ATRIO™ HEALTH PLANS

MEDICARE ADVANTAGE PROVIDER MANUAL

atriohp.com/oregon/

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HISTORY OF ATRIO HEALTH PLANS

Incorporated in Oregon, ATRIO has been offering Medicare Advantage plans since 2005 for Oregon Medicare beneficiaries. Oregon plans include PPO plans (with and without prescription drug coverage) along with Dual Eligible Special Needs Plans for individuals dually eligible for Medicare and Medicaid coverage. Partnering with local health care providers, ATRIO's PPO plans with prescription drug coverage has been offered in Nevada, since 2022.

CONTACT INFORMATION

ATRIO Health Plans Corporate	550 Hawthorne Ave SE Suite 140 Salem, OR 97301
Provider Customer Service	1-877-672-8620
Provider Relations Department	**ProviderRelations@atriohp.com**
Prior Authorization Status Phone	1-877-672-8620
Pharmacy Department	1-877-672-8620 - Request to transfer 8 a.m. – 5 p.m. Local Time ATRIO Pharmacy **Pharmacy@atriohp.com** After hours call MedImpact 1-800-681-9571; Option 4 Mon-Fri 8a.m.-5p.m. **Formulary Lookup Online:** **https://www.atriohp.com/oregon/providers/drug-formularies/** **Any pharmacy questions, email:** **pharmacy@atriohp.com**
Local Offices	**Douglas County** 2270 NW Aviation Drive, Suite 3 Roseburg, OR 97470 **Josephine & Jackson Counties** 810 O' Hare Parkway, Suite B Medford, OR 97504 **Klamath County** 404 Main Street, Suite 5 Klamath Falls, OR 97601 **Marion & Polk Counties** 550 Hawthorne Ave SE, Suite 140 Salem, OR 97301 **Washington & Yamhill Counties** 13193 SW 68th Parkway, Suite 100 Tigard, OR 97223

CONTRACTING & CREDENTIALING

EXCLUDED PROVIDERS

Contracted providers shall not refer members to or employ/contract with providers identified on either the Office of Inspector General (OIG), System for Award Management (SAM) exclusion lists, or Preclusion list.

ATRIO CREDENTIALING

All contracted providers and contracted facilities must be approved through credentialing prior to being considered an in-network provider and/or facility.

ATRIO may delegate the responsibility for the credentialing of contracted providers to other entities. However, ATRIO retains final authority regarding the credentialing and re-credentialing decisions for each provider and/or facility.

A provider's participation and credentialing status with ATRIO is determined after ATRIO's or the delegate's credentialing committee and/or Board has received and reviewed the credentials and other required documentation. Credentialed providers are re-credentialed at least every three years or as defined by credentialing committee and/or Board.

PROVIDER DIRECTORY UPDATES

ATRIO will provide complete and accurate provider directories, maintaining regular communications and contact with contracted providers. ATRIO will evaluate a provider's ability and capacity to accept new patients into their practices. ATRIO will work to accurately identify the practice name, location and any other data elements that may affect a provider's availability to an ATRIO member. No ATRIO contracted provider should be considered closed to accepting new members without first notifying ATRIO of the closed practice status.

Due to CMS mandates, contracted providers are asked to review and verify their practice demographic information on ATRIO's online Provider Directory at https://www.atriohp.com/oregon/members/find-a-provider/ . Any updates or changes to the demographic information listed on the ATRIO online Provider Directory shall be emailed to atriocontracting@atriohp.com.

CMS Mandate:

Managed Care Manual Chapter 4, sec. 110.2.2

CREDENTIALING TERMINATION

Conditions of denial, suspension, or termination of a provider's credentialing/re-credentialing may include, but are not limited to the following:

- Failure to comply with or meet the credentialing or re-credentialing requirements or standards of care and service required under ATRIO's Quality Improvement activities;
- Failure to provide or arrange for the provision of covered services as required under the provider agreement;
- Conviction of a felony in any state or federal court;
- Exclusion or Preclusion from participation in any federal health care program, including Medicare or Medicaid, or exclusion of a provider's subcontractor and provider fails to prohibit its subcontractor from providing services to members;
- Misrepresentation of information on credentialing application;
- Significant number of paid malpractices claims or settlements;
- Repeated failure to follow utilization rules;
- Loss or suspension of license to practice;
- Loss of malpractice insurance or inability to obtain coverage at levels required by ATRIO;
- Issues related to non-professional behavior;
- Refusal to cooperate with ATRIO regarding a suggested corrective action; or
- Determination by ATRIO that the health, safety, or welfare of members is in jeopardy.

ATRIO will report to the National Practitioner Databank (NPDB) and other appropriate regulatory bodies for all serious deficiencies including, but not limited to, quality of care issues that result in suspension or termination of a provider.

CREDENTIALING AFTER A TERMINATION

If ATRIO terminates a provider (including no cause terminations), and later wishes to reinstate the provider, and if the break in service is over 30 days, ATRIO will credential the provider using the initial credentialing process. ATRIO will review all credentials and make a final determination prior to the provider's re-entry into the organization.

OFFICE VISIT ACCESSIBILITY

ATRIO recommends the following office visit standards for member's appointments:

TYPE OF SERVICE TIME STANDARD

Non-urgent or routine care

- Symptomatic: within 7 days (1 week)
- Asymptomatic: within 30 days (4 weeks)

Urgent care

- Schedule as medically appropriate, within 72 hours

Emergent care

- Immediate assessment or referral for treatment

Preventative care

- Within 30 days (4 weeks)

Wait times

- Scheduled appointment not to exceed 45 minutes without an explanation
- "Walk-in" up to 2 hours
- Access to advice nurse on the phone 2 hours

Return telephone call from provider's office

- Routine calls: by close of the business day
- Urgent calls: within 4 hours

PROVIDER RIGHTS & RESPONSIBILITIES

PROVIDER RIGHTS

Providers have the right to:

- Receive training and oversight of member and participating provider rights and obligations under the plan(s) and agreements, including Quality Improvement activities;
- Receive timely authorizations and referrals for each medical necessary non-emergency hospital admission or outpatient covered service, in the form of a prior authorization in accordance with ATRIO's policies and procedures;
- Request ATRIO reconsider any denial of prior authorization or rejection of a claim based upon provider's failure to obtain prior authorization. A provider may request reconsideration by written notice and provide all relevant documents and information. ATRIO shall consider and decide all requests for reconsideration within a reasonable time; and/or timeframe.
- Receive copies of all ATRIO's policies and procedures applicable to the provider upon request.

PROVIDER RESPONSIBILITIES

Providers shall:

- Treat all members with respect and courtesy;
- Respond promptly to members' questions and document communications with members as appropriate;

- Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to health maintenance organizations, their employees and their network providers;
- Provide all members with information concerning the benefits available to them;
- Ensure members have reasonable access to the services to which they are entitled to under their plans;
- Ensure that member requests for access to medical records are provided within HIPAA guidelines;
- Ensure that member requests for access to medical records and information pertaining to their care are responded to in a timely manner;
- Provide members the opportunity to make informed decisions concerning their medical care, including providing information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Health care providers, as required by law, shall obtain informed consent;
- In making clinical decisions concerning a member's medical care or treatment, an ATRIO network provider shall not discriminate based on how the provider or provider network would be financially compensated, or whether a particular treatment or course of care would be covered by the member's plan;
- Not deny, limit, or add requirements or conditions to any benefits offered or services to a member based on any condition related to the member's health status;
- Agree to accept ATRIO's payment in full for services, and agree to bill ATRIO for all services rendered;
- Accept only coinsurance, deductibles, co-payments, and payment for non-covered services from members.
- "Write off" all other charges, and hold the member harmless for any remaining balances;
- Arrange for the provision of covered services during normal office hours or as otherwise necessary to provide reasonable access to services by members. Providers will arrange for call coverage for medically necessary services on a 24-hour per day, seven day per week basis;
- Return telephone calls from members within a reasonable length of time. The length of time should be appropriate to the members stated condition;
- Provide call share group listing to ATRIO Health Plans including any updates to the call share group;
- Meet and be able to provide documentation of completion of federal fraud, waste and abuse requirements at ATRIO's request;
- Provide required materials on a standing basis in an accessible format upon receiving a request for the materials or when otherwise learning of the enrollee's need for an accessible format (42 C.F.R §§ 422.2267(a)(3) and 423.2267(a)(3).
- Comply with provisions of the Americans with Disabilities Act (ADA). ADA Accessibility Guidelines (ADAAG);

- Be prepared to meet the special needs for members who need language interpretation; and
- Ensure physical access to provider offices. Practitioners must provide the following:
  - Street level access or accessible ramp into facility;
  - Wheelchair access to the lavatory;
  - Corridor railings; and
  - Elevators operable from a wheelchair.

ATRIO RIGHTS & RESPONSIBILITIES

ATRIO RIGHTS

- ATRIO has the right to request medical records at no charge from providers for the purpose of utilization review, payment, litigation, audit, retrospective reviews, and purposes related to the continuity of care of the member;
- ATRIO has the right to expect contracted providers to cooperate with ATRIO when auditing provider performance under contractual agreements. Providers should maintain financial records indicating payment from ATRIO and members for at least 10 years; and
- ATRIO has the right to expect timely billing within one year of date of service from providers in order to deliver compensation for services.

ATRIO RESPONSIBILITIES

- Provide members with a Member Handbook (Evidence of Coverage), Provider Directory, Pharmacy Directory, Formulary and Member ID Card within 10 days of confirmation of enrollment by CMS;
- Provide members with an Advance Directive Form and instructions on the purpose of this form;
- Provide members (or their legal guardians, when appropriate) the opportunity to make informed decisions concerning their medical care, including giving them information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Health care providers, as required by law, shall obtain informed consent;
- Prohibit screening potential members based on their health status, claims experience, medical history, or genetic information (beneficiaries with End Stage Renal Disease are excluded from this requirement);
- Prohibit discriminating against members based on race, ethnicity, religion, gender, sexual orientation, disability, health status, financial status, or geographic location within the service area;
- Provide culturally competent services to those in need of services;
- Avoid discriminating against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification;
- Provide information to contracted medical providers regarding ATRIO benefits, claims processing and authorization requirements;

- Process authorization requests in a timely and competent manner that is within Medicare required timeframes and that uses Medicare required criteria; and
- Process claims in a timely and accurate manner that is within Medicare required timeframes, using Medicare required criteria and meeting contractual obligations; and
- Upon request, reconsider the denials of claims or prior authorizations.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

- Be treated with respect and dignity at all times;
- Learn and understand their treatment choices in clear language and participate in treatment decisions. Get health care services in a language they understand and in a culturally sensitive manner;
- Be provided with information about their health care benefits, exclusions, and limitations of the plan, and any charges for which they may be responsible;
- Receive a Notice of Privacy Practices regarding Protected Health Information (PHI);
- Refuse the release of identifiable PHI, except when such release is required by law;
- Have complete confidentiality involving medical diagnosis, treatment or care received from any ATRIO contracted provider;
- Be informed by their physician or other medical care provider of their diagnosis, prognosis and plan of treatment in terms that are understood;
- Have discussions with their provider regarding appropriate or medically necessary treatment options regardless of cost or benefits;
- Expect ATRIO not to interfere with any contracted health provider's discussion regarding treatment options whether covered or not;
- Be protected from discrimination. — Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your race, color, national origin, disability, age, or sex (or gender identity).
- Be provided with access to a directory of contracted providers;
- Be informed by their physician or other medical care provider about any treatment they may receive;
- Be provided information on all alternate treatments available and their potential values and risks;
- Get emergency care when and where you need it. If your health is in danger because you have a bad injury, sudden illness, or an illness that quickly gets much worse, call 911. You can get emergency care anywhere in the U.S.
- Have their medical care provider request their consent for all treatment, unless there is an emergency, and they are unable to sign a consent form and their health is in serious danger;
- Refuse treatment, including any experimental treatment, and be advised of the probable consequences of their decision;

- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes;
- Express a complaint about ATRIO's notification, their provider(s) or the care they have received and to receive a response in a timely manner;
- Initiate the grievance procedure if they are not satisfied with ATRIO's decision regarding a complaint;
- Know how your doctors are paid. When you ask your plan how it pays its doctors, the plan must tell you. Medicare doesn't allow a plan to pay doctors in a way that could interfere with you getting the care you need; and
- Receive timely access to medical records.

MEMBER RESPONSIBILITIES

- Not be out of the service area for more than six months (apart from Emergent/Urgent Care or renal dialysis), or risk disenrollment from the plan.
- Know and confirm their benefits prior to receiving treatment;
- Show their ATRIO identification card before receiving services to protect against the wrongful use of the identification card by another user;
- Verify that the provider they receive services from is participating within the ATRIO network;
- Keep scheduled appointments with medical providers or notify the provider when unable to keep the appointment;
- Pay all necessary co-payments and fees at the time of service;
- Keep current on monthly premium payments;
- Provide complete and accurate information about medical conditions and history when seeking medical assistance;
- Ask questions and seek clarification until they understand the care they are receiving;
- Follow the treatment plan and advice of their medical care provider and be aware of the possible consequences if they do not;
- Notify ATRIO immediately of any changes in address, phone number or membership status; and
- Express their opinions, concerns and complaints to ATRIO.

CLAIMS SUBMISSION

ATRIO will pay clean claims according to CMS Medicare Advantage Regulations within 30 days from receipt of a clean claim or as determined by contract with ATRIO.

A clean claim is an original submission of a claim for a covered service that has no defect or impropriety. Any original submissions that have circumstances requiring special handling or treatment that prevents them from timely payment are not clean claims. If additional substantiating documentation involves a source outside of ATRIO, the claim is not a clean claim. Claims from a provider that are under investigation for fraud or abuse are not clean claims.

REQUIREMENTS FOR SUBMITTING PAPER CLAIMS

Submit Paper Claims to the Address Below:

ATRIO Health Plans

338 Jericho Turnpike #135

Syosset, NY 11791

CMS-1500 submissions:

- Box 1a requires member's identification number from their ATRIO ID card
- The member's name must appear exactly as it does on the ATRIO ID card in Box 2
- Authorization number (if applicable) must appear in Box 23
- The provider billing NPI must appear in Box 33a
- Procedure codes and modifiers must be properly aligned in order to appear in their designated boxes of Box 24d

UB-04 submissions:

- Box 60a requires member's identification number from their ATRIO ID card
- The member's name must appear exactly as it does on the ATRIO ID card in box 58a
- Authorization number (if applicable) must appear in Box 63a
- The vendor billing NPI must appear in Box 56
- Attending provider name and NPI must appear in box 76
- DX's, Procedure codes and modifiers must be properly aligned in order to appear in their designated boxes of 66-74

ELECTRONIC CLAIMS SUBMISSION- ELECTRONIC DATA INTERCHANGE (EDI)

For those providers interested in electronic claims submission, contact ATRIO at the below contact number/email to help facilitate the process. This process meets all HIPAA requirements.

ATRIO Customer Service 1-877-672-8620

providerrelations@atriohp.com

PAPER CLAIMS SUBMISSIONS

Professional Form:

CMS-1500 Health Insurance Claim Form, NUCC Approved OMB-0938-1197 FORM 1500 (02-12.) **Claims must be submitted on a red and white form.**

Institutional Form:

UB-04 CMS 1450, NUBC, Approved OMB NO. 0938-0997. **Claims must be submitted on a red and white form.**

Dental Form:

American Dental Association (ADA) Dental Claim Form 2012. **Black and white form is accepted.**

Paper claims must follow these guidelines:

- Providing a correct and complete Plan/Carrier name on the claim form increases the ability to process the claim without extra handling and delay
- Paper claims that are completely typed or printed are accepted. Claims that are completely handwritten are accepted. Individual claims that contain a combination of these methods *will not* be accepted
- A label, correction tape, or other editing media may not be used to change or edit information in a required field
- Labeled or stamped information on a claim, (i.e., "Tracer", "Corrected Claim", provider signatures, etc.) are considered informational and can be accepted on both handwritten and typed claims
- Paper claims with attached documentation that is not standard size (8.5"x11") cannot be scanned or processed without extra handling. This will delay processing of the claim. It is strongly encouraged that providers submit standard size documentation
- In accordance with HIPAA, attachments submitted with a claim may not contain information for individuals who are not the member indicated on the claim
- In order to be accepted, ambulance claims must have complete pick-up and drop-off locations, including street address, city, state, and zip code information on the claim, and/or attached documentation

Send Paper Claims Submissions To:

ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791

PRIOR AUTHORIZATION ON CLAIM FORM

Prior authorization numbers should be input in box 23 on the CMS-1500 or box 63 on the UB-04 CMS 1450claim form. *Please refer to the Prior Authorization section of this manual for further guidelines.*

If appropriate, include the following additional attachments when sending in a claim:

- Please include any additional documentation required under the terms of the provider's contract for review of authorization

RESUBMISSION OF CORRECTED CLAIMS

When resubmitting corrected claims, the provider should stamp or write "Corrected Claim" at the top of the CMS-1500 or UB-04 CMS 1450.

CLAIMS BILLING REQUIREMENTS

TIMELY FILING OF CLAIMS SUBMISSIONS

CMS Timely Filing rules dictate that providers must bill ATRIO within a reasonable length of time:

- First-time submissions must be submitted with all required information within 365 days (one year) from the date on which the service was rendered
- Resubmitted claims (Corrected Bills, COB, etc.) must be submitted within 365 days (one year) from the date of payment or denial on the *original first claim submission*

INCORRECT PAYMENT RECOVERY

An overpayment can occur due to reasons such as retroactive member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, etc.

ATRIO will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, ATRIO will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three years from the date of service.

In most cases, ATRIO will automatically recoup overpayments against future paid claims.

For more information on the CMS RAC, refer to the CMS website.

BALANCE BILLING

IN-NETWORK PROVIDERS

- Providers *may* collect co-payments, coinsurance and deductibles as appropriate from members
- Providers *may not* charge, or otherwise seek payment from ATRIO members for covered services, in the event of non-payment by ATRIO
- Under no circumstances will providers bill or seek payments from an ATRIO member for a service for which payment is denied or reduced because failure of the provider to comply with utilization management requirements
- Only services that are reasonable and necessary under original Medicare program standards are covered
- Members may seek and accept financial responsibility for non-covered services
- Providers and hospitals that balance bill for non-covered services are obligated to provide prior written notice to ATRIO's members detailing their potential liability. This must include a good faith estimate of the costs
- Providers shall hold-harmless any Dual Eligible members whose Part A & B expenses have been covered up to the full allowable of the State Medicaid Agency

OUT-OF-NETWORK PROVIDERS

- Providers *may* collect co-payments, coinsurance and deductibles as appropriate from members
- Providers *may* charge, or otherwise seek payment from ATRIO members for covered services, in the event of non-payment by ATRIO
- Under no circumstances will providers bill or seek payments from an ATRIO member for a service for which payment is denied or reduced because failure of the provider to comply with utilization management requirements
- Only services that are reasonable and necessary under original Medicare program standards are covered
- Members may seek and accept financial responsibility for non-covered services
- Providers and hospitals that balance bill for services are obligated to provide prior written notice to ATRIO's members detailing their potential liability. This must include a good faith estimate of the costs
- Providers shall hold-harmless any Dual Eligible members whose Part A & B expenses have been covered up to the full allowable of the State Medicaid Agency

COORDINATION OF BENEFITS

Coordination of Benefits (COB) enables members to receive benefits for their coverage from all health insurance plans for which they are enrolled. This ensures that the total combined payment from all sources is not more than the total charge for the services provided. When a member has coverage under two or more insurance plans, the primary plan will pay benefits first, with secondary and tertiary plans covering any remaining unpaid, eligible balances, up to their allowable amounts.

- If ATRIO is the secondary payer, please include the primary payer's explanation of benefits (EOB)

MOTOR VEHICLE ACCIDENT (MVA)

Any expense which results from a motor vehicle injury may be payable by a Motor Vehicle Insurance Policy.

ATRIO will extend benefits while the member is pursuing recovery from the applicable Motor Vehicle Insurance. Claims will be processed per applicable guidelines, and in turn, ATRIO would expect to be reimbursed for any claims paid once settlement is reached.

THIRD PARTY LIABILITY (TPL)

A member may have a legal right to recover the costs of their healthcare from a third party that may be responsible for the illness or injury.

Some examples of Third-Party Liability may include:

- If a member is injured at a business or place of employment, the owner may be responsible for the healthcare expenses arising out of the injury under the business' medical coverage.
- Homeowners insurance may be responsible for an injury to someone outside of the member's immediate family if an injury is sustained on the homeowner's property.

ATRIO will extend benefits while the member is pursuing recovery from the responsible party. Claims will be processed per applicable guidelines, and in turn, ATRIO would expect to be reimbursed for any claims paid once settlement is reached.

HOSPITAL ACQUIRED CONDITIONS & NEVER EVENTS

HOSPITAL ACQUIRED CONDITION (HAC)

A hospital-acquired condition (HAC) is an undesirable situation or condition resulting from a stay in a hospital or medical facility that affects a patient adversely.

Some examples of HAC's include, but are not limited to:

- Object left inside a member during surgery
- Air embolisms resulting from a procedure
- Blood incompatibility after transfusion
- Surgical site infections
- Pressure Ulcers

NEVER EVENTS

Never Events are serious, largely preventable mistakes that happen in the course of a member's treatment. They are events so adverse that they "never should have happened."

Some examples of Never Events include, but are not limited to:

- Performing the wrong procedure on a patient
- Performing the right procedure on the wrong patient
- Removing or operating on the wrong body part
- Patient death or serious disability resulting from provider error

ATRIO follows CMS guidelines regarding Hospital Acquired Conditions and Surgical Never Events. Neither ATRIO nor the member will be responsible for any services resulting from these occurrences, and providers will not seek payments from ATRIO or the Member for any charges that arise during these services.

PROVIDER APPEALS

Appeals/Grievance Contact Information

ATRIO Health Plans~~:~~
Attn: Appeals and Grievances
PO Box 5600
Scranton, PA 18505

Phone: (877) 672-8620 | Fax: (866) 339-8751

Based on CMS rules, contracted provider appeals are not allowed on claim decisions. Please refer to the Contracted (PAR) Provider Claim Reconsiderations section for guidance on contracted provider claim issues.

Non-contracted providers may appeal on their own behalf if they sign a Waiver of Liability (WOL) § 422.574 *Parties to the organization determination*. When a non-contracted provider signs a Waiver of Liability, and the denial is upheld, they agree not to bill the member for the services in question.

If a member is impacted financially, they have the right to appeal. The provider may act as an authorized representative on the member's behalf with a signed Appointment of Representative statement (AOR-CMS 1696) or equivalent § 422.574 *Parties to the organization determination*. *Please see* ***Member Appeal Section*** *below*.

Appeals may be made by mailing or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records or by submitting online.

Online appeal forms and printable appeal forms are located on ATRIO's website at:

https://www.atriohp.com/oregon/providers/

NON-CONTRACTED PROVIDER PAYMENT APPEALS

A non-contracted provider may appeal a payment on his or her own behalf with a Waiver of Liability (WOL) https://www.atriohp.com/oregon/providers/. Non-contracted provider must file a payment appeal request in writing within 60 calendar days of the date of the adverse organization determination.

Requests for appeals must include:

- Member name
- Claims Number
- Address
- Member number
- Reasons for appealing
- Any evidence included for review, such as medical records, doctor's letters, or other information that may support why the service or item should be covered.

ATRIO's review of the appeal begins with the receipt of the appeal request and signed WOL. Requests for appeal after 60 calendar days must show good cause in order for ATRIO to accept the untimely request. Examples of good cause include, but are not limited to:

- The provider did not personally receive the adverse organization determination notice or received it late;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The provider had incorrect or incomplete information concerning the process.

If the exception is granted, ATRIO will respond with a decision in writing within 60 days of when good cause is received.

NON-CONTRACTED EXPEDITED APPEALS

Non-contracted provider payment appeals **do not** qualify for the expedited appeals process.

PAYMENT DISPUTES

If Medicare providers dispute the original payment of claims, a dispute may be sent to ATRIO to be reviewed by appropriate staff. **Payment disputes must be submitted in writing via fax or online submission.**

Provider Claim Dispute Forms are located on ATRIO's website at:

Forms are located at https://www.atriohp.com/oregon/providers/provider-resources/ and can be submitted **via fax or online submission.**

1-866-339-8751 or online submission.

Attn: Provider Claim Disputes.

Any payment disputes must be received within 60 days of the date the payment was initially received by the provider.

ATRIO's payment review determination of the payment dispute will generally be provided within 60 days from the time of the valid payment dispute is first received.

*Non-contracted providers only —- Per CMS guidelines if a non-contracted provider has exhausted ATRIO's internal dispute process, but still maintains they have not been reimbursed fairly, a complaint may be filed through 1-800-Medicare (1-800-633-4227). Additionally, other actions may be taken that the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

MEMBER APPEALS

The member, member's representative, physician acting on behalf of the member for pre-service appeal or provider with the member's written consent, may file an appeal. If the member wishes to use a representative, then they must complete an Appointment of Representative (AOR) statement, and both must sign the AOR statement. The form is located at https://www.atriohp.com/oregon/providers/provider-forms/

Requests for appeals must include:

- Member name;
- Address;
- Decision reference number
- Member number;

- Reasons for appealing;
- Request for either a Standard or Expedited Appeal (pre-service only); and
- Any evidence included for review, such as medical records, doctor's letters, or other information that may support why the service or item is necessary.

Examples of actions that can be appealed include, but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state

ATRIO ensures that decision-makers on appeals were not involved in previous levels of review or decision-making. A grievance or appeal involving clinical issues; the appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

For concerns regarding a decision, action or statement by the member's provider, ATRIO encourages members to discuss these concerns with the provider. If the member remains dissatisfied after discussing the concern with the provider, then the provider, member or member representative may contact the Customer Service department at (877) 672-8620 for assistance.

MEMBER PRE-SERVICE APPEAL

A member, a provider on behalf of a member, or a member's representative, must file an appeal request either verbally or in writing within 60 calendar days of the date of the adverse organization determination.

ATRIO will respond accordingly:

- Part C - within 30 days for Standard Pre-Service
- Part D and B drugs - within 7 days for Standard Pre-Service

Appeals may be filed verbally, and do not require a member's signature. ATRIO's review of the appeal begins with the receipt of the valid appeal request. Requests for appeal after 60 calendar days must show good cause for ATRIO to accept the late request. Examples of good cause include but are not limited to:

- The member did not personally receive the adverse organization determination notice or received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the process.

REVERSAL OF DENIAL OF A PRE-SERVICE APPEAL

If, upon review, ATRIO overturns its adverse organization determination, then ATRIO will issue an approved authorization for the pre-service request.

AFFIRMATION OF DENIAL OF A STANDARD PRE-SERVICE APPEAL

If ATRIO affirms its denial (in whole or in part) is valid, it will:

- For members with Part C, ATRIO will notify the member or his/her representative with a written explanation for the final determination. The complete case file will be sent to the Independent Review Committee (IRE) contracted by CMS. The IRE has 30 calendar days (7 for part B drugs) from receipt of the case to issue a final determination.
- For members with Part D, appeals must be initiated by the member or a representative in order to be sent to the IRE.

The IRE will notify the member and ATRIO of its decision. In the event the IRE agrees with ATRIO, the IRE will provide the member further appeal rights. If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision.

EXPEDITED APPEAL PROCESS (PRE-SERVICE ONLY)

To request an expedited pre-service appeal, a member, their representative or a provider must submit an oral or written request within 60 days of the notification of adverse decision.

A request to expedite an appeal will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which ATRIO makes a less than fully favorable decision to the member.

RESOLUTION OF AN EXPEDITED APPEAL

ATRIO will make a determination within 72 hours from the receipt of a valid appeal and will notify the member (and the provider involved, as appropriate) of its decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving a valid appeal.

REVERSAL OF DENIAL OF AN EXPEDITED APPEAL

If ATRIO overturns its initial action and/or the denial, ATRIO will notify the member verbally within 72 hours of receipt of the valid expedited appeal request followed with written notification of the appeal decision. ATRIO will issue an approved authorization for the pre-service request.

AFFIRMATION OF DENIAL OF AN EXPEDITED APPEAL

If ATRIO affirms its initial denial (in whole or in part), it will:

- For members with Part C, ATRIO will notify the member or his/her representative with a written explanation for the final determination and that the case has been forwarded to the IRE. The complete case file will be sent to the Independent Review Committee (IRE) contracted by CMS The IRE has 72 hours from receipt of the case to issue a final determination
- For members with Part D, appeals must be initiated by the member or a representative in order to be sent to the IRE.
-

The IRE will notify the member and ATRIO of its decision. In the event the IRE agrees with ATRIO, the IRE will provide the member further appeal rights. If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision.

ATRIO will not take or threaten to take any punitive action against any provider acting on behalf or in support of a member in requesting an appeal or an expedited appeal.

APPEAL LEVELS

There are five levels of appeals available to Medicare beneficiaries enrolled in Medicare Advantage plans offered by ATRIO after an adverse organization determination. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity and it is requested per the rights included in their notification:

1. Review of adverse organization determination by ATRIO;
2. Review of adverse organization determination by the Independent Review Entity (IRE);
3. Hearing by an Administrative Law Judge (ALJ), if the appropriate threshold requirements have been met;

4. Medicare Appeals Council (MAC) Review; and

5. Judicial Review, if the appropriate threshold requirements have been met.

ATRIO will provide reasonable assistance to members in completing forms and other procedural steps for an appeal, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability. Members are provided with a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

CONTRACTED (PAR) PROVIDER RECONSIDERATIONS

Medicare contracted providers may request reconsiderations for payment denials. These reconsiderations are not a CMS requirement, but instead are a service provided by ATRIO to contracted providers.

Par Provider Claim Reconsiderations must be submitted in writing and include supporting documentation via fax or online submission only.

Provider Claim Dispute Forms are located on ATRIO's website at: https://www.atriohp.com/oregon/providers and must be submitted online or via fax:

F: 1-866-339-8751

Attn: Provider Claim Disputes.

WHEN CAN A CONTRACTED PROVIDER REQUEST A RECONSIDERATION?

- When the provider wants a second reviewer to make the determination
- When the provider has additional information for making the determination

HOW OFTEN CAN A CONTRACTED PROVIDER REQUEST A RECONSIDERATION?

Providers can only make the request **once**. ATRIO must receive the request within 60 calendar days of the denial notification date. Files will be considered untimely after that time.

If the provider believes they have filed their case within the appropriate time frame, they may submit documentation showing proof.

ATRIO has 60 calendar days to review the request. Necessary documentation is required for all cases. It is the responsibility of the provider to provide the requested documentation timely.

REVERSAL OF DENIAL

ATRIO will make a determination within 60 calendar days if ATRIO has received the relevant information. If it is determined during the review that the provider has complied with ATRIO protocols and that the services were medically necessary, the denial will be overturned. ATRIO will notify the provider in writing of this decision.

AFFIRMATION OF DENIAL

Denials will not be overturned for providers who failed to comply with ATRIO protocols. Providers will receive notice of a decision in writing. If you have any questions, please contact the Customer Service department at (877) 672-8620.

UTILIZATION MANAGEMENT

The Utilization Management Program includes components of prior authorization as well as prospective, concurrent and retrospective review activities. These activities are designed to provide for evaluation of health care and services based on the appropriateness of such care and services, and to determine the extent of coverage and payment based on the member's coverage.

ATRIO does not reward its associates or any practitioners, physicians, other individuals, or entities performing utilization management activities for issuing denials of coverage or encouraging services or care for financial incentives. ATRIO also does not encourage or promote under-utilization of services.

PRIOR AUTHORIZATION/ORGANIZATION DETERMINATION

ATRIO provides a process to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to administering or dispensing services. Prior authorization requirements are applicable for pre-service decisions.

Authorization Request Forms are available and located in **ATRIO's website**. Select your state, then under the Providers tab, see Prior Authorizations.

It is necessary to include the following information in the request for services:

- Member name and identification number;
- The requesting provider's contact information;
- Diagnosis Code(s) and place of service;
- Services being requested and CPT Code(s);
- The rendering provider's demographics to provide the service; and
- A history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals

CONCURRENT REVIEW

ATRIO provides the oversight and evaluation of members when admitted to hospitals, rehabilitation centers and skilled nursing facilities, including continued inpatient stays, to monitor appropriate utilization of health care resources and promote quality outcomes for members. ATRIO will determine the initial/ongoing medical necessity, appropriate level of care, and appropriate length of stay to help facilitate a timely discharge.

The Member's medical condition is the basis for the concurrent review process. ATRIO utilizes Evidence Based guidelines and Medicare Coverage guidelines for concurrent review decisions. Decisions will take into account the member's medical condition and co-morbidities. The ATRIO Medical Director oversees the performance of the review process.

Clinical information is required to support the appropriateness of the admission, continued length of stay, level of care, treatment plans and discharge plans.

Notification of hospital admission is required from the facility no later than the first business day following admission.

Observation care may be appropriate when monitoring, testing, or re-evaluation is needed to determine the patient's diagnosis and care needs, and/or Observation is needed to determine whether a patient's response is adequate.

Inpatient admission, or transition to inpatient from observation care, is generally indicated when a condition is diagnosed requiring a long-term stay (greater than 24-48 hours) or intensive monitoring and intervention is needed for a condition.

DISCHARGE PLANNING

Discharge planning begins upon notification of the member's inpatient status to facilitate medically appropriate continuity of care, post-hospitalization services, and referrals to a skilled nursing facility, rehabilitation facility, or outpatient services.

Some of the services involved in the discharge plan include, but are not limited to:

- Durable Medical Equipment (DME)
- Transfers to an appropriate level of care
- Inpatient Rehabilitation, Long Term Acute Care or Skilled Nursing and Rehabilitation
- Home Health Care
- Medication Therapy Management (Comprehensive Medication Review/Patient Education/Compliance Monitoring)
- Physical, Occupational, or Speech Therapy

RETROSPECTIVE REVIEW

ATRIO does not accept retro prior authorizations. If a service that requires prior authorization was performed, but prior authorization was overlooked, those requests should be submitted as a claim. If the claim is denied for authorization, please follow the process for Contracted Provider Reconsiderations.

Requests for retroactive approval should occur infrequently. Providers are required to seek approval in advance.

PRIOR AUTHORIZATIONS AND REFERRALS

MEDICARE PRIOR AUTHORIZATION GRID

See https://www.atriohp.com/oregon/providers/prior-authorizations/ for the most current PA Grid information.

REFERRALS

ATRIO Medicare Advantage plans *do not* require referrals to see a specialist.

AUTHORIZATIONS

Prior authorizations are required for certain services.

Prior authorizations are to determine medical necessity and not a guarantee of coverage. Please refer to the Medicare Prior Authorization Grid and plan documents for guidelines on covered services, and when to ask for an authorization. Plan documents can be located at the ATRIO website.

ORGANIZATION DETERMINATION (PRIOR AUTHORIZATION) TIMELINES

STANDARD ORGANIZATION DETERMINATION

ATRIO will make an organization determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after ATRIO receives the request for service. ATRIO may grant an extension for an additional 14 calendar days if the member requests an extension, or if ATRIO justifies a need for additional information and documents how the delay is in the interest of the member.

Standard Part B Drug reviews will be completed no later than 72 hours after ATRIO receives the request for service.

EXPEDITED ORGANIZATION DETERMINATION

A member, member's representative, or provider may request that ATRIO expedite an organization determination when there is belief that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The determination will be completed as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request for service. ATRIO may grant an extension for an additional 14 calendar days if the member requests an extension, or if ATRIO justifies a need for additional information and documents how the delay is in the interest of the member.

Expedited Part B Drug reviews will be completed no later than 24 hours after ATRIO receives the request.

ATRIO may downgrade an expedited request if it is determined that a standard timeframe would not place the member's life, health, or ability to regain maximum functions in serious jeopardy. ATRIO will provide notification of the downgraded status to requestor and the member or member's representative (if appropriate).

PRACTICE GUIDELINES

To promote quality care, patient safety and the most appropriate use of health care resources, ATRIO follows Medicare Local and National Coverage Determination guidelines, evidence-based guidelines, including InterQual and/or MCG (Milliman) guidelines, and peer reviewed medical literature. ATRIO Medical Directors and Review Nurses also consider individual clinical circumstances and the capabilities of the local delivery system in their reviews.

QUALITY IMPROVEMENT

MEDICARE QIO REVIEW PROCESS OF SNF/HHA/CORF TERMINATIONS

ATRIO will ensure members receive written notification of termination of service from providers no later than two calendar days before the proposed end of service for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORFs). ATRIO will issue the standard Notice of Medicare Non-Coverage letter required by CMS. This letter includes the date coverage of service ends and the process to request an expedited appeal with the appropriate Quality Improvement Organization (QIO) https://qioprogram.org/locate-your-bfcc-qio.

If the member's services are expected to be fewer than two calendar days in duration, the provider should notify the member or, if appropriate, the member's representative, at time of admission. If, in a non-institutional setting, the span of time between services exceeds two calendar days, the notice should be no later than two services prior to termination of the service. ATRIO is financially liable for continued services until two calendar days after the member receives valid notice. A member may waive continuation of services if they agree with discharge sooner than two calendar days after receiving the notice. Members who desire a fast-track appeal must submit a request for appeal to the QIO. The Fast-track appeal must be in writing or by telephone, by noon (12 p.m.) of the day before coverage ends.

Upon notification by the QIO that a member has requested an appeal, ATRIO will issue a Detailed Explanation of Non-Coverage (DENC) that indicates why services are either no longer reasonable or necessary or are no longer covered. Coverage of provider services continues until the date and time designated on the termination notice, unless the member appeals and the QIO reverses ATRIO's decision.

CHRONIC CARE IMPROVEMENT PROGRAM (CCIP)

All Medicare Advantage (MA) organizations must conduct a Chronic Care Improvement Program (CCIP) as part of their required Quality Improvement (QI) program under federal regulations at 42 CFR §422.152 in the CMS manual. CCIPs are initiatives focused on clinical areas with the aim of improving health outcomes and beneficiary satisfaction, especially for those members with chronic conditions.

QUALITY IMPROVEMENT PROGRAMS

ATRIO implements a variety of quality improvement programs (QIPs) at any given time. Some of the QIPs are designed for a short timeframe (such as the organization of flu vaccination clinics during peak flu season), and other QIPs last for several years (such as the osteoporosis management QIP.) Some of ATRIO's QIPs are mandated by CMS and/or URAC, and others are created based on the identification of member's needs or potential gaps in care. QIPs commonly revolve around disease management, disease prevention, and progression control, and seek to improve and/or maintain members' highest achievable quality of life.

CASE MANAGEMENT

ATRIO case managers are experienced healthcare professionals that utilize various assessments and surveys to collaborate with the members, their providers, and local community partners to address the needs of our members.

Case managers at ATRIO work with the members by telephone and/or by mailing the members information about health management, disease education and preventative services.

ATRIO's case managers encourage members to follow up with their primary care provider on a regular basis to discuss what may be addressed during case management. ATRIO's case managers defer interpretation, diagnosis, treatment and overall medical management to the primary care provider.

The goal of ATRIO case management is to help members maintain or regain optimum health and wellness. To refer a member to case management, please call ATRIO Customer Service at 877-672-8620.

SNP MODEL OF CARE

CMS requires Medicare Advantage plans with a Special Needs Plan (SNP) to develop and implement a Model of Care (MOC) that provides the structure for care management processes and systems that will enable them to provide coordinated care for the dual eligible special needs population. All SNP MOCs must include the following elements:

- MOC 1—Description of the SNP Population

- MOC 2—Care Coordination
- MOC 3—Provider Network
- MOC 4—MOC Quality Measurement and Performance Improvement

ACTION REQUIRED

It is a CMS requirement that all providers who routinely see ATRIO SNP beneficiaries complete annual SNP MOC training. The training and associated attestation can be accessed on the ATRIO website, under the "provider education" drop down. Once providers complete the SNP MOC training, they are required to attest they have completed the training. Providers should maintain their training records and make those training records available to ATRIO when requested. Cooperation and assistance in this process is a CMS requirement, as well as ensuring that the highest quality of care is provided to ATRIO's SNP members.

TRANSITIONS OF CARE (TOC)

ATRIO makes special effort to coordinate care when SNP members move from one health care setting to another, such as discharge from a hospital. Without coordination, such transitions often result in fragmented and unsafe care for older or disabled members, and the particularly vulnerable SNP beneficiary. ATRIO designed its program with the intent to minimize risks associated with health care transitions. Providers may be asked to participate in Interdisciplinary Care Team meetings to address complex cases or unmet needs.

HEALTH RISK ASSESSMENT (HRA)

The HRA is a CMS required comprehensive tool used by the Plan to identify the specialized needs of its beneficiaries and to coordinate care that reflects the member's preferences. The HRA questionnaire assesses medical, psychosocial, cognitive, and functional needs as well as the member's medical and mental health history.

Members are encouraged to share the HRA with their primary care provider for further discussion.

This sharing of the HRA seeks to foster health care decision-making and empowerment on the part of the member(s) and their caregiver(s).

Information gathered in the HRA will be used to create an individualized care plan, and direct interdisciplinary care team involvement by one of our service area case managers.

ATRIO conducts HRAs within 90 days of the effective date of enrollment, and annually thereafter.

HEDIS

ATRIO is dedicated to providing the highest quality service and care for members. Because of health care reform, quality standards continue to rise, and the Centers for Medicare and Medicaid Services (CMS) is requiring ATRIO and other payers to provide continuous documentation of quality health care. This documentation is used for the publishing of quality ratings and can affect reimbursement. The results from various performance measures combine to report scores in a five-star rating system known as the Medicare Health Plan Quality and Performance Ratings. The ratings are to assess the performance of Medicare Advantage plans by CMS for oversight activities, reimbursement, and to give beneficiaries information that can help them choose among health plans offered in their area.

CMS rates plans on a one to five-star scale, with five stars representing the highest quality and one star representing the lowest quality. A summary score is provided as an overall measure of a plan's quality. The Star Ratings measures span six domains: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Health Plan Descriptive Information, and Measures Reported Using Electronic Clinical Data Systems. Plans scoring four stars or higher are eligible for CMS payment incentives. These payment incentives are critical for ATRIO to deliver high quality services.

A primary source for the star ratings is the Health Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA) and reported June 30th of each year. In the United States, HEDIS evaluates more than 90 percent of health insurance plans. HEDIS rates are calculated in two ways: administrative data and hybrid data. Administrator data requires the plan to identify the eligible population and numerator using transaction data (i.e., claims) or other administrative data. The hybrid method requires the plan to look for numerator compliance in both administrative data and in medical records.

In order to report HEDIS data each year, ATRIO uses NCQA certified vendors to collect and review medical charts. These vendors are utilized for both HEDIS hybrid data and for Risk Adjustment medical record reviews (see Risk Adjustment).

ATRIO expects providers to:

- Maintain well-documented medical records at the clinic site in a manner that is current, detailed, accurate, organized and readily accessible in order to permit effective and confidential patient care and quality review of patient interactions. See Documentation and Coding Requirements under Risk Adjustment for further detail
- Provide ATRIO's staff and/or vendors access to the EHR, access to the medical record for scanning, or send copies upon request in a timely manner
- Participate with ATRIO's quality improvement initiatives to improve quality ratings

For more information, please visit atriohp.com.

HEDIS AND THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and use or disclosure for these purposes does not require the consent or authorization from the member/patient. For persons other than providers who are participating in HEDIS activities, such as third-party vendors and/or medical record review staff, they sign a HIPAA-compliant Business Associate Agreement with ATRIO prior to accessing any PHI.

RETROSPECTIVE CHART REVIEWS

ATRIO performs chart reviews of member records to ensure all relevant diagnoses obtained from compliant documentation sources are reported to CMS. The purpose of this initiative is to capture diagnoses not reported via claims data or the condition reported in claims data was not coded to the highest degree of specificity based on compliant chart documentation. Additionally, conditions previously reported in claims data but lack sufficient documentation are identified to submit “deletes” to CMS ensuring compliance with risk adjustment coding policies.

IN-HOME COMPREHENSIVE HEALTH EVALUATIONS

In an effort to ensure complete and accurate documentation of all medical conditions on an annual basis, ATRIO offers in-home comprehensive health evaluations for all members. These evaluations are performed by licensed medical providers (physicians, nurse practitioners or physician assistants) trained to evaluate for all current and chronic medical conditions. The evaluation provides a “birds-eye view” of the member’s living environment and serves as a detailed summary of conditions sometimes treated by multiple specialists. Evaluators review preventive care needs, medications, and make referrals for case management services if needed. Each report is reviewed through a quality assurance process by a professional coder, ensuring accuracy and documentation compliance prior to reporting diagnosis codes to CMS.

RISK ADJUSTMENT PROGRAM

Risk Adjustment is a critical element in the success of ATRIO and plays a significant role in the products and services offered to members.

Risk adjustment is based on Hierarchical Condition Categories (HCC) defined by Centers for Medicare & Medicaid Services (CMS), utilizing ICD-10-CM diagnostic codes submitted from physician and hospital inpatient and outpatient claims. CMS uses these diagnosis codes, along with demographic data, to calculate a risk score for each Medicare Advantage beneficiary that reflects his or her overall health status on an annual basis. Payments from CMS to ATRIO are based on the risk scores for each health plan member. All ICD-10-CM codes for existing and chronic conditions should be documented at least once each calendar year.

DOCUMENTATION AND CODING REQUIREMENTS

- Update all acute and chronic diagnoses with the current status and treatment plan in the progress notes
- Report diagnosis codes on the claim only if they were actively addressed on the date of service (not merely appearing on a problem list)
- Chronic conditions being medically managed or impacting medical decision-making should be reported, even if they are not the principal reason for the patient's visit that day; provide the status of the condition and/or treatment plan
- Contributory and co-morbid conditions should be reported if they affect the ongoing care for the patient and were addressed at the visit
- Do not report conditions that are inactive, immaterial, or have been ruled out; problem lists should be updated accordingly
- The treating provider's signature and credentials (either handwritten or electronic) must be present on each chart entry. Dictated/transcribed entries also require the provider's signature (either handwritten or electronic). Stamped signatures are not acceptable. Electronic medical record entries must be authenticated by the treating provider.
- Use only standard medical abbreviations
- Paper Charts: Record the patient's name and date of service on each page of the chart note; ensure notes are legible

PHARMACY

For health plans that include a prescription drug benefit, a comprehensive pharmacy services program is provided that includes formulary management, drug prior authorization, step therapy requirements, drug quantity limitations and clinical pharmacy programs to ensure cost-effective drug utilization and improve quality measures.

PHARMACY NETWORK

ATRIO contracts with MedImpact to access a nationwide network of pharmacies. For a comprehensive list of in-network pharmacies please visit our website at **https://www.atriohp.com/oregon/members/find-a-pharmacy/.**

MedImpact' s authorization process can be located online at **https://openenrollment.medimpact.com/#/web/atr/pharmacy**

FORMULARIES

To find out which formulary applies to a patient's pharmacy plan, refer to their ATRIO member ID card to verify what benefit plan they are on. Members can use Drug Price Check Tool to look up drug cost by entering a drug name and location **https://www.atriohp.com/oregon/members/find-a-drug/**

The PPO Formulary is a tiered formulary that consists of six tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

• **Tier 1** – Preferred Generic Drugs (Contains low-cost generic drugs; lowest cost-sharing tier)

• **Tier 2** – Generic Drugs (Contains most generic drugs. May include preferred brand drugs.)

• **Tier 3** – Preferred Brand Drugs (Contains preferred brand drugs and high-cost generic drugs)

• **Tier 4** – Non-Preferred Drugs (Contains non-preferred brand or generic, non-formulary drugs)

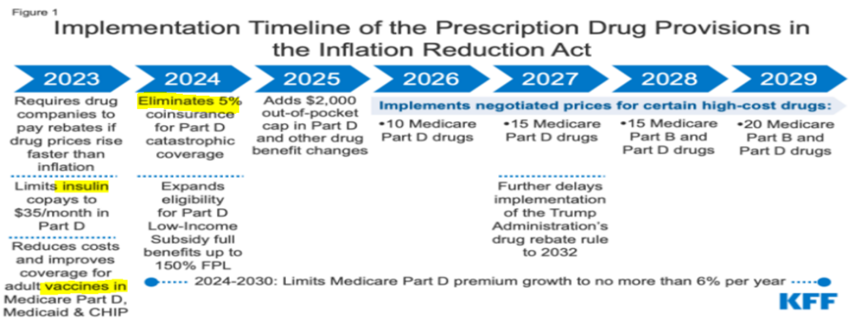
• **Tier 5** – Specialty Drugs (Contains specialty drugs; highest cost-sharing tier)

• **Tier 6** – Select Care Drugs for (Zero-copay)

- ~~**Selected (formulary) insulins** – Zero copay for initial coverage. No more than $35 for 30-day supply during coverage gap~~
- **Part D vaccines** e.g., Shingle or RSV recommended by CDC/ACIP
- **Generic drugs for management of chronic conditions:**
    - *Diabetic medications, ACE-I/ARBs or statins*

~~***CMS IRA (Inflation Reduction Act) Changes for 2024***~~

- ~~Members pay zero cost-sharing during Catastrophic Coverage~~



The Inflation Reduction Act of 2022 (IRA) is a federal law that makes improvements to the Medicare Program and help reduce Medicare and Medicare Advantage members' out-of-pocket costs for prescription drugs. Below are the changes you can expect to see in 2025.

- Medicare Part D coverage will have an out-of-pocket maximum of $2000 for prescription drug costs for the plan year
- The coverage gap phase will be eliminated
- The Medicare Prescription Payment Plan is a new payment option in the prescription drug law to help Part D enrollees manage their out-of-pocket

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https://www.cms.gov/inflation-reduction-act-and-medicare

20254 Formulary Changes

- **Generic Preferred**

Formulary 2023	**NEW Formulary 2024**
Advair Diskus	Fluticasone Propionate/Salmeterol or Wixela
Flovent HFA or Diskus	Fluticasone Propionate HFA or Diskus
Novolog	Insulin Aspart (Biosimilar)
Novolog Mix 70-30	Insulin Aspart PRT/Insulin Aspart 70-30 (Biosimilar)
Symbicort	Budesonide/Formoterol

- **Brand Preferred**

Brand Will process at Generic Tier
Azopt eye drops
Livalo
Mitigare
Restasis Droperette
Spiriva Handihaler
Vascepa
Tracleer (specialty tier)

Brand is Preferred and will process at Brand Tier
Advair HFA
Breo Ellipta
Epclusa
Harvoni

- Selected Formulary OTC medications are covered with **prescriptions required** (zero copay)

OTC formulary drugs covered

Generic Name	Brand Name – For Reference Only (*ATRIO only covers generic as OTC*)	Dosage Form
Cetirizine	(Zyrtec)	Chewable Tablet, Solution, Tablet
Cetirizine/Pseudoephedrine	(Zyrtec-D)	12 Hour Tablet
Fexofenadine	(Allegra)	12 Hour Tablet, 24 Hour Tablet, Tablet Rapids, Suspension
Fexofenadine/Pseudoephedrine	(Allegra-D)	12 Hour Tablet, 24 Hour Tablet
Ketotifen	(Zaditor)	Ophthalmic Drops
Levocetirizine	(Xyzal)	Tablet
Loratadine	(Claritin)	Solution, Tablet, Tablet Rapids, Chewable Tablet
Loratadine/Pseudoephedrine	(Claritin-D)	12 Hour Tablet, 24 Hour Tablet
Nicotine	(Nicorelief, Nicoderm)	Patch, Gum, Lozenge
Olopatadine	(Pataday)	Ophthalmic Drops

- ~~ATRIO Health Plans provides extra benefit coverage on OTC drugs/products. Information or catalog is available at **atriohp.com/extra-benefits**~~
- ~~Members can use an Rx ID card to apply some discount for non-covered medications.~~

FREE METER PROGRAM

Diabetic Supplies are covered 100%. Members will need a prescription to get the Free Meter at the Pharmacy, or they can visit their website or call the toll-free number listed on the voucher. **https://www.atriohp.com/diabetes-meters-and-test-strips/**

Preferred Test strips - OneTouch or FreeStyle. **Preferred CGM –** FreeStyle Libre or Dexcom

Members will need a prescription to get the Free Meter at the Pharmacy, or they can visit their website or call the toll-free number listed on the voucher.

- Members with a history of insulin within the last 120 days may receive 300 testing strips per 90-day period
- Members with no history of insulin within the last 120 days may receive 100 testing strips per 90-day period.

OneTouch ®(LifeScan) and Freestyle ®(Abbott) brands are the ATRIO preferred choices for Blood Glucose Meter &Strips with **ZERO out-of-pocket cost.**

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OneTouch Verio Reflect &OneTouch Verio Flex	Freestyle Lite &Freestyle Freedom Lite
	
• ColorSure® technology shows low, in range, or high on an easy-to-read large screen display. • Connect with OneTouch Reveal mobile app to log results, track patterns, and share data with your care team. • Verio Reflect has a backlit larger screen and text size making it easier to read and manage results. • Verio Flex has a smaller design that makes on-the-go testing easier and more convenient.	• ZipWik tabs absorb samples faster for quicker testing. • No coding required. • 1/3 the amount of blood sample required for accurate testing when compared to alternative meters. • Freestyle Lite has a backlit display and test strip port light allow you to test at any time of the day. • Freestyle Freedom Lite has a larger display with easy-to-read larger text. The larger design makes it easier to hold and use.

Preferred Test Strips

OneTouch Ultra Blue
OneTouch Verio
Freestyle Lite
Freestyle (original test strips)
Freestyle Precision Neo
Precision Xtra
Precision Xtra Beta Ketone Strips
Freestyle InsulinX (discontinued per manufacturer)

Continuous Glucose Monitors (CGM)

ATRIO has two CGM systems that are preferred for our members, **Dexcom and Freestyle Libre**. These systems are used to continuously monitor blood sugar levels in members who require more frequent testing to control their blood sugar levels.

Effective January 1, 2024 CGM supplies will require a Prior Authorization for coverage.

Dexcom G6 &Dexcom G7	Freestyle Libre 2 &Freestyle Libre 3
• Sends real-time glucose readings automatically to Dexcom receiver or smart device via the Dexcom app • Slim design wireless sensors make use easier and more comfortable • Easy to use monitor and tracking interface makes understanding your glucose levels easier and more accessible • Replace sensors once every 10 days	• Get real-time glucose readings every 1 minute to your reader device or using a smart device with the Freestyle Libre app • Set custom alarms for different readings to ensure you know when you are low or high • Discreet wireless sensor is smaller and thinner than other sensors for easy concealment and comfort. • Replace sensors once every 14 days

DRUG PRIOR AUTHORIZATION AND STEP THERAPY GUIDELINES

Certain drugs require prior authorization or step therapy for members with pharmacy prescription plans. This process includes an assessment of a patient's available benefits, as well as the medical indications for use. A prior authorization for medications may be required in order to avoid a member becoming responsible for the full cost of the medication.

Prior authorization and step therapy guidelines are based on current medical evidence. ATRIO will review and update the guidelines regularly in order to accommodate new

drugs and changing recommendations. The MedImpact Pharmacy and Therapeutics (P&T) Committee approves all guidelines and formulary changes. The P&T voting members are providers and pharmacists outside of MedImpact. In addition, Medicare prior authorization and step therapy guidelines are reviewed and approved by CMS. Providers can access the current Medicare prior authorization and step therapy guidelines on the ATRIO website or at
https://www.atriohp.com/oregon/providers/prior-authorizations/

https://www.covermymeds.com/main/prior-authorization-forms/atrio-health-plans/

Exceptions to standard formulary coverage and utilization management rules can be handled using the same prior authorization process indicated above. Formulary exceptions require that a member has tried all formulary drugs available prior to the exception request. Once a **standard request** for a drug is received, a written notification of the determination, or a request for more information, is sent to the prescriber as expeditiously as the member's health requires, but no later than **72 hours after receipt of the request.** This includes weekends and holidays. Decisions and requests for more information are communicated to prescribers via fax. Decision notifications are delivered to members via a written letter. If the clinical circumstances warrant an expedited review, and the member's health will be jeopardized by the standard review timelines, please indicate that the request is 'URGENT' or "Expedited". Expedited determinations decisions are communicated verbally and via fax to the prescriber and written letters are sent to members. **Expedited determinations will be reviewed within 24 hours.**

Note: *A member's policy determines benefits. Prescription drugs that are contract exclusions will not be authorized and will not be approved via notification to the pharmacy at the time of dispensing. Drugs not approved may be appealed as outlined in the Member Appeals & Grievances Process sections of this manual*.

DRUG QUANTITY LIMITATIONS

Quantity limitations are in place for certain drugs. These limitations include specific quantities over defined time periods. The drug limitations help manage utilization, lower drug costs. Quality limitations also prevent fraud, waste, and abuse of medications.

Some drugs on the formularies will have a limit on the quantity allowed in a 30-day period, and claims can only be considered for this limited amount due to federal regulations (e.g., opioids) or high-cost specialty medications. Limiting quantities helps ensure that members are using these products appropriately and in a safe manner, according to the FDA-approved dosing guidelines. If clinical indications warrant a quantity above the limit, please submit Prior Authorization, available on the website.

CLINICAL & QUALITY PROGRAMS

ATRIO's Pharmacy Department monitors CMS quality and safety measures with actionable reports to share with providers. Pharmacy performs quarterly drug utilization review with interventions if applicable and monitors the use of opioids to ensure patient safety per CMS requirements. Pharmacists perform clinical medication review with recommendation for cost-effective formulary alternatives upon request @*ATRIO Pharmacy* *Pharmacy@atriohp.com*

- **Medication Adherence:**
  - ✓ Members can pick up 90-day supply of chronic medications at most retail network pharmacy or mail-order for only 2 copays (depending on the plans or tiers)
  - ✓ To promote Medication Adherence, members can fill up to 100-day supply of medications!
- **Statin Use in Persons with Diabetes:**
  - ✓ Prescribe a statin in patients with diabetes to reduce the risk of CV events.
  - ✓ Document during an encounter if intolerant or contraindication: ESRD, liver disease
    - Rhabdomyolysis (M62.82), Myopathy, other unspecified (G72.89, G72.9) or myositis, unspecified site (M60.80)
    - Adverse effect of antihyperlimidemic and anti-arteriosclerotic drugs (T46.6X5A)
    - Pre-diabetes (R73.03 or R73.09)

- **Medication Therapy Management Program (MTM):**
  ATRIO Health Plans utilizes **MedWatchers** to offer Medication Therapy Management services to ATRIO Health Plans members who meet certain criteria. Through MedWatchers, credentialed providers help members to manage their medications.

2024 Requirements: You must meet ALL of the following criteria:
- ➢ You must have a total drug cost of over $1,623~~5,330~~ in previous 90 days ~~a year on medications~~; AND
- ➢ You must take 8~~7~~ (eight~~seven~~) or more medications for chronic illness; AND
- ➢ You must have 3 (three) or more of the ten CORE chronic diseases:
  - ~~Chronic Heart Failure (CHF)~~
  - ~~Diabetes~~
  - ~~End Stage Renal Disease (ESRD)~~
  - ~~Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD)~~
  - ~~Alzheimer's Disease~~
  - CORE: Alzheimer's Disease
  - CORE: Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
  - CORE: Chronic congestive heart failure (CHF)
  - CORE: Diabetes
  - CORE: Dyslipidemia
  - CORE: End-stage renal disease (ESRD)

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- CORE: Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV/AIDS)
- CORE: Hypertension
- CORE: Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
- CORE: Respiratory Disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders)

OR Members who are at-risk beneficiaries (ARBs) under a DMP (Drug Management Program)

Drug Management Program - Opioids Utilization Safety monitoring & Case management

ATRIO Health Plans collaborates with MedImpact (Pharmacy benefit Manager) to adhere to CMS requirements to monitor opioids utilization. There are several opioid utilization safety programs, based on CMS regulations, that are in place to prevent and combat opioid overuse:

- Opioid prescriptions will be monitored for safe dosage levels – If the cumulative MME (Morphine Milligram Equivalent) exceeds 200mg opioid prescriptions, the prescription will be stopped at the pharmacy for review to make sure that the prescription is medically necessary and appropriate.
- Opioid prescriptions that are taken together with benzodiazepines prescriptions will be stopped at the pharmacy for review to make sure that the prescriptions are medically necessary and appropriate.
- Members who have NOT been dispensed a prescription for an opioid within the last 60 days (opioid-naïve) will be limited to no more than a 7-day supply for their opioid prescription for the treatment of acute pain.
- Concurrent or duplicate Long-Acting opioids prescriptions will be stopped at the pharmacy for review to make sure that the prescriptions are medically necessary and appropriate.

Opioids Case Management are in place for members who meet the criteria for Overutilization Monitoring Symptom (OMS): 1) history of opioid related overdose OR **2)** Use of opioids with average daily MME over 90mg for any duration during the most recent 6 months and 3+ opioids prescribers or 5+ pharmacies. Prescriptions will be reviewed, and prescribers will be out reached by a pharmacist to determine the appropriateness. Members with diagnosis of cancer, sickle cell disease, receive hospice care or a resident of long-term care (LTC) are excluded from this program.

COMPLIANCE

REPORTING FRAUD, WASTE AND ABUSE HIPAA VIOLATIONS AND OTHER NON-COMPLIANCE

COMPLIANCE OFFICER

Message By Phone: ATRIO's Compliance Line: (877) 309-9952 (option for anonymous complaints)

By Email: **compliance@atriohp.com**

PRINTABLE/ONLINE FORM FOR REPORTING

https://www.atriohp.com/documents/compliance/Code-of-Conduct-Printable-Form.pdf

ANONYMOUS MAILBOX

ATRIO Health Plans

PO Box 12645

Salem, OR 97309

OFFICE OF INSPECTOR GENERAL (OIG)

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164

By TTY: 1-800-377-4950

By Online Form: **oig.hhs.gov/fraud/report-fraud**

By Physical Mail:

US Department of Health and Human Services

Office of Inspector General

ATTN: OIG Hotline Operations

PO Box 23489

Washington, DC 20026

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

By Phone: 1-800-MEDICARE (1-800-633-4227)

By TTY/TDD: 1-877-486-2048

MEDICAL RECORD ACCESSIBILITY AND HIPAA

ATRIO will conduct business in a manner that protects information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended. HIPAA privacy regulations are fully implemented throughout ATRIO, and the organization is committed to the protection of Personal Health Information (PHI).

All medical records are considered confidential and any specific information obtained by Utilization Management and/or exchanged for conducting utilization review is considered confidential. ATRIO will use this information solely for the purposes of medical management of the member. ATRIO may share confidential information with only those third parties who have written or legal authority to receive this information, and only for the purposes of treatment, payment, or operations (TPO) , as allowed by HIPAA regulation. ATRIO may not disclose medical, personal, or confidential information about a member obtained in performance of utilization review without the written consent of the member, or as otherwise allowed by law.

ATRIO recognizes that under HIPAA laws, requests may be made for only the minimum member information necessary to accomplish the task at hand. Please note that the regulations allow the transfer and sharing of member information that the plan may need in the normal course of the business activities to make decisions as allowed for TPO that , ~~about~~ treatment, payment, or operations that includes coordinating medical care. The requested information needed for payment or health care operations includes the member's medical record(s) to make an authorization determination or to resolve a payment issue.

When ATRIO requests information, it may be mailed, faxed, or uploaded through Provider Tools and Resources to ATRIO. Only authorized ATRIO personnel have access to the ATRIO secure fax system and Provider Tools and Resources. Internet e-mail will not be used to transfer member information unless it is encrypted and secured.

ATRIO requires all providers to retain their medical records for no less than ten (10) years. Members will be provided with timely access to their medical records upon request.

The Notice of Privacy Practices is posted at **www.atriohp.com**, and is available to all members. If there are any questions or concerns about ATRIO's policy, please contact Customer Service at (877) 672-8620.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information may be used and disclosed, and how Members can get access to this information. Please review it carefully.

PRIVACY COMMITMENT

ATRIO respects the privacy and confidentiality of Protected Health Information (PHI.) ATRIO will maintain PHI confidentiality in a responsible and professional manner. PHI includes any information regarding healthcare of the member that can identify the member as the recipient of the healthcare services. ATRIO is required by law to maintain the privacy of PHI, provide the member with a privacy notice upon enrollment and every three years we must notify members where they can locate the privacy notice or that they request a hard copy. ATRIO ~~,~~ abides by the terms of the notice, and will ~~to~~ notify the parties affected ~~involved~~ if a breach of unsecured PHI should occur.

HOW ATRIO MAY USE MEMBER INFORMATION

As explained above, to manage health benefits effectively, ATRIO may use and disclose PHI in certain ways, and without authorization. The following are the types of disclosures that may occur, as allowed or required by law:

- **For Treatment**: ATRIO may use or disclose information with health care providers who are involved in member health care. For example, information may be shared to create and carry out a plan for individual treatment.
- **For Payment**: To make sure that claims are paid correctly, and the member receives the benefits they are entitled to, ATRIO may use and disclose PHI to determine plan eligibility and responsibility for coverage and benefits. For example, ATRIO may use information to facilitate payment for the care a member receives from health care providers, to coordinate benefits with other plans and facilitate the adjudication or subrogation of health care claims. ATRIO may also use or disclose PHI to review health care services for medical necessity, appropriateness of care or justification for charges, and to facilitate utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review-
- **For Health Care Operations**: ATRIO may use or disclose information during the course of running the healthcare business. These include operational activities such as quality assessment and improvement, performance measurement and outcomes assessment; health services research; and preventative health, disease management, case management and care coordination. ATRIO may share member information with partners who perform business functions. Information will only be shared if there is a business need to do so, and if the business partner agrees to protect the information.

ADDITIONAL TYPES OF DISCLOSURES:

- State and federal agencies who regulate ATRIO. (For example, the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services, and the Oregon Department of Financial Regulation)
- Authorized public health agencies. For instance, ATRIO may report concerns to the Food and Drug Administration regarding prescription drug and medical device problems
- Appropriate authorities, if there is belief that the member is a victim of child abuse or neglect, domestic violence or other crimes
- The appropriate agencies, if it is believed there is a serious health or safety threat to the member, or others
- Health oversight agencies for activities authorized by law, including audits, criminal investigations, licensure or disciplinary actions

- Law enforcement agencies for identification and location of a suspect, fugitive, material witness, crime victim or missing person
- A court or administrative agency in response to a search warrant, subpoena or other lawful process
- Coroners, funeral directors, medical examiners and organ procurement entities, and for research in limited cases
- Military authorities and authorized federal officials for intelligence, counterintelligence, and other national security activities
- The extent necessary to comply with laws relating to worker's compensation or other similar programs
- To a public or private entity authorized by law to assist in disaster relief efforts

USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

If ATRIO uses or disclose PHI for any reasons other than the above, written authorization from the beneficiary or their appointed representative must be obtained prior to the release of the information.

Some examples include:

- For marketing purposes that are unrelated to the benefit plan(s)
- Before most disclosures of psychotherapy notes (exceptions exist such as disclosures required by law or disclosures in the defense of a legal proceeding brought by the member)
- Related to the sale of protected health information
- For other reasons as required by law

If written permission is given, but the member then changes their mind, he/she may revoke the written permission at any time. ATRIO will honor the revocation except to the extent that the permission was relied upon previously.

If ATRIO discloses information as a result of written permission, it may be re-disclosed by the receiving party and may no longer be protected by state and federal privacy rules. However, federal or state laws may restrict re-disclosure of additional information such as HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

PRIVACY RIGHTS

The member has the following rights regarding Protected Health Information that ATRIO maintains:

- **Right to request limits on uses or disclosures of PHI**. The member has the right to ask that ATRIO limit how their information is used or disclosed. They must make the request in writing and describe what information they want to limit and to whom they want the limits to apply. While ATRIO may honor the request for restrictions, it is not required that they agree to these restrictions.

The member can request that the restriction(s) be terminated in writing or verbally.

- **Right to request confidential communications.** The member has the right to ask that ATRIO share information in a certain way or in a certain place. For example, the member may ask ATRIO to send information to their work address instead of their home address. All reasonable requests will be considered and must be agreed to if the member states they would be in danger if the request were not granted.
- **Right to See and Get Copies of Records**. Members have the right to inspect and obtain a copy of information that is maintained about them in a designated record set. However, they may not be permitted to inspect or obtain a copy of information that is:
  - Contained in psychotherapy notes
  - Compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding
  - Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provisions of access to the individual would be prohibited by law or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2)

Additionally, in certain other situations, ATRIO may deny the request to inspect or obtain a copy of information. If that request is denied, ATRIO will notify the members in writing and will provide them with a right to have the denial reviewed. ATRIO may require that the request for information be made in writing. A response to the request will be made no later than 30 days after receipt. If additional time is needed, ATRIO will inform the approved requestor (member or Appointment of Representative) of the reason(s) for the delay and the date of completion of the request, which will be no more than 30 additional days. If a copy is requested, it will be provided to the member in the form and format requested if the information is readily producible in that format. ATRIO will charge a reasonable fee based on copying and postage costs. The member may request a copy of the portion of the enrollment and claim record related to an appeal or grievance, free of charge.

- **Right to Request a Correction or Update of Records**. The member has the right to ask ATRIO to amend information that is maintained in a designated record set. ATRIO may require that the request be in writing and that a reason for the request is provided. ATRIO will respond to the request no later than 60 days after receipt. If ATRIO is unable to act within 60 days, they may extend that time by no more than an additional 30 days. If they need to extend this time, they will notify the member of the delay and the date the request will be completed. If ATRIO makes the amendment, the member will be notified that it was made, and will then obtain an agreement to share the amendment with the relevant persons the member has identified. ATRIO will notify these persons, including their business associates, of the amendment. If the request to amend is denied, ATRIO will notify the member in writing of the reason for the denial. The denial will explain the right to file a written statement of disagreement.

ATRIO has a right to rebut member statements. However, the member has the right to request that the written request, the written denial, and the statement of disagreement be included with their information for any future disclosures.

- **Right to Get a List of Disclosures**. The member has the right to receive an accounting of certain disclosures of their information made by ATRIO during the six years prior to the request. ATRIO will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any the member requested.) ATRIO will provide one accounting a year for free but will charge a reasonable, cost-based fee if another is requested within 12 months.
- **Right to choose someone to act ~~in place of the memb~~on their behalf~~er~~**. If the member has given someone medical power of attorney, or if someone is a legal guardian, that person can exercise the rights and make choices about the member's health information. ATRIO will make sure the person has this authority and can act on behalf of the member before any action is taken.
- **Right to get a paper copy of the Notice of Privacy Practices.** The member has the right to ask for a paper copy of this notice at any time.

HOW TO CONTACT ATRIO TO REVIEW, CORRECT OR LIMIT PHI

The member may contact ATRIO or the ATRIO Privacy Officer at the address listed at the end of this notice to ask:

- To look at or copy their records
- To limit how information about them is used or disclosed
- To cancel an authorization
- To correct or change their records
- For a list of the times ATRIO disclosed information about the member

ATRIO may deny the request to look at, copy or change the records. If ATRIO denies the request, ATRIO will send a letter to the requestor that explains why the request is being denied, and how a review of the denial can be obtained. The member will also receive information about how to file a complaint with ATRIO or with the U.S. Department of Health and Human Services.

EXERCISING RIGHTS

If the member wants additional information regarding ATRIO's Privacy Practices, or if they believe ATRIO has violated any of the rights listed in this notice, he/she may contact ATRIO at the address or phone numbers listed below. Their benefits will not be affected by any complaints they make. ATRIO will not and by law cannot retaliate for filing a complaint, cooperating in an investigation, or refusing to agree to something that the member believes to be unlawful.

CONFIDENTIALITY REQUIRED

When a member is enrolled into ATRIO, a substantial amount of medical, personal and insurance information is collected and retained for purposes of enrollment, treatment and payment and other health care operations. This information is also known as Protected Health Information (PHI) and the usage or disclosure of this information is governed by state and federal law including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ATRIO is required by law to make sure that this information is kept private, and it is a legal responsibility to ensure full compliance with these laws. Employees must never disclose or release any PHI in a manner that violates the privacy rights of the member. Member information will only be discussed in a manner that relates to the business at hand and no employee will have access to any information unless it is necessary to perform his/her job. Violation of this is subject to disciplinary action up to and including dismissal.

In addition, confidential information that is acquired during the course of employment while at ATRIO is not to be discussed except as needed to perform job duties. Upon termination for any reason(s), an employee is prohibited from taking, retaining or copying any information that is related to ATRIO without express permission from the Chief Executive Officer.

Every employee will be required to sign a confidentiality pledge on an annual basis and any violation of the company policy must be immediately reported to the Chief Compliance Officer, CEO and/or the Audit & Compliance Committee for further action.

FILING A HIPAA COMPLAINT

Private & Confidential Mailing Address:

P.O Box 12645
Salem, OR 97309

Toll Free: (877) 672-8620
TTY: (800) 735-2900

Members may contact ATRIO's Privacy Officer, at (971) 304-0043 or by email at **compliance@atriohp.com** for further information about ATRIO's privacy practices or the complaint process.

Members may also notify the Office for Civil Rights, U.S. Department of Health and Human Services of any complaints.

HIPAA VIOLATIONS AND OTHER NON-COMPLIANCE

The office may be contacted at:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Phone: 1-800-368-1019
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/
OCR Complaint Portal: ocrportal.hhs.gov/ocr/smartscreen/main.jsf

CORPORATE CODE OF CONDUCT &

~~C~~ODE OF CONDUCT

ATRIO will conduct its business in compliance with all federal, state, and local laws, rules, and regulations in a manner consistent with the highest standards of business and professional ethics

To ensure company compliance with this code ATRIO offers this guidance to all employees. ATRIO recognizes that the successful plan administration relies upon the continued competence and integrity of its employees and that all policies and processes are committed to full compliance with all federal and state rules and regulations. The Code of Conduct (also known as the Standards of Conduct are the products of this commitment and will provide guidelines that encourage and promote a working environment of legal, ethical, and professional standards.

These guidelines are for all ATRIO employees to follow while acting and representing ATRIO in any capacity. These standards do not outline individual job responsibilities but provide a framework in which employees must operate. No one standard can be written to cover every possible business situation that may arise in the complex regulatory environment in which we operate. However, the use of available resources, including all state and federal regulations and guidance, honest behavior, personal integrity, common sense, and good judgment will help to identify appropriate action. If you have any doubts or concerns, please contact any member of management or ATRIO's Chief Compliance Officer.

ATRIO employees are asked to review Compliance Department policies carefully. If an employee is directed to do something that is or believed to be contrary to the ethical and legal representations of this code, the employee is required to report the incident to the one or all of the following; Chief Compliance Officer, Privacy Officer, any member of management, directly to the Audit & Compliance Committee of the ATRIO's Board, or to the Board of Directors.

Failure to adhere to these standards can result in criminal and civil penalties. Those actions found to defraud local and/or state health care programs may exclude the offending individuals from participation in these healthcare programs.

ATRIO operates in a heavily regulated environment with a variety of areas that may be considered at risk. An effective compliance program seeks to mitigate these risks while providing a high standard of quality care and service to the members that they serve. The various policies and procedures that describe ATRIO operations represent their response to ensure day-to-day operational activities fully comply with legal, regulatory, ethical and professional responsibilities.

CONFLICT OF INTEREST

ATRIO employees and provider's staff should not have any personal interests or outside activities that are incompatible or appear to compromise the integrity of the Plan. All employees are expected to maintain impartial relationships with outside entities and to treat each interaction with the foremost interest of ATRIO in mind. Employees should avoid any outside financial interest that may influence a decision or action in the performance of their job requirements for the Plan.

These interests may include:

- A personal or family interest in another entity that has business relationships with the Plan. This does not apply to minimal holdings of stock or security in another corporation whose shares are publicly traded and may do business with the Plan; or
- An investment in another business that competes with the Plan

Conflict of Interest may occur if an employee uses their position with ATRIO for personal gain or for the benefit of relatives or friends, or if an employee is involved in outside activities that interfere with their job responsibilities.

All employees and Board members are required to disclose *any* potential conflicts of interest and will be asked to confirm on an annual basis that they are not aware of any conflicts that they are engaged in. If such a relationship exists that may pose a conflict, the activity will be reviewed by the Audit & Compliance Committee and the Board of Directors for further action.

ATRIO has a Conflict of Interests Policy that is given to each Employee and member of ATRIO's Board of Directors upon hire and/or appointment and annually thereafter. This policy outlines the expectations and requirements regarding Conflicts of Interest in more detail.

FRAUD, WASTE AND ABUSE

ATRIO is committed to the detection and prevention of potential fraud and abuse activities.

- Fraud is defined as an intentional deception or misrepresentation made by an individual who knows that the information is false and could result in an unauthorized benefit to him/herself, another person or the Plan;
- Waste is defined as the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program; and
- Abuse is an incident or practice that is not consistent with sound medical business or fiscal practices that may result in unnecessary program costs, improper payment for services and directly or indirectly results in unnecessary costs to the programs that ATRIO administers.

REPORTING/INVESTIGATION AND RESPONSE

ATRIO has an anonymous and/or confidential reporting disclosure program for all employees to report known or *suspected conduct or activities* by any person engaged in the performance of duties for ATRIO that *violates, or may violate, is contrary, or may be contrary to* the code or standards of conduct or any state or federal laws. Reporting may be used for individuals who are uncertain whether an action violates the code of conduct, including fraud, waste, and abuse and would like to communicate with the company on a confidential basis.

All reports will be treated with respect, held in the strictest confidence, and investigated as expeditiously as possible. Based on the facts of the investigation the Audit & Compliance Committee may take additional corrective action.

ATRIO will not tolerate any retribution or retaliation against any person for reporting good faith suspected violations of the code or of state or federal law. Any member of management who takes retaliatory action against an employee for reporting a compliance issue will be subject to severe disciplinary action up to and including discharge.

Questions or concerns about potential compliance issues or violations may be addressed to *any* of the following at any time or in any order:

- Supervisors or managers
- The Compliance Team
- Chief Compliance Officer
- Chief Executive Officer
- Privacy Officer
- Chairman of the Audit Committee
- Any Board of director member
- Website reporting at atriohp.com/oregon/
- Confidential mailbox – PO Box 12645, Salem, OR 97309
- Complaint Hotline: 877-309-9952

These reports may be made anonymously and will be investigated and acted upon in the same manner as reports made by employees who choose to identify themselves.

Prompt, appropriate, and confidential investigation will be conducted on all reports. The Chief Compliance Officer or their designee will coordinate any findings from the investigations and may present to the Audit and Compliance Committee for recommendations. Once a reported violation is researched through the investigation process the Chief Compliance Officer or their designee will initiate corrective actions. Any corrective actions related to employees will be managed in alignment with Human Resources.

EMPLOYEE RESPONSIBILITIES

To act with honesty and integrity and in full compliance with the Code/Standards of Conduct;

Promote honest and ethical behavior within the company;

Avoid conflicts of interest or if one is possible to disclose the potential conflict for further evaluation;

To comply with all state and federal rules and regulations;

Respect the confidentiality of all information acquired in the course of my work and to not disclose information that violates the Confidentiality/Privacy policy of the company;

To report any violations of this Code/Standards of Conduct or any violations of local, state or federal law;

To disclose any indictment or potential indictment with regard to a felony, a misdemeanor involving fraud or dishonesty; or any crime punishable by imprisonment for more than one year; and

To disclose any exclusions by the Department of Health and Human Services (DHHS) Officer of the Inspector General (OIG) or General Services Administration (GSA), or other entity as required.

ATRIO values the relationship with all Providers and their staff and endeavors to ensure that all business activity is conducted in full compliance with all contracts, state and federal laws that govern the business activities of ATRIO. No policy will be created that undermines this intent and no activity by an employee will be tolerated that violates these provisions.