PROVIDER MANUAL

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www.capitoldentalcare.com

April 30, 2024

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Welcome

Welcome to Capitol Dental Care! Thank you for being part of our network of offices. This handbook is a reference to provide you with information regarding processes and procedures.

Capitol Dental Care

Capitol Dental Care (CDC) is a dental care organization that contracts with the state and multiple coordinated care organizations to deliver dental care to members covered under the Oregon Health Plan. CDC has served members of the Oregon Health Plan since its inception in 1994. CDC has a track record of being "user friendly" to dentists and their offices. We have built a solid reputation for fast service, fair treatment, and being readily available. CDC's commitment to those values remains firm. We aim to improve the oral and overall health of our members.

Mission Statement

Capitol Dental Care is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. We create access to quality care, use evidence-based methods and provide dental leadership within the communities we serve.

Contact Information

Capitol Dental Care, Inc.
610 Hawthorne Ave SE, Suite #200
Salem, OR 97301
Phone: (800) 525-6800
Fax: 503-581-0043
Office Hours: Monday–Friday from 7:00 a.m. to 6:00 p.m.

Claims Mailing Address:
Capitol Dental Care
PO BOX 5308
Salem, OR 97304

Email Addresses:

- Member Services – members@capitoldentalcare.com
- Provider Services – providers@capitoldentalcare.com
- Pre-Authorizations
    - Dentures – dentures@capitoldentalcare.com
    - Hospital and Office General Anesthesia – ga@capitoldentalcare.com
    - Hygiene, Endo, Crowns, Surgery, Other – pa@capitoldentalcare.com
- Referrals
    - Pedo and Special Needs – pedoreferrals@capitoldentalcare.com
    - Endodontics and Periodontics – endoperioreferrals@capitoldentalcare.com

    - Oral Surgery and Dentures – osdenturereferrals@capitoldentalcare.com
- Interpreter Services – interpreter@capitoldentalcare.com
- Compliance – compliance@capitoldentalcare.com
- Other – admin@capitoldentalcare.com

IMPORTANT: Please do not submit any personal information such as social security number, Oregon Health Plan member number or any personal health information through email. Email is not secure and has the potential to be seen by others. Please call, fax or ensure you are using secure email before sending confidential or protected data.

Our Members

Our members select or are assigned to Capitol Dental Care upon enrolling in the Oregon Health Plan (OHP), the Oregon Medicaid program. The enrollment process is handled by the State or the Coordinated Care Organizations. Questions regarding members should be directed to CDC's Member Services Team.

Coordinated Care Organizations

Coordinated Care Organizations (CCOs) were developed by the state to manage the members' physical, mental and oral health needs. A CCO develops a network of health care providers with the goal of improving member health and quality of care at a lower cost. The CDC network of dental providers is a critical component of the dental delivery system for many of the CCOs. CDC encourages oral health professionals to be aware of manifestation of systemic health that are present in the mouth. We can help improve overall health in partnership with the CCOs through awareness, coordination, early identification of disease and preventive services.

Learn more about CCOs and how they are helping improve the care and health of Oregonians at http://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx

Providers

Joining the CDC Network

The first step in becoming a CDC provider is to complete a Prospective Provider Form. The form can be found on the CDC website. Completion of this form allows CDC to determine if the services you provide and your practice location meet existing needs within the network. You will be informed either that your office does not meet an existing need or you will receive information to initiate the credentialing process.

Credentialing

Provider credentialing is a process of assessing, re-assessing and validating the qualifications and practice history of a dental provider for the purpose of obtaining approval from a health plan to join their network. CDC credentialing requirements are based on OHP, state and other regulatory agencies national standards of accrediting. Dental Specialists, General Dentists, Denturists, and Expanded Practice Dental Hygienists (working outside a dental office) are required to credential with CDC. The credentialing process must be completed and approved prior to a provider treating members. CDC is only able to pay credentialed providers and credentialing cannot be backdated to cover a service provided before the process is complete.

The following are some of the criteria that must be met to be credentialed.

1. Completion of applicable dental degree.
2. Proof of minimum malpractice insurance coverage.
3. Current, active and in good standing with the applicable professional state license(s).
4. Never proven guilty of a federal crime.
5. Not on any federal health care program exclusion list.
6. Not have questionable work, complaint, or health history which could negatively affect the provision of dental care to our members.

CDC reserves the right to deny participation based on but not limited to, these criteria.

The provider is responsible for accuracy of information on the application and signing and dating the application, the attestation, and the authorization to release information form. CDC verifies information in the application and checks the National Practitioner Data Bank, Dental Licensing Boards and other sources. A provider is entitled to provide a written explanation for any negative findings or for information obtained during the verification process that varies substantially from the information submitted on the application. CDC will notify you and request a written explanation if this is necessary. If no response is received, the application process is terminated.

Please attach legible, current and valid documents requested in the application. We do not accept an application and/or attached documents that have been altered, unsigned, incomplete, inaccurate, expired, and illegible or that have missing information.

CDC's credentialing team will review the information submitted in the packet for final review and participation decision. All information provided during the credentialing and re-credentialing process is kept confidential. The credentialing application, source data verification and all other pertinent information will be reviewed and presented to CDC's Dental Director and the CDC Quality Improvement Committee for final approval in determining one of the following actions:

- Approve the application.
- Approve the application conditionally. The provider is monitored until the conditional status is removed.
- Pend the application and request additional information to be reviewed at a future date.
- Deny the application.

Recredentialing

Recredentialing is a necessary requirement to remain an eligible participating provider. Re-credentialing occurs every three years. The recredentialing process is similar to the initial credentialing.

In the case of a recredentialing denial, written information on the appeal process will be provided to the provider. The provider has 30 calendar days from the date of denial of participation to request an appeal. The request must be in writing and mailed to us by certified mail. A provider who fails to request an appeal within the time and manner specified waives any right to an appeal of the decision in the future.

Provider Rights

Providers have the right to:

- Not be discriminated against based on provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or patients in whom provider specializes.
- Review information obtained by us to evaluate the credentialing application, except that which is peer-protected by law and not to be shared with the provider.
- Correct erroneous information discovered during the verification process.
- Request a status via telephone, e-mail or correspondence of the application.
- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions. In accordance with ORS 41.675, no disclosure of peer review information is released, except to those authorized to receive such information to conduct credentialing activities.
- Be notified of their rights as a provider.

Provider Communication

Capitol Dental Care CDC) is committed to proactively communicating with its provider network, with sufficient quality and quantity, about all relevant matters, including but not limited to the following:

- OHA/CMS rules and regulations regarding CDC's operations and those of its contracted provider network or delegated entities;
- Trainings and attestations regarding their operations as a part of CDC's network;
- Participation in CDC's network, including credentialing and contracting activities
- CDC expectations, standards, goals, and objectives;
- Monitoring of performance, quality, clinical correctness, etc.; and
- Corrective action and associated potential disciplinary action

Keeping channels of communication open with providers is a two-way street, and CDC is also committed to being available for its providers, to hear them and understand what they have to say, both positive and negative. In this manner, CDC strives to establish a culture of open and substantive communication with its provider network.

Please see Capitol Dental Care's policy on Provider Communication for further details.

Notifications

At all times while participating with CDC, dentists must have and maintain in good standing all licenses, registrations, certifications and accreditations required by law to provide dental care as applicable. Each participating provider must promptly notify CDC of any changes, formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations. Additionally, providers must notify CDC credentialing in writing of any changes in practice ownership or business address.

Provider Directory

CDC's provider directory identifies participating providers, their availability to new patients and information about their practices to assist members understand options available to them such as if the provider utilizes telehealth consults. CDC attempts to keep the directory accurate and up-to-date. Your assistance in notifying CDC of any changes and or corrections needed is appreciated.

Case Management

CDC's Member Services Team is available to help with member case management as needed for difficult clinical situations and for coordinating efforts with physical or mental health providers.

Quality Review

CDC has a Quality Improvement (QI) Committee charged with ensuring members receive care that is both high in quality and appropriate to improve their health. Periodic chart and facility audits and internal outcome measures obtained from administrative data will be used to track the quality of care provided by contracted providers. We also track providers' utilization and claims data.

Areas of concern are access to care, outcomes of care, over and underutilization of services, patient safety, member satisfaction, and compliance with rules and regulations. Providers are expected to cooperate with quality review efforts, which may include responding to questions that arise during CDC's quality review audit process.

Teledentistry

Capitol Dental Care (CDC) is committed to providing oral health services to its members through teledentistry under various circumstances. CDC believes in the proactive adoption of methods that increase access to services for its members, and teledentistry is one such method.

CDC accomplishes teledentistry through its expanded-practice dental hygienist (EPDH) team as well as through its doctor providers.

Teledentistry is defined by OAR 410–123–1265(2) as "[both synchronous and asynchronous modalities,] using electronic and telecommunications technologies for the distance delivery of dental care services and clinical information designed to improve a patient's health status and to enhance delivery of the health care services and clinical information."

There are several ways in which CDC utilizes dental codes D9995 and D9996 to deliver services generally covered as part of the primary service completed, in order to better serve its members through teledentistry.

Please refer to CDC's Teledentistry policy for additional details.

Termination of Participation

Termination of participation with CDC is determined by the Provider Agreement. In general a provider can be terminated for cause when failing to meet the terms of the agreement. Either the provider or CDC is allowed to terminate participation with notice as specified in the agreement. Termination with CDC does not relieve a provider of any obligation they may have to a member who is a patient of record.

Training

CDC's provider relations group will provide OHA-approved/required trainings on an annual basis at a minimum and often more frequently. Such trainings are mandatory, and network participation is conditional upon cooperation and participation.

CDC is required by regulation and contract terms to provide certain trainings. Many trainings require the participation of support staff in addition to providers. Topics may include and might not be limited to the following:

- Social Determinants of Health and Equity
- Cultural Responsiveness and Implicit Bias
- Language access and the use of interpreters
- CLAS standards
- Adverse childhood experiences/trauma-informed care practices
- The use of REALD data to advance health equity
- Universal access and accessibility in addition to compliance with the ADA
- Health literacy
- Program Fraud, Waste and Abuse

CDC will work with its network providers to offer continuing clinical education credits for required trainings whenever possible and to offer the trainings in a manner that is as convenient and efficient as possible. CDC is mindful of the value of participants' time.

Record Retention and Review

Participating providers must keep and maintain necessary financial, dental and other records pertaining to services rendered to members of CDC. All records must be kept in accordance with federal and/or state laws governing record retention. Termination of participation with CDC does not terminate a provider's obligation to retain records.

CDC will have the right to conduct on site visits and to request and inspect all records of the provider related to a member as permitted by law, and as may be necessary for CDC to perform its contract obligations. These records will be provided at no cost.

Documentation Signature Requirements

Capitol Dental Care is required to ensure that all credentialed providers are compliant with Provider Signature Requirements. The Provider Signature Requirements have been put in order to validate that services rendered have been accurately and fully documented, reviewed and authenticated. All records, chart notes, procedures, and orders submitted for review must be signed and dated by the rendering provider at the time of service. If documentation does not show a valid, timely signature, claims may be denied or overpayments may be recouped.

Handwritten Signatures Must:

- Appear on each entry (multi-page medical records require one signature at the end of the last page as long as it is clearly documented to be one encounter)
- Be legible
- Include the practitioner's first initial and last name, at minimum
- Requires the practitioner's credentials (DDS, DMD, RDH, EPDH, DT, etc.)

- Capitol Dental may request a signature log with any review of medical records to verify providers' signatures or initials.

Digitized/Electronic Signatures:

- The responsibility for, and authorship of, the digitized or electronic signature should be clearly defined in the record.
- A "digitized signature" is an electronic image of an individual's handwritten signature. It is typically generated by encrypted software that allows for sole usage by the practitioner.
- An electronic or digitized signature requires a minimum of a date stamp (preferably including both date and time notation) along with a printed statement such as, "Electronically signed by," or "Verified/reviewed by," followed by the practitioner's name and a professional designation. An example would be: Electronically signed by: John Doe, DMD 03/31/2016 08:42 a.m.

Unacceptable Signatures:

- Signature "stamps"
- Missing signature on dictated and/or transcribed documentation
- "Signed but not read" notations
- Illegible lines or marks

Elements of a complete medical record Per CMS Documentation Guidelines, elements of a complete medical record may include:

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray, and diagnostic reports
- Signature and date

The Provider Signature Requirement is one element assessed in the Capitol Dental Care chart audit.

Provider Responsibilities

CDC Providers are responsible for providing services to the member that they are entitled to receive in a manner that ensures member rights are maintained. To ensure members have access to quality care in a timely manner, emergency needs should be addressed within 24 hours, urgent needs within 7 days and routine care within 4-8 weeks.

Claims Processing

A claim must be submitted to CDC for each service provided to a CDC member.

Third Party Administrator

CDC's, third party administrator, PH TECH processes and pays claims on behalf of CDC. PH TECH can be reached for assistance at (866) 947-9443. Web site help is found at https://help.phtech.com/hc/en-us.

PH Tech's Clinical Integration Manager (CIM)

PH Tech offers a web based system, CIM, to CDC providers as a tool to find information on member's eligibility, referrals, predeterminations and claims. Certain operational tasks such as referral requests and communications regarding claims can also be initiated in CIM.

To obtain CIM access contact PH Tech at (866) 947-9443; for assistance with using CIM contact PH Tech CIM Support at (503) 584-2169, option 2.

Verifying Eligibility

It is the responsibility of the provider to verify a patient's eligibility including benefits on the date of service. All services billed must be dentally necessary, an OHP covered service and provided in accordance with OHP rules and regulations governing reimbursement.

A member's eligibility may be confirmed in the CIM system. CDC's member service staff can also help you determine a member's eligibility. A member service representative is available 7 AM to 6 PM Monday through Friday, other than Federal holidays, at 1-800-525-6800. The provider assumes full financial risk for serving a patient whose eligibility was not confirmed on the date of service.

Submitting Claims

Participating providers agree to bill CDC for covered services provided to CDC members. CDC requires that all claims be received within 120 days of the date of service. Corrected billings to previously submitted claims need to be clearly marked as —corrected billing. If a claim is previously denied and/or additional information is requested, the provider has 95 days to submit the requested information or appeal the denial. All claim processing, including corrections, adjustments, and requested information must be received within 12 months after the date of service to be valid.

Provider shall not submit a false claim for payment including an altered claim for a service that has already been paid, claims expected to be paid by another source or a claim for services that have not been provided.

Electronic Claims: It is preferable to have claims submitted electronically. When submitting claims electronically, it is important to check the error report from your

electronic claims service or clearinghouse to verify that all claims have been successfully sent. For information or assistance with billing electronically, please contact PH Tech.

Paper Claims: Claims can be submitted on paper using a current ADA form. Please add the member's CCO name (Box 3 of the American Dental Association Dental Claim form is recommended) to your claim to ensure more accurate and quicker processing. For example: Pacific Source Willamette or Trillium Lane.

Mail to:
Capitol Dental Care
PO BOX 5308
Salem, OR 97304

OHP coverage is always secondary to other insurance carriers. If there is a primary carrier, such as private insurance, that carrier's Explanation of Benefits should be submitted with the claim as soon as the EOB is received. As secondary payer, CDC pays for benefits only when the primary carrier paid less than the CDC allowed amount. Payment is based upon the difference of either the primary carrier's allowed charge or our allowed amount and the primary carrier's payment, whichever is less. If the primary plan pays more than the CDC allowed amount, it constitutes the total allowable payment and CDC will not make any payment.

In order for claims to be processed correctly, each claim must include the correct Tax Identification Number (TIN), correct NPI(s) and correct DMAP number. If you operate within a clinic with multiple providers, these numbers must accurately align with the identified billing entity and treating dentist. The treating dentist must be the individual who provided the service.

Taxpayer Identification Number: A Taxpayer Identification Number (TIN) is an identifying number used for tax purposes in the United States. A TIN may be assigned by the Social Security Administration or by the Internal Revenue Service (IRS). You can apply online at https://www.irs.gov/businesses/small-businesses-self-employed/apply-for-an-employer-identification-number-ein-online.

National Provider Identifier (NPI): The NPI is a standard unique health identifier for healthcare providers. The NPI was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Apply through the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/NPPES/Welcome.do or by calling 800-465-3203 (NPI toll-free).

DMAP Provider Number: In order for CDC to pay claims all providers must have a Division of Medical Assistance Programs (DMAP) provider number. The link to sign up for a DMAP provider number is https://www.oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx Obtaining a DMAP provider number does not require you to accept all

Medicaid patients or to do business directly with the state. You can restrict the use of your DMAP number to your claims and encounter data submissions with CDC.

Recordkeeping

Financial and clinical records that support and accurately document the specific care or services provided to the member shall be retained in secure storage for at least 10 years. Upon request, regulatory agencies, the CCOs or CDC shall have immediate access to review and make copies of any and all records.

Claims Inquiries

Questions regarding claims may be answered by using the CIM system. You can also contact PH TECH or CDC provider services group.

Claims Appeals

Claims denied for information that is incorrect or lacking should be resubmitted to PH Tech to be adjudicated. To appeal coverage decisions, include comprehensive documentation to include, a detailed description of the issue or dispute, the basis for your disagreement, as well as all evidence and documentation supporting your position.

Referrals

Sometimes it becomes necessary to refer a patient to a specialist or different provider. The referral form (found on CDC's website) must be filled out in its entirety. Omitting information may delay processing of the referral.

If assistance is needed with a referral call 1-800-525-6800. Fax the completed referral form to (503) 581-0043 or e-mail to the appropriate address below:

All Pedodontic referrals including Special Needs Referrals – pedoreferrals@capitoldentalcare.com

All Endodontic and Periodontic Referrals – endoperioreferrals@capitoldentalcare.com

All OS and Denture Referrals – osdenturereferrals@capitoldentalcare.com

We will notify you if a referral is denied, approved or pending further review. When a referral is approved the Primary Care Dentist (PCD) will be given a referral number. If a referral is denied, we will fax or mail the referral request back to the PCD and include the reason for the denial. A formal written denial is mailed to the member.

Specialists must receive an approved referral from CDC before seeing a member. In an emergency, the specialist must notify CDC as soon as possible to obtain approval for the visit. Eligibility must be checked before providing services regardless of whether or not there is an approved referral. The patient must be eligible on the date of a service for the referral to be valid.

Referral Request Requirements:

- All pertinent patient information (name, ID number, birth date, medical concerns etc.)
- Dental procedures, type of service provider being requested (i.e. oral surgery, children's dentistry).
- Any important details as to why the referral is needed (I.e. young child with abscess office treatment attempted but failed).
- Provider contact information including mailing address and a return fax number, when applicable.

Prior Authorization of Benefits

CDC will allow you to confirm in advance during normal business hours whether the dental services to be provided are dentally necessary and covered benefits; and to determine CDC's requirements that apply to you in providing the service.

CDC has also identified certain services for which you must submit for prior authorization (PA). In the event you fail to submit a required prior authorization, CDC may deny, in whole or in part, any claims for those services. A prior authorization is based on a member's history and eligibility at the time the prior authorization is processed. It is not a guarantee of payment should changes occur after the date of the prior authorization.

A current American Dental Association (ADA) form should be submitted, separate from your claims, with the following information:

- The request for prior authorization (predetermination) box at the top of the ADA form should be checked.
- Current ADA codes for all procedures proposed.
- Any written clinical (i.e. chart notes, periodontal charting applicable) and X-rays to determine benefits.
-

Email PA requests to: providers@capitoldentalcare.com

Or send PA requests by mail to:

Capitol Dental Care, Attn: PA Request
610 Hawthorne Ave SE, Suite #200
Salem, Oregon 97301

Payments

Provider will accept CDC payment as complete remuneration for the covered services. As condition of payment, Provider will meet and maintain compliance with their Provider Agreement and rules and regulations of the OHP.

Hospital Dentistry

Hospital dentistry or in office dentistry under general anesthesia requires coordination with the member's physical health providers. A form to facilitate the process was jointly developed and is available on the CDC web site.

Discrimination

Services will be provided to members without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability. Provider will reasonably accommodate the cultural, language and other special needs of the member. Provider shall adhere to the Civil Rights Act, Rehabilitation Act, Americans with Disabilities Act and the Vietnam Era Veterans Readjustment Assistance Act.

Compliance with Law

Provider will comply with federal, state and local laws and regulations.

Members

Enrollment

Eligibility for OHP Members is granted by the Department of Human Services (DHS). An OHP member will chose a CCO in their application process. Once enrolled, a CCO will place its member in a dental care organization. Some CCOs allow the member to select the dental care organization. Others assign the member to a dental care organization with the option to change if the member deems the assignment is less than a good fit. All CCOs want their members to be in a dental care organization that is a good fit for them. If a member is not, have him/her contact CDC for additional options.

Second Opinions

A member has a right to request a second opinion from a qualified participating provider. The provider shall work with CDC to assist the member in obtaining a second opinion at no cost to the member. This assistance may take the form of a referral request to CDC on behalf of the member or a discussion regarding benefits/outcomes with the member. Whenever possible, the member shall be referred to a participating provider in the same office.

Dismissal of a Member

Dismissal is when a member is removed from the care of his or her assigned PCD Provider. Disenrollment is when a member is removed from the CCO.
CDC follows Department of Human Services (DHS) rules regarding member dismissal. We encourage a member and his/her provider to resolve complaints, problems and concerns at the clinic level.

Key points when considering dismissing a member
In general, prior to dismissing a member consider the following:

- A plan generated by the PCD provider to attempt to address the problem or concern.
- The use of contracts and case conferences with the member, CDC and his/her CCO.
- Mental health conditions.
- Thorough documentation of events, problems and behaviors.

When can a member be dismissed?
A member may be dismissed from a PCD provider with just cause subject to Americans with Disabilities Act (ADA) requirements. The list of just causes, identified by DHS includes but is not limited to the following:

- Missed appointments, except prenatal care patients
- Disruptive, unruly or abusive behavior.
- Drug-seeking behavior.
- The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients.

- Mutual agreement between the member and the provider.
- Provider and CDC agree that adequate, safe and effective care can no longer be provided.
- The member commits a fraudulent or illegal act, such as permitting someone else to use his or her medical ID card, altering a prescription, or committing theft or any other criminal act on any provider's premises.

If PCD provider decides to dismiss a member

When the clinic management moves to dismiss a member, a letter is sent to the member informing him or her of the dismissal with a copy sent to CDC. PCD providers are required to provide urgent care for the dismissed member for 30 days following notification of the member.

CDC's Member Services Team will work with the member to establish a new PCD provider.

When a member cannot be dismissed

Oregon Administrative Rules state that members shall not be dismissed solely because:

- The member has a physical or mental disability.
- There is an adverse change in the member's health.
- The PCD provider or CDC believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
- The member requests a hearing.
- The member exercises his or her option to make decisions regarding his or her medical care with which the provider or the plan disagrees.
- The member's behavior resulting from special needs.

Missed appointments

Providers should individually establish an office policy for the number of missed appointments they allow before dismissing a member from their practice. This policy must be administered the same way for all patients. The provider's office must inform all members of their office policy on missed appointments at the member's first visit. The provider should have members sign an acknowledgement of the office policy. DMAP rules do not allow providers to bill members or charge them a fee for missed appointments.

If the member continues to miss appointments and the provider decides to dismiss the member, the provider must send a letter to the member informing him or her of the dismissal. A copy of the dismissal letter should be sent to CDC along with a copy of the office policy on missed appointments and any other relevant documentation, including chart notes, correspondence sent to the member, signed contracts and/or documentation of case conferences.

A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment.

Member Rights

1. Be treated with dignity and respect;
2. Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;
3. Choose a Primary Care Dentist (PCD) or service site and to change those choices as permitted in administrative policies;
4. Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;
5. (Have a friend, family member, member representative, or advocate present during appointments and other times as needed within clinical guidelines;
6. Be actively involved in the development of their treatment plan;
7. Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;
8. Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;
9. Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
10. Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;
11. Receive culturally and linguistically appropriate services and supports in locations as geographically close to where members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;
12. Receive oversight, care coordination and transition and planning management from CDC or their CCO within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;
13. Receive necessary and reasonable services to diagnose the presenting condition;
14. Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are dentally appropriate;
15. Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;
16. Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the free use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the

member's need to access appropriate services and participate in processes affecting the member's care and services; This includes receiving consent forms in the Members preferred language.

17. Obtain covered preventive services;
18. Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;
19. Receive a referral to specialty providers for dentally appropriate covered coordinated care services in the manner provided in CDC's referral policy;
20. Have a clinical record maintained that documents conditions, services received, and referrals made;
21. Have access to one's own clinical record, unless restricted by statute;
22. Transfer of a copy of the clinical record to another provider;
23. Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
24. Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
25. Be able to make a complaint or appeal with CDC or their CCO and receive a response; Request a contested case hearing;
26. Receive certified or qualified health care interpreter services at no charge; and
27. Receive a notice of an appointment cancellation in a timely manner;
28. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

Member Responsibilities:

1. Choose or help with assignment to a PCD or service site;
2. Treat their CCO, CDC, provider, and clinic staff members with respect;
3. Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;
4. Seek periodic dental exams and preventive services from the PCD or clinic;
5. Use the PCD or clinic for diagnostic and other care except in an emergency;
6. Obtain a referral to a specialist from the PCD or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
7. Use urgent and emergency services appropriately and notify the member's PCD or clinic within 72 hours of using emergency services in the manner provided in CDC or CCO referral policy;
8. Give accurate information for inclusion in the clinical record;
9. Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
10. Ask questions about conditions, treatments, and other issues related to care that is not understood;
11. Use information provided by CDC providers or care teams to make informed decisions about treatment before it is given;

12. Help in the creation of a treatment plan with the provider;
13. Follow prescribed agreed upon treatment plans and actively engage in their health care;
14. Tell the provider that the member's health care is covered under the OHP before services are received and, if requested, show the provider the Division Medical Care Identification form;
15. Tell the Department or Authority worker of a change of address or phone number;
16. Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child;
17. Tell the Department or Authority worker if any family members move in or out of the household;
18. Tell the Department or Authority worker if there is any other insurance available;
19. Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
20. Pay the monthly OHP premium on time if so required;
21. Assist the CDC or provider in pursuing any third-party resources available and reimburse the CDC the amount of benefits it paid for an injury from any recovery received from that injury; and
22. Bring issues or complaints or grievances to the attention of the CDC or CCO.

Member Grievances and Appeals

Complaints and Grievances

A complaint or grievance is an expression of dissatisfaction a member has about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. Examples include, but are not limited to, access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities.

Members have the right to file complaints. CDC follows OHP guidelines to report and resolve all expressed complaints. CDC encourages both the provider and member to resolve complaints, problems and concerns directly with those involved. Providers should inform the member of the formal complaint process as outlined in the member handbook. ALL complaints should be reported to CDC.

Members (or providers) can contact our member service department to file a verbal complaint or request an OHP complaint form.

Denials, Appeals, Administrative Hearings

If a referral or prior authorization is denied, a written denial letter with appeal and hearing rights will be mailed to the member with a copy to the PCD provider and/or specialist.

Letters sent denying a referral or a prior authorization inform the member he/she has a right to file an appeal. The member can contact CDC or their CCO to request an appeal. Oral requests must be followed up with a written request. Providers can also appeal on behalf of the member with the member's approval to do so.

Appeals
Capitol Dental Care
610 Hawthorne Ave SE, Suite #200
Salem, Oregon 97301
Fax: 503-581-0043
Telephone: CDC Member Services at 1-800-525-6800.
E-Mail: members@capitoldentalcare.com

The denial letter informs the member of the right to request an administrative hearing. The letter advises the member on how to make the request.

Member Benefits

The OHP Plus benefit group is broken into three categories with slightly different benefits: Under 21, pregnant age 21 and older and non-pregnant age 21 and older.

Covered Services

The member benefits include urgent treatment to relieve pain and basic services such as cleaning, fluoride varnish, fillings, extractions, and dentures. Pregnant women and children under 21 are eligible for root canals on back teeth and crowns that are not available to adults 21 and older. A complete listing by ADA Code of what is covered can be found in the OHP Dental Services rules: https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx

Service Limitations and Exclusions

Services that are excluded from or have limited coverage include treatment for: injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws, cosmetic purposes, experimental, TMJ and orthodontics. Charges for missed appointments are not allowed.

Charging for Services Not Covered

Providers must do the following prior to treatment in order to bill an OHP member for any **non-covered** services: Inform the member the service is not covered, provide an estimate of the cost of the service, and explain to the member they are financial responsible for the service. The member must also sign an OHP approved financial waiver; after signature the waiver is only valid for 30 days.

An OHP Client Agreement to Pay for Health Services (financial waiver) is available in multiple languages by searching for form 3165 at:
https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx?wp2131=se:%22client+agreement%22

A member cannot be held financially responsible for a service that is covered by OHP. The difference between a provider's fee for a service and the payment we make to you cannot be charged to the patient. Services that have been denied due to provider error cannot be charged to the patient.

Other Benefits

Transportation: Transportation to dental appointments is the responsibility of the state and the CCOs. Members may contact their Department of Human Services (DHS) caseworker, local Adult and Family Services (AFS) branch or their CCO to arrange transportation or for information about transportation options.

Interpreter Services: Interpreter services for a member's appointment to provide covered benefits can be provided at no charge to the Member. To arrange for interpretation services, call the CDC Member Services Team. Requests for interpreter services may be e-mailed to Interpreter@Capitoldentalcare.com.

Tobacco Cessation: Tobacco cessation is a covered OHP service. Basic treatment includes the following services: Ask — systematically identify all tobacco users. Advise — strongly urge all tobacco users to quit. Assess — measure willingness to attempt to quit using tobacco within the next 30 days. Assist — help with brief behavioral counseling and including prescription of nicotine patches and medications. Arrange — schedule follow-up support or referral to more intensive treatments. Oral Health Providers are expected to participate with Ask, Advise, and Assess. Referrals should be made to the appropriate healthcare provider to Assist and Arrange.

A brief discussion regarding tobacco can help address a patient's concerns and provide support and encouragement to facilitate tobacco cessation efforts. The Oregon Tobacco Quit Line is a free telephone service available to all Oregon residents and offers free information and counseling. For more information regarding the Oregon Tobacco Quit line, you can visit its website at https://www.quitnow.net/oregon.

Phone: 800-QUIT-NOW
Spanish: 877-2NO-FUME
TTY: 877-777-6534

Rules and Guidelines

OHP Rules

The rules governing the OHP program and dental services with OHP can be found at the following link:

DENTAL SERVICES PROGRAM RULES

https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87

Click on the link for Chapter 123

OHP POLICY, RULES AND GUIDELINES

https://www.oregon.gov/oha/hsd/ohp/pages/policies.aspx

CDC Clinical Practice Guidelines

CDC Providers are expected to follow practice guidelines established by their regulatory board and professional associations. CDC has adopted the following evidence based practice guidelines:

- Association of State and Territorial Dental Directors Best Practices
- American Dental Hygienists Association Standards in Practice
- United States Food and Drug Administration Guidelines for Prescribing Dental Radiographs
- American Dental Association Center for Evidence-Based Dentistry Practice Guidelines
- American Association of Pediatric Dentistry Clinical Practice Guidelines and Recommendations
- Oregon Pain Guidance Group Pain Treatment Guidelines
- American Heart Association Guideline for the Prevention of Infective Endocarditis

CDC Seclusion and Restraint and Advance Directive Policies These guidelines can be reached via links at CapitolDentalCare.com.

CDC will not restrict or limit the following activities from its network of providers acting on our Members behalf:

(a) Advising or otherwise advocating for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under this Contract or is subject to Co-Payment;

(b) Providing any and all information a Member needs in order to decide among relevant treatment options;

(c) Advising a Member of the risks, benefits, and consequences of treatment or non-treatment; and

(d) Advising and advocating for a Member's right to participate in decisions regarding the Member's own health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Fraud, Waste & Abuse

CDC providers must comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse in the provision and billing of healthcare services to CDC members.

CDC has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees as outlined in our Fraud, Waste and Abuse Detection and Prevention policy that is available on our web site.

CDC has an obligation to report cases of fraud, waste or abuse to the appropriate regulatory agency.

All suspected provider-related (including subcontractors, employees, providers, or other third-parties) fraud, waste, and abuse, including potential provider overpayments, must be reported to the following units no later than seven (7) days after being made aware of the suspicious case:

Medicaid Fraud Control Unit
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

OHA Program Integrity Audit Unit
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)

Suspected cases of member-related fraud are reported by CDC to the following unit no later than seven (7) days after being made aware of the suspicious case:

DHS Fraud Investigations Unit
PO Box 14150
Salem, OR 97309

Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline

Access Standards

Capitol Dental Care is committed to providing members access to the services that are appropriate and necessary for their dental needs. Additionally, CDC is committed to comply with all regulatory and contractual standards related thereto.

Depending on the member's needs, Providers will adhere to the following timeframe standards in scheduling appointments to provide care:

Routine Care	Within 8 weeks
Urgent Care	Within 1 week
Emergency Care	Within 24 hours
Care for Pregnant Members	Within 4 weeks

Routine: Any service that is not classified as urgent or an emergency, including comprehensive and periodic exams as well as restorative and hygiene procedures.

Emergency: Any service that can become life threatening and, if not attended to immediately, may result in the patient visiting the ER.

Urgent: Any service that is not life threatening but urgent in nature.
Care for Pregnant members: Any routine care type appointment that is recommended for a pregnant patient.

Specialty: Any specialty care type appointment available for a defined service when the intention is to complete a service and refer back to PCD for follow up.

Additionally, CDC will provide services to its members in a way that is accessible relative to the travel time and distance that the member must incur in obtaining those services. CDC has the following standards regarding travel time and distance:

In Urban Areas	30 miles or 30 minutes
In Rural Areas	60 miles or 60 minutes

CDC monitors adherence to and provides information about access standards in several ways, and providers are encouraged to review CDC's Access Standards policy for further details.

Privacy and Security Standards

Healthcare providers must adhere to the Health Insurance Portability and Accountability Act (HIPAA) and ensure their staff is adequately trained in privacy and security.

All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored, physically or electronically. Health information contained in medical or financial records is to be disclosed only to the patient or personal representative unless the patient or personal representative authorizes the disclosure to some other individual or organization, or a court order has been sent to the provider. Health information may only be disclosed to those immediate family members (and to friends participating in the patient's care) with the verbal or written permission of the patient or the patient's personal representative. Health information may be disclosed to other providers involved in caring for the member without the member's or the legal representative's written or verbal permission.

Patients must have access to, and be able to obtain copies of, their medical and financial records from the provider as required by federal law. Information may be disclosed to insurance companies or their representatives for the purposes of quality and utilization review, payment or medical management. Providers may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.

All healthcare personnel who generate, use or otherwise deal with individually identifiable health information must uphold the patient's right to privacy. Extra care shall be taken not to discuss patient information (financial as well as clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care.

Providers' employees (including physicians) must not have unapproved access to their own records or records of anyone known to them who is not under their care.

Physical Access

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

Seclusion and Restraint

Capitol Dental Care (CDC) recognizes that there are circumstances where pediatric and special needs patients may need to be restrained in order to safely deliver quality dental treatment and care. It is the policy of CDC that use of physical restraint is only to be used as a last resort after other methods have failed. In those circumstances where it is the only option, it is critical to build a trusting relationship between the dentist, dental staff, the patient and the parent or guardian.

The term "seclusion" means the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

The term "restraint" means any method of physically restricting or reducing a patient's freedom of movement, physical activity, or normal access to his or her body. Within this policy the terms immobilization and restraint are used interchangeably and when used strictly by the parent or guardian is not considered restraint.

The term "time out" refers to requiring the patient to abstain from social interaction with others and all activities. While CDC understands that a "time out" may be necessary in certain instances for the patient to gain control of emotions, seclusion is never acceptable behavior management in the dental office environment.

CDC requires participating dentists to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations *(42 CFR, 438.100,*

be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation) **and also requires the provider to provide CDC a copy of their policy upon request.**

Please refer to Capitol Dental Care Seclusion and Restraint Policy for more details.

Advance Directives and Declarations for Mental Health Treatment

An advance directive is a written instruction, such as a living will or durable power of attorney for health care, relating to the provision of health care when the individual is incapacitated.

Declarations for Mental Health Treatment are instructions regarding the kind of care a patient wants if they become unable to make decisions.

Dental providers should be aware that their patients may have these instructions in place or they may inquire regarding how to put them in place. Information can be found on the State and most CCO websites, or from their medical or mental health providers.

Name:	**Fraud, Waste, and Abuse Detection and Prevention**
Date of Origin:	**10/23/2002**
Current Effective Date:	**10/20/2021**
Scheduled Review Date:	**10/20/2022**

I. Policy Overview

Capitol Dental Care (CDC) and its employees and subcontractors will comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste, and abuse ("FWA") in the provision of health care services to our members and payment for such services to dental health care practitioners. This policy establishes the plan for fraud, waste, and abuse prevention, detection, and reporting. It applies to all CDC employees and subcontractors. In addition, CDC provides new hires FWA training within 60 days of hire. The FWA training is also provided to existing employees on an annual basis. CDC also distributes to its employees and subcontractors written standards of conduct that promote CDC's commitment to compliance, and those standards address additional areas of potential fraud.

CDC has internal controls and procedures designed to prevent and detect potential fraud, waste, and abuse activities by members, providers, and employees. This plan includes policies and controls in areas such as claims, prior authorization, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and CDC employee education, and corrective action plans to address fraud, waste and abuse activities. Cases of potential FWA as indicated in the Oregon Administrative Rules will be reported to the appropriate regulatory agency. This policy will be reviewed and revised, as necessary, but no less than on an annual basis.

CDC has staff dedicated to implementing the Annual FWA Prevention Plan. CDC has an appointed full time Chief Compliance Officer charged to develop, implement, and oversee compliance effectiveness, the Compliance Plan, and the FWA Program. A Compliance Support employee assists in this effort and reports to the Chief Compliance Officer. The Chief Compliance Officer reports to the CDC President (Chief Executive Officer). CDC's Compliance Committee has been developed with a charter of responsibilities. Members of CDC's senior leadership, including the Chief Compliance Officer, are members of the Compliance Committee.

II. Definitions

Abuse – An activity or practice undertaken by a member, practitioner, employee, or contractor that is inconsistent with sound fiscal, business or dental practices and results in unnecessary cost to reimburse for services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge (or with reckless disregard) that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2). Member fraud may include a member's misuse of a dental card, altering or forging a prescription, theft, or any fraudulent activity committed against CDC or any subcontractor.

Incident - A situation of possible fraud, abuse, neglect, and/or exploitation which has the potential for liability to the State of Oregon, community CCO partners, CDC or subcontractors.

Potential – If, in one's professional judgment, it appears as if an incident of fraud or abuse may have occurred. The standard of professional judgment used would be "**that judgment exercised by a reasonable and prudent person acting in a similar capacity."**

Waste - The extravagant, careless, or unnecessary utilization of or payment for health care services.

III. Federal Laws

As a contractor participating in federal health care programs, CDC is required to comply with the following federal laws:

False Claims Act - The federal civil False Claims Act (FCA") is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid.

Under the statute the terms "knowing" and "knowingly" mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, treating members that pay cash for services different from members that participate in a health plan, unbundling of services (where the law requires the service remain bundled), and up-coding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation, or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $5,500 and not more than $11,000, plus up to three times the amount of damages sustained by the federal government. The United States Department of Justice may also bring criminal charges under FCA in

appropriate circumstances. The criminal provisions of the FCA provide for significant fines and up to 5 years in jail.

Qui Tam and Whistleblower Protection Provisions - The False Claims Act contains a *qui tam*, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government.

A *qui tam* action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has sixty days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim. However, if the government decides not to join, the whistleblower may pursue the action alone, but the government may still join at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent) plus attorneys' fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed, or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest, and compensation for any special damages including attorneys' fees and costs of litigation. Please see CDC's policy on Zero Tolerance for Retaliation in response to reporting misconduct.

Federal Program Fraud Civil Remedies Act Information - The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents, or submits, or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

IV. State Laws

False Claims – Oregon law prohibits a person from (1) presenting, or causing to present, for payment or approval a claim to a public agency that the person knows is a false claim; (2) making or using, in the course of presenting, or causing to present, a claim to a public agency for payment or approval, a record or statement that the person knows is a false claim; (3) agreeing or conspiring with other persons to present for payment or approval a claim to a public agency that the person knows is false; (4) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid, or decrease an obligation to pay a public agency if the person knows that the statement is false or fraudulent; or (5) failing to disclose a false claim to a public agency that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval. The Oregon

Attorney General may bring a civil action against a person that violates this law. If a violation is proven, a court can order the person who violated the law to repay the government for all damages and order a penalty equal to the greater of $10,000 for each violation or an amount equal to twice the amount of damages occurred for each violation.

Public Assistance: Submitting Wrongful Claim or Payment - Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment which has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment which is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C Felony.

Any person who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) The amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Any person who after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

False Claims for Health Care Payments - A person commits the crime of making a false claim for health care payment when the person: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails to disclose to a health care payer the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled. The district attorney or the Attorney General may commence a prosecution under this law and the Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Whistle blowing and Non-retaliation - CDC may not terminate, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported fraud, waste or abuse by any person, has in good faith caused a complainant's information or complaint

to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste, or abuse, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

Racketeering – An individual who commits, attempts to commit, or solicits, coerces, or intimidates another to make a false claim for health care payment may also be guilty of unlawful racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

V. Fraud, Waste, and Abuse Plan Components

CDC's plan to detect and prevent fraud, waste and abuse is comprised of the following components:

Internal Activities and Controls

CDC maintains the following activities and controls within various departments to promote effective utilization of dental resources and/or identify potential fraud, waste, or abuse occurrences (not inclusive):

- Information system edits and audits claims submitted.
- Post payment review of claims and other claims analysis activities.
- Provider credentialing and re-credentialing policies and procedures, including on-site reviews if applicable.
- Provider and utilization profiling.
- Prior authorization policies and procedures (member eligibility verification, review of dental necessity and appropriateness of service requested, and covered service verification).
- Utilization management and prior authorization policies and procedures, including quality improvement committee and peer review, corrective action planning, and provider participation limitations and or termination as applicable.
- Quality improvement practices, as indicated in CDC's Quality Improvement and Monitoring Plan.
- Dental claims review for appropriateness of services and level(s) of care, reasonable charges, and potential under and over utilization.
- As applicable, follow-up and receive recommendations and referrals from committees such as Quality Improvement, and Credentialing related to providers and utilization.
- Provider education regarding potential fraud, waste and abuse occurrences and reporting
- Employee education regarding potential fraud, waste and abuse occurrences, detection and reporting
- Provider notice by letter and or phone, and training either by phone or face-to-face by CDC Member Services staff, if problem identified.
- Monitoring of provider and member complaints and grievances.
- Ask a member as applicable if he/she received the service and level of billed.
- As applicable, apply risk evaluation technologies to monitor compliance and assist in the reduction of identified problem areas.
- Verification of Services – CDC, through its vendor: Performance Health Technology (PH Tech)

sends a **Verification of Services** letter to members who have received services. The mailings occur monthly and are based on a random sampling of 5% of unique members who have paid dates in the previous month. The letter communicates the following:

1) The communication is NOT A BILL for services
2) Recipient name
3) Member ID#
4) Specific services received, showing provider name, service provided, and date(s) of service, paid amount (if any), amount of payment made by DMAP member (if any).
5) A request that the member contacts PH Tech customer service if any of the services listed do not agree with the member's account / record / recall of those services.

The **Verification of Services** letter will not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.

If PH Tech receives a call from a member related to the **Verification of Service** mailing, PH Tech will notify the plan for investigation in accordance with this policy.

CDC will provide to DHS, upon request, verification that DMAP members were contacted to confirm that billed services were provided in accordance with 42 CFR 455.20 and 433.116 (e) and (f).

Reporting Mechanisms and Primary Contact

The CDC Chief Fraud and Abuse Team oversees the investigation of potential fraud, waste and abuse occurrences, and is comprised of the Dental Director, President, and Chief Compliance Officer. (This team is consistent with CDC's senior management Staff).

Employees who interact with providers and members are trained in fraud, waste and abuse detection and reporting. Any potential fraud, waste and abuse occurrence identified by a CDC employee during the course of his/her performance of duties is reported to one of the senior management staff members. That data is maintained in a log, and any investigation that is performed in response to this information is logged in an Investigations Log.

Additionally, CDC provides OHA with several reporting deliverables, as stipulated in the Contract. These include, but may not be limited to, the following:

- Quarterly and annual reports of all audits performed. The Annual FWA Audit Report must include information on any Provider Overpayments that were recovered, the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by Contractor on its Subcontractors or Providers.
- An annual summary report of Referrals and cases investigated
- All suspected cases of FWA, including suspected Fraud committed by its employees, Providers, Subcontractors, Members, or any other third parties are reported to OHA's Program Integrity Audit Unit and DOJ's Medicaid Fraud Control Unit (MFCU) within seven days.
- Regardless of CDC's own suspicions or lack thereof, to the MFCU, a report of an incident with any of the characteristics listed in Section 16 of the Contract, Exhibit. B, Part 9

- Quarterly and annual Financial Reports required under section 1, paragraph a., subparagraph (2) of Exhibit L, all Overpayments, identified or recovered regardless of whether the Overpayments were the result of (i) self-reporting under subparagraphs (15) and (16) above of paragraph b. section 11, Exhibit B Part 9, or (ii) the result of a routine or planned audit or other review.

Timeliness standards for these deliverables and other notices are outlined in the Contract.

Applicability of the Plan to Contractors and Subcontractors

CDC and subcontractors are required to comply with these policies and procedures. CDC will promote Contractor and Subcontractors compliance with these policies and procedures which:

(a) Promote the Contractor's commitment to compliance;

(b) Address specific areas of potential fraud, such as claims submission process, and financial relationships with its Subcontractors;

(c) Provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b.

(d) Provide as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse; and

(e) Include in any employee handbook for the Contractor, a specific discussion of the laws described in subsection (c) of this section, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

VI. Reporting Suspected Fraud, Waste or Abuse

Each CDC employee has an obligation to report suspected fraud, waste, or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, provider, or member. When an employee suspects fraud, waste or abuse, such employee should complete a Fraud & Abuse Incident Referral Form (use only if the alleged activity involves a member or a provider). Any potential fraud, waste and abuse occurrence identified by a CDC employee during the course of performing CDC duties is initially reported to the department supervisor. The department supervisor or the employee, with the supervisor's guidance, completes a Member Fraud & Abuse Incident Referral Form (Attachment A) or a Provider Fraud & Abuse Incident Referral Form (Attachment B) and sends the respective form to the Chief Compliance Officer for review.

VII. Fraud, Waste and Abuse Investigations

When acting within the scope of this policy, designated CDC personnel have the right to access applicable records necessary to audit or conduct an investigation into allegations of fraud, waste, or abuse. This right to audit or inspect may extend to information subject to attorney-client privilege.

The following summary provides a general overview of the steps typically taken when CDC receives a report of suspected fraud, waste or abuse, though additional steps may be necessary depending upon the circumstances of each case. CDC promptly responds to all detected fraud, waste and abuse offenses.

Members - Upon receipt of an internal member Fraud & Abuse Incident Referral Form (See Attachment A) or other communication, the CDC Fraud and Abuse Team:

(a) Reviews member demographic database information (county of residence, eligibility segments).

(b) Reviews member claims history for a period not less than 12 months previous to month of receipt of referral.

(c) Obtains necessary information based upon the appropriate category of the referral. This may include claims history, dental records, customer service, complaint management, professional relations, or management as circumstances warrant) or obtaining necessary information from outside sources as warranted.

(d) Performs determined necessary audit steps of encounters, billing, medical/dental procedure coding or other information as circumstances warrant to develop data for further analysis and decision.

(e) Review case file information and make referral assessment decision. If the circumstances and data warrant referral, the CDC Fraud and Abuse Team will forward to appropriate state or federal regulatory agencies, or forward OHP plan information to the OMAP Medicaid Fraud Control Unit, the Provider Audit Unit or the appropriate state or federal regulatory agency or CCO community partner. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will be included in the file and the case will be closed.

(f) Provides feedback to originator and management, as appropriate.

Practitioners - Upon receipt of internal practitioner Fraud & Abuse Incident referral Form (See Attachment B) or other communication, the CDC Fraud and Abuse Team:

(a) Reviews provider data base information (county of practice, provider ID#, tax ID#, contract status, provider type/specialty).

(b) Reviews practitioner contract, if applicable.

(c) Reviews practitioner claims history/reconciliation report for a period not less than 12 months previous to month of receipt of referral.

(d) Obtains necessary information based upon the issue/incident raised (such as dental abuse or financial/billing/ encounters, coding abuse). This may include contacting others for relevant information or discussion (dental review, quality improvement, professional relations' practitioner file, customer service, office managers, directors or senior management as circumstances warrant). In addition, the CDC Fraud and Abuse Team may obtain necessary information from outside sources as warranted under the circumstances.

(e) Performs appropriate audit steps of encounters, billing, medical/dental procedure coding or other information as circumstances warrant to develop data for further analysis and decision.

(f) Reviews assembled case file information and make decision regarding the appropriate course of action based upon the facts (e.g., provide billing education to provider's office, put provider on focus review, terminate contract etc.). If circumstances and data warrant referral to an external agency, the CDC Fraud and Abuse Team will forward information to appropriate state or federal regulatory agencies, and will forward OHP plan information to the DHS Audit Unit or other appropriate regulatory agency. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will be included in the file and the case will be closed.

(g) Provides feedback to originator and management, as appropriate.

Employees and Subcontractors – If an employee suspects that another CDC employee or a CDC Subcontractor has engaged in fraud, waste or abuse, the individual should immediately report the incident to their Supervisor, or Senior Management. The CDC Fraud and Abuse Team is responsible for the investigation and reporting of cases of fraud, waste and abuse committed by CDC employees and subcontractors. Appropriate disciplinary action, up to and including immediate termination of employment, is taken against employees who have violated CDC Fraud, Waste and Abuse policies, applicable statutes, regulations, or Federal or State health care program requirements. In accordance with CDC's policies relating to subcontractors, CDC will ensure that appropriate disciplinary action, up to and including immediate termination of the relationship, is enforced against subcontractors who violate CDC's fraud and abuse policies, applicable statutes, regulations or Federal or State dental care program requirements.

Corrective Action– As necessary based on the outcome of a fraud, waste and abuse investigation, CDC will correct any identified system problems.

VIII. Confidentiality of Investigation

Information identified, researched or obtained for or as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants in the investigation of a potential fraud, waste, and abuse occurrence is maintained solely for this specific purpose and no other. CDC assures the anonymity of complainants to the extent permitted by law. CDC is responsible for maintaining the confidentiality of all potential fraud, waste, and abuse information identified, researched or obtained, in accordance with the terms and conditions of CDC' Confidentiality Policy.

IX. Coordination with External Agencies

The CDC Fraud and Abuse Team coordinates all information requests and reporting, whether initiated internally or externally. CDC promptly refers all suspected cases of fraud, waste and abuse by groups, members, practitioner and employees of the organization to the appropriate regulatory agencies for further investigation. In addition, CDC assists various governmental agencies as practical in providing information and other resources during the course of investigations of potential practitioner or member fraud or abuse. These agencies include, but are not limited city, county, state and federal agencies; the OHA Provider Audit Unit, the Medicaid Fraud Control Unit of the Oregon Attorney Generals' Office, CCO community partners, as applicable and the United States Office of the Inspector General.

X. Suspended, Debarred and Excluded Practitioners

Participating practitioner contracts stipulate practitioner responsibilities to comply with all applicable Federal, State and local laws, rules and regulations, to maintain and furnish records and documents as required by law. Practitioners who are found to have violated a state or federal law regarding fraud, waste and abuse or are suspended, debarred or excluded from participation in federal programs will have the practitioner's participating provider agreement with CDC.

Except in very limited circumstances (i.e., provision of emergency services, sole source provider), the following individuals or entities may not be reimbursed from federal funds for otherwise covered services provided to CDC members:

1. Practitioners who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to any executive order or under guidelines implementing such order;

2. Persons or entities who are currently suspended or terminated from MAP or excluded from participation in the Medicare program; or

3. Persons who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII or XX of the Social Security Act and/or related laws (or entered a plea of nolo contendere).

CDC does not refer members to such suspended or terminated practitioners and does not accept billings for services to CDC members submitted by such practitioners.

XI. Periodic Review of Policies and Procedures

CDC shall review its fraud, waste and abuse policies at least annually and will submit any such revised policies to the Department of Human Services, Division of Medical Assistance Programs, Medical Section, Quality Assurance and Improvement Unit on or before March 15th of the current contracted calendar year. CDC will also review and revise these policies and procedures to address problems in any risk evaluation techniques or internal controls.

XII. Revision Activity

Modification Date	Change or Revision and Rationale	**Effective** Date of Policy Change
12/15/2007	Annual Update	01/01/2008
02/17/2010	Annual Update	05/01/2010
05/01/2011	Annual Review	05/01/2011
09/30/2011	Update	9/30/2011
02/06/2012	Update	02/06/2012
6/26/2013	Annual Review Scheduled	6/26/2013
11/13/2014	Annual Update	11/13/2014
11/12/2015	Annual Update	10/28/2015
10/26/2016	Annual Update	10/26/2016
1/18/2018	Annual Update	1/18/2018
2/18/2019	Review	2/18/2019
2/18/2020	Review	2/18/2020
2/10/2021	Review and Update	2/10/2022
10/11/2021	Revision	10/20/2021

XIII. Affected Departments:

All CDC Employees and Contractors

XIV. References:

Employee Handbook
CDC Deficit Reduction Act False Claims Act Notification
Employee and Contractor False Claims Act Policies and Procedures
Zero Tolerance Policy in response to retaliation for reporting misconduct.

Provider Contracts
False Claims Act
OAR 410-120-1380