having a geographic need. The Director of Provider Relations and Engagement or the Chief Clinical Officer will review exception considerations.

In such an event, the office will be required to meet Heraya site visit policies and the following criteria:

- The office meets or exceed Heraya's Office Facility Questionnaire threshold.
- The provider must not provide services in a facility where customers are receiving non-related health care services that create noxious odors such as acrylic nail manicures, hair dying and permanents,
- The provider's office must be located on a separate floor or office adjacent where the member is not required to walk through health clubs, other athletic facilities, gymnasiums and/or salon/spa or residential living quarters, and
- Heraya may request pictures of the location, both inside and outside the clinic.

3.02 Office Site Approval/Site Visits

Office Facility Questionnaire (OFQ) reviews are an integral part of the Heraya credentialing process relating to all contracted providers. A provider's office must meet or exceed a score of 80% to be considered for network participation. The self-attested OFQ received from the provider at initial application and subsequent recredentialing (if structural changes have occurred since initial application) serves as the site visit audit tool and evaluates the following criteria:

- Patient access-appointment availability,
- Patient safety,

- Privacy-confidentiality,
- Clinical recordkeeping practices,
- Cleanliness,
- ADA accessibility,
- Adequacy of waiting- and examining room space, and
- Other miscellaneous information.

The following will result in a failed OFQ score automatically:

- A room without floor to ceiling walls for patient confidentiality and privacy,
- Patient information accessible to patients or guests,
- Providers performing Acupuncture not utilizing FDA-approved disposable needles.

Credentialing Committee OFQ Reviews

An OFQ scoring below the 80% threshold relating to a contracted provider's office will result in the opportunity to correct areas to meet the threshold. If the provider refuses to meet threshold, the providers OFQ may be presented to the Credentialing Committee for a decision as to network membership.

Random On-Site Visits

Heraya may conduct random site visits to ensure compliance with Heraya office site policies. The Chief Clinical Officer or Director of Provider Relations and Engagement oversees the site visit process. Heraya provides 10 business days advance notification to the provider when scheduling a random site visit.

Heraya reserves the right to perform a random site visit on any participating provider's office site in the event of quality of care concerns made by members, health plans or other sources. Providers will be given a 24-hour notice provided in writing of such visit, as per the Professional Services Agreement.

Networks in Process of Being Developed Outside of Oregon and Southwest Washington

During the development of new networks outside of Oregon and Southwest Washington, a provider's office will be provided the opportunity to make necessary alterations and demonstrate compliance with Heraya's Site Visit Policies within a specified time frame and in accordance with contractual agreements prior to treating Heraya members.

3.03 Office Relocation or Additional Offices

Heraya provides contracted clients with a credentialed and contracted provider network within designated service areas to deliver access for Heraya members. Heraya providers who relocate to another office or wish to add an additional office must contact Heraya as noted below for approval. Continued Heraya network membership will be evaluated for the new or additional location and is dependent upon geographic need.

This policy was established to ensure all Heraya members are treated only by credentialed and contracted Heraya participating providers with adequate coverage in specified geographic locations.

Request for Relocations or Additional Offices

Providers are to submit written notice to Heraya 60 days in advance for consideration of a relocation and will be notified in writing of an approval. This allows Heraya adequate time to review all criteria and relative information, to render a decision, to notify Heraya clients, and to initiate directory and website changes. The new location must meet or exceed the Office Facility Questionnaire as outlined in policy 3.02 Office Site Approval/Site Visits.

An office relocation request may be denied for the following reasons:

- There is adequate provider access in the area of relocation.
- The provider requesting relocation must be in good standing* with Heraya at the time of the request to relocate.
- The provider has moved twice within a one-year period.
- The new office is in the same office as that of a provider who has previously been terminated or denied participation by Heraya.
- If the new office is in the same office as other Heraya providers:
    - All providers must be providing services congruent with Heraya's Philosophy of Care and
    - Must be in good standing* with Heraya's Utilization Management, Quality Management, and Credentialing Programs.

*Good Standing is defined as a provider:

- Who is not under review, in an intervention process or corrective action plan, or investigation, and whose credentialing/re-credentialing is in good standing with the Credentialing Committee and whose practice is congruent with Heraya's Philosophy of Care.
- Whose professional license is current and without sanctions, restrictions or limitations and is not under review or investigation by the licensing board.
- Who has not had adverse actions taken either by a licensing board or another professional entity, regulatory body or judicial body within the past three years (Malpractice claims will be evaluated individually).

3.04 Vacation/Sabbatical/Leave of Absence Policy

Vacation/Absence Notification (less than 10 days)

Notification of vacation or any absence for 10 days or less is not required if coverage will be provided by another Heraya participating provider or if the provider is not currently treating active Heraya members. For the purposes of this policy, an active member will be considered any patient treated in the past ninety days.

Vacation/Absence Notification (over 10 days and up to 30 days)

Heraya must receive written notification such as letter, fax, or e-mail when a participating provider is taking a vacation or other absence from his/her practice and health services must be provided by a pre-approved non-participating provider. Heraya will vet the non-contracted provider for call coverage and notify the provider of the decision to allow coverage. This is outlined in Policy 3.06 Coverage for Heraya Provider's During an Absence.

Leave of Absence Requests (over 10 days and up to six months)

Heraya providers are to submit a written request for a leave of absence when the provider plans to be out of the office for a period over 10 days and up to six months, at least 30 days prior to the proposed leave of absence unless an urgent situation arises. Notifications are forwarded to contracted health plans as required.

A leave of absence is customarily granted for conditions covered under the Family Medical Leave Act and includes family medical leave, chronic or acute health conditions or illnesses. A leave of absence may be granted for personal matters not relating to health at the discretion of Heraya. Call coverage or Locum Tenens coverage may not be provided by a non-participating provider during a leave of absence.

All providers must update all credentialing information before being re-instated to the network and before treating Heraya members. Upon return from a leave of absence, recredentialing may be required by providers who are past due.

Extended Leave of Absence Requests (Six months and over)/Sabbaticals

These written requests should be submitted to Heraya within 30 days prior to the proposed leave of absence. This allows Heraya time to evaluate the request and allow for patient transitions.

The following outlines the length of time for:

- Extended Leaves - are over six (6) months.
- Sabbaticals - are up to two (2) years.

Heraya will take into consideration:

- The length of time the participating provider has been contracted with Heraya.
- If the provider plans to return to their approved geographic office location. Please note this does not guarantee a transfer of network status by the individual health plans.
- The reason for the request.
    - In regard to sabbaticals, due to Heraya's responsibility for continuity of care to its member population, sabbaticals are granted only for purposes of special studies, military leave, or continued education.
- Current standing with Heraya.

Requests for absences should be sent to one of the following:

Mail:
Heraya Health
Attn: Provider Relations
6600 SW 105th Avenue, Suite 115
Beaverton, Oregon 97008

Fax:
877-482-2856

Email:
ps@herayahealth.com

The request must indicate:

- Name of Heraya provider
- Type of absence/reason for absence
- Proposed absence start date
- Anticipated date of return to practice, and
- Name, address, and phone number of proposed covering provider

3.05 Coverage for Heraya Providers During an Absence

Heraya providers are to refer patients to a Heraya participating provider when out of the office. Heraya patients are not to be examined or treated by non-participating providers unless the situation is urgent and/or the non-participating provider has been pre-approved as noted below. Heraya reserves the right to deny authorization of non-participating providers from rendering services in accordance with applicable state laws.

The purpose of allowing for a non-participating provider to treat a Heraya patient is to avoid disruption of the current treating patient's immediate access to service within the same office.

- A Locum Tenens is allowed up to ninety days of a provider's absence. An exception may be made in extenuating circumstances where no other Heraya provider is located within the geographic area.
- A Locum Tenens will not be granted to a non-participating provider when there is another Heraya provider located within the same office.

Definitions:

- ***Locum Tenens***: A provider specifically hired by a participating provider to provide coverage of his or her patients during a scheduled absence.
- ***Call Coverage***: Back-up coverage provided by another provider of the same profession, typically in cases of unscheduled appointments when the participating provider is away from the office or in cases of emergencies when the patient is unable to receive necessary care from the treating provider in a timely manner. See policy 3.07 Emergency Coverage.

Locum Tenens & Call Coverage Request

The Heraya provider is to submit the Call Coverage Application form to Heraya.

The non-participating provider is to submit to Heraya the following:

- A completed Call-Coverage credentialing form.
- Provide a copy of their professional liability (malpractice) insurance coverage.

Heraya providers requesting Locum Tenens/Call coverage relief more than three times in a one-year period may be denied. A Locum Tenens/Call coverage may be denied if in Heraya's opinion the privilege is being abused or another Heraya provider is available within the area.

Approval Notice

Heraya will notify the Heraya provider in writing if the non-contracted provider is granted approval to provide coverage. The (non-participating) covering provider will only be eligible to provide services to Heraya members up to the approved timeframe.

The following members can only be seen by a fully credentialed Heraya participating provider:

- Kaiser Permanente PCP direct patient referrals.
- Kaiser Permanente Health Savings Accounts and High Deductible Health Plans.
- Kaiser Permanente Self-Funded Groups.
- Samaritan Health Plans.
- PacificSource Health Plans.
- Providence MCO providers.

Billing

Below are important points relating to billing Heraya for services rendered by a Locum Tenens/Call Coverage provider:

- The Heraya provider submits claims for services rendered by the approved Locum Tenens/Call Coverage provider who is identified in the field called “Name of Referring Provider or Other Source”. The claim should have the Locum Tenens/Call Coverage NPI Type I indicated in the rendering NPI field.
- The Heraya provider will have sole responsibility for reimbursing the non-participating provider for services rendered.

3.06 Emergency Coverage Policy

Heraya members are to be treated by a Heraya participating provider. A non-network provider may see a patient only in an emergency or as prescribed by applicable state laws.

An emergency is defined as a patient is in ***severe distress*** and cannot wait until the participating provider is available.

When a patient is seen in an emergency by a non-participating provider, who is a non-participating associate or by another non-participating provider providing coverage in an emergency situation, the claim must be submitted under the Locum Tenens/Call Coverage emergency provider’s name and the Heraya provider’s tax identification number with corresponding chart notes.

There should be a note in the patient’s chart describing the emergency and that the non-participating provider was covering for the Heraya provider.

The non-participating provider must agree to accept payment directly from the network provider and at the current reimbursement level set by Heraya. The participating provider is responsible for payment of the services provided to the Heraya patient; any difference between Heraya’s payment and the amount billed by the non-participating provider must either be written off or reimbursed by the participating provider. The patient must be scheduled to return to their regular Heraya provider at the next visit.

It is a serious breach of the Heraya Professional Services Agreement for a non-participating provider to treat health plan members when not approved to provide Locum Tenens/Call coverage unless it is for a true emergency.

3.07 Provider Availability

Heraya providers must ensure health services are available and accessible to all Heraya members including after-hours for urgent needs. Providers shall make services available to all classes of members, in the same manner, in accordance with the same standards, and with the same availability.

Providing Office Hours to Members

Heraya providers must provide patients written, accurate, and complete information regarding access to health care services during and after clinic hours and in an emergency. This may be achieved by a brochure or handout containing:

- Office Hours-the days and hours the clinic is open.
- Heraya Provider Hours-the days and hours the provider is available to treat patients.
- Emergency Number(s).
- After-Hours Information:
    - A phone number should be provided to patients to call for advice or treatment after hours; and
    - The after-hours telephone number such as the provider's office telephone number with an answering machine referring the patient to:
        - The provider's emergency number, or
        - A covering provider.

3.08 Closed Practices

Heraya providers may request a closure to new patients for a period up to six months. This request should be submitted to Heraya within (30) days prior to the date the provider closes his/her practice to new Heraya patients.

Close Practice Requests

To request a temporary office closure to new Heraya patients, please submit the following information:

- Heraya provider's name.
- Heraya provider's address.
- Heraya provider's phone, fax, and e-mail.
- The date range of the closure (not to exceed six (6) months).
- The names and phone numbers of other contracted providers to whom the patients will be referred.
- Close the practice to all new Heraya patients regardless of payer or reopen the practice to all new Heraya patients, regardless of payer.
- Continue to treat patients already accepted in their practice.
- Notify Heraya members at the time of scheduling that the provider is not accepting new Heraya members.

Notification of Closed Practice
Heraya will send written notification of an approved temporary office closure. Heraya may monitor the provider's claims submissions for instances of new patient visits. Extensions of temporarily closed practices for a period beyond six months will be reviewed by Heraya on an case by case basis for purposes of evaluating Heraya member needs concerning access and continuity of care.

Accurate reporting of closed practices by providers is important. It is a business necessity for Heraya to have a reliable network that can be marketed to a variety of payers. It is expected occasional new patients could enter a closed practice (i.e., family members of existing patients); however, more than two (2) new patients per month for three (3) consecutive months may result in an inquiry from Heraya. Unexplained new patients or continued acceptance of new patients from Heraya plans may be considered a violation of this policy.

Provider Directory Updates
Heraya updates our website daily and providers with closed offices will be updated with a closed status on our website until active status is resumed. Heraya's contracted clients are notified that your office is closed to new patients, at minimum monthly. The time for a payer directory to reflect a provider change can range from one (1) to 12 months depending on if the directory is published in hard copy or is an electronic, web-based version.

4.00 Member/Patient Information

4.01 Definitions

- ***Customer***: Includes members/subscribers, member's spouse or dependents, individual enrollees or employer groups or the designated representatives, health plans and their staff, participating and non-participating providers or others, as appropriate.
- ***Member***: A person eligible to receive care or reimbursement under an insurance plan; includes the subscriber, spouse and other eligible dependents as defined by insurer.
- ***Patient***: A person receiving care from a provider. A patient may be a member; a member is not a patient until under care.
- ***Provider***: A licensed health care professional.
- ***Subscriber***: The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO, self-funded employer group, association, TPA, or other health plan.
- ***Complaint***: A member's initial oral or written expression of dissatisfaction.
    - Complaints do not necessarily require a formal review process or have a right to appeal.
    - Complaints requiring a formal review process, or an appeal will be categorized as a grievance.
- ***Grievance***: The formal request and review of a complaint regarding dissatisfaction with healthcare, service or contractual relationship or adverse determination, with a request for further action or a request for payment for services already rendered. A grievance may be the result of an unsatisfactorily resolved complaint. It has a formal review process and a right of appeal.
- ***Appeal***: A written request to review and change a previous adverse determination made by Heraya. Please refer to Section Three 8.00 UM Appeals policies for appeals relating to UM.

4.02 Statement of Members' Rights

Heraya does not delegate any aspect of Member Rights and Responsibilities. All customer service activities are guided and conducted in accordance with NCQA and contracted health plan agreements.

Heraya believes all members should be treated in a manner that respects their specific needs and their basic rights as human beings. Consistent with this belief, Heraya is committed to guaranteeing members' rights as follows:

- A right to receive information about Heraya, its services, providers, members' rights and responsibilities.
- A right to be treated with respect, recognition of their dignity and the right to their privacy.
- A right to participate with providers in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about Heraya or the care it provides.
- A right to make recommendations regarding Heraya's member rights and responsibilities policy.
- A right to confidentiality and privacy during interviews and examinations by all those involved in providing care and healthcare information.
- A right to trust that all information about a member's care and records will be treated in a confidential manner.
- A right to receive all medically necessary care covered by their contracts.

4.03 Member Responsibilities

While Heraya is obligated to review and respond to issues regarding its providers and contracted health plan members and their medical care, all members have a responsibility to appropriately participate with Heraya and their participating providers.

Member responsibilities are as follows:

- A responsibility to supply information (to the extent possible) that Heraya and its providers need to provide care.
- A responsibility to follow plans and instruction of care that they have agreed to with their provider.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- A responsibility to ask for clarification about any aspect of their health care or benefits that they do not fully understand.

- A responsibility to keep scheduled appointments or give adequate notice of delay or cancellation.
- A responsibility to treat those caring for them with respect and courtesy.

4.04 Distribution of Information

Information to Members

- Heraya is restricted from distributing member information directly to health plan members. Member rights are distributed to members by each of Heraya's contracted health plans. Heraya provides members with as much information concerning their health plan benefits relating to IH benefits as allowed by the contracted health plans.

- Access to participating IH providers is provided by the contracted health plans and via the Heraya website. Heraya directories can be mailed to health plan members requesting a paper directory.
- Heraya does not provide written information about benefits and charges applicable to members/subscribers unless required while resolving a member complaint.
- Heraya provides members with information on how to appeal a Heraya decision that adversely affects coverage, benefits, or their relationship with Heraya. Appeals are handled by the contracted health plans.
- Members are notified directly by Heraya if a provider is inactivated from the network; 65 calendar days' notice is provided unless a formal action necessitates the provider's immediate inactivation from the network. A listing is mailed to the members providing the names of other Heraya participating providers within the same geographic area. Please refer to Sections 1.09 and 1.10 within this section.
- Contracted health plans are responsible for disseminating all other member information.

Information to Providers

- A Statement of Member Rights & Responsibilities is provided to initial and existing providers in the Provider Operations Manual which is posted on the Heraya website and available in print form upon request.
- Member Rights & Responsibilities are to be displayed in the provider's office.
- Information on Heraya's customer grievances policies are provided to all initial and existing providers upon initial credentialing approval and provided to initial and existing providers in the Provider Operations Manual which is posted on the Heraya website and available in print form upon request.
- Providers are sent timely notification of revisions to the Provider Operations Manual containing Member Rights and Grievance and Appeal Policies in accordance with contractual agreement.

4.05 Provider Directories

- Access to participating Heraya providers is provided through directories given to the members from the contracted health plans.
- Heraya will mail a directory upon request as well as provide information over the telephone.
- Heraya provides a searchable, web-based directory outlining participating providers' names, clinic name, disciplines, office locations, city, state, and other contracted Heraya providers within an office.
- The website is updated daily. Heraya provides regular reports to contracted entities per the applicable contract requirements.

4.06 Communication and Follow-Up with Members

Communicating with Members Who Have Missed an Appointment

Patients who miss an appointment should be contacted. All attempts and contacts should be documented in the chart. Members may not be charged for missed or cancelled appointments as outlined in Heraya's Billing Manual; however, this does not pertain to members being treated under the CAMplus program.

Communicating Significantly Abnormal Results

When a patient has test results that are abnormal, the provider needs to take steps to notify the patient expeditiously. If the results are of significant concern, notification to the patient is expected immediately by phone, within 24-72 hours, unless a follow-up appointment is already scheduled within this timeframe.

If the abnormal results are not critical, contact with the patient should be made within two (2) weeks either by phone or certified mail.

Meeting Compliance in Communication with Members Having Hearing Impairments

To make it easy for people who use a TTY/TDD to communicate with businesses and individuals who do not have a TTY/TDD, the ADA established a state-by-state relay network nationwide that handles voice-to-TDD and TDD-to-voice calls. Patients who use a TDD to make telephone calls may telephone your office using a relay network. The relays consist of an operator with a TDD who translates TDD and voice messages. Providers can access this service through Signing Resources & Interpreters (SRI) via telephone 877-512-2246 for Kaiser Permanente members.

For Communications Relating to Patient Confidentiality

Please refer to Policy 4.09 within this section.

For Communication Requirements Regarding Non-Covered Services

Please refer to Policy 4.07 within this section for communication requirements when a service will not be covered under the contracted health plan.

4.07 Non-Covered Benefits, Services, or Charges

(This policy does not pertain to members being treated under the CAMplus program.)

By contract and law, providers operating under an “HMO” contract cannot balance forward bill an insured member (patient) for covered services. This means the provider is not allowed to bill patients for any amounts beyond the co-payment, coinsurance, or deductible unless the services or supplies are not covered, and the patient has been notified in advance and provided written authorization that the member will be personally responsible for the charges. Charging what may be called an “up-front” fee beyond the amount of the immediate co-payment, coinsurance, or deductible or for what are sometimes referred to as “anticipated services,” including charges for future co-payments in advance of scheduled appointments is not allowed.

In accordance with the Professional Services Agreement, Heraya’s Billing Manual, and Heraya contracts with health care plans, the provider may not provide services for the member or refer them for services that are not covered under the members contracted plan unless the following steps have been taken:

- The provider will discuss with the member the reasons for requesting non-covered services and will allow the member to make the final decision regarding such services.
- The provider must notify the member the services being requested will not be paid for by the health plan and will be the responsibility of the member.
- The provider must obtain a written authorization from the member agreeing to the services and charges prior to such services being rendered.

- The written, signed, authorization must be only for the immediate treatment plan or date of service and cannot be an ongoing authorization. The written authorization must be repeated each time non-covered services are requested or within each immediate treatment plan prescribed and agreed upon.
- Failure to procure a written authorization may result in the provider being held responsible for costs incurred for services not authorized.
- Non-covered services include referring the member to a non-Heraya provider for treatment, referring the member to a non-participating lab or imaging facility, or for non-covered treatment.

The Professional Services Agreement states under Section 2.3(e):

"At a minimum, the Member consent form must include the following information: Member name, specific service(s) and/or supplies, date(s) of service(s), cost of service(s) and/or supplies, and why the services are not covered by Payer. The consent form must be signed by the Member or Member's legal guardian prior to Provider's rendering the service or supply and be maintained in the Member's clinical record."

Providers may not have members sign an agreement that supersedes the member's obligations under the terms of his/her health plan contract or the Heraya Professional Services Agreement. Contract language cannot state, "Supersedes all other contracts."

Allowable Charges

The only charges for which Heraya patients are liable and may be collected by Heraya providers are:

- Co-payment, co-insurance, and deductible amounts required by the member's health plan.
- Amounts from services not covered by the member's benefit plan.
- Amounts from services on dates when the member was not eligible for coverage; and
- Amounts outstanding due to a reduction or denial for benefits when the member has been notified the services would not be certified as being medically necessary, and the member has signed a prior consent for the service agreeing to be responsible for payment of those specific charges. Prior member consent shall be obtained by the Heraya participating provider.

4.08 Informed Consent

Introduction

Documentation of informed consent in the patient's chart is important from several perspectives: health care ethics, malpractice risk management, and effective patient management. The most important goal of informed consent is that the patient has an opportunity to be an informed participant in health care decision making. It is generally accepted that complete informed consent should be obtained from patients before carrying out any diagnostic or therapeutic procedure and includes a discussion of the following elements:

- The nature of the treatment plan, procedure, or diagnostic testing.
- Reasonable alternatives to the proposed intervention.
- The relevant risks, benefits, and uncertainties related to each alternative, including the risk of refusing care.
- Assessment of patient understanding.
- The acceptance of the intervention by the patient.

Ethics

Informed consent is the process by which fully informed patients can participate in choices about their health care. It originates from the legal and ethical right each patient must direct what happens to their body and from the ethical duty of the physician to involve the patient in his or her health care. Fully informed patients have adequate foreknowledge or understanding of the recommended treatment and/or diagnostic testing, the anticipated outcomes, and alternatives to it. It is the process of effectively communicating with patients in terms they understand and allowing them the opportunity to ask questions.

Malpractice Risk Management

Despite our best efforts as careful clinicians to do what is right, bad outcomes do happen. In an informed consent process, the potential risks of an adverse outcome are dealt with up front with each patient in a straight-forward and non-threatening manner. Having this conversation with patients first helps a great deal in those unlikely cases with a less-than-optimum outcome. What is more, patients who have access to open information exchanges are less likely to sue for malpractice.

To protect your patient and yourself in malpractice litigation, in addition to carrying adequate liability insurance, it is important that communication about the informed consent process itself be documented in the clinical file. Good documentation can serve as evidence in a court of the law that the process indeed took place. A timely and thorough documentation in the patient's chart by the provider of the treatment can be a strong piece of evidence that the provider engaged the patient in an appropriate discussion.

Of the complaints that we receive at Heraya, the most common is “the practitioner hurt me.” Often the patient goes on to describe an uncomfortable procedure (adjusting, massage, acupuncture needles) followed by post-treatment soreness, stiffness, or other symptoms. A complete “informed consent” discussion with that patient acknowledging the risk of discomfort with the procedure and the potential of post-treatment soreness may well have prevented this perception and prevented a complaint.

Patient Management

Informed patients make better health care decisions. Open discussion with patients about treatment plans, common alternative treatments that may be available, the risks that may be associated with them, including refusing care, and invitation to patients to ask questions and receive clarification are primary activities for all health care providers. Often dubbed the “PARQ” conference (an acronym for “procedures, alternatives, risks, and questions”), this open communication empowers each patient to obtain all necessary information, ask questions and to collaborate with the clinician in making decisions about care.

Patients who can make informed decisions are more likely to follow through on your treatment recommendations, have demonstrably better clinical outcomes, are more satisfied with you and your care, and are more likely to refer their family and friends.

Documenting Informed Consent: "PARQ"

Informed consent is a process involving verbal discussion as well as proper documentation. Heraya recommends as a "best practice" that informed consent be fully documented and included in the clinical file.

One common option for documenting informed consent is noting the acronym "PARQ" which can be written in the patient's chart indicating that the provider has explained the procedures (P), viable alternatives (A), material risks (R), if any, and has asked if the patient has any questions (Q). "PARQ" should be noted prior to the implementation of any treatment. If the patient requests further information or has specific questions, the provider can underline the PARQ chart notation to reflect the patient's request. The provider should note the question and note the more detailed information provided. While this is an appropriate method of documenting this process has occurred, there is no substitute for the patient's written confirmation of those facts.

It is also recommended that the patient execute some document acknowledging that they have been part of an informed consent process, the material risks have been disclosed including a description of those risks and that the patient has agreed ("consented") to the procedures understanding any risks inherent to that procedure. This could be accomplished using a prepared written consent form that must be signed by the patient and should be signed by the provider. Again, it is important to note that providers should not rely exclusively on those forms and must communicate directly with the patients.

As new conditions occur that may require different evaluation procedures or different treatment procedures, additional informed consent should be obtained from the patient. In addition, consent given to one provider is not consent for any other provider unless the patient agrees to the substitute. This assent to the substitute provider should be noted in the clinical record.

The Minor Patient

As with all members, informed consent is required for minor members. There are different considerations required based on the type of provider delivering the service, as well as the services that are being provided. It is strongly recommended that the provider review the specific statutes or rules regarding obtaining informed consent from a parent/legal guardian or the minor patient, whichever is appropriate, that applies to the services rendered in the state in which they practice.

4.09 Patient Confidentiality and Protected Health Information (PHI)

Patient Confidentiality

Standards for Members' Rights and Responsibilities as set by the National Committee for Quality Assurance (NCQA) state, "Members have a right to be treated with respect and recognition of their dignity and right to privacy." As a delegated agent for NCQA-accredited health plans or other organizations, Heraya has a contractual obligation to ensure that every Heraya network provider who renders care to contracted members upholds the obligation to maintain patient privacy. Providers and their office staff are obligated to keep all patient information strictly confidential. This includes all medical and financial information as well as names of patients and all demographic information.

Patient confidentiality is protected by not releasing any information about the patient without expressed written consent. This includes billing information, the “Assignment of Benefits” form, or similar forms used for billing an insurance company.

In accordance with HIPAA, providers are responsible for providing the patient with access to his/her Protected Health Information (PHI) and to allow (with some exceptions) the patient to amend his or her PHI. Patients may have access to their health records or obtain copies upon request. Access and amendments to patient records must be documented in the patient record.

Requiring office staff to sign a confidentiality statement is one method to remind staff of their responsibilities to maintain patient privacy. A sample Confidentiality Statement is included in the Heraya Forms section of this manual.

Providers are also bound to protect each patient’s confidentiality by state licensing regulations. Please refer to your state and licensing board for these requirements.

Data shared with employers, whether self-insured or insured, shall not implicitly or explicitly identify a patient without written consent of the patient, except as permitted by law.

Physical and Auditory Privacy

To ensure physical and auditory privacy for contracted patients, Heraya requires at least one private treatment room be available in each provider’s office for treatment and/or discussion of matters of a confidential nature.

In the context of a professional-patient relationship, it is the obligation of the professional to respect each patient’s privacy. It is the responsibility of the clinical professional to manage that context, from both a physical and process standpoint, to ensure that a patient’s rights to privacy are not violated.

Protected Health Information (PHI)

Heraya is authorized through contractual arrangements with providers and contracted health plans to have access to and review medical record information pertinent to health care plan services provided to members. Heraya is committed to protecting the confidentiality of all member information and records and using and disclosing protected health information (PHI) appropriately to protect member privacy.

PHI is health care information, in any form whatsoever, that may be identified as pertaining to a particular person and that relates to the person’s past, present or future physical or mental health, health care treatment or payment for health care services, including information that relates to the diagnosis, treatment and/or prognosis of drug or alcohol abuse, sexually transmitted diseases, HIV or AIDS, mental health or genetic testing.

Under HIPAA, PHI is confidential, personal, identifiable health information about individuals that is created or received by a health plan, provider, or health care clearinghouse and is transmitted or maintained in any form. "Identifiable" means that a person reading this information could reasonably use it to identify an individual.

PHI includes written documents, electronic files, and verbal information. Even information from an informal conversation can be considered PHI. Examples of PHI include completed health care claim forms, detailed claim reports, explanations of benefits (EOB), and notes documenting discussions with plan participants. Below are the 18 HIPAA Identifiers:

- Name
- Address (all geographic subdivisions smaller than state, including street address, city county, and zip code)
- All elements (except years) of dates related to an individual (including birthdate, admission date, discharge date, date of death, and exact age if over 89)
- Telephone numbers
- Fax number
- Email address
- Social Security Number
- Medical record number
- Health plan beneficiary number
- Account number
- Certificate or license number
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web URL
- Internet Protocol (IP) Address
- Finger or voice print
- Photographic image - Photographic images are not limited to images of the face.
- Any other characteristic that could uniquely identify the individual

Authorization

Because Heraya is a Business Associate, most instances of the member's exercise of the right to authorize or deny the release of PHI beyond its use for treatment, payment and health care operations are handled by the covered entity. In those instances, Heraya will follow the direction of the covered entity. In instances where Heraya needs additional medical record information (i.e., to investigate a complaint or coordinate benefits), Heraya will collect a signed Authorization to Release Medical Information form from the member prior to gathering information.

4.10 Health Care Record Transfer

Requesting Protected Health Information from Other Providers

Medical information is routinely exchanged between healthcare professionals. The decision to obtain prior medical records and imaging studies is made by the provider if there is a reasonable expectation that the information will affect clinical decision making.

Obtaining a patient's medical records and imaging studies requires the use of a valid record release. A sample form is provided in the Forms section of this manual. It is recommended that the records release include:

- Patient's full name,
- Date of birth or other unique identifier (Health Record number for example),
- The complete address, phone number, and fax number where you want the information sent,

- The requesting provider's address, e-mail address, and/or phone number, and
- If the patient is under age 18, the parent or guardian's signature is required.

Release of Protected Health Information to Another Provider
No protected health information should be released without receiving a signed authorization.

Releasing a patient's medical records and imaging studies requires the use of a valid record release. A sample form is provided in the Forms section of this manual. It is recommended that the records release include:

- Patient's full name,
- Date of birth or other unique identifier (Heath Record number for example),
- The complete address, phone number, and fax number where you want the information sent,
- The requesting provider's address, e-mail address, and/or phone number, and
- If the patient is under age 18, the parent or guardian's signature is required.

Timely Transfer
It is expected that records will be made available and released in a timely manner, upon receiving a valid release.

5.00 Network Consideration

5.01 Network Advisory Team

The Network Advisory Team (NAT) convenes monthly, or as needed, to evaluate the provider network for geographic distribution to meet the access needs of our contracted clients and prospects. This includes an objective and impartial review of provider nominations.

To submit a request for a provider nomination to the Heraya network, the non-contracted provider may request an application by visiting our website at herayahealth.com and click on Providers, then click on "Request an Application".

The requesting party will be notified in writing of the decision within five business days of the NAT meeting. An appeal process is not available for decisions of the NAT. The NAT may review a request for "reconsideration" in some cases, if new information is provided.

5.02 Associate Policy

Heraya Participating Associates
This policy defines the status of an Associate and the requirements of both the Associate Provider and the Sponsoring Provider. The policy also defines the process for requesting a Heraya associate.

Heraya providers in good standing (see Section Two - 3.03 for definition) may request to have an associate provider approved for purposes of adding in-house coverage for their patients. The Chief Clinical Officer and Heraya's Regional Medical Director may approve an associate provided all stipulations outlined in this policy are met. An associate request may require NAT approval.

Definitions

- ***Heraya Contracted Provider***: A participating Heraya provider is a one who has successfully completed all credentialing and/or recredentialing Heraya contracting requirements and has been granted the status of a full participating provider.
- ***Non-Contracted Provider***: Non-contracted providers are not permitted to perform services for Heraya members on the behalf of a participating provider except for properly approved absence coverage or in approved emergency situations.
- ***Heraya Associate Participating Provider***: An associate, for the purposes of this policy, is defined as "Any provider of the same discipline working within the same office, regardless of business relationship." No associate status is granted within the Massage Therapy discipline.
    - A provider who is approved as a Heraya associate will be referred to within Heraya as a Heraya associate provider and will be expected to meet the requirements stipulated for an associate status as defined in this policy. This distinction will be made to determine specific associate provider rights, as defined by policy and the Associate's contract.
    - The associate will not be distinguished separately as an 'associate provider' with contracted health plans or members but will be identified as a Heraya participating provider.
- ***Sponsoring Provider***: A provider requesting an associate is referred to as a Sponsoring Provider for purposes of this policy.

Purpose

The purpose of allowing for a Heraya Associate is to ensure a provider within in the same office can provide the care of contracted health plan members in the absence of, or full schedule, of the primary Heraya provider.

The policy is not for the purpose of allowing one provider to expand their practice to additional offices with the associate running one practice while the primary runs another, nor is it made for the purpose of transferring sale of one office to an associate. Heraya does not accept applications for an associate in offices already having two providers of the same discipline in areas where there is not additional geographic need.

Heraya reserves the right to grant or deny replacement of an associate position based upon geographic need at that time. Heraya may close or revise the associate policy at any time in the event the policy contributes to an adverse effect upon the financial aspects of Heraya's business due to overpopulation of the network size.

Length of Associate Affiliation

An associate provider in good standing (see Section Two - 3.03 for definition) may apply and compete for a full active status position as network openings become available.

Sponsoring Provider Requirements

- The sponsoring provider must have been on the Heraya network for a minimum of three years.
- The sponsoring provider must request and complete a Heraya Associate Request and Reference Form.

- The sponsoring provider must be currently active and in good standing (see Section Two - 3.03 for definition) 2Fwith the Credentialing, UM and QM programs, and Heraya's Philosophy of Care.
- Only one Heraya associate will be allowed per practice site regardless of the number of Heraya providers at that site.
- The sponsoring provider may request only one associate regardless of the number of offices owned by the sponsoring provider.
- The sponsoring provider must take responsibility to monitor the associate's compliance with Heraya's policies and practice patterns.
- Relocation requests must include the associate if the sponsoring provider wishes the associate to relocate with their practice.
- If the associate does not continue with the sponsor the associate may not be permitted to continue participation.

Requirements of Applicant for Associate Status

The Associate must:

- Pass the Heraya credentialing process.
- Have a written recommendation from a sponsoring Heraya provider who agrees to monitor the applicant.
- Be of the same discipline as the sponsoring provider.
- Understand that participation on the Heraya network is dependent upon affiliation with the sponsoring provider.
- Provide services at the approved site of the sponsoring Heraya provider.

Associate Requests

Providers wishing to apply for associate status must contact the Heraya Provider Relations Department. Requests must come from the sponsoring Heraya provider. A reference form will be sent to the sponsoring provider to complete and return prior to Heraya considering an associate application. The sponsoring provider must agree to monitor the associate. The Associate Request Form may be found in the Forms section of this manual.

If approved, the Provider Relations staff will notify both the associate and sponsoring provider via written notification. An application will be sent to the associate who may not treat members until successfully passing the credentialing date and is notified in writing of their effective date. The associate may not begin treating Heraya members prior to their approved effective date.

5.03 Sale of Practice

This policy defines the position of Heraya regarding the sale of a provider's practice and addresses the process for determining if a new owner may be eligible for participation on the network.

Heraya providers may sell their practices to whomever they desire, whenever they desire. Heraya does not interfere with the sale of a provider's practice. However, Heraya contracts only with individual providers in approved locations. Heraya does not contract with businesses. Therefore, a sale of practice does not guarantee the new owner participation on the network.

Process
All requests to join the network must be presented to the Network Advisory Team for network consideration as referenced in policy 5.01, regardless of the reason for the request. Requests for a new owner's participation with Heraya may be made prior to selling a practice or after the sale of a practice. Consideration will be given to the current practice of the provider selling the practice in accordance with the criteria outlined in this policy and will include:

- Number of years the current provider has been with Heraya,
- Current status/congruent clinical philosophy and good quality profile,
- Number of Heraya or other providers in office location,
- Geographic need, and
- Extenuating circumstances.

Providers applying for participation with Heraya must complete a Standard Credentialing Application, meet all Heraya credentialing requirements, and obtain approval by the Credentialing Committee.

Requests must be submitted in writing, faxed, or emailed to the Heraya's Provider Relations Department. Provider claims of verbal approvals, past, present, or future will not be honored in the event of a dispute.

6.00 Complaints/Appeals

6.01 Member Access to and Assistance in Registering Complaints

Members may contact Heraya at any time and with any issue via telephone, fax, email or letter. Members are not required to submit paperwork; all requests may be submitted by telephone or in writing to Heraya. Members are aided, as necessary or requested, in registering a complaint. Patient records may or may not be required as outlined in the Complaint Procedure Policy.

6.02 Categories of Complaints

The type of grievance addressed includes those involving benefits, program administration, service, and health care as prescribed under ORS 743.801. Complaints may be made in any category and are evaluated to determine appropriate handling.

Grievances are categorized as follows:

A. Quality/Delivery of healthcare services by providers
    1) Diagnosis based
    2) Treatment based
B. Administrative
    1) Matters pertaining to the contractual relationship between members and Heraya
    2) Member complaints regarding access (This does not include member requests for adding providers of their choice to the network)
C. Performance of Personnel
    1) Heraya staff performance
    2) Heraya provider's staff performance
D. Claims Management
    1) Adverse determination pursuant to a Utilization Review
    2) Claims handling

3) Reimbursement

6.03 Complaint Procedures

Heraya has a thorough and consistent process for addressing complaints. All complaints will be acknowledged and addressed in a timely, respectful, confidential, and customer-focused manner. Heraya offers an interpretive assistance via Language Line® Personal Interpreter Service for those in need.

General Information

The Chief Clinical Officer and Provider Service Supervisor holds responsibility for monitoring complaints, grievances and appeals, reviewing trends, and making recommendations for appropriate actions to improve the quality of care, service, communication, and the determined resolutions. Heraya's Chief Clinical Officer and Director of Provider Relations and Engagement are kept apprised of any complaint involving attorneys for informational purposes and consultation.

The Heraya Customer Complaint Procedure is designed to handle issues expeditiously and equitably. Complaints received via telephone, fax, email, or letter in regards to or from providers are initially addressed and documented by the staff person taking the call. All complaints are forwarded to the Director of Provider Relations and Engagement or staff for tracking and trending purposes. If further action is required, the Chief Clinical Officer, Regional Medical Director, and Director of Provider Relations and Engagement will initiate steps to resolution, to include collaboration with the appropriate Heraya staff person(s) to do so. For example, qualities of care concerns involve Heraya Regional Medical Director's direction.

Complaint Process

Upon receipt of a complaint, the following occurs:

1) Any Heraya staff receiving a complaint will document the information outlined below on the Customer Complaint/Concern Form and forward it to the Director of Provider Relations and Engagement or staff:
    - Date of initial contact,
    - Person making the complaint,
    - Contact information,
    - Nature and summary of the complaint,
    - Person receiving the complaint,
    - Response made to the complaint, and
    - If further action is needed.
2) The Director of Provider Relations and Engagement or staff will determine if Heraya is authorized to proceed with processing the complaint or if the complaint is to be directed to the contracted health plan as per a delegation agreement. Heraya will assist members in directly contacting appropriate health plan when required to do so.
3) If Heraya is responsible for addressing the complaint, the appropriate Heraya staff will contact the person by telephone or in writing within two (2) business days and proceed in collecting information from applicable sources. Sources may include but is not limited to information from the patient alleging complaint, contracted health plans, the relevant Heraya provider, and/or

Heraya claims information. A Release of Records Form, signed and dated by the member, may be obtained if medical records outside of Heraya are necessary.
Every effort is made to maintain patient confidentiality and privacy when members request anonymity. Heraya providers are contacted when appropriate and are provided the opportunity to respond to a complaint, either in writing or verbally whichever is deemed most appropriate by the Director of Provider Relations and Engagement.

4) Upon Heraya's investigation, the following will occur:
    - ***Complaint Review***
      Heraya's Director of Provider Relations and Engagement or staff will review documentation and consult with appropriate Heraya department head to determine appropriate course of action. All complaints relating to clinical issues are referred to Heraya's Chief Clinical Officer, Regional Medical Directors or Associate Medical Directors for advisement and course of action.
    - ***Final Resolution***
      Heraya notifies all relevant parties of the final resolution via letter, email or verbally whichever is deemed most appropriate. Any adverse courses of actions or decisions impacting a Heraya provider are communicated in writing and include information on appeal rights in cases of adverse decisions. The provider may request reconsideration of the resolution if additional information is provided which was not part of the original investigation. In the event the member requests an appeal, refer to Sections 4.04 Distribution of Information and 6.04 Grievance Policies and Procedures.
    - ***Documentation***
      Complaints are tracked by the Director of Provider Relations and Engagement. Documentation includes all aspects of the complaint not limited to allegations, actions taken and resolution. Documented complaints are maintained in the Provider MSOW system for a period of seven (7) years. Heraya systems are backed up on a daily basis.
    - ***Complaint Monitoring***
      All complaints are reviewed for concerning trends both at the time of complaint, quarterly when reported to the Clinical Management Committee (CMC) for oversight, and at the provider level at recredentialing.

      The CMC reviews the number per quarter, the type of complaints, the average response and resolution turnaround time. Trends are identified for further review and consideration or corrective actions. Periodic internal audits of complaints are reported to Heraya's Management Team on a quarterly basis for administrative opportunities for improvement.

      A provider's file with multiple complaints, if deemed necessary by the Chief Clinical Officer, Director of Provider Relations and Engagement and/or the Regional Medical Director, may be presented to the Credentialing Committee for corrective action at any time.

Complaint Handling

Heraya handles complaints in a thorough, objective, and consistent process with the goal of timely and satisfactory resolution for all parties involved, to the extent possible. Heraya providers are notified when a complaint is alleged and provided the opportunity to respond. Upon collection of all necessary

information, a careful review is performed, including any aspects of clinical care. All complaints are acknowledged and addressed in a timely, respectful, confidential, and customer-focused manner.

6.04 Grievance Policies and Procedures

General Rules Pertaining to Grievances or Appeals

In some instances, Heraya is not delegated by a contracted health plan to handle member grievance and appeals. The Chief Clinical Officer or Director of Provider Relations and Engagement will determine the extent of Heraya's responsibility with each grievance or appeal. Grievances or appeals which are not delegated to Heraya will be referred to the appropriate organization.

A grievance may be the result of an unsatisfactorily resolved complaint. Heraya has a formal review process and a right of appeal. A grievance is a written complaint requesting a specific action, submitted by or on behalf of a member.

- ***Member Complaint/Grievance and Appeal Review Oversight***
  The Clinical Management Committee (CMC) reviews each grievance to determine if it was handled appropriately regarding the timeframe in which it was handled as well as the content and resolution. If the CMC determined a grievance was handled inappropriately, the grievance/appeal would be revisited.

  The CMC is responsible for monitoring member grievances and appeals, reviewing trends, and taking appropriate action to improve the quality of care, service, and communication. Member complaints/grievances concerning Heraya staff or providers will be used in staff performance evaluations and for re-credentialing of providers.

  All member grievances and appeals and resolutions are documented in the secured Heraya complaint database. The Director of Provider Relations and Engagement will summarize the details of all activities relating to the concern/grievance and appeal process.

- ***Conflict of Interest***
  No person may participate in the final review and evaluation of any case in which he/she has been professionally involved or where judgment may be compromised.

- ***Administration***
  The Heraya Customer Grievance/Appeal Procedure is designed to handle issues expeditiously and equitably, and is administered by the following staff:
  - The Director of Provider Relations and Engagement for administrative concerns.
  - The Director of Claims for claims concerns.
  - The Regional Medical Director and the Associate Medical Directors for provider quality of care and treatment concerns.

Member Request for Review

A member who registers a complaint expressing a desire for a formal review regarding dissatisfaction with decisions relating to healthcare, service, or contractual relationship, or adverse determination, or for

a request for payment for services already rendered will be processed under the Grievance Procedure as outlined below:

- Grievances may be made by telephone, fax, e-mail or letter.
- The grievance is tracked in Call Tracking within Heraya's enterprise system and routed to the Director of Provider Relations and Engagement or staff or the Director of Claims.
- Translation services are provided by the contracted health plans within their respective Member Services telephone functions and based upon the linguistic needs of its members. Heraya has interpretive service available for providers.
- For health plan members of entities not delegating the grievance process to Heraya, a report will be made to the health plan's applicable department of any and all grievances, regardless if specific actions are required of the health plan.
- If the health plan not delegating grievances to Heraya agrees the grievance would be best handled by the health plan, the grievance will be logged into the complaint tracking sheet and the file closed.

Criteria for Grievance Correspondence

Correspondence from Heraya in addressing grievances will meet the following criteria:

- Heraya letters will acknowledge receipt of member concerns, as appropriate, and requests for grievance or appeal explaining in layman's terms the specific reason(s) for any decisions made by Heraya.
- The letter will provide a clear explanation of the grievance process and will provide all information for the member to make an appeal, including notification procedures, mailing address, fax and email addresses and timeframes.
- Heraya will provide the member with information for contacting the Director of the Department of Consumer and Business Services, except in cases where contracted delegations require grievances be submitted directly to contracted health plan for processing.

Timelines for Grievance Correspondence

The timeliness of responses to member grievances and appeals shall follow the timeframes specified as follows, unless the situation is considered a clinical emergency. If the grievance or appeal is considered to be an "emergency medical condition" as per state regulations, then all resources will be dedicated to resolving the issue as quickly as possible.

Once a grievance has been received at Heraya, either by letter, fax, e-mail, or telephone call the following will occur:

- The document will be date stamped upon receipt at Heraya office,
- Documentation will be entered immediately into the complaint database,
- The member will be called within one business day and will be sent a letter to acknowledge the grievance within 7 calendar days (emergencies will be addressed immediately),
- Release of records will be requested at the same time from the involved provider, if appropriate,
- A written decision from Heraya within 30 calendar days of receipt of grievance (may be extended to 45 calendar days, providing notification) will be provided, and
- The member will be notified immediately of their right to appeal the decision within 185 days from the date of the denial notice.

6.05 First Level Appeal Process

Currently Heraya is not delegated by a contracted health plan to handle member grievance and appeals. The Chief Clinical Officer or Director of Provider Relations and Engagement will determine the extent of Heraya's responsibility with each grievance or appeal. Grievances or appeals which are not delegated to Heraya will be referred to the appropriate organization.

Procedure for First Level Appeals:

Member appeals are processed by Heraya in accordance with contractual delegation agreements. Heraya is not delegated to manage appeals by its health plans. If Heraya was responsible for processing a member's 1st level appeal, the following policies would apply:

1) Complete and accurate minutes of the 1st and 2nd level review of appeals will be prepared and maintained for each meeting. The minutes will reflect the names of the committee members, the date and duration of the meeting, the members present and absent, and the names and titles of any guests. All complaints, grievances and appeals will be documented on a central register. The central register will summarize the details contained on the complaint register and the individual grievance form.
2) First appeal is initiated upon receipt of a signed Member Appeal Request form. The form must be received within 185 calendar days after the date of the grievance decision. A letter will be sent within five (5) calendar days notifying the appellant of:
    a) The receipt of the appeal request,
    b) The appeal process, and
    c) Their right to a representative of his/her choosing.
3) If the member has requested specific resolution or the appeal requires additional follow-up, notification of the decision or action taken is sent to the member, as well as information on how to appeal to the Clinical Management Committee (CMC) or the Chief Clinical Officer, as appropriate, or health plan, as appropriate (2nd level of appeal).
4) A Heraya representative will be appointed to coordinate the review of the first level appeal. The representative will not have been involved in the proceedings of the original decision. The individuals appointed to review an appeal concerning clinical issues will include at least one provider in the same discipline and/or specialty.
5) The member has the right to appear before the CMC to explain the appeal. If the member is unable to attend in person, the member may communicate to the reviewers via telephone conference or other appropriate technology. The member also has the right to have a representative of his/her choosing act on his/her behalf. Any representatives standing-in for the member are required to provide advance notification of the number of representatives attending and their relationship to the insurer or member.
6) A written decision including specific references to relevant provisions of the health benefit plan and related written corporate practices will be sent to the member or his/her representative within 30 calendar days after receipt of the appeal. If more extensive review is required, the member and/or his/her representative will be notified of the delay within the initial 30 calendar day period and the decision will be made within 45 calendar days.
7) Grievances concerning Heraya staff are thoroughly investigated, managed, and/or periodically monitored throughout the resolution process by the Human Resources Administrator, Chief Clinical Officer, Director of Provider Relations and Engagement, or the Regional Medical Director.

8) Final determination of grievances concerning Heraya staff will be based upon the data obtained from the following sources:
    a) Correspondence from the provider, member, health plan, or other outlining the circumstances of the case;
    b) The staff member's supervisor; and
    c) Other sources as appropriate.

6.06 Second Level Appeal Process

Currently Heraya is not delegated by a contracted health plan to handle member grievance and appeals. The Chief Clinical Officer or Director of Provider Relations and Engagement will determine the extent of Heraya's responsibility with each grievance or appeal. Grievances or appeals which are not delegated to Heraya will be referred to the appropriate organization.

1) The Regional Medical Directors hold direct responsibility for reviewing or designating a Committee review of all 2nd level appeals not required to be forwarded to delegating entities per contractual agreement.
2) Complete and accurate minutes will be prepared and maintained for each meeting held for the review and investigation of a member grievance or appeal. The minutes will reflect the name of the committee members, the date and duration of the meeting, the members present and absent, and the names and titles of any guests.
3) Individually identifying information will be removed from all documents presented to the committee. In the case of reviews performed for quality of care complaints, the identified provider will be presented using a unique identifying number. All information will be considered confidential and protected under statues relating to peer review protection.

Procedure for Second Level Member Appeals

Heraya is not delegated by any NCQA accredited health plans to handle member grievances beyond the 1st level appeal. If a member wishes to appeal a 1st level appeal decision made by Heraya, the member is referred to the contracting health plan. Policies written herein are established should a situation arise wherein a Heraya member's appeal were to fall under the authority of Heraya to process.

1) A second appeal is initiated upon receipt of a signed Member Appeal Request form only when member complaints, grievances and appeals are the direct responsibility of Heraya and do not violate contracted health plan agreements. All other appeals are forwarded immediately to the affiliated health plan. The form must be received within 60 calendar days of the notification of the decision relating to the first level appeal. A letter will be sent within five (5) calendar days notifying the appellant of:
    a) The receipt of the member appeal request,
    b) The member appeal process, and
    c) Their right to a representative of their choosing.
2) If the customer is a member of a contracted health plan, the appeal is forwarded to the health plan for resolution. If the customer is a health plan representative, provider or other customer, information from the previous reviews is requested.
3) A Heraya representative will be appointed to coordinate the review of the member appeal by the CMC. This person will not have been involved in the proceedings of the previous decisions. Two additional providers from the Heraya provider network may be asked to attend a 2nd level

appeal review. The individuals appointed to review an appeal concerning clinical issues will include at least one provider in the same discipline and/or specialty. The Chair may designate additional guests as necessary.

4) The customer or provider has the right to appear before the CMC to explain the appeal. If the customer or provider is unable to attend in person, the customer or provider may communicate to the reviewers via telephone conference or other appropriate technology. The customer or provider also has the right to have a representative of their choosing act on their behalf. Any representatives standing in for the customer are required to provide advance notification of: 1) the number of representatives attending and 2) their relationship to the member.
5) A written decision including specific references to relevant provisions of the health benefit plan and related written corporate practices will be sent to the customer, provider, or their representative within 30 calendar days after receipt of the appeal. The decision of the CMC is final and binding.
6) Final determination regarding quality of care may be based upon the data obtained from, but is not limited to, the following sources:
    a) Out of plan health care records,
    b) The provider's health care records of the member,
    c) Correspondence from the member or member's representative outlining the special circumstances of the case,
    d) Clinical Management Committee (CMC),
    e) Heraya Regional Medical Director, and
    f) Community standards of practice as determined by outside provider consultants.

7.00 Adverse Events

7.01 Provider Review Process

Provider specific issues may be identified by the Chief Clinical Officer, Regional Medical Directors, Credentialing Committee, Combined Medical Directors Committee, and the Clinical Management Committee or through other appropriate sources.

If the identified issue or issues are not resolved in a timely manner, an action plan may be sent to the provider for development or the appropriate committee may require a stipulation for compliance. When problems or opportunities for improvement are identified, individual provider action plans may be developed and implemented in accordance with Heraya policies and procedures.

The resolution step(s) proposed by the provider are subject to approval by the committee involved with the action. In utilization management matters the Chief Clinical Officer, Regional Medical Directors and/or Associate Medical Directors are available as resources to the provider, but the provider is ultimately responsible for developing and implementing the action plan. Other resources may include: Clinical Pathways, Provider Operations Manual, and the Quality Improvement Guide to Clinical Record Keeping.

Resolution steps may include, but are not limited to, changes in communication channels, changes in office policies and procedures, changes in structure or process, changes in equipment or forms, changes in assignment or staffing, changes in treatment procedures, and provider and/or patient education.

The effectiveness of all actions taken is evaluated on an ongoing basis to determine whether care or service has improved. Continued monitoring/tracking takes place with adjustments to the action plan as needed, within the established timeframe. Monitoring is done by the appropriate Heraya committee, the Chief Clinical Officer, the Regional Medical Directors, or the Director of Provider Relations and Engagement as required, and progress is reported on a regular basis to the responsible committee.

If a provider refuses to complete the action plan, does not identify resolution steps, does not meet the objectives within the specified timeframe, or meet prescribed stipulations, Heraya's administration or the responsible committee will make a recommendation for termination from the network.

Actions plans or requests for compliance will specify:

- Who and what is expected to change,
- What action is appropriate based on the identified issue(s), and
- When the action is to take place and what the expected timeframe is for implementation and completion.

7.02 Provider Rights Pertaining to Corrective/Disciplinary Actions

When corrective or disciplinary action is required, the provider will be given notice of his/her rights. These rights are granted under Heraya's Professional Services Agreement Section 8.5 and relate only to disciplinary actions taken against a provider when such actions pertain to quality of care concerns, unless otherwise stipulated.

The provider has the right to:

- Notification of a corrective action plan or disciplinary action being taken by Heraya. (Provided in all cases).
- Reasons for the proposed corrective action plan request or disciplinary action. (Provided in all cases).
- Request a hearing on the proposed action for an appeal if disciplinary action relates to quality of care issues.
- Request a review of the proposed action within 30 days of providing an appeal request and providing all supporting information to Heraya.
- Receive a written copy of the Appeals Policy at time of notification of a disciplinary action (Appeal rights may not be applicable in some incidences).
- Receive written decision of the committee reviewing the appeal, including a statement of the basis for the decision. (This applies to an appealed decision and relates only to a quality of care appeal).
- Present evidence determined to be relevant by the appropriate committee regardless of its admissibility in any court of law. Applies only to Appeal Rights for disciplinary actions taken for quality of care reasons.
- Representation by an attorney or other person of the provider's choice in matters.

Communication of Information

The Credentialing Committee, Chief Clinical Officer, Regional Medical Director and/or Heraya administration report findings about provider discipline activities to the CMC.

Records, reports, and other documents created as a result of these activities and peer review are considered confidential. The information is maintained as confidential in accordance with the appropriate state and federal statutes.

7.03 Disciplinary Actions

This policy was developed as a guideline when adverse information necessitates a consideration or implementation of a disciplinary action upon a participating provider of Heraya Health. Heraya will not discriminate in its monitoring and review of the performance of its participating providers. All quality information will be considered confidential and maintained as protected under state statutes for the purpose of conducting peer review evaluation.

Adverse information may be defined as, but is not limited to, failure to comply with established standards relating to quality of care and service, utilization of resources, compliance with administrative processes, credentialing/quality standards, proposed or initiated license actions or malpractice claims.

In all cases of disciplinary actions, the Chief Clinical Officer, Regional Medical Directors and/or the Director of Provider Relations and Engagement will conduct a preliminary investigation of the circumstances and may review the case with an applicable Associate Medical Director, if necessary, to determine the appropriate actions.

Range of Actions

The range of disciplinary actions may include, but are not limited to, a warning, a request for corrective action, a letter of reprimand or stipulation, suspension, terms of probation, requirements for consultation and termination of membership. Heraya staff may only initiate and manage suspensions in cases of expired malpractice and license expirations, in conjunction with the Director of Provider Relations and Engagement. All other actions are initiated by the Chief Clinical Officer, Regional Medical Director, Director of Provider Relations and Engagement, or the Heraya Credentialing Committee.

Providers who are dual discipline licensed may be suspended, denied ongoing participation or terminated based on issues with one license, even though the second license is in good standing.

Suspension

The following outlines reasons to suspend a provider's participation when all attempts to resolve the issue have been performed:

- The provider is temporarily unable to perform duties due to mental or physical impairments;
- The provider is being investigated by a licensing board, other regulatory bodies, public safety agencies, heath care entity, or Heraya;
- The provider fails to provide proof of current professional licensure, malpractice insurance, or office liability;
- The provider fails to comply with contractual requirements of Utilization, Credentialing or Quality Management programs

Denial of Ongoing Participation by the Credentialing Committee

The Heraya Credentialing Committee has the right to deny a provider's ongoing participation when:

- The provider's professional license is suspended or revoked by a licensing board;

- The provider fails to maintain current professional licensure or professional liability insurance meeting minimum requirements;
- The provider admits sexual misconduct with patient;
- The provider is convicted of a felony or when a provider is arrested or charged with a criminal offense and does not notify Heraya in a timely manner of the charges and investigation;
- The provider fails to maintain compliance with legal obligations of the Heraya contract;
- The provider is found to be unethical or incompetent;
- The provider's conduct is deemed detrimental to quality patient care or non-compliant;
- The provider fails to notify Heraya in a timely manner of actions taken against his/her professional status by another health plan, insurer, state or federal agency, licensing agency or malpractice insurer, or any other sanction activity;
- The provider fails to comply fully with Heraya's requests pertaining to chart notes, re-credentialing, quality and utilization requirements, an investigation, a corrective action plan, or requirements of the Credentialing, Utilization or Quality programs, or refuses to comply with the terms of the Professional Service Agreement and all attempts to obtain compliance by Heraya have failed.

Breach of Contract Termination

The Chief Clinical Officer, Regional Medical Directors and/or the Director of Provider Relations and Engagement have the right to terminate a provider's participation administratively for contractual violations when appropriate and expedient to do so for the following reasons:

- The provider's license is revoked by a licensing board;
- The provider fails to maintain current professional licensure or professional liability insurance meeting minimum requirements;
- The provider is convicted of a felony;
- The provider fails to notify Heraya in a timely manner of licensing board actions or criminal charges or arrest and investigations;
- The provider fails to maintain compliance with legal obligations of Heraya contract;
- The provider fails to comply fully with Heraya's credentialing, re-credentialing, quality and utilization requirements and all attempts to obtain compliance by Heraya have failed;
- The provider submits false claims information or bills for services in an unethical manner after receiving notice to correct billing practices;
- The provider fails to comply with requests for chart notes, re-credentialing, utilization management criteria, or refuses to comply in accordance with the terms of the Professional Service Agreement and all attempts to obtain compliance by Heraya have failed; and
- Other reasons that raise serious concerns regarding unethical, unsafe, or unprofessional conduct.

Provider Notification

In cases of Heraya staff suspensions related to license, malpractice or office liability providers are notified via letter the day prior to suspension date.

In cases of Credentialing Committee reviews, Heraya providers are notified in writing within 10 business days of a Credentialing Committee decision. The notice includes the reason, the effective date of termination, survival of obligations and appeal rights if applicable. Notice of altered status in participation or pended decisions is sent via certified mail.

In cases of breach of contract terminations, Heraya providers are notified at the time of decision in writing via certified mail. The notice includes the reason, the effective date of termination, survival of obligations, and appeal rights if applicable.

Appeal Rights

Appeal rights are granted when an adverse action is initiated against a Heraya participating provider for reasons related to quality of care and/or service. The Appeals Policy is not applicable to breaches of the contractual agreement between Heraya and the participating provider. In such cases, providers may be terminated in accordance with the Professional Services Agreement.

Appeal rights are given to providers at the time initial credentialing via the Provider Operations Manual and the Professional Services Agreement and additionally through written notification at the time of an adverse action initiated by Heraya, if applicable.

Organizations delegating credentialing to Heraya reserve the right to remove a Heraya provider from providing care to their members in accordance with their specific organizations policies.

7.04 Appeals Process

This policy was developed to assure all Heraya providers are provided the right to appeal adverse decisions when quality of care issues are cited as reasons for termination from the Heraya network. For appeals relating to Medical Necessity please refer to the UM Section of this manual.

Heraya and its respective committees participate in evaluating issues relating to quality of care and service. When quality of care/service issues arise, Heraya may initiate disciplinary action and may choose to place the provider on suspension (administrative leave of absence), monitor performance for a prescribed period of time, attach provisional stipulations, or terminate participation on the Heraya network. Heraya may also deny initial applicant participation on the Heraya network. Heraya acts in accordance with the Professional Services Agreement section.

Heraya makes the appeals process known to participating providers at the time of contracting with Heraya and at the time of any adverse decision or action is taken by the Credentialing Committee or other designated Heraya Committee regarding quality of care concerns. Heraya notifies the participating provider of the appeals process by registered mail when disciplinary action has occurred due to quality of care concerns.

Heraya is not required to provide an appeal process when a provider's contract is terminated pursuant to a "without cause" contract provision when no quality–related reason for the termination is sited. Heraya is also not required to provide an appeal process to an initial applicant.

A two-level appeal process is available to participating providers (hereafter referred to as "Appellant") who do not agree with the committee's decision concerning quality of care terminations.

First Level Appeal

1) The committee will advise the appellant in writing via certified mail of its decision to terminate the provider's participation with Heraya. The appellant will be provided with

the reasons for the decision and be given the right to appeal the decision, if appropriate, including instructions regarding the committee's appeals process.

2) Heraya must receive appellant's written notice of intent to appeal within 30 days of the date of the notification letter.
3) In the event the appellant asks for a delay to allow time to submit additional documentation to support the appeal that documentation must be received by Heraya within 45 days of the date of the notification letter, or the appeal will be denied.
4) The Credentialing Committee or other designated committee will review the written appeal and any additional documentation submitted by the appellant at the first scheduled meeting after all of the materials have been received or the 30 to 45-day period has expired, whichever comes first.
5) After reviewing and discussing the written appeal and accompanying documentation, the committee will vote to uphold, revise, or reverse its decision. The appellant will be notified in writing via certified mail of the results of the first level of appeal within ten business days. If the committee upholds the initial decision, the notification will include instructions regarding the second-level appeal process.

Second Level Appeal

In the event the appellant is not satisfied with the outcome of the first-level appeal, the appellant may institute a second-level appeal by notifying Heraya, in writing, of his/her intent to appeal the outcome of the first-level appeal.

1) The appellant's written notice of intent to appeal must be received within 30 days of the date of the committee's letter upholding the termination or deferral of the appellant's participation with Heraya.
2) In the event the appellant asks for a delay to allow time to submit additional documentation to support the appeal, that documentation must be received within 45 days of the date of the notification letter or the appeal will proceed without the additional documentation.
3) The second-level appeal will be made to the Clinical Management Committee. The appellant may present the appeal in writing or in person at a scheduled meeting of the committee. In the case of a personal appearance by the appellant before the committee, legal counsel or other representative(s) may accompany the appellant for the limited purpose of advising the appellant.
4) The second-level appeal before the committee will take place at a scheduled meeting within 30 days of receipt of all of the materials or the 45-day period has expired, whichever comes first.
5) After reviewing and discussing the written appeal and/or oral testimony and any accompanying documentation, the committee will vote to uphold, revise, or reverse the first-level appeal decision. The appellant will be notified by certified mail of the decision of the committee. If the decision is upheld, the notification will indicate the appeals process has been exhausted.

Reconsiderations

The right to appeal an adverse decision is provided only for adverse determinations relating to a provider's quality of care. A provider may request reconsideration on all other disciplinary actions by

submitting a written request to Heraya and by providing new or additional information not previously reviewed. The same committee or persons making the first determination will reconsider the information. Reconsiderations are subject to the same timelines as for appeals.

Summary of Notification Timelines for Appeals

- **First Level Appeal**
  The provider must submit written notification of intent to appeal within 30 days of notice of disciplinary or corrective action. The provider may request a delay for up to 45 days from receiving Heraya's notice of action for time to provide additional supporting documents.

- **Second Level Appeal**
  The provider must submit written notification of intent to appeal within 30 days of notice of committee decision. The provider may request a delay for up to 45 days from receiving Heraya's notice of action for time to provide additional supporting documents.

All requests for appeals must be directed to the following address:

Heraya Health
Attn: Provider Relations
6600 SW 105th Avenue, Suite 115
Beaverton, Oregon 97008

7.05 Sexual Misconduct Policy

Heraya does not tolerate sexual misconduct by a Heraya participating provider or the employee of a Heraya participating provider towards a member or employee. Heraya may terminate, at its discretion, a participating provider or will deny participation to an applicant based upon commission or admission of sexual misconduct by the provider the employee of a participating provider.

Definitions Relative to Terms used in this Policy

- ***Applicant***: Any licensed healthcare professional who has submitted an application to Heraya and is seeking a Professional Services Agreement.
- ***Credentialing Committee***: The Credentialing Committee has been granted the authority to accept, defer, suspend, or deny applications for participation or continued participation at credentialing and re-credentialing to the Heraya networks.
- ***Participating Provider***: Any licensed healthcare professional that has a Professional Services Agreement with Heraya.
- ***Employee of a Heraya Participating Provider***: Any assistant, whether licensed or not, in the employment of or contracted by a licensed Heraya participating provider or applicant.
- ***Patient:*** Any individual who has been examined, treated or has otherwise received healthcare services from a participating provider.
- ***Provider/Patient Relationship:*** A relationship is presumed to exist until explicit termination occurs and termination is documented in the patient record, or as ascribed by State Professional Licensing Boards or other state statutes.
- ***Respondent Superior:*** A legal clause which makes an employer vicariously liable for harms inflicted by a negligent employee.

- ***Sexual Misconduct:*** Any physical contact, conduct, or verbal behavior that may reasonably be interpreted as a sexual provider-patient relationship, regardless of whether that contact occurs in the clinical setting or in a non-clinical social setting. Sexual Misconduct does not include sexual contact in the context of a pre-existing relationship between a participating provider and an individual who subsequently obtains health care services from that participating provider.

Review Procedures

The standard procedure for presenting the file of an applicant or participating provider who has at any time been brought or voluntarily appeared before a professional licensing board facing civil charges or having other activities brought against them due to allegations of sexual misconduct, who is currently under any investigation, or has limitations of licensure due to allegations of sexual misconduct will be as follows:

1) The Heraya credentialing staff will obtain a copy of the licensing board's disciplinary report, legal preceding or other pertinent documentation describing the allegations and findings, as available.
2) The applicant/provider may be asked to submit detailed information on how he/she is trying to or has eliminated or minimized the risk of future complaints of this nature or actual offenses. For example, this may include continuing counseling, having an attendant present in the exam/treatment room, etc.
3) The Regional Medical Director will review all documentation gathered by the credentialing staff and determine if additional information should be gathered prior to presentation to the Credentialing Committee.
4) All information gathered from the applicant, licensing board and other sources as appropriate will be placed in the quality file and sanitized for review by the Credentialing Committee at the next meeting.

In all cases the committee may request one or both of the following actions:

1) Obtain a written statement from the applicant that responds to specific questions posed by the committee regarding the circumstances of the sexual misconduct or allegation, and
2) Ask the applicant to appear in person (with the option of having one additional person accompany him/her) to address specific questions posed by the committee regarding the circumstances of the sexual misconduct.

Immediate action will be taken to administratively suspend a provider in the event of a new sexual misconduct charge being investigated by the State Professional Licensing Board, under police investigation or under an investigation by Heraya.

Applicants with a History of Sexual Misconduct

Upon completion of the above steps, the committee will review all information and vote to approve, deny, or grant provisional approval for participation depending on the nature of the relationship or the severity of the sexual misconduct.

Applicants with Active Sexual Misconduct Cases

The committee will recommend one of the following:

- Defer the application. The applicant may reapply when all allegations have been dropped or the applicant's licensing board removes limitations on licensure.

- Deny the application. The applicant may not reapply to the network if the committee determines that the risk of future offenses would be too high.

Participating Providers with a History of Sexual Misconduct

The committee will vote to terminate or continue unrestricted participation based upon an evaluation of the relationship and the severity of the sexual misconduct.

At each re-credentialing, the committee may request the provider give details of how he/she continues to minimize the risks of future offenses. The committee has the authority to ask the Credentialing staff to perform site visits to confirm statements made by the provider.

Participating Providers with New Sexual Misconduct Cases

The committee will recommend one of the following:

- Termination. The provider may reapply when all allegations have been dropped or the provider's licensing board removes limitations on licensure.
- Monitoring. The provider may be asked to make regular reports to the committee regarding compliance with the Licensing Board Stipulations, or other requirements may be placed upon the provider as deemed appropriate by the Credentialing Committee.

Immediate action will be taken to administratively suspend a provider in the event of a new sexual misconduct charge being investigated by the State Professional Licensing Board, under police investigation or under an investigation by Heraya.

Employees of Participating Providers with New or Existing Sexual Misconduct Cases

In the event of a sexual misconduct charge being investigated by the State Professional Licensing Board, under police investigation or under an investigation by Heraya, immediate action will be taken to administratively suspend the provider's office from providing services to Heraya member/patients until an initial investigation has been completed, or the offender is removed and restricted from the location.

The Credentialing Committee will review information obtained from the employee and the participating provider and will recommend one of the following:

- Monitoring. If a decision has not been reached on the allegations at the time of the review, the participating provider may be asked to make regular reports to the committee regarding the status of the allegations,
- Discharge of the Employee. Heraya may request an employee be discharged immediately,
- Termination or Suspension. If the provider refuses to cooperate with the recommendations of the Credentialing Committee.

Appeals

The procedure for the applicant or participating provider to appeal the decision of the Credentialing Committee is outlined in the Appeals policy, Section 7.04.

Preventive Measures

(Extracted from NCMIC Insurance Company publication "Sexual Misconduct: Ethical, Clinical and Legal Ramifications and the Chiropractic Profession")

1) Perform all initial examinations, when possible, during normal business hours. This is especially important when the member is of the opposite sex.
2) Special attention should be given to performing initial examinations in a room that is closest to the front office where others could be called upon for purposes of chaperoning. This would also prevent the allegation that the examination room was purposely designed to be in the back of the office to prevent anyone from hearing any claims of misconduct.
3) Chaperoning practices. When a clinical investigation involves an examination of the patient's genitals, breasts and/or rectum, a chaperon is highly recommended. At a minimum, the doctor should give the member the option to have a third-party present.
4) Gowns are used when necessary which afford the greatest degree of privacy but still allow for a competent clinical examination of the area of investigation.
5) Explicit instructions regarding which articles of clothing need to be removed should be given. An example: "Please remove both your shoes, socks, pants and shirt, but do not remove any of your undergarments."
6) After giving the gowning instructions to the patient, the patient should be given instructions to slightly open the examination room door to acknowledge that they are finished gowning. This prevents embarrassing situations where the doctor walks in while the member is still in the process of gowning. By asking the patient to open the door, the patient initiates the examination process.
7) When the clinical investigation includes placing the patient in a prone position, draping of a towel over the buttocks is suggested. Again, this affords the patient every possible level of privacy while still not interfering with the clinical investigation at hand.
8) The doctor should try to explain testing procedures to the patient and why such testing is done. For example, removal of a brassiere for the purpose of conducting imaging.
9) Make all staff keenly aware of gowning, chaperoning and other preventive-measures procedures. This can be done at the time of hiring, performance review, and staff meetings or in written format.
10) Finally, adding a question to the patient intake forms such as, "Do you wish to have a third person or chaperon present during your exam and treatment?" may help to identify those patients who are most sensitive to such issues before they even enter the examination room. This also could alert the staff to allow for chaperoning without the patient having to ask.

7.06 Fraud and Abuse Policy

Health care fraud and abuse is not tolerated in any aspect of Heraya operations including the delivery of and billing for services in Heraya provider offices or in Heraya's processing or paying claims.

Health care fraud and abuse includes:

- Billing for services not rendered;
- Billing for services that are not medically necessary;
- Double billing for services provided;
- Up-coding (e.g., billing for a more highly reimbursed service than the one provided, E/M and CMT services);
- Unbundling (e.g., billing separately for groups of procedures performed together in order to get a higher reimbursement);
- Kickbacks in return for referring patients or influencing the provision of health care;

- Providing services by untrained personnel, failing to supervise unlicensed personnel, distributing unapproved devices or drugs; and
- Allowing the misuse of a provider signature, tax identification number, provider identification number, National Provider Identifier.
- The patient record should never be backdated, erased, deleted, or altered in any way. If corrections need to be made or addendums added to a written record, a line should be drawn through the correction or the addendum inserted and the change initialed and dated. In the case of electronic patient records, corrections or amendments should be made using an addendum that is signed or initialed and dated. In both cases, the original record should be preserved.

Heraya Claims, Utilization Management, Provider Relations, and clinical staff are alert to all of these forms of potential fraud and abuse. The Heraya claims system is configured to identify double billing, inappropriate procedure and diagnosis codes and up-coding. Sentinel events, such as member complaints or aberrant provider profiles also can identify potential fraud and abuse. Heraya conducts random audits for compliance. Fraud and abuse sometimes occur inadvertently because of poor training, misinformation or ignorance on the part of providers and provider office staff. Heraya provides information and training to providers and provider office staff on Heraya billing policy and proper billing procedures to avoid unintended fraud or abuse.

Section Three – Heraya Utilization Management Policies & Procedures

The Utilization Management (UM) Policies described in this section pertain only to services managed or paid directly by Heraya. These policies relating to UM are not applicable to all Heraya contracted plans:

- UM is not applicable to providers treating CAM Plus members.
- UM is not applicable to some leased network contracts. UM Policies specific to such plans are provided separately.

UM Program Overview

0.01 Mission, Goals and Objectives

The mission of Heraya Health Utilization Management (UM) Program is to ensure the quality and medical necessity of health care services provided to members of contracted plans. The UM Program has three primary goals:

- Validate the medical necessity of services rendered.
- Confirm the health care services are provided at the appropriate level of care.
- Substantiate the health care services meet local community standards for quality of care.

In support of these goals, the UM Program has the following objectives:

- Have clearly a defined structure aligned with explicit policies and procedures for utilization management functions.
- Make utilization management decisions that are fair, impartial, consistent and in compliance with established policy and law.
- Use the best available evidence-based criteria for assessing quality, appropriateness, and necessity of service.
- Provide useful information to providers and members about the UM criteria and processes.
- Use only qualified licensed health professionals to assess clinical information to support UM decisions.
- Make and communicate utilization management decisions in a timely manner.
- Obtain all relevant clinical information and appropriate consults to support UM decision making.
- Clearly document and communicate to affected providers the reasons for any denial of services or payment.
- Maintain explicit policies and procedures for thorough, appropriate, and timely resolution of appeals of UM decisions.
- Resolve appeals in a thorough, appropriate, and timely manner.
- Evaluate new technology and new application of existing technology for coverage by the contracted health plans.
- Monitor utilization to detect and correct unexplainable variation, under-use, and over-use of services.

0.02 Effectiveness of UM Program

The effectiveness of the UM Program is measured by the extent to which medically necessary services are delivered, medically unnecessary services are constrained, and underutilization of medically necessary services is avoided.

0.03 Scope of Program

The scope of the UM Program is comprehensive and addresses the demographic and epidemiological factors of the member population served as well as the needs of individual members, i.e., where, who, and how care and service are provided.

0.04 Environments and Service Area

Credentialed providers are located throughout the States of Oregon, Washington, Idaho, Utah, Montana, Alaska, and Colorado. Heraya's network is comprised of both sole provider offices and offices with multiple providers.

0.05 Delivery System

The network is distributed to provide optimum access for members enrolled in contracted health plans with over 2400 providers in the service area. All providers have met initial credentialing standards and participate in timely re-credentialing in compliance with NCQA standards.

0.06 Access

Care is provided to members within provider offices. The majority of provider offices are open four to five days per week with standard office hours (ranging from 7 a.m. to 7 p.m.). Offices are instructed to have either an answering machine or answering service to direct members appropriately after-hours. Surveys of office wait times reveal the majority of providers begin treatment 5 to 10 minutes after the member's arrival at their office and offer urgent appointments within 24 hours. Access is monitored annually to encourage offices to meet ADA requirements.

0.07 Members Served

Any member has the right to access a provider; there are no limitations on age, sex, race or national origin, gender, or sexual orientation. Members may receive treatment at any age (birth to death).

0.08 Important Aspects of Care and Services

Important aspects of care and service relating to acute and chronic conditions are evaluated and monitored. The focus is on those functions having the greatest impact on the quality of care and service ultimately received by the member. When appropriate, the following topics/activities are coordinated with Quality Management and Credentialing Programs. Information from each of these areas is kept in the provider's quality file.

The following list contains the topics and activities reviewed on an ongoing basis by Heraya:

- Patient Satisfaction Surveys related to the quality of care.
- Complaint/grievance monitoring related to the quality of care.
- Provider Satisfaction surveys related to Heraya's claims and UM process.
- Review of contracted services.
- Review of UM Interventions.
- Clinical record evaluations.
- Health promotion.
- Monitoring of clinical pathways.
- Continuity and coordination of care.
- Under- and over-utilization.
- Provider performance.
- Participation in studies mandated by health plans, regulatory and accreditation agencies.

0.09 Urgent Requests

There are mechanisms in place to expedite reviews or treatment extension requests when a member or provider believes an urgent condition exists. Please Refer to Section 5.00.

0.10 Appropriateness of Clinical Services

Appropriateness of clinical services is evaluated in light of evidence-based standards of practice. Evidence from consensus of expert opinion and review of scientific clinical literature are combined to develop criteria used for determination of medical necessity. Evidence is summarized in clinical pathways, which are posted on the website and are available to every network provider. This evidence drives policy development, which in turn guides Heraya's Medical Directors in determining appropriateness and necessity. Criteria are reviewed by the Heraya Medical Director's and the Combined Medical Directors (CMD) Committee annually, or as new evidence becomes available.

Review criteria and procedures are more thoroughly described in Section 2.00. UM decisions are reviewed by using an internal audit process for consistency with professional standards and Heraya criteria.

Clinical policy is developed through the collaborative efforts of the Clinical Management Committee (CMC) and the Combined Medical Directors Committee (CMD). In the development process the following sources may be utilized:

- Health care literature databases such as Medline and PubMed, Index to Chiropractic literature, CINHAL, MANTIS.
- Systematic reviews such as the Cochrane Collaboration
- Government agencies such as the Agency for Healthcare Research and Quality, National Center for Complementary and Integrative Health.
- Clinical guidelines resources such as ECRI Institute.
- Professional sources such as the Society for Acupuncture Research, American Chiropractic Association.
- Current authoritative sources such as textbooks, professional journals.
- Online point-of-care evidence-based clinical resources such as UpToDate, DynaMed.
- Provider advisors.
- Provider surveys.

0.11 Consideration of Non-Covered Services

The scope of services offered by Heraya providers is limited by the contracts defined by health plans. All services used to provide treatment and/or evaluate Heraya members in provider offices must be recognized by Heraya and be appropriate to the type and level of benefit.

If a provider requests a non-covered service be provided to a member, the provider will work with the Chief Clinical Officer or appropriate designee to determine where the most appropriate delivery of the recommended service would occur. In most cases, it is appropriate to refer the member to the Primary Care Physician or referring clinician of the contracted health plan. If a non-covered service is deemed appropriate and effective for use by the provider, Heraya's Chief Clinical Officer or appropriate designee will review and determine payment. This will be done on a case-by-case basis. Consultation will most usually occur between the Heraya Chief Clinical Officer or appropriate designee, the health plan representative, the provider and, in some cases, the member.

1.00 Utilization Management Structure and Function

1.01 Role of the Heraya Board of Directors (Heraya BOD)

The Heraya BOD is ultimately responsible for the UM Program. As with other management functions, the BOD delegates responsibility for the UM Program to the Chief Executive Officer.

1.02 Role of the Chief Executive Officer (CEO)

The CEO is accountable to the Heraya BOD for the overall performance and results of the UM Program. The CEO maintains authority to allocate resources and staff for utilization management activities. The CEO is responsible for:

- Ensuring identified UM deficits are corrected.
- Monitoring UM reports to detect trends in the ongoing delivery of healthcare.
- Ensuring the Clinical Management Committee is performing diligent oversight of the UM Program.
- Providing an Annual Utilization and Quality Management Summary report to the Heraya BOD.

The CEO delegates responsibility for coordinating and implementing the UM Program to the Chief Clinical Officer; oversight of the UM Program to the Clinical Management Committee; and performance of UM activities to the Combined Medical Directors (CMD) Committee.

1.03 Clinical Management Committee (CMC)

The CEO grants oversight responsibility of the UM Program to the Clinical Management Committee, which includes non-staff network providers. The responsibilities of the Clinical Management Committee to the UM Program are:

- Oversee that Heraya's strategic goals relating to the UM Program are met.
- Review quarterly and annual reports from the Chief Clinical Officer pertaining to the UM Program.
- Oversee the clinical activities of the Combined Medical Directors Committee.
- Approve all clinical policies and procedures recommended by Heraya administration and the clinician committees.
- Monitor provider utilization management outlier behavior is corrected in accordance with policies.
- Monitor policies for oversight of the Heraya's UM Program.

1.04 The Combined Medical Directors Committee (CMD)

Members of the Combined Medical Directors Committee are the Chief Clinical Officer, Regional Medical Director(s) and Associate Medical Directors representing each of Heraya's disciplines, all of which hold voting authority. The responsibilities of the Combined Medical Directors Committee to the UM Program are:

- Oversee the effectiveness of monitoring, evaluating, and improvement of UM systems and providers.
- Coordinate UM clinical and quality activities with related activities to improve quality of care and service.
- Analyze UM findings to make clinical recommendations based on results and assess improvements.

- Monitor compliance with regulatory requirements, including health plan delegation and claims processing.
- Provide reports to Clinical Management Committee regarding UM clinical program performance.
- Develop and review the UM Policies and Procedures annually.

1.05 Ad Hoc Advisory Committees

Ad Hoc Advisory Committees may be called periodically. These Committees serve in a clinical advisory capacity to the CEO, the Chief Clinical Officer, the Regional Medical Directors(s), and the Clinical Management Committee regarding discipline specific issues. Membership of each Advisory Committee includes the Chief Clinical Officer, an Associate Medical Director for the respective discipline, the Clinical Services Supervisor, and network providers of the respective discipline.

1.06 Role of the Regional Medical Director

The Regional Medical Director acts at the direction of the Chief Clinical Officer and supports the Heraya Clinical Services Department to accomplish the goals and objectives of the Clinical Quality Management (QM), Credentialing and UM Programs. This also includes QM, Credentialing and UM policy and program support, maintenance, development, and implementation. The Regional Medical Director provides direction and participates with internal and external staff to ensure the goals and objectives of the programs are achieved as well as develops and implements strategies to improve the quality, safety and efficiency of services provided by contracted providers. The Regional Medical Director serves as the chair of the Credentialing Committee as well as provides support to the Associate Medical Director functions as necessary. The Regional Medical Director must be a licensed practitioner; provide proof of current, unrestricted licensure; and have been in active practice for a minimum of 5 years.

1.07 Role of the Chief Clinical Officer

Heraya's Chief Clinical Officer is accountable to the CEO and leads the organization in the establishment and accomplishment of goals and objectives of the QM, Credentialing and UM Programs, The Chief Clinical Officer's responsibilities also include the following: collaborate with the Regional Medical Director(s) for effective coordination and integration of the QM, Credentialing, and UM programs, timely reporting to appropriate entities relating to UM activities; providing CMD ,CMC and Credentialing Committee support; overseeing Heraya's Clinical Services Department to manage timely completion of all UM and QM activities, collaborate with internal and external staff in aligning Heraya Policies and Procedures with NCQA standards, provide support to the Associate Medical Director function as necessary, and facilitating and preparing for external delegated audits. The Chief Clinical Officer must be a licensed practitioner; provide proof of current, unrestricted licensure; and have a minimum of 5 years' experience in the health care insurance industry.

1.08 Role of the Associate Medical Director(s)

Associate Medical Director(s) (AMD) perform medical necessity and clinical record reviews, initial credential, and re-credential file reviews, and are actively involved in setting UM policy. All AMD's must meet Heraya's participation criteria which include proper education and training and a current, active license. Additional qualifications of an AMD include in active practice in the representative discipline for a minimum of 3 years and an unrestricted license. Training is provided by the Chief Clinical Officer and Regional Medical Directors(s) who are the direct reports for the AMD personnel. The AMDs participate on the Combined Medical Directors Committee as well as participate in multi-disciplinary problem solving, as needed.

1.09 Role of the Heraya Staff

The UM staff collects data and has authority to authorize services based on Heraya policy. The UM staff functions as the administrative interface between the Claims and UM departments, collecting and disseminating information for claims determinations of all UM claim reviews under the supervision of Heraya's Chief Clinical Officer. The UM staff is responsible for maintaining accurate documentation of all UM activities to include internal and external audits, claims review tracking, file documentation, and correspondence to members and providers regarding UM decisions to include ensuring documentation of appropriate professional review via signature or the UM staff signature attributing the specific professional reviewing the case.

The UM staff is not authorized to approve or deny claims relating to a medical necessity determination. Decisions requiring clinical judgment are referred to the Chief Clinical Officer, Regional Medical Director, Associate Medical Directors, or other qualified professional. Any denial of medical necessity or appropriateness is a result of a review by a fully licensed professional practicing with an unrestricted license and in the same discipline as the provider in question, with the exception of OR where medical necessity denials must be performed by an MD/DO. The UM staff may deny a claim for reasons other than medical necessity and appropriateness only in accordance with established UM policies as documented in Heraya's Billing Manual and the Professional Services Agreement.

1.10 Provider Participation

Providers are expected to make themselves available for service within the UM Program. Additionally, each provider's signed Professional Services Agreement states the agreement to participate in and comply with all peer review, utilization review and quality assurance activities, and with dispute resolution processes.

1.11 Appeals

The Heraya UM Appeal process is designed to handle appeals expeditiously and equitably. The timeliness of responses and the appeal process shall follow the timeframes and procedures specified in the UM Appeals Policy, Section 8.00.

1.12 Annual Program Evaluation and Update

The UM-QM Program is evaluated annually for effectiveness and consistency with program objectives by the Chief Clinical Officer, with support from the Regional Medical Director(s) and Associate Medical Director (s). Heraya's written Year End Summary Report includes the completed UM-QM activities, evaluation of improvements in care, evaluation of effectiveness of UM-QM activities, and trending of clinical and service indicators.

Heraya updates the UM and QM programs and develops quality improvement initiatives based on the annual assessment of the UM-QM activities performed in the previous year, or earlier, if necessary. The Clinical Management section of Year End Summary Report is presented to the CMD Committee; reviewed and approved by the CMC; and reported to the CEO and the Board of Directors.

The annual update involves review and revisions as appropriate of the UM Policies and Procedures which are posted on the Heraya website. Providers are notified of updated UM policies and procedures via written notification of such with the availability to obtain a written copy upon request.

The primary goal of UM is the delivery of medically necessary services. Effectiveness of UM is measured by the extent to which medically necessary services are delivered, medically unnecessary services are constrained, and the underutilization of medically necessary services is avoided.

Direct measures of UM effectiveness are derived from claims data for individually reviewed claims, samplings achieved during provider-specific interventions and clinical pathway reviews. Evaluation of practice variation is conducted quarterly by Heraya UM Staff. At least annually, all Heraya Chiropractic physicians, Naturopathic physicians and providers of acupuncture services receive a Provider Trend Analysis report. Provider Trend Analysis reports are distributed to the outlier and high-volume providers on a quarterly basis and are utilized in monitoring these providers as evidence of practice quality assessment and improvement.

Indirect measurement of UM Program effectiveness occurs through the analysis of patient complaints and satisfaction regarding access to care and the adequacy of that care. Provider complaints regarding UM also measure the impact of the UM Program on the provider's perception of their ability to render quality care. Annual provider satisfaction surveys inquire about provider and provider office staff experiences with Heraya's UM Program.

Evaluation of the UM Program includes a formal evaluation of the AMD's. This evaluation includes assessing the consistency of UM decisions across reviewers on a routine basis, completion of duties as described in this document and review of the Associate Medical Director job descriptions. Program evaluation and revisions are reviewed and approved by the Clinical Management Committee at least annually.

2.00 Clinical Criteria for Utilization Management

2.01 Medical Necessity

"Medical Necessity" or "Medically Necessary" shall mean health care services that a provider, who is exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. Medically necessary care is intended to help the member achieve maximum therapeutic benefit. Medically necessary care is:

- in accordance with generally accepted standards of medical practice,
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the member or the health care provider.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature, generally recognized by the relevant medical community.

"Maximum therapeutic benefit" has been achieved when the member's health status has returned to a pre-clinical/pre-illness condition, or the member's condition no longer shows progressive improvement toward a return to a pre-clinical/pre-illness condition. Health care services rendered beyond the point of maximum therapeutic benefit are not medically necessary.

“Medically necessary supportive care” is treatment of a member’s condition that has achieved maximum therapeutic benefit, but when periodic trials of withdrawal of care fail to sustain previous objective and subjective improvement. In addition to passive therapies, appropriate supportive care includes education, active care, lifestyle modification, exercise programs, and other self-care techniques.

“Elective treatment” is defined as care provided for a stable condition that will remain stable without further care; care that is discretionary and at the option of the member; care that is intended to promote optimum function, wellness or maintenance. Elective treatment is not medically necessary.

2.02 Criteria for Medical Necessity and Clinical Appropriateness Determinations

Heraya Health has an obligation to review the services provided to members for medical necessity and clinical appropriateness verification. Determination of medical necessity and clinical appropriateness includes assessment of the following parameters within the information outlined in Section 6.01:

- Appropriateness:
    - Is treatment recognized as appropriate for the condition?
    - Has there been consideration of patient age, co-morbidities, risk factors, and psychosocial factors?
    - Is there evidence of exacerbation or complications?
    - Is care appropriate for the clinical stage of the condition?
- Consistency:
    - Is the diagnosis consistent with the subjective and objective data?
    - Is the treatment consistent with the diagnosis?
- Community standards:
    - Is the treatment consistent with professional consensus and expressed in documents such as treatment guidelines, textbooks, and professional literature?
    - Does the care provided correlate with standards of quality care?
- Member Progress:
    - Are there signs of progress in the subjective or objective information?
    - Are there functional indicators or outcome assessments indicating improvement?
    - Is there documentation of a change in therapeutic approach in response to lack of progress?
    - Is there indication of an active care component to the treatment regimen?

2.03 Medical Necessity and Clinical Appropriateness Determinations

The term “medical necessity” refers to what is medically necessary and clinically appropriate for a particular member, and hence medical necessity and clinical appropriateness determinations entail an individual assessment rather than a general determination of what works in the ordinary case. If there is sufficient evidence to show that a treatment is not medically necessary and clinically appropriate in the usual case, it is up to the member and their provider to show the individual member is different from the usual in ways that make the treatment medically necessary and clinically appropriate for that member.

Medical necessity and clinical appropriateness determinations are made by a clinician with training and practical experience in the same discipline as the provider submitting the claim in question, with the exception of OR where medical necessity denials must be performed by an MD/DO. Determinations are based on the reviewer’s clinical experience, the clinical pathways, Heraya clinical policy and available current evidence. Generally, if the clinical records show evidence of the presence of a covered condition

and documentation of sustained improvement through outcome measures, a positive change in subjective complaints, or indication of objective improvement, then the care is considered to be medically necessary and clinically appropriate.

2.04 Evidence-Based Criteria

Appropriateness of clinical services is evaluated in light of evidence-based standards of practice. Evidence from consensus of expert opinion and review of scientific clinical literature are combined to develop criteria used for determination of medical necessity and clinical appropriateness. Evidence is summarized in clinical pathways, which are provided to every network provider via Heraya's website with written notification of such and availability of copies upon request. This evidence also drives policy development, which in turn guides clinical staff in determining appropriateness and necessity.

Clinical pathways are suggested clinical approaches and not rigid protocols. Heraya expects there will be members whose needs vary from the clinical pathways. In those instances, the provider is expected to maintain a clinical record that clearly outlines subjective and objective information documenting the variation in clinical presentation and giving a clear indication of the assessment and treatment plan.

2.05 Consistency in applying UM Criteria

Heraya evaluates consistency in applying UM Criteria on an ongoing basis via audits performed to evaluate the consistency of the UM decisions. Such audits evaluate all Heraya UM decisions against professional standards and Heraya UM criteria. Written reports are provided to the Chief Clinical Officer and Combined Medical Directors Committee for review and appropriate action upon identification of any opportunity for improvements as necessitated.

2.06 Review Criteria Development

UM review criteria are developed through collaborative efforts of the Medical Director's, the Combined Medical Directors Committee, and the Clinical Management Committee.
In the development process the review of the following relevant sources may be utilized:

- Health care literature data bases such as Medline and PubMed, Index to Chiropractic Literature, CINHAL, MANTIS.
- Systematic reviews such as the Cochrane Collaboration.
- Government agencies such as the Agency for Healthcare Research and Quality, National Center for Complementary and Integrative Health.
- Clinical guidelines resources such as ECRI Institute.
- Professional sources such as the Society for Acupuncture Research, American Chiropractic Association.
- Current authoritative sources such as textbooks, professional journals.
- Online point-of-care evidence-based clinical resources such as UpToDate, DynaMed.
- Provider advisors.
- Provider surveys.

2.07 Annual Review of UM Criteria

UM Criteria for medical necessity and clinical appropriateness is reviewed annually by the Associate Medical Directors at the Combined Medical Directors Committee, or as new evidence becomes available. The Heraya Chief Clinical Officer routinely monitors updates from evidence-based clinical resources such as those listed in Section 2.06, e.g., PubMed, Cochrane Collaboration, Agency for Healthcare

Research and Quality, National Center for Complementary and Integrative Healthcare, ECRI Institute, professional journals, online point-of-care resources.

The UM Policies, containing the UM Criteria, are updated at least annually at which time providers are notified in writing of the availability of the policies on Heraya's website. The opportunity is provided for providers to obtain a copy upon request.

Availability of Clinical Criteria
The clinical criteria are distributed via the Heraya Provider Operations Manual to newly participating providers. Revisions of the Provider Operations Manual are communicated to participating providers in writing, with the opportunity to obtain a copy upon request. The clinical criteria are within the Utilization Management Policies and Procedures which are posted separately from the Provider Operations Manual on the Heraya website.

3.00 Communication Services

3.01 Availability of Staff
Providers and members with questions about UM issues will have access to UM staff during normal business hours, between 8:00 am and 5:00 pm Monday through Friday.

3.02 Contact Outside Normal Business Hours
Contact outside of normal business hours is available via Heraya's dedicated UM fax or will be accommodated by special arrangement with affected parties.

3.03 Outbound Communication
UM decisions will be communicated to the affected parties during normal business hours between 8:00 am and 5:00 pm, Monday through Friday, excluding holidays and office closures.

3.04 Staff Identification
Heraya policies and procedures state when UM staff initiate, receive, or return calls to members or practitioners regarding UM issues, they identify themselves by name, title, and Heraya Health.

3.05 Toll free Number
Heraya maintains a toll-free number, 800-449-9479, for out-of-area members and providers to access UM staff. There is also a Heraya UM dedicated toll-free fax, 877-252-8452. This fax number is available 24/7 and accepts all non-urgent requests outside of business hours but is not monitored during non-business hours. Receipt of requests will be documented on the next business day. For TDD (telecommunication device for the deaf) or TTY (telephone typewriter, or teletypewriter) assistance, members may call 711 Relay Services. For members not able to use the 711 number, they may use 1-800-735-2900 as an alternate number. For language interpretation services, Kaiser Permanente members may call 800-324-8010.

3.06 Access to Staff for Callers with Questions
The Provider Operations Manual and the Billing Manual provide instructions regarding contact with Heraya's UM department. Any correspondence related to UM is sent to providers or members includes

contact information such as Heraya's toll-free telephone and toll-free fax numbers, including information about requesting an interpreter when one is needed. Heraya uses Language Line Personal Interpreter Services on an as needed basis for members or providers requesting language assistance in discussing UM concerns.

General UM inquiries may be addressed by customer service or the Clinical Services staff. Specific UM inquiries will be forwarded to the UM staff, the Chief Clinical Officer or appropriate designee who are responsible for describing or explaining UM processes, criteria, or decisions.

4.00 UM Reviews Performed by Appropriate Professionals

4.01 Appropriate Licensed Professionals (Clinician Reviewers)

Qualified licensed professionals include Heraya's Chief Clinical Officer, Regional Medical Director and the Associate Medical Director's (AMD's) representing the following disciplines: Chiropractic and Naturopathic Physicians, Acupuncture, Massage Therapy.

4.02 Authority for UM Decision Making

Heraya's Clinician Reviewers, i.e., Chief Clinical Officer, Regional Medical Director and the Associate Medical Directors are the only individuals in the organization who may make claims denials pertaining to medical necessity.
Heraya staff review claims identified by claim system edits and approve claims payment consistent with established UM and Clinical Review policy. Staff may not deny claim payments regarding medical necessity.

4.03 Qualifications for Reviewers

Refer to Section 1.06, 1.07 and 1.08 for qualifications for reviewers. Heraya also has written job descriptions that define qualifications for reviewers.

4.04 Reviewer Responsibilities

The Clinician Reviewers are responsible for reviewing all available material to ascertain whether there is sufficient information in order to make a determination on medical necessity of either covered or non-covered health care services. Upon determination, the Reviewer provides the decision and rationale for the decision to Heraya's UM Department in accordance with Heraya policy.

4.05 Documentation of Reviews

Thorough documentation of all reviews is the responsibility of UM staff. In addition, items listed in 8.06, UM staff assures the following on all UM case reviews:

- The date of receipt of each request
- The date of resolution
- Documentation of appropriate professional review on the Heraya review form by:
    - Completion of the applicable Heraya review form containing any of the following:
        - Handwritten signature or initials of the reviewer.
        - The reviewer's unique electronic signature or identifier.

- UM staff signature or initials attributing the review to the specific reviewer of the case.

5.00 Timeliness of UM Decisions

5.01 Timely UM Decisions

Heraya Health makes UM decisions in a timely fashion as prescribed by the type of request and in accordance with applicable NCQA Standards, contracted health plans, and state law in order to minimize any disruption in the provision of health care. The UM staff, under the oversight of the Chief Clinical Officer, is responsible for accurate tracking and timeliness of all UM activities which is routinely monitored and reported as part of Heraya's UM Program. Elements to be tracked are clearly outlined in Section 8.06.

5.02 Definition of Nonurgent and Urgent

Definitions used when classifying UM requests:

- Nonurgent:
    - In accordance with NCQA Standards, non-urgent is defined as, "A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain."
    - The inclusion of a more restrictive state law definition of "nonurgent" or "standard" will be applied where applicable, e.g., Washington state, "'Standard prior authorization request' means a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited.
- Urgent:
    - In accordance with NCQA Standards, urgent is defined as, "A request for medical care or services where application of the time frame for making routine or non-life- threatening care determinations:
        - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement, or
        - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
        - In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request."
    - The inclusion of a more restrictive state law definition of "urgent" or "expedited" will be applied where applicable, e.g. Washington State: "'Expedited prior authorization request' means any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request."

Heraya allows a provider with knowledge of the member's medical condition to act as the member's authorized representative and to indicate "urgent" or "expedited" on Heraya's review form.

5.03 Receipt of Requests

Heraya documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at Heraya, even if it is not received by the UM department, regardless of whether all information necessary to make the decision at the time of the request. If information on the attending or treating practitioner was not provided with the request, or the request was from a provider (e.g., facility), rather than a practitioner, the organization attempts to identify the practitioner and documents its attempt as follows:

- Non-urgent:
  - For OR the next business day is the time of receipt for requests received outside normal business hours, as prescribed in Section 3.02, via fax machine. This is communicated to providers via this policy contained in the Provider Operations Manual. If received by mail, the date of receipt is the day Heraya receives the mailed document.
- Urgent:
  - The receipt for urgent requests is the exact time received via fax machine, regardless of outside normal business hours. If received by mail, the date of receipt is the day Heraya receives the mailed document.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. Heraya documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

5.04 Pre-Service Decisions

Treatment Extension Requests (TER) are considered pre-service requests as interpreted by Heraya's contracted health plans. Certain benefit plan designs require a treatment plan review prior to additional services being rendered and are conducted during a course of care at specified intervals. For example, individual member-focused reviews occur at specific intervals during a course of care as indicated by the number of visits, such as beyond 12 visits. These reviews are intended to assess medical necessity and detect potential excessive utilization and potential compromises of quality care.

Certain health plan contracts require Treatment Extension Requests (TER) by performing specified threshold reviews as described above. The resulting UM decisions are communicated to the requesting provider within the timeframes prescribed below in accordance with the most restrictive of applicable NCQA Standards, contracted health plans or applicable state laws. The decision is communicated to the member in cases of denial or partial denial of services.

These pre-service request or prior authorization request requirements are applied in accordance with applicable NCQA standards, contracted health plan or applicable state laws, e.g. Washington state law for public employees, a health carrier may not require prior authorization for an evaluation and management visit or an initial treatment visit in a new episode of chiropractic care where a "new episode of care" means treatment for a new or recurrent condition for which the enrollee has not been treated by the provider with in the previous 90 days and is not currently undergoing any active treatment. For additional details please refer to Heraya's Billing Manual Section 3.2 Kaiser Permanente For Southwest Washington and Washington regulations RCW 41.05.074 and RCW 48.43.016 6157-S.SL.

Non-Urgent Pre-Service Decisions: (*Includes "Standard prior authorization requests" in Washington state)*

Standard Timeframe

The final decision is communicated in writing to the provider and in the case of a denial also to the member. This must occur in accordance with the most restrictive of applicable NCQA standards (within 7 calendar days for Medicaid and Medicare and within 15 calendar days of the request for others), contracted health plans or applicable state law, e.g., within 5 calendar days from the receipt of such requests, as per the more restrictive policy required by Washington State law. Heraya UM staff documents the time and date of the verbal notification as well as who spoke with the provider. A voicemail is not an acceptable form of oral notification. Where there is a denial and notification is by telephone, Heraya UM staff also documents notification of physician reviewer availability.

In the event a pre-service request from a provider is not accompanied by necessary information, Heraya UM Staff will contact the provider via telephone, unless otherwise requested, within 5 calendar days of receipt to advise of the proper protocol and deadline for submission. Heraya UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

Extending Timeframes

If Heraya is unable to make a decision due to circumstances beyond control or lack of necessary information, the decision timeframe may be extended by the most restrictive of applicable NCQA standards (up to 15 calendar days) or applicable state law (e.g., Washington state law, up to 14 days) if the following exists:

- The provider is notified of the specific information required within the decision timeframe for the pre-service request.
- The provider is given the most restrictive of applicable NCQA standards (at least 45 calendar days) or applicable state law (e.g., WA state law, within 5 calendar days) to provide the specific information requested.
- The provider is notified of the expected decision date upon receipt of requested information.

A decision must be made within the most restrictive of applicable NCQA standards (up to 15 calendar days) or applicable state law (e.g., WA state law, within 4 calendar days) which begins on either of the following:

- The date the provider's response is received by Heraya, regardless if all requested information is received, or
- The end of the deadline given to the provider to supply the additional information if no response is received.

Heraya may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Urgent Pre-Service Decisions: (*Includes "Expedited prior authorization requests" in Washington state)*

Standard Timeframe

Decisions must be made in accordance with the most restrictive of applicable NCQA standards (within 72 hours of the request), contracted health plan or applicable state law, e.g., within 2 calendar days of receipt as per the more restrictive policy of the Washington state law. Verbal notification is acceptable as long as electronic or written notification is given no later than 3 calendar days of the verbal notice. A

voicemail is not an acceptable form of oral notification. Heraya UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

In the event an urgent pre-service request from a provider is not accompanied by necessary information, Heraya UM staff will contact the provider via telephone, unless otherwise requested, within 24 hours of receipt to advise of the proper protocol and a deadline for submission. Heraya UM staff documents the time and date of the verbal notification as well as who spoke with the provider.

Extending Timeframes

If Heraya is unable to make a decision due to lack of necessary information, the decision timeframe may be extended, once, to the most restrictive of applicable NCQA standards (48 hours or up to 14 days for Medicare and Medicaid with member request) or applicable state law if different (e.g., WA state law is 2 calendar days). The notification to the provider of the need for such extension within 1 calendar day must include the following:

- The provider is notified of the specific information required to make a decision on the urgent pre-service request.
- The provider is given the most restrictive of applicable NCQA standards (48 hours) or applicable state law if different (e.g., WA state law is 2 calendar days) to provide the specific information requested.
- The provider is notified of the expected decision date upon receipt of requested information.

A decision must be made within the most restrictive of applicable NCQA standards (48 hours) or applicable state law if different (e.g., WA state law is 2 calendar days) which begins on either of the following:

- The date the provider's response is received by Heraya, regardless if all requested information is received, or
- The end of the deadline given to the provider to supply the additional information if no response is received.

5.05 Concurrent Decisions

Concurrent requests are defined, as per NCQA Standards, "A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care." For example, if a TER was approved for a time period through a specified date and more visits are needed during that time period, the provider may submit a concurrent request for additional care.

- Nonurgent:
  - The timeframes for non-urgent concurrent decisions are the same as noted above in 5.04 Pre-Service Decisions.
- Urgent:
  - The timeframes for urgent concurrent decisions are made in accordance with the most restrictive of NCQA standards (24 hours of receipt for commercial and Marketplace and 72 hours of receipt for Medicare and Medicaid) or applicable state law (e.g., WA state law, as soon as possible, taking into account the medical exigencies, and no later than 24 hours provided the request is made at least 24 hours prior to the expiration of previously approved period of time or number of treatments). Per NCQA, if the request was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments, the

request may be treated as urgent preservice and make a decision within the most restrictive of NCQA standards (within 72 hours) or applicable state law (e.g., WA state law, within 48 hours). The time frames and criteria for extending decisions specifically for Medicare and Medicaid are the same as for urgent pre-service decisions.

5.06 Post-Service Reviews

Post-service (retrospective) reviews are conducted for UM purposes to detect potential under- and over-utilization or quality deficits. The organization may deny a post service request without conducting a medical necessity review, even if a medical necessity review is required, if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures but must provide the reason for the denial.

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or post service if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by Heraya. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or post service).

5.07 Reclassification of Request – Not Meeting Urgent Care Definition

If a request to extent a course of treatment beyond the previously approved time period or number of treatments previously approved by the organization does not meet the definition of "urgent care", the request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., pre-service or post-service).

5.08 Filing Procedures

Heraya may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures, e.g., provider files a request over the phone or outside specific time frames.

5.09 Daily Claims Reviews – Heraya Reimbursement Policies

Daily claims reviews are processed by the UM staff responsible for timely distribution to the appropriate Clinician Reviewer within 2 weeks of receipt by Heraya. The Clinician Reviewer will review and communicate the claims decision to Heraya UM staff within two weeks of their receipt to enable Heraya to process the claim within 30 days of Heraya claim receipt date. Please refer to 1.09 Role of Heraya Staff for further information.

6.00 Clinical Information for UM Decisions

6.01 Relevant Clinical Information

Clinician Reviewers assure all relevant clinical information needed to make a determination of medical necessity has been collected and documented.

Information used to support medical necessity decision-making includes documentation supplied by the treating provider of the health care services such as CMS-1500, examination and treatment notes, member self-reports, reports of consultations, and diagnosis codes.

Clinician Reviewers may request additional information from the treating provider when available documentation does not support medical necessity.

6.02 Contacting the Treating Provider

Clinician Reviewers may contact the treating provider directly in the event written documentation does not demonstrate medical necessity of the service under review.

7.00 Denial Notices

Denial notices to the provider and member contain sufficient information regarding the rationale of the UM decision for such parties to determine the need to appeal a medical necessity denial or partial denial. A denial is defined as denial of all requested services or a partial denial of some of the requested services. In situations when the reviewer approves an alternative service and the provider and member agree to the alternative services, the provider has essentially withdrawn the initial request, and this would not be considered a denial. In the event a denial notice is issued due to a lack of necessary information and a phone call, or the required information is received not as a result of the denial notice, the reviewer who issued the initial denial may review the case with the new information and reverse the decision. In this scenario, the case should be classified as a denial because the denial notice was issued.

7.01 Discussing a Denial with a Nonbehavioral Healthcare Reviewer

The denial notice to the provider will contain a name and telephone number for Heraya's UM department to facilitate contact with the Clinician Reviewer providing the opportunity to discuss the denial decision.

7.02 Specific Reasons for Denial

The Clinician Reviewers will clearly document the rationale for denial of service due to lack of medical necessity which will be communicated in writing directly to the treating provider and member. The explanation for the denial will be provided in easily understandable language and will not include insufficient language such as treatment is determined not to be medically necessary or not a covered benefit.

7.03 Criterion for Decision

The explanation to both the provider and member will contain a reference to the benefit provision, guideline, protocol or other criteria, or an excerpt specific to the denial criteria on which the denial decision is based and instructions to obtain a copy of the actual benefit provision guideline protocols and other criteria, or an excerpt specific of the denial criteria upon which the denial was based.

7.04 Elements of Member Notification

Electronic or written notification to the member will include:

- The date of the decision.
- Documentation of the name of the individual who notified the practitioner.

- If a voice mail is left, the denial file must include who left the message and the date and time.
- The decision in a culturally and linguistically appropriate manner.
- The specific reasons for the decision, in easy understandable language.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the decision was based. The member is advised a copy of such reference may be requested.
- Notification the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to an appeal.
- Notification the member has the right to have a representative act on their behalf.
- A list of the titles, qualifications, and specialty of each individual participating in the review. Names of such individuals do not need to be included unless the member requests this information.
- The written notification of the medical necessity denial will include the following in reference to the right to appeal the denial decision:
    - A description of appeal rights, including the right to submit written comments, documents, or other relevant information.
    - An explanation of the appeals process, including the description of the expedited appeals process, if an urgent pre-service or urgent concurrent request.
    - Notification the member has the right to have a representative act on their behalf at all levels of appeal.
    - A Right to Appeal brochure provided by the contracted health plan, as applicable, to include:
        - An explanation of the appeals process, and
        - In applicable cases pertaining to urgent services, a description of an expedited appeal process.

7.05 Reconsideration Reviews

Reconsideration is defined as providing new information not previously reviewed in the original decision. Heraya will grant a reconsideration review upon submission of additional information by the Heraya provider. The UM staff will send an acknowledgement of a reconsideration request to the provider within 5 business days of receipt, to include the expected timeframe for a decision. The final decision will be communicated in writing to the provider within 30 calendar days of receipt.

7.06 File Documentation

UM staff will document UM cases denied as outlined in Section 4.05.

7.07 Information Integrity for Denial Notification Dates

Authorized UM staff will document and maintain information specific to UM prior authorization requests and decisions, including receipt dates/times, denial notification dates, and modification of dates.

Date of Receipt

Upon receipt of a prior authorization request, UM staff are responsible for verifying the receipt date/time and manually entering the date/time into a custom field in a secure electronic data system.

When the regulatory timeframe for processing a case is calculated and the request is received after business hours or on a weekend/holiday, the actual receipt date is recorded as the first business day after receipt to accurately reflect regulatory timeliness rules.

When a prior authorization denial decision is received from a clinician reviewer, written denial notices are issued to the member and the member's provider within regulatory timeframes. If the member's provider is notified of the denial decision verbally, the date and time, the authorized UM staff member who placed the call, and the person the UM staff member spoke to are documented. Verbal notification is followed by written notification within regulatory timeframes. The date/time of notifications are manually entered by authorized UM staff into a secure electronic data system, which is passphrase protected, requiring an authorized UM staff member's unique ID and passphrase in order to gain access. Hard copies of UM information are locked in filing cabinets with access limited to authorized UM staff.

Authorization to Modify Dates

Only authorized UM staff members are able to enter and modify dates/times in the secure electronic data system. UM staff authorized to access paper and/or electronic UM information is limited to the Chief Clinical Officer, Regional Medical Director, Clinical Services Supervisor, Clinical Services Coordinator, and Medical Directors involved in conducting or overseeing UM reviews via role-based authorization at the direction of the Chief Clinical Officer. All authorized users are trained on NCQA and Heraya UM Policy and Procedures to protect the accuracy of information gathered and accessed. When modifications are made to a receipt and/or notification date/time, the secure electronic data system automatically creates an audit trail that documents the date/time the modification was made and the individual who made the modification. The reason a date is modified is documented within the applicable member's file. UM staff authorized to modify dates, which may occur due to a data entry error, will track/document the modification in the secure electronic data system and includes, at a minimum:

a. What modification was made.
b. When the date was modified.
c. Why the date was modified.
d. Staff who made the modification.
e. Scanned supporting images when appropriate.

At least annually, the organization demonstrates that it monitors compliance with its UM denial information integrity. This is done by identifying all modifications to receipt and decision notification dates and analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.

Securing Information Integrity Data

All personal computers are automatically set to lock after 5 minutes of inactivity. Additionally, all staff are required to ensure their computers are locked when leaving their workstations. All staff use strong passphrases, do not write down or share their passphrases, have user ID's and passphrases unique to each other, and use unique logins for different accounts. Passphrases are changed on a regular basis. Heraya servers are located behind secure access doors and are regularly backed up. Appropriate staff who oversee computer security which may include HR and/or IT Departments are alerted when a passphrase needs to be disabled or removed in the event of an employee's departure or for other reasons. Only authorized UM staff have access to UM information within the

secure electronic data system. There are steps in limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware, and physical records and files. "Physical access" does not refer to only the organization's building or office location.

Examples of preventing unauthorized access and changes may include:

- Limiting login attempts.
- Multifactor authentication.
- IP address authentication/matching.
- Use of firewalls.
- Use of antivirus software or spyware protection programs.
- Assigning user rights and leveling (permission tiers).

UM Process Audit

All modifications are audited in real time by the Clinical Services Supervisor and/or the Chief Clinical Officer to ensure appropriateness and accuracy of the information recorded in the secure electronic data system. At least semi-annually, all denial files are audited by the delegating authority. The results of the Denial Audit are reported to the Clinical Services Supervisor and Chief Clinical Officer, who is responsible for the oversite of the audit process, UM staff, and the Clinical Services Department.

7.08 UM Denial Information Integrity Oversight

At least annually, the organization demonstrates that it monitors compliance with its UM information integrity:

1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.
2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.

Heraya determines when modification is appropriate.

8.00 UM Appeals

Heraya Health has an appeals process in place to handle provider appeals, on the member's behalf. This element applies to all medical necessity and benefit decision appeals. Where Heraya is delegated to handle member appeals or deal with continued or rescission of coverage during an appeals process, regardless of whether the denial resulted from medical necessity review; this will be performed in accordance with the more restrictive of applicable NCQA standards, contracted health plans and state law. Members of contracted health plans are provided written instructions at the time of a medical necessity denial advising them of their appeal rights and are referred directly to their health plan carrier, as outlined in Section 7.04. An appeal is defined as any request to reverse a decision.

8.01 Full and Fair Investigation Process

The Heraya UM Appeal process is designed to handle provider appeals thoroughly, promptly and fairly. This includes a full investigation of the substance of the appeal, including any aspects of clinical care

involved. Relevant documentation is collected, as outlined in Section 6.00. Reference to a denial is precluded by sanitizing all references to the initial denial decision and the initial reviewer(s).

Utilization Management decision-making is based only on appropriateness of care and service and the existence of coverage. No compensation is given to the Clinician Reviewers for conducting utilization review for denials of coverage or service as described completely in Section 12.00.

8.02 Member's Appeal Time Frame

As stated within the right to appeal brochure enclosed with Heraya's denial or partial denial letter, a member's request for an appeal must be received by their health plan carrier within 180 days or the more restrictive of applicable NCQA standards (e.g., 60 calendar days for Medicare and Medicaid), contracted health plans, and state law, of the notification of an adverse decision. The member is advised if the appeal involves urgently needed future or continuing care services. A decision will be expedited to meet the clinical urgency of the situation as outlined in the health plan's member brochure accompanying the denial notice.

8.03 Opportunity for Member Input

The member is notified within the right to appeal brochure, enclosed with Heraya's denial or partial denial letter, of the right to submit written comments, documents, records and other information relevant to the member's appeal directly to their health plan carrier.

8.04 Member or Representative Appeal

The member is notified within the right to appeal brochure enclosed with Heraya's denial or partial denial letter, of the right, or the member's representative's right, to appeal any adverse decision directly impacting the member directly to the health plan carrier.

8.05 Provider Appeal

Heraya providers, acting on behalf of the member, may appeal a UM decision for which the member is not held financially responsible. Upon receipt, Heraya UM staff will follow the process outlined below.

8.06 Heraya Process for Provider Appeals:

The UM staff will perform the following procedure below in handling provider appeals:

- Gather and track all relevant documentation to include the substance of the appeal/ original decision, any action taken, and documentation provided with the appeal.
- Determine if Heraya is delegated to handle the appeal or forward to appropriate contracted health plan.
    - ***If not delegated***, the UM staff will forward the appeal to the appropriate contracted health plan within 1 business day of receipt of the appeal and notify the member and provider of such within this same timeframe.
    - ***If delegated***, the UM staff will send the provider (acting on behalf of a member) an acknowledgement of receipt within 5 business days of receipt, to include the applicable timeframe, as outlined in Section 8.07 for the final decision. The UM staff will follow the process below.

- Forward all relevant documentation to the appropriate clinician reviewer for a determination. The clinician reviewer will not have been involved in the initial decision and will not be a subordinate of the individual making the initial decision.
- Upon receipt of decision, notify the member and provider of the appeal decision as outlined below in Section 8.09.

The UM staff is responsible for document management, accurate tracking, and appropriate reporting of the following, which also applies to all UM decisions:

- Date received
- Type of Appeal or review
- Member name
- Provider name
- Date(s) of service
- Type(s) of service
- Date forwarded to Clinician Reviewer
- Date decision received from Reviewer, if no Reviewer signature the UM staff may initial or sign attributing the decision to the Reviewer.
- Decision documented
- Date provider and member notified
- Percentage rate calculations for timeliness adherence for UM decision making and notifications using at least 6 months of data

Recording dates in UM systems

Upon receipt of an appeal, UM staff are responsible for verifying the receipt date/time and manually entering the date/time into a custom field in a secure electronic data system. All appeal information is recorded in a secure electronic data system which is passphrase protected, requiring an authorized UM staff person's unique ID and passphrase in order to log on and gain access to UM information. Hard copies of UM information are locked in filing cabinets with access limited to authorized UM staff members.

Authorization to Modify Dates

Staff authorized to access paper or electronic UM information is limited to the Chief Clinical Officer, Regional Medical Director, Clinical Services Supervisor, Clinical Services Coordinator, and Medical Directors involved in conducting or overseeing UM reviews via role-based authorization at the direction of the Chief Clinical Officer. All authorized users are trained on NCQA and Heraya UM Policy and Procedures to protect the accuracy of information gathered and accessed. When modifications are made to a receipt and/or notification date/time, the secure electronic data system automatically creates an audit trail that documents the date/time the modification was made and the individual who made the modification. The reason a date is modified is documented within the applicable member's file. UM staff authorized to modify dates, which may occur due to a data entry error, will track/document the modification in the secure electronic data system with and includes, at a minimum:

a. What modification to date was made.
b. When the date was modified.
c. Why the date was modified.

d. The staff who made the modification.
e. Scanned supporting images when appropriate.

Securing System Data

All personal computers are automatically set to lock after 5 minutes of inactivity. Additionally, all staff are required to ensure their computers are locked when leaving their workstations. All staff use strong passphrases, do not write down or share their passphrases, have user ID's and passphrases unique to each other, and use unique logins for different accounts. Passphrases are changed on a regular basis. Heraya servers are located behind secure access doors and are regularly backed up. Appropriate staff who oversee computer security which may include HR and/or IT Departments are alerted when a passphrase needs to be disabled or removed in the event of an employee's departure or for other reasons. Only authorized UM staff have access to UM information within the secure electronic data system. There are steps in limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware, and physical records and files. "Physical access" does not refer to only the organization's building or office location.

Examples of preventing unauthorized access and changes may include:

- Limiting login attempts.
- Multifactor authentication.
- IP address authentication/matching.
- Use of firewalls.
- Use of antivirus software or spyware protection programs.
- Assigning user rights and leveling (permission tiers).

UM Process Audit

All appeal modifications are audited in real time by the Clinical Services Supervisor and/or the Chief Clinical Officer to ensure appropriateness and accuracy of the information recorded in the secure electronic data system. At least semi-annually, all denial files are audited by the delegating authority. The results of the Denial Audit are reported to the Clinical Services Supervisor and Chief Clinical Officer, who is responsible for the oversite of the audit process, UM staff, and the Clinical Services Department. Heraya's policies and procedures must include a description of the monitoring process outlined above, regardless of system functionality.

8.07 Heraya's Provider Appeal Timeframes

The following timeframes, depending on the type of appeal, apply upon receipt of a provider's appeal:

- ***Pre-Service Appeals***: Some contracted health plans require a pre-service authorization in the form of a Treatment Extension Requests (TERs). Upon receipt of a TER pre-service appeal, Heraya will notify the provider in writing of such decision within 14 days of receipt. In the event an extension is necessary, a decision delay will be communicated, but not longer than 30 days. For other pre-service appeals, notification to the provider and resolution will be provided in accordance with the more restrictive of applicable NCQA standards, contracted health plans and applicable State law.
- ***Expedited Appeals***: The resolution to an expedited appeal will be made within 1 business day to meet the clinical urgency of the request but not to exceed 72 hours (including weekends and holidays), regardless of whether or not all necessary information is received. Any request for an

expedited appeal for services already rendered will be denied and treated as a standard appeal. An oral initial notification may be provided within 72 hours with the requirement that written notification is issued not later than 3 calendar days after the initial oral notification.

- ***Post-Service Member Appeals***: Where Heraya is delegated to perform appeals for services already provided to members, notification to the provider and resolution of post-service appeals will be provided in accordance with the more restrictive of applicable NCQA standards (e.g., Medicaid and Medicare within 30 days, others within 60 days), contracted health plans and applicable state law, e.g., within 14 days of receipt of the appeal per the more restrictive policy of Washington State law
- ***Member Appeals***: Where Heraya is delegated for member appeals, Heraya will follow the more restrictive of applicable NCQA standards, contracted health plans and applicable state laws in providing an external independent review.
- ***Member Appeal Allowable Extensions***:
    - Heraya may extend the appeal time frames to obtain additional information when the member agrees to extend the appeal time frame, or where Federal program regulations allow Heraya to request additional information from the member.
    - Allowable extensions for Medicare and Medicaid product line only:
        - For Medicare and Medicaid Heraya may allow a 14-day extension if the member requests the extension or Heraya demonstrates that more information is needed and the delay is in the member's interest.
        - For Medicaid, oral notification is appropriate for nonurgent preservice, post service and expedited appeals, but Heraya will notify members of any delay and resolve appeals as expeditiously as the member's health requires.
    - Any extensions are documented in the appeal file and Heraya may deny the appeal and notify the member if it does not receive the information within the time frames.
    - For Medicare appeals, Heraya will notify the member that an upheld denial was sent to MAXIMUS.

8.08 Same or Similar Specialist Review

Medical Necessity-Same Reviewer: A licensed clinician of the same discipline as the provider providing the disputed service will review appeals related to medical necessity determinations, with the exception of OR where medical necessity denials must be performed by an MD/DO. That clinician will not have had involvement in the initial decision and will not be a subordinate of the clinician making the initial decision.

Medical Necessity-Similar Specialist Reviewer: A similar provider who has experience treating the same problems as those in question of the appeal may review appeals related to medical necessity.

Non-Medical Necessity: Appeals of UM determinations not related to medical necessity will be reviewed by the Chief Clinical Officer or appropriate designee; that individual will not have had involvement in the initial decision.

8.09 Elements of Provider and Member Notification

Appeal policies and procedures specify that Heraya informs the member, or the member's authorized representative, with written notification to both parties and will include:

- The date of the appeal decision.

- The decision and specific reasons in easy, understandable language.
- A reference to the benefit provision, guideline, protocol or other similar criterion, or an excerpt of the criterion on which the appeal decision was based specific to the member's condition or the requested service with the opportunity to obtain in writing.
- Notification the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal, free of charge. Information indicating specific criteria, or an excerpt of the criterion used in reaching the determination, in easily understandable language.
- Notification the member has the right to have a representative act on their behalf at all levels of appeal.
- A list of the titles, qualifications, and specialty of each individual participating in the review. Names of such individuals do not need to be included unless the provider or member requests this information.
- The written notification of the medical necessity denial will provide the following in reference to the right to appeal the denial decision:
    - A description of appeal rights, including the right to submit written comments, documents or other relevant information.
    - An explanation of the appeals process, including the description of the expedited appeals process, if an urgent pre-service or urgent concurrent request.
    - Notification the member has the right to have a representative act on their behalf at all levels of appeal.
    - Notification of how the member may receive, upon request, their notification in a culturally and linguistically appropriate manner.
    - A Right to Appeal brochure provided by the contracted health plan, as applicable, to include: an explanation of the appeals process, and in applicable cases pertaining to urgent services, a description of an expedited appeal process.
    - A description of the next level of appeal, either within the organization or to an independent review organization, as applicable, along with any relevant written procedures.
    - Where the next level of appeal is an independent external review, the notification includes a statement that members are not required to bear costs of the IRO, including any filing fees, unless state law mandates that members pay an IRO filing fee.

8.10 Expedited Appeals

A denial of an urgent care request is not common and would rarely be seen at Heraya as explained in the UM Program Overview Section. However, Heraya has a mechanism in place to expedite denials for treatment extension requests when a member believes an emergency condition exists due to the presence of severe pain or other symptoms, whether or not it is clinically considered an emergent or urgent situation.

The expedited claims appeal process is stated in Section 8.07 above and is available to member's by Heraya when permitted by the contracted health plan, their representative or provider's acting on behalf of the member. An expedited appeal includes pre-service issues felt to possibly jeopardize the member's life, health, or ability to regain maximum function, based upon a prudent layperson's judgment. An expedited appeal, in the opinion of a provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

9.00 Technology Assessment

9.01 Relevant Professional Expertise

The Heraya Chief Clinical Officer is responsible for ensuring new medical technologies and new application of existing technologies are evaluated as necessary for inclusion in benefit plans. The purpose of this written evaluation is to remain current with new technology. This includes modalities, therapeutic procedures, and diagnostic devices and procedures. The Chief Clinical Officer, Regional Medical Director, and Associate Medical Directors are responsible for identifying new technology or new applications of existing technology that are appropriate for assessment. Heraya will also respond to requests from network clinicians for technology assessment.

9.02 Review of Information

A written technology assessment will be based on:

- Thorough review of the relevant scientific and clinical literature.
- Review of information from appropriate government agencies.
- Information from relevant specialists and professionals who have expertise in the technology.

9.03 Decision Variables

Consideration for inclusion of a new technology will be based on:

- Evidence of efficacy.
- Assessment of risk.
- Evidence that the new technology produces better outcomes than existing technology.

9.04 Decision and Implementation

The written assessment of new technology will be presented to and reviewed by the Combined Medical Directors Committee, with final approval by the Clinical Management Committee. The final decision(s) may be either of the following:

- A policy determination to include a new technology as a covered benefit in the future, or
- A case-based decision whether or not to cover a specifically requested service.

If the new technology is deemed appropriate and effective for use by providers with covered members, the Chief Clinical Officer will contact their counterparts with contracted health plans and ask for their review and approval before Heraya endorsement is made public to the providers.

10.00 Experience with UM Process

10.01 Member Experience with UM Program

Heraya is not delegated to assess member satisfaction with the UM Program. Service denials do not generally impact members adversely in that there is generally no financial responsibility on the member's part. Heraya elects to conduct annual member satisfaction surveys for the purpose of opportunities for improvement.

10.02 Provider Experience with UM Program

Heraya Health conducts annual provider satisfaction surveys to inquire about satisfaction with the UM Program and various other aspects of Heraya business performance to identify improvement opportunities.

10.03 Opportunities for Improvement

The Quality Management (QM) Program is structured to identify any opportunities for quality improvement in the UM Program with appropriate action if necessitated.

11.00 Appropriate Utilization

11.01 Monitoring Potential Under- and Over-Utilization of Services

The Chief Clinical Officer, Regional Medical Directors, and Associate Medical Directors regularly review utilization reports to identify unexplainable variation which may indicate potential under or over-utilization. At least annually, all chiropractic, naturopathic physicians and providers rendering acupuncture services receive information about their own utilization in relation to explicit utilization targets. High volume and outlier providers may receive such reports on a quarterly basis. Providers identified as having significant deviation from expected utilization which cannot be explained will result in a corrective intervention.

11.02 Established Thresholds

Performance indicators are well-defined, objective measurements of provider performance assessing important aspects of care and service. The process analyzes available demographic and health data in order to identify areas for study and determine priorities. Clinical indicators are based on clinically valid, current knowledge and experience and direct attention to potential problems or opportunities to improve care. Variation in clinical practice in the use of services is widely documented.

The distribution analysis of provider performance identifies statistical outliers, both above and below the mean. Statistical variation serves to identify practice patterns and individual providers of interest for further analysis. Investigation may reveal explainable variation such as certain uncontrollable factors, including case mix or condition severity, co morbidities and member response. Unexplainable variation may indicate problems with over or under utilization of healthcare services.

- Over-utilization is the provision of healthcare services, which cannot be demonstrated to be medically necessary. It may be revealed by unexplainable statistical variation, which appears in the third (3rd) standard deviation or more above the network mean.
- Under-utilization is failure to provide healthcare services that are medically necessary. Unexplained statistical variation which appears in the negative third (3rd) standard deviation or more below the network mean is underutilization.

Over-utilization is relatively easy to identify. The claims processing system can pick out high volume services, providers, and even high utilizing members, any of which might represent over utilization. It is much more difficult to identify services which should have been rendered but were not.

Under-utilization results from a number of causes. Systemic sources of failure to deliver or receive appropriate healthcare include problems of access whether due to geography, culture, language,

member preference, or economics. Health plan characteristics such as benefit design, limitations on coverage, deductibles, co pay levels, referral protocols, to name a few may have a detrimental effect on the delivery of medically appropriate services. Provider-driven under-utilization stems from lack of awareness of clinical protocols, lack of protocols themselves, or inappropriate financial incentives impacting the clinician.
Member preference and expectations also can have an effect on both under- and over-utilization. Inadequate member education, lack of personal motivation, and unrealistic expectations for a healthcare provider encounter can drive underutilization of otherwise appropriate healthcare services.

11.03 Qualitative Analysis Data Not Within Thresholds

The data collected must be analyzed to determine the level of improvement and/or achievement of desired outcomes. Data is analyzed and compared to patient expectations; appropriate standards and guidelines consistent with current literature; clinical pathways and clinical experience; approved policies, procedures, and protocols; and regulatory requirements. Data analysis may include trending and comparison with standards of best practices and outcomes of other organizations.

The evaluation of data is documented in reports, minutes, or similar documents at the committee level. Documentation of analysis indicates the possible cause(s) for the data variance thereby providing the direction for the specific action to be taken.

11.04 Types of Relevant Utilization Data Monitored

The primary screen for medical necessity and appropriateness is embedded in the claims processing system. The system is “loaded” with the edits for allowable procedures determined by peer professionals to be appropriate in the evaluation and treatment of member’s and for which services are allowable by health plan contract.

Heraya performs pre-service, concurrent and post service reviews. There are some services, allowed under Heraya benefits, which require clinical records to be submitted to substantiate complex codes or infrequently utilized codes. There are also a number of opportunities to evaluate medical necessity on an ad-hoc basis as files come up for review during quality management activities. These include reviews of clinical records for clinical record keeping quality improvement program, monthly clinical record audit reviews, pathway reviews, and quality studies. The procedural details related to medical necessity review activities are contained under Section 2.00, Clinical Criteria for Utilization Management.

11.05 Actions to Correct Patterns of Potential or Actual Inappropriate Utilization

The Utilization Management Program consists of two approaches:

- Evaluation of aggregate data, including provider profiles, to identify services that require focused review and/or providers whose practice patterns are inconsistent with local community standards for quality cost efficient care, and
- Identification of specific claims or cases for review using embedded edits, as described in Section 11.04 above, in the claims processing system. These reviews are primarily non-urgent post service, pre-service or concurrent reviews.

The purpose of data collection is to identify trends, patterns, or problems. Data is systematically collected concurrently or retrospectively using established criteria. If sampling is appropriate for high

volume aspects of care or service, the sample size and selection are pre-established and statistically valid.

Data may be collected and displayed utilizing one or several quality improvement tools such as cause and effect diagrams, tables, graphs and charts, stratification, Pareto analysis, histograms, and scatter diagrams.

11.06 UM Intervention: Provider Care and Service Review

The effectiveness of UM intervention is measured by the length of time required for an outlier provider to demonstrate practice that is aligned with Heraya benchmark performance. Non-compliance of outliers in a corrective action process may result in termination from the network as per the terms of the Professional Services Agreement.

This process was developed to monitor, evaluate, and continuously improve the quality and effectiveness of care and services provided by Heraya providers and to detect and investigate potential under- and over- utilization of services and to apply appropriate intervention steps when utilization issues are identified.

Provider Reporting

Computer generated reports and/or dashboards allow for review of claims data for provider profiling information. The following reports and/or dashboards are generated and reviewed on a regular basis:

- ***Provider Distribution Analysis***: Reports 12-month trailing data that gives practice pattern information for each provider. Categories include average cost (per visit and an average per patient per year), patient visit average, number of visits, number of new patients, number of individual patients, and average services per visit. Each category is compared to the network mean. A report with the same information is produced for all contracts combined and for each individual contract and line of business.
- ***Line- Item Profile***: Reports patient specific information in terms of frequency and number of visits, and service types correlated with diagnoses for a 12-month period organized by provider for added detail in terms of practice pattern information.
- ***CPT Utilization Report***: Reports the frequency of CPT code utilization (i.e., CMT, radiographic, laboratory, etc.) for fair distribution of resources.
- ***Radiology Detail Report and Radiology CPT Report***: Reports specific utilization information related to x-rays.
- ***Provider Trend Analysis***: Reports are mailed to providers on a quarterly and/or annual basis that include trends of some of the measures reported on the Provider Distribution Analysis. These measures are reported as the providers' activity against the network norm. The reports give a provider the opportunity to evaluate and/or address any variation before it rises to a level necessitating some level of Medical Director intervention.

The above reports are designed to look at utilization from several different aspects. Significant variation from the norm results in inquiry to determine if it is explainable or unexplainable. Contributing factors may provide explainable variation to include:

- Practice specialization (e.g., sports injuries, complex cases, etc.),
- Low member volume causing skewing of the data,

- Provider being new to the network or to practice location causing increased number of new member services, and
- Geographic or demographic variation in member needs or expectations.

Provider Monitoring

The Provider Distribution Analysis (PDA) reports, reviewed on a quarterly basis, relate to those providers falling in the third (3rd) standard deviation above the mean for any measure. These measures are used as indicators for further exploration of possible over-utilization and/or quality issues and allow for the evaluation of trend, severity, and response to intervention. The provider trends above are analyzed for potential under-utilization and quality issues. Such evaluation may involve any and/or all of the following:

- Checking the database for information on member's seen, number of visits, over what time period, and whether those individuals have sought care anywhere else within our system.
- Compiling existing information from quality studies, patient satisfaction surveys, credentialing file, and quality file.
- Sending files for review (recommended sample includes three files with one visit, two with two to six visits, and one with many visits). The file review assesses the following elements:
    - Quality of treatment plans
    - Possible issues with:
        - Communication skills
        - Clinical competency
        - Personality issues
        - Performing a targeted member survey by telephone or mail using the same patient's whose files were reviewed if possible.

The number of members seen in the twelve-month period under review is an important indicator of statistical validity. Those providers who are new to the network or who are in a geographic area where the number of members with the benefit is low may well have their statistics skewed by low member volume. It is our experience that once the number of members seen in that time period is over 10, the measures become quite reliable.

UM Intervention Process

First Contact with Provider

The appropriate Medical Director contacts any provider who is monitored for either over-utilization or under-utilization if their statistics reflect over the 3rd standard deviation for three consecutive quarters or four of the last six quarters of the 12-month trailing period. The tone of this contact is informational and amounts to inquiry rather than accusation. Utilization management reports will have been reviewed before contact to further clarify any potential utilization or quality issues. Prior to the contact, the UM staff mails the provider a letter advising of a future call from the appropriate Medical Director, a copy of the most recent Provider Trend Analysis report to be discussed in the telephone meeting and a copy of Heraya's UM Intervention: Provider Care and Service Review policy.

This contact offers an opportunity to explain the statistical measures and share information with the provider, inquire about possible explanation for the variation, and to offer assistance if appropriate. The

provider is generally asked to review his/her practice policies and procedures in addition to an explanation for the practice variation. The goal is to provide the Medical Director with an explanation regarding the provider's marked practice variation from the rest of the network.

A subsequent memo is mailed to the provider documenting the discussion, which provides the provider an opportunity to correct or clarify the memo. A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline Heraya's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file.

Second Contact with Provider

A second contact is made by the appropriate Medical Director if unexplainable variation persists after there has been sufficient time for any changes to be reflected in the UM data. This time period will vary with the measure in question and the member volume of the provider. The following feedback is provided by the appropriate Medical Director:

- A telephone call to provide positive feedback if the data indicates the desired trend.
- A telephone call or a face-to-face meeting may be scheduled regarding no change in the measures in question as well as further explanation of the issues involved. Information or help in solving problems is offered.

A subsequent memo is mailed to the provider documenting the discussion, which provides the provider an opportunity to correct or clarify the memo. A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline Heraya's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file.

Third Contact with Provider

A third contact is made by the appropriate Medical Director if no substantial improvement is reflected in the UM data. The provider is contacted by telephone and instructed that he/she will be required to develop an action plan addressing the continuing unexplainable variation.

The provider is notified by letter which outlines the issues and the previous contacts attempting to resolve the issue. Specific time frames and targets are provided and the specific steps the provider intends to implement in order to deal with the unexplainable variation is requested. The provider is given two weeks to present an action plan to the Combined Medical Directors. Upon receipt of the action plan, the Combined Medical Directors will review the action plan and vote on a majority approval. The UM staff notifies the provider of approval within 5 business days of decision and continued monitoring by Heraya.

Failure to respond to a request for an action plan or failure to complete an action plan will result in termination from the network.

Regression

A provider who had successfully completed the action plan process may become an outlier again. In such cases, the provider will receive a telephone contact from the appropriate Medical Director. Either of the following will occur:

- ***Telephone contact occurs***: A memo is mailed to the provider summarizing the conversation with the Medical Director which gives the provider an opportunity to correct or clarify the memo.

A copy of the UM Intervention Policy 11.06 is attached with the memo to clearly outline Heraya's expectations. A copy of the memo is placed in the provider's quality file and the intervention is tracked in the UM tracking file. The provider continues to be monitored on a regular basis.

- ***No telephone contact***: If there is no response from the provider, a second action plan is requested in writing and the process under Third Contact above is followed.

12.00 Affirmation Statements

As an employee of Heraya Health, Inc., I affirm that:

- Utilization Management decision-making is based only on the appropriateness of care and service and the existence of coverage,
- Heraya Health, Inc. does not specifically reward providers or other individuals for issuing denials of coverage or care, and
- No compensation or financial incentives are in place to encourage decisions which result in under-utilization.

Reviewing Professional Name (Print): _____

Reviewing Professional Signature: _____

Date: _____

Section Four – Radiographic Guidelines

Heraya Radiographic Guidelines

Heraya Health has established guidelines for radiographic examinations and for the treatment of common musculoskeletal conditions that help to clarify Heraya expectations and reflect our commitment to the delivery of evidence-based quality chiropractic care. Because x-ray exposure poses some risk to patients, it is generally agreed that x-rays must be used carefully with an assessment of the risk-to-benefit ratio. It is Heraya policy that:

- Radiographic examinations must be justified by clinical need and have a direct impact on patient management. This should be reflected in the chart notes.
- Appropriate technical procedure must be followed to prevent retakes and minimize radiation exposure.
- Radiographs must be of sufficient diagnostic quality.
- Radiographic examinations are not appropriate as screening procedures.

Heraya relies on the providers' professional opinion and clinical documentation to determine when an x-ray examination is appropriate. The following guidelines are provided to foster clinical quality:

Non-Indicators for Radiographic Exams

Unnecessary duplication of services
Patient education
Routine screening
Habit
Discharge status assessment
Routine biomechanical analysis
Pre-employment status
Financial gain
Pregnancy

Possible Indicators for Radiographic Exams

Corticosteroid use
High risk for osteoporosis
Constitutional/systemic disease
Inflammatory arthritis
Neuro-motor deficit
Medico-legal implications when combined with clinical indicators

Other Indicators for Radiographic Exams

Suspicion of fracture
Suspicion of primary or metastatic tumor
Suspicion of infection of bone or joint
Suspicion of progressive deformity (e.g., spondylolisthesis)
Failure to respond to therapy

Section Five – Heraya Forms

Vacation / Leave of Absence / Sabbatical Request Form

☐ **Vacation**

☐ **Leave of Absence** (up to 6 mo)

☐ **Leave of Absence Extension** (6 mo - 1 year)

☐ **Sabbatical** (over 1 year or up to 2 years)

To be completed by the Heraya Provider requesting absence:

Name of Heraya Provider Requesting Absence:		Discipline: (circle one) DC ND LAc LMT	
Reason for Absence:	Number of Days:	From:	To:
Have you reviewed the policy of Vacation/ Leave of Absence policy?		Yes ☐	No ☐

Call Coverage Request

Are you requesting call coverage?	☐	Yes	☐	No	If yes, complete section below.		
Name of Call Coverage Provider:					Provider's Office Phone:		
Provider's Business Address		City			State	Zip	
1. Is the provider currently on the Heraya network?					Yes	☐	No
2. Will you be available to the provider or Heraya during your leave?					Yes	☐	No
3. I understand the following with respect to Call Coverage: • Call coverage, once approved, is allowed up to 90 days • Call Coverage providers may not treat specified members references in policy 3.06 • Please refer to the Provider Operations Manual and: • Read the Call Coverage policy 1. Submit the Call Coverage Application, to be completed by the covering provider via fax to 877-482-2856					Yes	☐	No

Requesting Provider Signature: _____ Date: _____

Submit Request (and questions if any) to Heraya in any of the following methods:

- Email: ps@herayahealth.com
- Fax: 877-482-2856
- Mail: 6600 SW 105th Avenue Suite 115, Beaverton, OR 97008

Associate Request Form

This form serves as a Request to Add an Associate. Heraya providers requesting an Associate must have been on the network for a period of three years, successfully completed at least one re-credential cycle, and must be in good standing to apply for an Associate. Please review the Associate Policy. The required letter of reference below must be completed and returned to Heraya Health, along with the release of information form signed by the Associate.

Confidential Associate Reference/Evaluation Form

Name of Associate Provider		**Phone Number:**	
Home Address	**City**	**State**	**Zip**

Please complete all questions on this form. Base your evaluation of the following factors on the provider's demonstrated performance compared to that reasonably expected of a provider with similar level of training, experience, and background. If more space is needed, use a separate sheet.

Basic Medical Knowledge	**Favorable**	**Unfavorable**	**Don't Know**
Clinical Judgment	☐	☐	☐
Technical Skills	☐	☐	☐
Sense of Responsibility	☐	☐	☐
Clinical Competence	☐	☐	☐
Ability to work with others	☐	☐	☐
Clinical Record Currency	☐	☐	☐
Quality of Clinical Records	☐	☐	☐
Patient Management	☐	☐	☐
Provider – Patient Relationships	☐	☐	☐
Understand, Speak, Write English	☐	☐	☐
Relationship with Associates, Health Plans, and Office Staff	☐	☐	☐

How many years have you known the provider? _____

What is your relationship to the provider? _____

Action Taken
(If you answer "yes" to any of the questions below, please give details on separate sheet)

During the time noted above, and to your knowledge, was this provider ever subject to any disciplinary action, such as imposition of consultation requirements, suspension, termination, or any action pending against them? Yes ☐ No ☐

To your knowledge, has this provider ever been under investigation by any governmental or other legal body? Yes ☐ No ☐

Conduct and Health Status
(If you answer "yes" to any of the questions below, please give written details on separately)

Has this provider ever shown signs of drug, or alcohol behavior problems? Yes ☐ No ☐

Does the provider have any medical or mental conditions that might prevent them from performing any aspect of patient care in a safe and efficient manner? Yes ☐ No ☐

Have you reviewed and agreed to the terms of Heraya's current Associate Policy and Sponsorship responsibilities? Yes ☐ No ☐

General impression of the provider:

_____

_____

_____

_____ _____

Printed Name Date

_____

Signature

Association Authorization and Release of Information Form

By submitting this release of information, I understand and agree to the following:

I understand and acknowledge that, **as an applicant** for Associate status on Heraya Health network and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] pertaining to this release:

I authorize, **(Sponsoring Provider)** _____ with whom I have been associated or who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to communicate any relevant information to Heraya Health, their staff, and agents.

Print Associate's Name: _____

Associate's Signature: _____ Date: _____

Submit Request (and questions if any) to Heraya in any of the following methods:

- Email: ps@herayahealth.com
- Fax: 877-482-2856
- Mail: 6600 SW 105th Avenue Suite 115, Beaverton, OR 97008

Call Coverage Application Form

This application is to be complete by the non-contracted provider and returned to Heraya Health for approval and prior to treating Heraya members.

This form should be typed or legibly printed. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please submit the following, along with the application:

- ❑ A copy of Professional Liability declaration page of Insurance Policy
- ❑ A copy of DEA Certificate, if applicable

Questions pertaining to the completion of this application or submission procedures should be directed to Provider Relations staff, 503-203-8333 or 800-449-9479.

PLEASE COMPLETE:

I am requesting authorization to provide Call Coverage for the following Heraya Provider:

Name: _____

Specialty circle one: DC ND LAc LMT

Dates of coverage: From:_____ To:_____

Submit request (and questions if any) to Heraya in any of the following methods:

- Email: ps@herayahealth.com
- Fax: 877-482-2856
- Mail: 6600 SW 105th Avenue, Suite 115, Beaverton, OR 97008

I. Call Coverage Provider Information

Last Name	First Name	Middle Name	Suffix	Degree(s)

Social Security Number	Gender	Birth Date	Birth Place

Tax ID Number	Name affiliated with Tax ID Number	NPI Number

Home Address	City	State	Zip

	Home Phone

II. Call Coverage Provider Information

Name of Practice Affiliation or Clinic Name Associated with Primary Office	Primary Office Phone Number	Primary Office Fax Number

Primary Office Address	Pager
	E-mail

Office Mailing Address (if different from Primary)	City	State	Zip

Are you able to accept new patients within two working days?	Y [ ] N[ ]

III. Professional/Medical Education (Attach additional sheets if necessary)

Institution Name	Degree Received	Graduation Date

Address	City	State	Zip

Did you successfully complete this program?	Yes [ ] No [ ] (If "No", please explain on a separate sheet.)

IV. Board Certification

Are you board or otherwise professionally certified?	Yes [ ] No [ ] If Yes, fill out below information. If no, skip to Section V.

Name of Issuing Board	Specify	Date Certified	Expiration Date (if any)

V. Healthcare Licensure, Registration and Certifications (Attach certificate if applicable)

Professional License Number	Issue Date	Expiration Date	Current State

Professional License Number	Issue Date	Expiration Date	Current State

VI. Drug Enforcement Administration (DEA) Registration Number

Does not apply:	Yes [ ] No [ ] If Yes, skip to Section VII.

Drug Enforcement Administration (DEA) Registration Number	Expiration Date

VII. Professional References

List two (2) professional references, preferably from your primary discipline, not including relatives. NOTE: References must be from individuals who, through recent observation, are directly familiar with your work.

Name	Specify Relationship	Phone Number	
Address	City	State	Zip
Name	Specify Relationship	Phone Number	
Address	City	State	Zip

VIII. Professional Liability

Current Insurance Carrier	Policy Number		
Mailing Address	City	State	Zip

Per Claim Amount $	Aggregate Amount $	Date Began	Expiration Date

Printed Name Date

Signature

Confidentiality Statement

I acknowledge and agree to maintain the confidentiality of all information including, but not limited to, deliberations, discussions, and other records and proceedings of Heraya Health (including standing and special committees and departments) and other committees and departments of the Heraya which have responsibility for peer review or other activities for the evaluation and improvement of the quality of care rendered in Heraya providers, the reduction of morbidity or mortality, or assuring proper utilization. Additionally, I acknowledge and agree to maintain the confidentiality of (1) all information pertaining to medical and certain other personal information about patients; (2) medical and certain other information about employees; (3) proprietary information (this information may be on any media including but not limited to computer information, paper records, microfiche, x-rays, videotape and e-mail); and (4) reports, policies and procedures, marketing or financial information, and other information related to the business or services of Heraya and its affiliates which has not been previously released to the public at large by a duly authorized representative.

Further, I agree to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Heraya affairs, unless law expressly mandates such disclosure. I recognize that maintenance of confidentiality of such information is necessary to promote free and candid discussion, which is essential to assuring the effectiveness of peer review, and other activities related to evaluating, improving, and maintaining the quality and efficiency of patient care. Furthermore, my participation in such Heraya peer review and quality assurance activities is in reliance on my belief that the confidentiality of the activities will be preserved by every other Heraya member or other individual involved.

I understand that unauthorized disclosure of such confidential information shall be deemed disruptive of operations, detrimental to the delivery of quality patient care, and a violation of the policies and rules, and therefore shall be grounds for corrective action against me. I further understand that the Heraya may also seek injunctive relief in court to prevent to terminate threatened or actual unauthorized disclosure of such confidential information or may undertake such other action as it deems appropriate to assure that such confidentiality is maintained.

Printed Name	Date

Signature

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Jon McElfresh at jonathan.p.mcelfresh@oha.oregon.gov or 503-385-3075 (voice). We accept all relay calls.

Heraya Philosophy of Care

Heraya Health provides access to members and enrollees to quality health care services through insured benefits and access plans. Regardless of the financial arrangement, Heraya and its providers adhere to a philosophy of care that is patient-centered and evidence-based.

- Patients deserve care that is accessible, appropriate for their condition, considerate of their values and preferences, and respectful of their autonomy, time and resources.
- Providers must have the latitude to advocate for quality care for their patients and be able to provide that care without intrusion.
- Those who pay for the care deserve assurance that the services they are paying for are provided in ways consistent with contracted arrangements and expectations for appropriate care.
- Treatment plans and care recommendations are expected to adhere to community standards of practice and be consistent with best practices benchmarks established by Heraya clinicians, advisory groups, and Regional Medical Directors.
- Care must be "medically necessary" – care that is appropriate for the condition, is being provided for that condition, is within the community standards of good care, and is for the benefit of the patient, not the caregiver.
    - ***Treat and release.*** Care is rendered to correct the presenting condition, bring it to maximum improvement, and lead to discharging the patient with appropriate instruction for follow-up, self-care, and prevention of future occurrences.
    - ***Recognized condition.*** The condition itself is one that is generally recognized throughout the health care community. While there may be discipline-specific clinical assessments, these must also be characterized in diagnostic terms relevant and comprehensible to all clinicians.
    - ***"Maintenance" or "wellness" care is not a covered benefit in insured health plans.*** While these modes of care are of value, they are not part of the insurance benefit that the payer is obligated to provide in most instances. Maintenance and wellness care are usually the financial responsibility of the patient.

These expectations and values are shared with each provider and held by all. We enable and encourage providers continuously to evaluate and enhance their own practices, philosophies, and goals.

Printed Name	Date

Signature

XXI. Attestation Questions – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.** NOTE: Answering "yes" to Question L does not require any further details.

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES	NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES	NO
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES	NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?	YES	NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
G.	Have you **ever** voluntarily or involuntarily left or been discharged from any education or training programs related to your current licensure or certification?	YES	NO
H.	Have you **ever** had board certification revoked?	YES	NO
I.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES	NO
J.	Have you ever been charged with a criminal violation (*felony or misdemeanor*)?	YES	NO
K.	Do you presently use any illegal drugs?	YES	NO
L.	We recognize that providers encounter health conditions, including those involving physical and mental health and substance use disorders, just as their patients do. It is imperative that providers address their health concerns for their own well-being, as well as for patient safety. Do you attest to no current physical, mental health, or chemical dependency conditions (alcohol or other substances) that currently affect your ability to practice, with or without reasonable accommodation? Please disclose any current conditions that require employer-provided accommodations on a separate sheet.	YES	NO
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/ hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES	NO
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail, for each** past or current claim and/or lawsuit.	YES	NO
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES	NO

e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

Addendum to Attestation

XXII.	**ADDENDUM TO ATTESTATION – This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the application.**	
Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.**		
A.	**In the last three (3) three years**, have there **ever been** any formal allegations (including any complaint, indictment or other initiation of a proceeding) before a court of law, state licensing authority or professional society, or the commencement of an investigation by, or the filing of a complaint before a governmental authority or professional society, which relates adversely to your practice or fitness to practice, or involves a claim of alleged malpractice by you or persons under your supervision?	YES NO
B.	Has there **ever been** a complaint made concerning you to the **state licensing board** or similar organization?	YES NO
C.	In the last three (3) three years, has there **ever been** an initiation of any investigation, audit, review, or other administrative proceeding, or the issuance of any subpoena, warrant, or civil or criminal investigative demand, relating to compliance with state or federal fraud and abuse laws?	YES NO

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership, or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. **I understand my obligation to provide Heraya Health with an immediate update to this information, as required under the Professional Services Agreement, Section 2.12, should there be any change in this information**.

Signature Date