PROFESSIONAL SERVICES AGREEMENT # 21/22-002
TILLAMOOK COUNTY AND TILLAMOOK FAMILY DENTAL
FOR FQHC OREGON HEALTH PLAN MEDICAID AND NON-INSURED DENTAL SERVICES

This Professional Services Agreement, hereafter "agreement" is entered into by and between TILLAMOOK FAMILY DENTAL, hereafter "contractor", and Tillamook County, a political subdivision of the State of Oregon, hereafter "county", pursuant to ORS 203.010, through the Tillamook County Health Department, Community Health Center (CHC), a Federally Qualified Health Center (FQHC). County and contractor intend to contract for providing access to dental services to all Oregon Health Plan (OHP) and uninsured patients residing in CHC's federally approved area and who are registered patients of the CHC. The mutual promises of each are given in exchange and as consideration for, the promises of the other.

COUNTY AND CONTRACTOR MUTUALLY COVENANT AND AGREE AS FOLLOWS:

1. AGREEMENT

Contractor promises to provide, and county promises to pay for, the services described below according to the provisions of this agreement. Contractor and county further agree that funding for this project is subject to the availability of grant funding and/or legislative appropriation of such funds. Therefore, county reserves the right to reduce the amount of funding for this project with notice, based on reductions in grant funding to county. Upon submission of approved invoices, county will reimburse contractor for expenses of services outlined in this agreement. County will not reimburse contractor for any additional out of pocket expenses associated with this project and any such expenses incurred by contractor in connection with this project shall be contractor's sole responsibility.

2. AGREEMENT PRICE AND AMOUNT

The price for the services provided by contractor shall be:

- One Hundred Sixty-Five and 00/100 Dollars ($165.00) per encounter for one (1) to sixty-four (64) dental patients per month;
- Seventeen Thousand Five Hundred and 00/100 Dollars ($17,500.00) per month with a minimum of sixty-five (65) to one hundred (100) dental patient encounters per month;
- Twenty-Two Thousand and 00/100 Dollars ($22,000.00) per month with a minimum of one hundred one (101) to one hundred twenty-five (125) dental encounters per month;
- Twenty-Six Thousand and 00/100 Dollars ($26,000.00) per month with a minimum of one hundred twenty-six (126) to one hundred fifty (150) dental patient encounters per month;
- Thirty Thousand and 00/100 Dollars ($30,000.00) per month with a minimum of one hundred fifty-one (151) to one hundred seventy-five (175) dental encounters per month;

- Thirty-Four Thousand and 00/100 Dollars ($34,000.00) per month with a minimum of one hundred seventy-six (176) to two-hundred (200) dental encounters per month;
- Thirty-Eight Thousand and 00/100 Dollars ($38,000.00) per month with a minimum of two hundred one (201) to two hundred twenty-five (225) dental encounters per month;
- Forty-Two Thousand and 00/100 Dollars ($42,000.00) per month with a minimum of two hundred twenty-six (226) to two hundred fifty (250) dental encounters per month;
- Forty-Five Thousand Five Hundred and 00/100 Dollars ($45,500.00) per month with a minimum of two hundred fifty-one (251) to two hundred seventy-five (275) dental encounters per month;
- Forty-Nine Thousand and 00/100 Dollars ($49,000.00) per month with a minimum of two hundred seventy-six (276) to three hundred (300) dental encounters per month;
- Fifty-Two Thousand Five Hundred and 00/100 Dollars ($52,500.00) per month with a minimum of three hundred one (301) to three hundred twenty-five (325) dental encounters per month;
- Fifty-Six Thousand and 00/100 Dollars ($56,000.00) per month with a minimum of three hundred twenty-six (326) to three hundred fifty (350) dental encounters per month;
- Fifty-Nine Thousand Five Hundred and 00/100 Dollars ($59,500.00) per month with a minimum of three hundred fifty-one (351) to three hundred seventy-five (375) dental encounters per month;
- Sixty-Three Thousand and 00/100 Dollars ($63,000.00) per month with a minimum of three hundred seventy-six (376) to four hundred (400) dental encounters per month;
- These amounts and the related numbers of dental encounters may be reviewed at least every three (3) months from the date of execution of this agreement to determine appropriate cost for services, or anytime at the request of contractor or county.

3. AGREEMENT TERM

The term or period of this agreement shall begin July 1, 2021 and end June 30, 2022.

4. AGREEMENT DOCUMENTS

The following documents comprise the agreement and are incorporated herein by reference in their entirety.

4.1. This agreement;

4.2. Exhibit A: ODS OHP Dental Provider Handbook, or most current as updated by ODS and/or OHA;

4.3. Exhibit B: OHP Client Agreement Waiver;
4.4. Exhibit C: Dental Encounter Form;
4.5. Exhibit D: Cultural and Linguistic Policy;
4.6. Exhibit E: Chronic Pain Management;
4.7. Exhibit F: HIPAA Business Associate Agreement; and
4.8. Statutory Public Contract Provisions.

5. TERMINATION

5.1. WITHOUT NOTICE
This agreement shall terminate without any requirement of notice to either party when the first of the following events occurs:
5.1.1. The parties mutually consent to termination in writing.
5.1.2. The agreement term ends.
5.1.3. The moment prior to contractor filing for the settlement of debts or any debt restructuring in any state, federal or other court of competent jurisdiction.
5.1.4. When contractor's proposed agreement price adjustments exceed agreement specifications.

5.2. WITH NOTICE
This agreement may also end and notice shall be served as required when:
5.2.1. Any party breaches any duty, term or condition of this agreement.
5.2.2. Either party commits a fraud or misrepresentation upon the other party.
5.2.3. Public funds are no longer available to support this agreement.
5.2.4. Either party gives thirty (30) days written notice.

GENERAL PROVISIONS

6. STATUS OF CONTRACTOR

The parties intend that contractor, in performing the services specified in this agreement, shall act as an independent contractor.

6.1. Contractor is an individual licensed to perform dentistry under State of Oregon Statute 670.020, meets the applicable provisions thereunder, and is not the subject of any Medicaid/Medicare related actions, suspensions, exclusions or debarments that would disqualify him or her from providing services under this agreement.

6.2. COVERED SERVICES: Contractor agrees to provide dental services consistent with OHP Covered Services, as of the time-of-service provision, to participating patients. The most current ODS OHP Dental

Provider Handbook for Covered and Non-Covered services is attached for reference as Exhibit A. Contractor is responsible for checking for updated covered services by contacting CHC dental staff. Additionally, current services can be verified by calling ODS Customer Services at 1-800-452-1058. CHC is responsible for contacting contractor to make initial appointments for participating patients, and for verifying insurance coverage prior to the appointment, contractor is responsible for notifying CHC if the patient's appointment has been changed by dental office; all appointments need to be made or changed by CHC. Notwithstanding, CHC is under no obligation to utilize contractor to provide dental services to any or all participating patients who require such services.

6.3. DESCRIPTION OF SERVICES: Contractor agrees to establish and maintain dental records that will contain descriptions of any dental services provided to participating patients, as well as proposed follow-up treatment plans for subsequent visits (if any). The descriptions of the services will be made using American Dental Association CDT-3 Standard Claims Codes and will include the contractor's customary charge for each service provided. In the event that such records are housed in a location other than the health center facility, CHC shall have reasonable and timely access to such records.

6.4. SPECIAL SERVICES: For dental services needing individual consideration or prior approval from CHC, contractor must provide CHC with documentation necessary to seek or provide such approval and may not render such services until CHC notifies contractor that approval has been obtained.

6.5. AGREEMENT NOT TO CHARGE PATIENTS: The parties agree that all participating patients receiving services from contractor pursuant to this Agreement shall be considered patients of CHC. All CHC patients that are referred to contractor should be provided treatment regardless of the patient's insurance coverage. Patient's coverage status will not be divulged to contractor by CHC. Accordingly, CHC shall be responsible for the billing of such patients, as applicable, as well as the billing of Federal, State and private payors, and the collection and retention of any and all payments. Contractor agrees not to bill, charge or collect from participating patients or payors any amount for any dental services provided under this agreement. If contractor should receive any payment from participating patients or payors for services provided hereunder, contractor agrees to remit such payment to CHC within ten (10) days of receipt. If services are services not covered an Appeal is denied, and the participating patient requests services by contractor under a payment plan, a waiver must be signed and received by CHC

prior to scheduling subsequent appointments to provide said services. Patients who enter into a contract with contractor need to be advised that the patient may seek dental services from a dental provider of their choice prior to signing an agreement with contractor, and patient will sign a waiver of understanding that services provided by contractor are not covered services through CHC, incorporated and attached as Exhibit B.

6.6. OVERSIGHT AND EVALUATION OF SERVICES BY CHC:

6.6.1. CHC, through its governing Community Health Council, Board of County Commissioners, its Administrator, Dental Director, and Dental Care Organization, shall, consistent with the Council and Board's authorities and CHC's federally-approved scope of project (as approved by Bureau of Primary Health Care (BPHC)), establish and implement clinical and personnel policies and procedures relevant to the provision of services by contractor pursuant to this Agreement (e.g., qualifications, and credentials, clinical guidelines, standards of conduct, quality assurance standards, productivity standards, patient and provider grievance and complaint procedures, and peer review). Notwithstanding, nothing herein is intended to interfere with contractor's professional judgment in connection with the provision of such services.

6.6.2. CHC, through its Administrator and/or Medical Director, shall retain and exercise ultimate authority and responsibility for the services provided to participating patients pursuant to the Agreement, consistent with the policies, procedures and standards set forth above. In particular, CHC shall retain ultimate authority over the following:

6.6.2.1. Determination as to whether contractor meets CHC's qualification and credentials, consistent with Section 6.1 of this agreement;

6.6.2.2. Interpretation of CHC's health care, personnel and other policies and procedures, clinical guidelines, quality assurance standards, productivity standards, standards of conduct and provider and patient grievance and complaint resolution procedures, and their applicability to contractor; and

6.6.2.3. Determination with respect to whether contractor is performing satisfactorily and consistent with CHC's policies, procedures, and standards, in accordance with this Section.

6.6.3. Contractor shall, as soon as reasonably practicable, notify CHC of any action, event, claim, proceeding, or investigation (including, but not limited to, any report made to the National Practitioner Data Bank) that could result in the revocation, termination, suspension, limitation, or restriction of contractor's licensure, certification, or qualification to provide such services. CHC may suspend this agreement, until such time as a final determination has been made with respect to the applicable action, event, claim, proceeding, or investigation.

6.7. NO OBLIGATION TO REFER AND NON-SOLICITATION OF PATIENTS:

6.7.1. It is specifically agreed and understood between the parties that nothing in this Agreement is intended to require, nor requires, nor provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party.

6.7.2. Contractor agrees that during the term of this agreement, he or she shall not, directly or indirectly, solicit or attempt to solicit or treat, for contractor's or her own account or for the account of any other person or entity, through a written agreement or otherwise, any patient of CHC seeking covered services.

6.8. CONTRACTS WITH OTHERS: CHC retains the authority to contract with other dentists or dental practices, if, and to the extent that, CHC's Administrator reasonably determines that such contracts are necessary in order to implement the CHC Board's policies and procedures, or as otherwise may be necessary to assure appropriate collaboration with other local providers to enhance patient freedom of choice, and/or to enhance accessibility, availability, quality and comprehensiveness of care.

6.9. REFUSAL TO PROVIDE SERVICES. Should any participating patient, who has a history of breaking appointments with contractor without good cause (as determined by contractor), or who has behaved in a disruptive or grossly discourteous manner towards contractor, contractor's employees or other patients, contractor must promptly report all such instances to CHC. The CHC will address concerns with the participating patient and/or will notify the participating patient that, unless the participating patient corrects such behavior immediately, he or she may no longer be eligible to receive dental services from contractor. In such a case, upon notification from CHC, contractor has no obligation to provide further services for that participating patient.

6.10. The compensation provided herein shall be exclusive and county shall neither pay nor provide contractor with any fringe benefits, including, but not limited to, retirement, health insurance, Workers' Compensation insurance, unemployment insurance or sick leave. No additional compensation or alternate form thereof shall be payable by county to contractor for any purpose whatsoever unless otherwise agreed in writing. Contractor shall be responsible for paying all income taxes, Social Security or self-employment taxes, or any other taxes or assessments imposed by any governmental body incurred by reason of county's payment of compensation hereunder to contractor. County will report the total amount of all payments to contractor, including any expense, in accordance with Federal Internal Revenue Service and State of Oregon Department of Revenue regulations.

6.11. This agreement is personal as to contractor and contractor may not subcontract any portion of the services to be performed hereunder without the prior written approval of county; provided nothing herein shall prohibit any other consultants employed by contractor or in a firm of which he shall be a member to assist contractor in carrying out the responsibilities herein.

6.12. This agreement is not a contract of employment. The parties intend that contractor, in performing the services specified herein, shall be and act as an independent contractor and shall have professional control of the work and the manner in which it is performed. Contractor shall have the sole authority to determine the manner and means of performing the services described herein and county shall not interfere with, control or direct the manner or method in which such services are performed; provided, county shall direct contractor as to the work to be assigned and shall have the right to direct the required results to the extent such direction may be consistent with the nature of contractor's services. Except as otherwise expressly provided herein and except for the purposes of the Oregon Tort Claims Act, ORS 30.265, contractor shall not be considered an agent of county.

6.13. Contractor shall be responsible for and has obtained or shall obtain and maintain all necessary professional licenses and professional liability insurance, as required by law.

6.14. In the event contractor's labor or services shall be performed by contractor's employees, such employees shall be and at all times remain the employees of contractor, under the contractor's sole and exclusive control and shall not be deemed employees of county for any purpose.

6.15. Contractor is an independent contractor for purposes of the Workers' Compensation Law (ORS Chapter 656) and unemployment insurance.

6.15.1 Contractor is solely liable for any Workers' Compensation coverage under this agreement. If contractor has the assistance of other persons in the performance of this agreement, contractor shall qualify and remain qualified for the term of the agreement as an insured employer under ORS 656.407. If contractor performs this agreement without the assistance of any other persons, contractor shall execute a Joint Declaration with county's Workers' Compensation carrier absolving county of any and all liability as provided in ORS 656.029.

6.15.2. If contractor is a subject employee for Workers' Compensation or unemployment insurance purposes, contractor shall provide such Workers' Compensation and unemployment coverage benefits at contractor's sole cost and expense and shall provide proof of such insurance and benefits at county's request.

6.16. Contractor represents that he has filed federal and state income tax returns (a) in contractor's business name or (b) on a business Schedule C as part of contractor's personal income tax returns, if contractor provided consulting services as an independent contractor during the previous calendar year.

6.17. Contractor represents that he is customarily engaged in an independently established business. To that end, contractor represents that at least three (3) of the following apply to contractor's business (initial those that apply):

6.17.1. ____ Contractor maintains a business location that is separate from the business or work location of the person for whom the services are provided or that is in a portion of contractor's residence and that portion is used primarily for the business.

6.17.2. ____ Contractor bears the risk of loss related to the business or the provision of services as shown by factors such as: Contractor enters into fixed price contracts; contractor is required to correct defective work; contractor warrants the services provided; or contractor negotiates indemnification agreements or purchases liability insurance, performance bonds or errors and omissions insurance.

6.17.3. ____ Contractor provides contracted services for two (2) or more different persons within a twelve (12) month period, or contractor routinely engages in business advertising solicitation or other marketing efforts reasonably calculated to obtain new contracts to provide similar services.

6.17.4. ___ Contractor makes a significant investment in the business, through means such as: purchasing tools or equipment necessary to provide the services; paying for the premises or facilities where the services are provided; or paying for licenses, certificates or specialized training required to provide the services.

6.17.5. ___ Contractor has the authority to hire other persons to provide or to assist in providing the services and has the authority to fire those persons.

7. NON-DISCRIMINATION

Contractor agrees to provide dental services to participating patients in the same professional manner and pursuant to the same professional standards as generally provided by contractor to contractor's or her patients, regardless of an individual's or family's ability to pay for services rendered. This section shall not be read to prevent contractor from limiting the number of hours and/or days during which contractor agrees to see participating patients, provided that such limitation shall not be based on a participating patient's payor source or insurance status. Contractor also agrees not to differentiate or discriminate in the provision of services provided to participating patients on the basis of race, color, religious creed, age, marital status, national origin, alienage, sex, blindness, mental or physical disability or sexual orientation pursuant to Title 45 of the Code of Federal Regulations. Contractor shall comply with all applicable federal, state and local laws, rules and regulations on non-discrimination in employment because of race, color, ancestry, national origin, religion, sex, marital status, age, medical condition or disability.

8. NOTICES

Any notice required or permitted under this agreement shall be in writing.

8.1. Notices shall be deemed given when:

8.2. Personally delivered, or

8.2.1 Three (3) days after deposit in United States certified mail, postage prepaid, addressed to the other party at their last known address.

8.3. Notices, bills and payments sent by mail should be addressed as follows:

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TILLAMOOK COUNTY AND TILLAMOOK FAMILY DENTAL
FOR FQHC OREGON HEALTH PLAN MEDICAID AND NON-INSURED DENTAL SERVICES

COUNTY:	Tillamook County Attn: Marlene Putman 201 Laurel Avenue Tillamook, Oregon 97141 503-842-3922 mputman@co.tillamook.or
CONTRACTOR:	Tillamook Family Dentistry Dr. Jin Ahn 2503 Hwy 101N Tillamook, Oregon 97141 503-815-1777 jinlee1111@yahoo.com

9. STATUTORY PUBLIC CONTRACT PROVISIONS

Contractor shall comply with the statutory public contract provisions as more particularly set forth herein.

10. CONFLICT OF INTEREST

Contractor covenants that he presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of contractor's services. Contractor further covenants that in the performance of this agreement no person having any such interest shall be employed.

11. RECORDS

Contractor shall create and maintain records in accordance with generally accepted standards of contractor's practice and the records requirements of county. The records shall remain the property of county and be made available to county upon request. Contractor shall exercise due care to maintain the confidentiality of client records in accordance with law.

12. CONSTRAINTS

This agreement is expressly subject to the debt limitations of the Oregon Constitution set forth in Article XI, Section 10 and is contingent upon funds being available and appropriated therefore. Any provisions of this agreement which would conflict with law are deemed inoperative to that extent.

13. INTEGRATION

This agreement supersedes all prior oral or written agreements between contractor and county regarding this project. It represents the entire agreement between the parties.

Time is of the essence in all terms, provisions, covenants and conditions in this agreement.

14. SAVINGS

Should any clause or section of this agreement be declared by a court to be void or voidable, the remainder of this agreement shall remain in full force and effect.

15. WAIVER; MODIFICATION

Failure by county to enforce any provision of this agreement does not constitute county's continuing waiver of that provision, any other provision or of the entire agreement. The rights and duties under this agreement shall not be modified, delegated, transferred, or assigned, except upon the written, signed consent of both parties.

16. LIABILITY; INDEMNIFICATION

County has relied upon the professional ability, qualifications and training of contractor as a material inducement to enter into this agreement. Contractor warrants that all of contractor's services will be performed in accordance with generally accepted professional practices and standards as well as the requirements of applicable federal, state and local laws, it being understood that acceptance of contractor's work by county shall not operate as a waiver or release of any claim. Contractor shall defend, indemnify and hold harmless county, its officers, agents and employees from any claims, liabilities, demands, damages, actions or proceedings, arising from or relating to the professional negligence of contractor in connection with the performance of any services hereunder. **Minimum limits required for professional malpractice is $1,000,000.** Notwithstanding the foregoing, where applicable, contractor shall be deemed an agent of county, for the sole purposes of a tort liability pursuant to the Oregon Tort Claims Act, ORS 30.265.

Contractor shall provide a certificate of coverage at the time of execution of this agreement, indicating proof of insurance coverage with limits not less than the following:

Property Damage:	$1,000,000 (one claimant) $2,000,000 (all claimants)
Personal Injury or Death:	$2,000,000 (one claimant) $2,000,000 (all claimants)
Professional Liability/ Errors and Omissions:	$1,000,000

Such insurance shall be on an occurrence basis only and be evidenced by a Certificate of Insurance provided to the county, indicating coverages, limits and effective dates, by an insurance company licensed to do business in the State of Oregon. An endorsement shall be issued by the company showing the county as an additional insured

on all coverages, excepting medical/professional malpractice insurance. The endorsement shall also contain a notice of cancellation provision.

17. JURISDICTION; LAW

This agreement is executed in the State of Oregon and is subject to Tillamook County and Oregon law and jurisdiction. Venue shall be in Tillamook County, Oregon, unless otherwise agreed by the parties.

18. LEGAL REPRESENTATION

In entering into this agreement, each party has relied solely upon the advice of their own attorney. Each party has had the opportunity to consult with counsel. Each party represents and warrants to the other that they are fully satisfied with the representation received from their respective attorneys.

19. ATTORNEYS' FEES

Attorneys' fees, costs and disbursements necessary to enforce this agreement through mediation, arbitration and/or litigation, including appeals, shall be awarded to the prevailing party, unless otherwise specified herein or agreed.

20. LANGUAGE

The headings of the agreement paragraphs are intended for information only and shall not be used to interpret paragraph contents. All masculine, feminine and neuter genders are interchangeable. All singular and plural nouns are interchangeable, unless the context requires otherwise.

21. SUBCONTRACTING

Any subcontract ad infinitum of this agreement shall express the GENERAL PROVISIONS section of this agreement or incorporate it by reference.

ACKNOWLEDGEMENT:

EACH PARTY REPRESENTS TO THE OTHER BY THEIR SIGNATURES BELOW THAT EACH HAS READ, UNDERSTANDS AND AGREES TO ALL COVENANTS, TERMS AND CONDITIONS OF THIS AGREEMENT. EACH PARTY REPRESENTS TO THE OTHER TO HAVE THE ACTUAL AND/OR APPARENT AUTHORITY TO BIND THEIR RESPECTIVE LEGAL PERSONS, CORPORATE OR OTHERWISE, IN CONTRACT.

Approved as to form and content this 11th day of August, 2021.

Rachel Hagerty
Contract Officer

PROFESSIONAL SERVICES AGREEMENT # 21/22-002
TILLAMOOK COUNTY AND TILLAMOOK FAMILY DENTAL
FOR FQHC OREGON HEALTH PLAN MEDICAID AND NON-INSURED DENTAL SERVICES

DATED this 11 day of August, 2021.

CONTRACTOR: TILLAMOOK FAMILY DENTISTRY

Tillamook Family Dentistry
Dr. Jin Ahn
2503 Hwy 101N
Tillamook, Oregon 97141
503-815-1777
jinlee1111@yahoo.com

DATED this 11 day of August, 2021.

THE BOARD OF COMMISSIONERS
FOR TILLAMOOK COUNTY, OREGON

	Aye	Nay	Abstain/Absent
Mary Faith Bell, Chair	___	___	___/___
David Yamamoto, Vice-Chair	___	___	___/___
Erin D. Skaar, Commissioner	___	___	___/___

ATTEST: Tassi O'Neil,
County Clerk

By: _____
Special Deputy

APPROVED AS TO FORM:

_____
Joel W. Stevens
County Counsel

PROFESSIONAL SERVICES AGREEMENT # 21/22-002
TILLAMOOK COUNTY AND TILLAMOOK FAMILY DENTAL
FOR FQHC OREGON HEALTH PLAN MEDICAID AND NON-INSURED DENTAL SERVICES

STATUTORY PUBLIC
CONTRACT PROVISIONS

1. Contractor shall pay promptly, as due, all persons supplying labor or materials for the prosecution of the work provided for in the contract and shall be responsible for such payment of all persons supplying such labor or material to any sub-contractor. If contractor fails, neglects or refuses to make prompt payment of any claim for labor or materials furnished to the contractor or a sub-contractor by any person in connection with the contract as such claim becomes due, the owner may pay such claim to the persons furnishing the labor or materials and charge the amount of payment against funds due or to become due contractor by reason of the contract. The payment of a claim in the manner authorized hereby shall not relieve the contractor or contractor's surety from contractor's or its obligation with respect to any unpaid claim. If the owner is unable to determine the validity of any claim for labor or materials furnished, the owner may withhold from any current payment due contractor an amount equal to said claim until its validity is determined and the claim, if valid, is paid.

2. Contractor shall promptly pay all contributions or amounts due the Industrial Accident Fund from such contractor or sub-contractor incurred in the performance of the contract and shall be responsible that all sums due the State Unemployment Compensation Fund from contractor or any sub-contractor in connection with the performance of the contract shall promptly be paid.

3. Contractor shall not permit any lien or claim to be filed or prosecuted against the owner on account of any labor or materials furnished and agrees to assume responsibility for satisfaction of any such lien so filed or prosecuted.

4. Contractor and any sub-contractor shall pay to the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.

5. If this contract involves lawn and landscape maintenance, contractor shall salvage, recycle, compost or mulch yard waste material at an approved site, if feasible and cost effective.

6. Contractor shall promptly, as due, make payment to any person, co-partnership, association, or corporation furnishing medical surgical and hospital care or other needed care and attention, incident to sickness or injury, to employees of such contractor, of all sums which the contractor agrees to pay for such services and all monies and sums which the contractor collected or deducted from the wages of employees pursuant to any law, contract or agreement for the purpose of providing or paying for such service.

7. Contractor shall employ no person for more than ten (10) hours in any one (1) day, or forty (40) in any one (1) week, except in cases of necessity, emergency or where public policy absolutely requires it.

   Contractor's employees shall be paid at least time and one-half (1 and 1/2) for all overtime worked in excess of forty (40) hours in any one (1) week, except for individuals under Personal Services Contracts who are excluded under ORS 653.010 to 653.261 or under 29 USC 201 to 209 from receiving overtime.

   Persons employed by contractor shall receive at least time and one-half (1 and 1/2) pay for work performed on legal holidays specified in a collective bargaining agreement or in ORS 279C.540(1)(b)(B) to (G) and for all time worked in excess of ten (10) hours in any one (1) day or in excess of forty (40) hours in any one (1) week, whichever is greater.

8. The contractor must give notice to employees who work on this contract in writing, either at the time of hire or before commencement of work on the contract, or by posting a notice in a location frequented by employees, of the number of hours per day and the days per week that the employees may be required to work.

9. Contractor must give notice to employees, in writing, that they cannot be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of a law, rule, or regulation related to a Federal contract or grant.

10. All employers working under the contract are either subject employers who will comply with ORS 656.017 or employers that are exempt under ORS 656.126.

11. The contract may be cancelled at the election of owner for any willful failure on the part of contractor to faithfully perform the contract according to its terms.

EXHIBIT A

2017 ODS OHP Dental Provider Handbook

A guide for dental office staff

moda

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WELCOME TO OUR NETWORK OF MEDICAID (OHP) DENTISTS

First and most importantly, thank you for your participation in the ODS OHP Dental Provider network. The services that you provide ODS members directly impact the improved health of our fellow citizens of Oregon. Your services help them obtain not just a healthy mouth but also a healthy body.

The information in this handbook is intended to assist you in your interactions with ODS OHP and answer many of the questions we receive on an ongoing basis. Once you have had a chance to review this handbook, we welcome your comments and suggestions to improve it and make it your one-stop resource.

ODS offers OHP Plus Dental Plans to members residing in the following counties. Dentists in other counties may participate in our Medicaid network and see patients from these counties who are assigned to ODS:

Baker	Grant	Malheur	Wallowa
Benton	Hood River	Marion	Wasco
Clackamas	Jackson	Multnomah	Washington
Clatsop	Jefferson	Polk	Yamhill
Columbia	Josephine	Tillamook	
Crook	Lane	Umatilla	
Deschutes	Linn	Union	

ODS is committed to partnering with dentists to ensure the best possible service for information and eligibility, claims payment accuracy, timely claims processing and excellent customer service. We are here to help you via telephone, email or in person, or through our web-based tools and online service Benefit Tracker.

ODS periodically conducts Dental Workshops to bring you information on updates and changes. These also provide an opportunity to answer any questions you may have and to personally introduce you to our team members.

ODS is always looking for dentists to participate on the ODS OHP dental network. If you know of a dentist who is interested, please contact us.

Again, thank you for your support and your participation in the ODS OHP dental plan. Your contributions are significant and truly appreciated.

Sincerely,

Teri Barichello, DMD
VP, Chief Dental Officer

ODS OHP MISSION

The mission of ODS OHP is to ensure our members have access to and receive quality dental services. We are a dedicated team that works collaboratively with our Medicaid partners to achieve the Triple Aim vision of reducing costs and improving health outcomes and patient experiences for our members. We do this because we believe good oral health contributes to good overall health.

RULES FOR PARTICIPATING DENTISTS

Participating dentists agree to abide by the following rules of ODS, in addition to the OARs that govern OHP. You can locate these OAR rule books online at:

OREGON ADMINISTRATIVE RULES
www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

OHP DENTAL SERVICES
www.oregon.gov/oha/healthplan/Pages/dental.aspx

OHP GENERAL RULES
www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

Other rules established and set forth by ODS. Participating providers must agree:

1. To submit a completed ADA standard dental claim form to ODS at no charge to the patient.
2. To accept the ODS OHP Fee Schedule benefit payments for services rendered as payment in full.
3. To keep accurate and complete financial and patient records in a manner that meets generally accepted practices.
4. To allow ODS access at reasonable times and upon request to inspect and make copies of the books, records and papers of a participating dentist relating to the services provided to the members and to any payments received by the dentist from such patients.
5. To not charge the member an amount over the OHP fee listed for any procedure or for a non-covered service that is not funded by OHP unless the member signs a financial waiver before the treatment is rendered.
6. To not submit charges to ODS for payment for treatment that is not completed.
7. To not submit charges to ODS for services for which no charge is made or for which a charge increased because insurance is available.
8. To have the patient statement reflect the same billed charges as the amount submitted to ODS. For example, if a discount is offered to a patient, the discount needs to be reflected in the claim submitted to ODS.
9. If ODS fails to pay for covered healthcare services as set forth in the member contract, the member is not liable to the provider for any amounts owed by ODS in accordance with the provisions of ORS 750.095 (2)
10. To provide accurate and complete information to ODS.
11. To provide after-hours contact information to members for dental emergencies.
12. To maintain OHP par status by complying with credentialing standards. Credentialing needs to be completed for all dental associates prior to rendering treatment to ODS OHP members.

CREDENTIALING

Credentialing is the process of verifying elements of a licensed practitioner's training, experience and current competence. Credentialing is a healthcare industry standard and helps ensure ODS members have access to a high-quality dentist within the ODS dental provider networks. The ODS credentialing program is based on the standards of national, federal and state accrediting and regulatory agencies.

A practitioner is credentialed when initially joining an ODS dental provider network and is re-credentialed every three years thereafter. The practitioner completes an application that attests to his or her ability to practice and requires proof of liability insurance.

ODS verifies the information provided on the application and refers the application to a committee of peers for final review and participation decision. All information provided during the credentialing and re-credentialing process is kept confidential. If we do not have current credentials on file for the treating dentist, the claim may be paid at the out-of-network level or may be returned to your office.

At all times while participating with ODS, 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 practitioner must promptly notify ODS in writing of any formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations. Participating practitioners also must notify ODS of any changes in practice ownership or business address, along with any other facts that may or will impair the ability of the participating practitioner to provide services to ODS members.

Dental practitioners have the right to appeal an ODS decision to restrict, suspend or take other adverse action against the dental practitioner's participation status.

Practitioners have rights during the credentialing and re-credentialing process and are notified of these rights through various means.

Practitioners have the right to:

- Credentialing and re-credentialing decisions that are not based on the practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed (provided such procedures are legal under US law) or patients in which the practitioner specializes.
- Review information the practitioner submitted to ODS to support their credentialing application.
- Correct erroneous information discovered during the verification process.
- Request and be informed of the credentialing application status.
- Withdraw, in writing, the application at any time.
- Have the confidentiality of the application and all supporting documents protected and the information used for the sole purpose of application verification, peer review and panel participation decisions, subject to any disclosures required under state or federal law.
- Be notified of these rights.

- Appeal application denials and adverse action taken by ODS as outlined in the Appeal of ODS Health Adverse Action.

Practitioners are notified of their rights in the ODS participating provider administrative manuals and on the Moda Health website.

PROFESSIONAL LIABILITY INSURANCE

ODS requires a $1 million minimum per claim and a $3 million minimum aggregate amount for participation in our network.

SERVICE COVERED BY ODS OHP PLUS

OHP PLUS is provided to children and adults who are eligible for traditional Medicaid programs or for the Children's Health Insurance Program (CHIP). It does not have premiums when enrolled with ODS as their managed care plan. Some adults who receive the OHP Plus benefit package have small copayments for some outpatient services and prescription drugs. Copayments do not apply to covered dental services.

Benefits on OHP are separated into the following three member categories:

- Pregnant women
- Non-pregnant women and adults age 21 and over
- Children under the age of 21

The following services may be covered by ODS for members on the OHP Plus:

DIAGNOSTIC
- Clinic oral evaluations
- Radiographs

ORTHODONTICS
- Covered for patients who have a diagnosis of cleft palate with cleft lip

PROSTHODONTICS (Removable)
- Complete and partial dentures
- Repairs to complete and partial dentures
- Denture rebase and reline procedures

ENDODONTICS
- Root Canal Therapy

PERIODONTICS
- Non-surgical services

RESTORATIVE
- Amalgam
- Composite resin restorations
- Build-ups
- Crowns

ORAL SURGERY
- Extractions
- Surgical extractions

PREVENTIVE
- Prophylaxis
- Fluoride treatment
- Sealants

PLUS SERVICE LIMITATIONS AND EXCLUSIONS NON-PREGNANT MEMBERS AGE 21 AND OVER

Based on the Oregon Administrative Rules (OAR) that govern OHP, the following service limitations apply for ODS members on OHP Plus:

CLASS I LIMITATIONS

A. Diagnostic

- Comprehensive and periodic oral evaluations are covered twice in any 12-month period. Limited oral evaluation and re-evaluation limited problem focused exams are covered five times in a twelve-month period.
- Detailed and extensive oral evaluations are covered once in a twelve-month period. Full-mouth X-rays or panoramic films are covered once in any five-year period.
- Bitewing X-rays are covered once in a twelve-month period.

B. Preventive

- Prophylaxis is covered twice in a 12-month period.
- Fluoride treatment is covered twice in a 12-month period.
- Sealants are not covered.
- Plaque control, oral hygiene and/or dietary instruction are not covered.

CLASS II LIMITATIONS

C. Restorative

- Amalgam restorations have no frequency limitation. Initial benefits for restorations include repair or replacement to the same surface within 24 months when performed by the same provider and/or office.
- Composite resin restorations are covered one time every five years.
- Refer to Class III Limitations for further guidelines when teeth are restored with crowns.
- A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered unless the member is classed by Health Systems as special needs.

D. Oral Surgery

- Clinical information showing multiple symptoms is required for any surgical extraction of third molars.
- A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.

E. Endodontics

- A separate charge for cultures is not covered.
- Pulp capping is not covered.
- Retreatments are allowed for anterior teeth by review only. Retreatments are not covered on posterior teeth.
- Endodontics for molars is not covered.
- Root canal therapy is only covered when the final restoration on the tooth is covered.

F. Periodontics

- A separate charge for periodontal charting is not covered.
- Periodontal scaling and root planing is covered once per quadrant in any two-year period. Periodontal scaling and root planing four or more teeth (D4341) up to two quadrants may be performed on the same date of service. Periodontal scaling and root planing one to three teeth (D4342) all quadrants may be performed on the same date of service.
- Periodontal maintenance procedure is covered once in any six-month period. Additional periodontal maintenance may be allowed when dentally necessary.
- Full-mouth debridement is covered once in any two-year period.
- Separate charge for post-operative care done within six months following periodontal surgery is not covered.

CLASS III LIMITATIONS

G. Restorative

- Stainless steel crowns are covered on molars.
- Porcelain crowns are not covered.

H. Prosthodontics — Removable

- Full and/or immediate dentures (upper and/or lower) are covered once every 10 years regardless of when the last tooth was extracted (per arch).
- Partial dentures are covered once in a five-year period and require X-ray and clinical information for review.
- Cast partials are not covered.
- Adjustments to complete and partial dentures are allowed four times per calendar year.
- Denture rebase and reline procedures are covered once in a three-year period ages 16-20 and once in a five-year period over 21.
- Replacement of a partial denture with a full denture is allowed ten years after the partial denture placement.

I. Orthodontics

- Orthodontic treatment (covered only for patients to age 20 who have a diagnosis at birth of cleft palate or cleft lip).

PLUS SERVICE LIMITATIONS AND EXCLUSIONS MEMBERS UNDER 21 YEARS OF AGE AND/OR PREGNANT

Based on the Oregon Administrative Rules (OAR) that govern OHP, the following service limitations apply for ODS members on OHP Plus:

CLASS I LIMITATIONS

A. Diagnostic

- Comprehensive and periodic oral evaluations are covered twice in any twelve-month period. Limited oral evaluation and re-evaluation limited problem focused exams are covered five times in a twelve-month period.
- Detailed and extensive oral evaluations are covered once in a twelve-month period. Full-mouth X-rays or panoramic films are covered once in any five-year period.
- Bitewing X-rays are covered once in a twelve-month period.

B. Preventive

- Prophylaxis is covered twice in a twelve-month period.
- Fluoride treatment is covered twice in a 12-month period.
- Sealant benefits are limited to the un-restored occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five-year period for members ages 15 and younger.
- Plaque control, oral hygiene and/or dietary instruction are not covered.

CLASS II LIMITATIONS

C. Restorative

- Amalgam restorations have no frequency limitation. Initial benefits for restorations include repair or replacement to the same surface within 24 months when performed by the same provider and/or office.
- Composite resin restorations are covered one time every five years.
- Refer to Class III Limitations for further guidelines when teeth are restored with crowns.
- A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered unless the member is classed by Health Systems as special needs.

D. Oral Surgery

- Clinical information showing multiple symptoms is required for any surgical extraction of third molars.
- A separate, additional charge for alveoloplasty done in conjunction with removal of teeth is not covered.

E. Endodontics

- A separate charge for cultures is not covered.
- Pulp capping is not covered.
- Re-treatments are allowed for anterior teeth by review only. Retreatments are not covered on posterior teeth.
- Endodontics for second molars is covered for members under 21 if the final restoration is covered.
- Endodontics for third molars is not covered.

- Root canal therapy is only covered when the final restoration on the tooth is covered.

F. Periodontics

- A separate charge for periodontal charting is not covered.
- Periodontal scaling and root planing is covered once per quadrant in any two-year period. Periodontal scaling and root planing four or more teeth (D4341) up to two quadrants may be performed on the same date of service. Periodontal scaling and root planing one to three teeth (D4342) all quadrants may be performed on the same date of service.
- Periodontal maintenance procedure is covered once in any six-month period. Additional periodontal maintenance may be allowed when dentally necessary.
- Full-mouth debridement is covered once in any-two year period.
- Separate charge for post-operative care done within six months following periodontal surgery is not covered.

CLASS III LIMITATIONS

G. Restorative

- Stainless steel crowns are limited to posterior primary or permanent teeth and primary anterior teeth once in a five-year period.
- Porcelain Crowns are covered once in a seven-year period for members ages 16-20 and pregnant women of all ages and require clinical and X-ray information for review. Benefit is available for the following anterior teeth only: 6-11, 22 & 27.
- Permanent crowns are limited to a total of four crowns in a seven-year period.

H. Prosthodontics — Removable

- Full and/or Immediate Dentures (upper and/or lower) are covered once every 10 years regardless of when the last tooth was extracted (per arch).
- Partial Dentures are covered once in a five-year period and require X-ray and clinical information for review.
- Cast Partials are not covered.
- Adjustments to complete and partial dentures are allowed four times per calendar year.
- Denture Rebase and Reline Procedures are covered once in a three-year period.
- Replacement of a partial denture with a full denture is allowed ten years after the partial denture placement.

I. Orthodontics

- Orthodontic Treatment (covered only for patients to age 20 who have a diagnosis at birth of cleft palate or cleft lip).

OTHER SERVICE LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

1. Services for injuries or conditions that are compensable under worker's compensation or Employer's Liability Laws.
2. Procedures, appliances, restorations or other services that are primarily for cosmetic purposes are excluded.
3. Charges for missed or broken appointments are excluded.
4. Hospital charges for services, supplies or additional fees charged by the dentist for hospital treatment are excluded.
5. Experimental procedures or supplies are excluded.
6. Dental services started prior to the date the individual became eligible for such services under the OHP contract are excluded.
7. Any services related to the treatment of TMJ are excluded.
8. Claims submitted more than 12 months after the date of rendition of the services are not covered.
9. Exclusions include all other services or supplies not specifically included in the OHP Plus Fee Schedule.

Please be sure to verify the member's eligibility prior to rendering services.

NON-COVERED SERVICES

ODS providers must inform OHP members of any charges for non-covered services prior to services being delivered. If a member chooses to receive a specific service that is not covered by ODS OHP, arrangements must be made between the provider and the member prior to rendering the service. You are required to:

1. Inform the member that the service is not covered
2. Provide an estimate of the cost of the service
3. Explain to the member their financial responsibility for the service
4. Complete the ODS OHP Patient Responsibility Waiver located in the back of this handbook.

The agreement between you and the member to pursue non-covered treatment must be documented using the OHP Patient Responsibility Waiver and must be signed by the member prior to rendering non-covered services. A sample of this Health Systems approved form has been included in the back of this handbook for your convenience. A copy of this form can also be downloaded from our website.

A member cannot be held financially responsible for the following (copayments do not apply):

- Services that are covered by ODS OHP
- Services that have been denied due to provider office error

A brief listing of non-covered services by OHP includes the following:

- Fixed prosthodontics
- Retreatment of previous root canal therapy to bicuspid and molars
- Veneers

- Implant and implant services
- Teeth whitening and other cosmetic procedures or appliances

For a list of allowed CDT codes and fees, contact dental professional relations at 503-265-5720, 888-374-8905 or dpr@modahealth.com. A complete CDT list with fees and frequency limitations is also available by selecting the OHP Covered/Non-Covered Services link in Benefit Tracker.

THE PRIORITIZED LIST

The Oregon Health Services Commission maintains a list of condition and treatment pairings known as the Prioritized List of Health Services. These pairings have been ranked by priority from most important to least important and subsequently assigned a line number.

Services prioritized as most important are funded by the state. The funding level is set at a line designated by the state. This means any pairing that occurs above the line is considered funded. Any pairing that occurs below the line is not funded. Below-the-line services include treatments that do not have beneficial results, treatments for cosmetic reasons and conditions that resolve on their own.

ODS OHP covers all funded services for dental. Legislative decisions may affect the funding line, therefore affecting covered services.

GETTING STARTED

To verify whether a dental service is covered by ODS, and to find out where the OHP line is currently set, check the Prioritized List of Health Services.

You can access the list by visiting the website:

- www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx. The list can be found by clicking on the link titled "Current Prioritized List."
- In addition to the list, Health Systems has provided a searchable index to assist you in locating the line(s) on which a condition or a treatment is listed.
- You may also find the covered/non-covered list helpful. This is located at www.modahealth.com/pdfs/covered_and_non_covered_dental_services.pdf.

IMPORTANT TO KNOW

- Due to legislative decisions, the funding line is subject to change. For the most current information, be sure to check with either Health Systems or ODS.
- Treatment may be covered for one condition but not covered for another. Remember that the pairing of the condition with the treatment determines which line the service is on.
- Oregon Administrative Rule 410-123-0000-1670-141-0860.

If the service is not covered by ODS OHP but treatment is deemed essential, additional information such as chart notes, narrative and any related X-rays can be submitted to ODS Dental Correspondence at 601 SW Second Ave., Portland, OR 97204.

MEMBER TRANSPORTATION

Transportation to dental appointments is available to patients who have no other means to the dental appointment. Non-urgent transportation is a benefit provided to the member by the member's

Coordinated Care Organization (CCO). Members should contact their CCO for transportation assistance by calling the transportation phone number listed in the following CCO section.

COORDINATED CARE ORGANIZATION (CCO)

OHP recipients select a Coordinated Care Organization (CCO) for their Medicaid coverage. CCOs bring together all types of health care providers (physical, mental health and dental care providers) in a community. The goal of the CCO is to help OHP members receive better care and stay healthy.

ODS began partnering with the CCOs in October 2013. There are a total of 16 CCOs in the state of Oregon. ODS has partnered with the following 13 CCOs:

CCO	General Contact	Transportation Contact	Counties Served
AllCare Health Plan	888-460-0185	800-479-7920	Curry, Douglas, Jackson, Josephine
Columbia Pacific CCO	800-224-4840	888-793-0439	Clatsop, Columbia, Coos, Douglas, Tillamook
Eastern Oregon CCO	888-788-9821	877-875-4657	Baker, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
FamilyCare Tri-county CCO	800-458-9518	503-416-3955	Clackamas, Marion, Multnomah, Washington
Health Share of Oregon	888-519-3845	503-416-3955	Clackamas, Multnomah, Washington
InterCommunity Health Network CCO	800-832-4580	866-724-2975	Benton, Lincoln, Linn
Jackson Care Connect	800-224-4840	888-518-8160	Jackson
PacificSource Community Solutions – Columbia Gorge	800-431-4135	877-875-4657	Hood River, Wasco
PacificSource Community Solutions – Central	800-431-4135	866-385-8680	Crook, Deschutes, Jefferson, Klamath,
Primary Health of Josephine County	800-471-0304	888-518-8160	Douglas, Jackson, Josephine
Trillium Community Health Plan	877-600-5472	877-800-9899	Benton, Lane, Linn
Willamette Valley Community Health	866-362-4794	888-315-5544	Benton, Clackamas, Linn, Marion, Polk, Yamhill
Yamhill County Care Organizations	855-722-8205	844-256-5720	Clackamas, Marion, Polk, Washington, Yamhill

QUALIFIED INTERPRETER SERVICES

ODS covers and coordinates interpreter services for OHP member dental appointments for covered services.

To arrange for interpreter services, complete the ODS Interpreter Request form, which is available in the back of this handbook and on our website, and fax it to our customer service department at 503-765-3297 no less than 48 hours prior to the appointment.

For confirmation of interpreter services, please contact ODS Customer Service at 800-342-0526 to confirm that an interpreter has been arranged.

For urgent needs (less than 48 hours' notice), it is better to call the ODS Customer Service department at 800-342-0526 to arrange for an interpreter.

ODS OHP providers can choose to coordinate interpreter services themselves rather than coordinating them through ODS; however, the provider will be responsible for paying for the interpreter services. ODS does not reimburse for interpreter services that are not coordinated through the ODS Customer Service department.

REFERRALS

Effective July 1, 2016, we began only offering written referral services for special needs members. Referral requests for oral surgery, endodontics, pediatric dentistry, denturists and periodontics can now be handled personally between your office and the ODS OHP Specialist. You can search Find Care for a specialist in your area or call our customer service department at 800-342-0526, and they'll be happy to assist you.

REFERRAL REQUEST REQUIREMENTS

- Referrals for special needs members are accepted on the ODS OHP referral form located in the back of this handbook.
- All pertinent patient information (name, ID number, birth date, medical concerns, etc.)
- Procedure that is being requested.
- Provider contact information, including mailing address and a return fax number, when applicable.

SECOND OPINIONS

ODS provides for a second opinion from a qualified healthcare professional within the network or arranges for the enrollee to obtain a second opinion outside the network at no cost to the enrollee.

A dental second opinion is defined as a patient privilege of requesting an examination and evaluation of a dental health condition by the appropriate qualified healthcare professional or clinician to verify or challenge the diagnosis by a first healthcare professional or clinician.

The member or provider (on behalf of the member) contacts ODS to request a referral for a second opinion. ODS reviews the request according to its respective referral processing guidelines and assists the member or provider acting on behalf of the member to locate an appropriate in-network provider for the second opinion. If no appropriate provider is available in-network, the member may access an out-of-network provider at no cost.

The requesting provider may call 800-342-0526 or fax the completed referral request form to 503-765-3297.

THE REFERRAL PROCESS

REFERRAL PROCESS FOR GENERAL DENTISTS

- A written referral to a specialty provider is no longer required. The general dentist can call ODS OHP Dental Customer Service at 800-342-0526 for names of ODS OHP specialty providers. ODS will accept a referral request for patients with special needs or when a second opinion is needed. The general dentist can fax the completed ODS referral form request to 503-765-3297 (see form in the back of this handbook).
- ODS notifies the general dentist within 10 working days of receiving the request if the referral is approved, denied or pending for further review. Urgent referrals are processed within 1-2 working days.
- Once the referral is approved, ODS documents in the member record the specialist the member was referred to.
- If the referral request is denied, a formal written denial is mailed to the member and to the general dentist providing reason for denial. The notification includes the reason for denial and the member's right to appeal the denial.
- Referrals are not a guarantee of payment.

REFERRAL PROCESS FOR SPECIALISTS

- A written referral to a specialty provider is no longer required. Specialists must check eligibility before seeing a patient, regardless of the origin of the referral. If the patient was referred by the general dentist or contacted by the patient directly eligibility must be checked. The patient must be eligible with ODS on the date of service.
- Specialists requesting additional follow-up visits or wishing to send a patient to another specialist for consultation or treatment must consult with the patient's general dentist.
- Referrals are not a guarantee of payment.

ELIGIBILITY

Eligibility requirements for all OHP members are reviewed and granted by Health Systems, and a dental carrier is chosen by the member once enrolled. It is the responsibility of the provider to verify that the individual receiving dental services is an eligible individual on the date of service for the service provided and that ODS is the dental plan responsible for reimbursement. The provider assumes full financial risk of serving a person not confirmed by Health Systems as eligible for the service provided on the date of service. (OAR 410-120-1140)

ODS recommends that the provider always make a photocopy of the member's Medicaid ID card and photo identification for the patient each time they present for services.

Oregon residents can seek assistance with Medicaid enrollment through the federal health insurance exchange at HealthCare.gov. Oregon residents can also call 1-855-CoverOR for a list of people in the member's area who can assist. The assistance for completing an application from a community partner is free.

VERIFYING MEMBER ELIGIBILITY – ONLINE

There are two online systems available for verifying ODS Oregon Health Plan member eligibility and benefits. Health Systems' MMIS will display member's eligibility and CCO contact information (but not which DCO the member is assigned to) and the ODS Benefit Tracker will display eligibility information for our active dental members in all our partnered CCOs.

Medicaid Management Information System (MMIS):

MMIS provides a 24-hour, 7-days-a-week access for eligibility from Health Systems. MMIS will require a PIN issued by Health Systems for you to access information. For more information on MMIS, please visit https://www.or-medicaid.gov/ProdPortal/.

OHP providers that are not contracted directly with the State for fee for service reimbursement should confirm MMIS access with Health Systems.

Benefit Tracker:

Benefit Tracker (BT) is a free online service designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims status information and patient eligibility directly from ODS. For more information on how to register, please see the Benefit Tracker section in this handbook or visit our website at www.modahealth.com/dental

VERIFYING MEMBER ELIGIBILITY – TELEPHONE

ODS Customer Service staff is knowledgeable and helpful when it comes to your questions. They utilize Health Systems' MMIS system and Benefit Tracker to provide up-to-date information and policies so you can be confident you will receive the most current information available. You can reach them at 800-342-0526 from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays.

Due to HIPAA privacy rules, we require the following prior to verifying information about a member. Under OHP, each member has a separately assigned ID and a separate record.

Office information:

- First name of caller
- Provider's last name or clinic/provider office name
- Provider TIN

Member information:

- Member recipient ID number*
- Member last name and first name
- Member date of birth

*If the recipient ID is not known, please be prepared to provide the member Social Security Number (SSN) and member address.

VERIFYING MEMBER ELIGIBILITY – EMAIL AND FAX

Email ODS OHP Customer Service at dentalcasemanagement@modahealth.com.

You will need to identify yourself, as explained above, your patient and your request. Our goal is to send a response within 24 hours Monday through Friday, excluding holidays.

Fax ODS OHP Customer Service at 503-765-3297
You can fax a list of ODS OHP members including the member's first and last name, member ID and the member's date of birth. ODS Customer Service will use Health Systems' MMIS system, CCO web portals and Benefit Tracker to verify the member's eligibility. Faxes received by 3 p.m. will be returned no later than 9 a.m. on the following business day.

PLEASE NOTE: ODS receives daily eligibility updates, and these will be reflected in the Benefit Tracker system. ODS advises that whichever option you choose, you also obtain a photocopy of the member's ID card and photo ID for each visit.

ASSIGNED DENTISTS

Plus members who are assigned to a specific dentist or office must seek treatment from their assigned dentist for their benefits to be paid. If a patient presents for treatment and is assigned to one of the following offices, your office would need to direct the member to that office for treatment. Members assigned to a specific office can be identified on Benefit Tracker under Group Limitations.

Arrow Dental LLC Offices
1880 Lancaster Drive NE
Suite 121
Salem, OR 97305
971-600-3498

890 Seneca Road
Suite 101
Eugene, OR 97402
541-653-8610

OHSU Dental Clinics
2730 SW Moody Ave.
Portland, OR 97201
503-494-8867

James Klusmier
165 NW 1st Ave.
John Day, OR 97845
541-575-0363

Elisha B. Mayes
1400 Division Street
Elgin, OR 97827
541-437-6321

Yakima Valley Farm Workers Clinic
Family Medical Center
1120 West Rose Street
Walla Walla, WA 99362
509-525-0247

Yakima Valley Farm Workers Clinic
Salud Medical Center
1175 Mt. Hood Ave.
Woodburn, OR 97071
503-982-2000

ODS contracts with Tyack Dental Group to provide all dental care for ODS OHP Plus members who reside in Clatsop and Columbia counties. This allows ODS to remain an option in these counties and provide stable access for members.

Cities in Columbia and Clatsop County include the Following:

- Cannon Beach
- Columbia City
- St. Helens
- Astoria
- Clatskanie
- Seaside
- Rainier
- Vernonia
- Gearhart
- Prescott
- Warrenton
- Scappoose

TYACK DENTAL GROUP INFORMATION
Tyack Dental Group has several associates practicing in two offices located in Clatskanie and Astoria. The contact information is listed below.

400 S.W. Bel Air Drive
Clatskanie, OR 97016
503-728-2114

433 30th Street
Astoria, OR 97103
503-338-6000

EXCEPTIONS

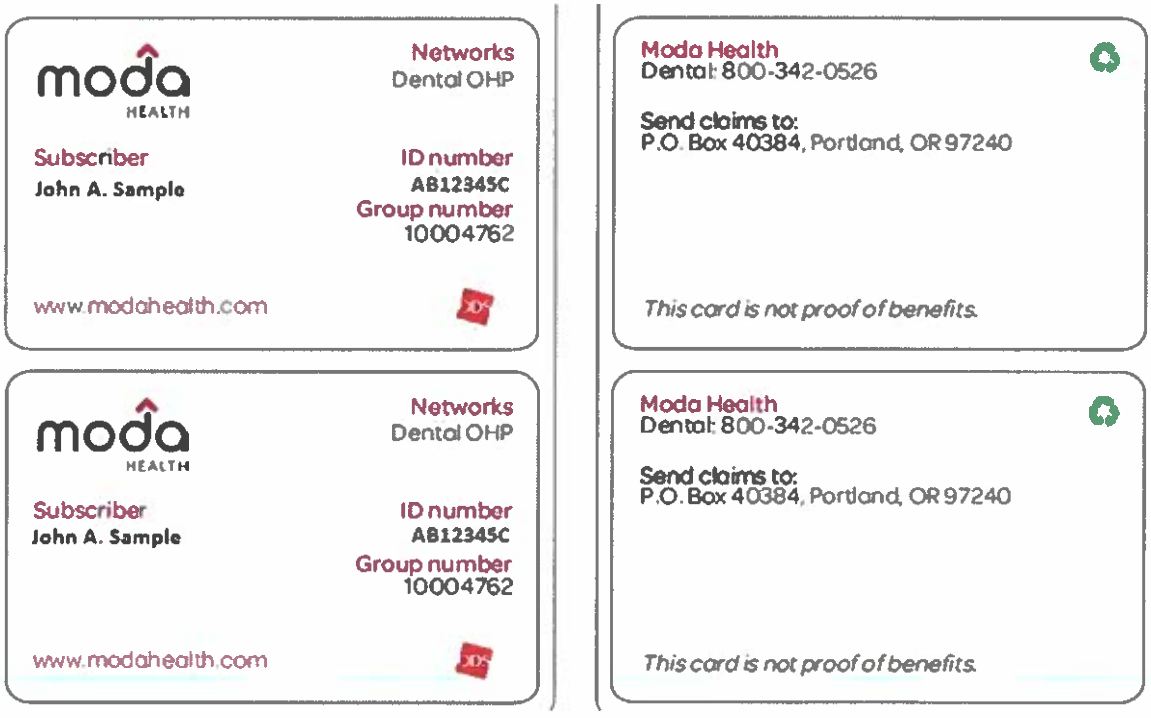
If the member who has been assigned to a specific office travels outside of the service area and experiences a dental emergency, you can treat the member to relieve pain and in the case of a dental emergency. However, upon treatment completion for the dental emergency or pain relief, your office needs to refer the patient to their assigned dentist for follow up and future dental care.

Payment to a different provider or an ODS OHP specialist (with the exception of a dental emergency outlined above) is only issued when the patient is referred by their general dentist. If a referral is needed to a specialist, please call our customer service department at 800-342-0526 or email dentalcasemanagement@modahealth.com for an ODS OHP specialist provider.

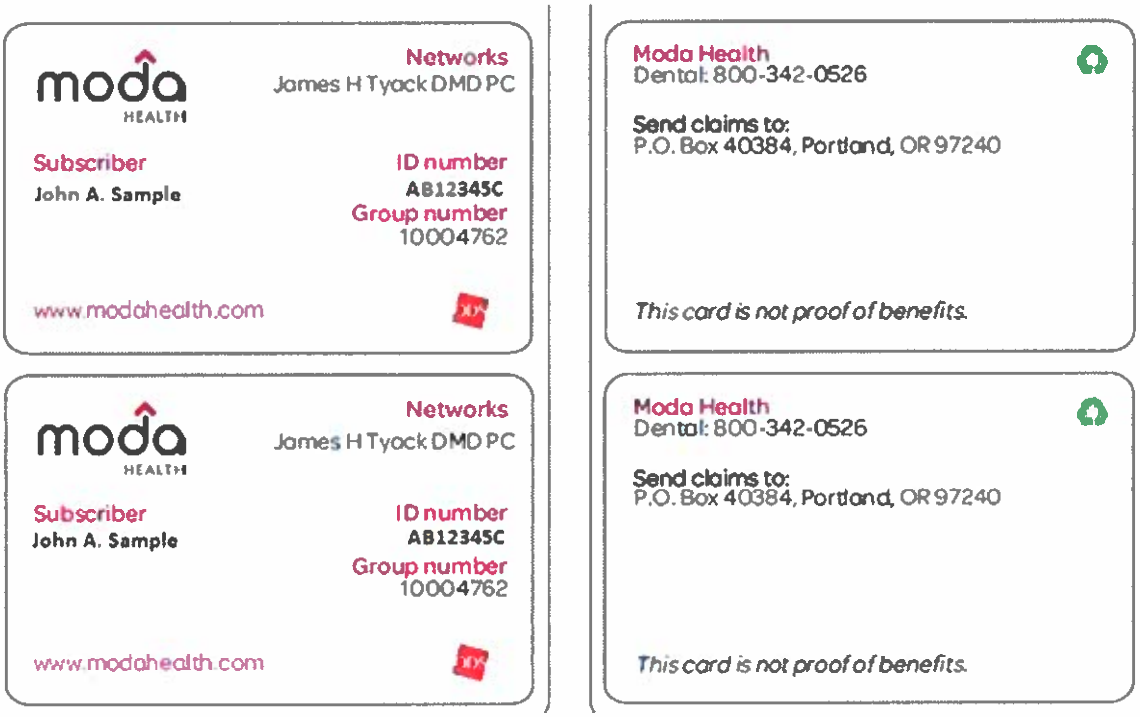
ODS OHP ID CARD

When an OHP member is assigned to ODS for dental care, ODS sends them an ID card to take to dental appointments in addition to the Health Systems Medical Care ID Cards.

Example #1:
This card shows the member is enrolled with Dental OHP. It does not show the member has an assigned dentist and is able to see any participating OHP ODS provider.



Example #2:
This card shows the member is enrolled with James Tyack DMD, PC and may only be seen by this Primary Care Provider. Refer to the *Assigned Dentists* section of the handbook for further details.



Members enrolled through a Coordinated Care Organization (CCO) will receive an ID card from the CCO; however, ODS will be indicated on the card as their dental plan if they have been assigned to ODS.

TIMELY ACCESS

To ensure that ODS OHP members have access to high-quality service and dental care in a timely manner, ODS has adopted the following Oregon Administrative Rule standards: These standards are monitored through the ODS after-hour's access survey and through member complaints.

A. Telephone Triage for Appointment Scheduling

Members calling to request dental care are assessed to determine if the level of care required is emergent, urgent or routine.

1. When members request an appointment, the receptionist/scheduler asks questions to determine the urgency of the dental need. Based on the responses, the member is scheduled appropriately.
2. The questions asked serve as guidelines and are not intended to substitute for the assistance of clinical staff in making determinations. Office staff consults with clinical staff or the practitioner to determine the appropriate length of time the member's condition requires for treatment.

B. Walk-in Triage

Walk-in members requesting dental care are assessed to determine if the level of care required is emergent, urgent or routine.

1. When a walk-in patient does not have an appointment, clinical personnel undertake triage. The triage process may consist of, but is not limited to:
    a. Discussion with member or family to determine nature of problem
    b. Superficial examination of affected area, if appropriate
    c. Review of member's dental record and/or dental history
    d. Assessment of needs based on discussion, examination and review
2. If clinical personnel are unable to assess the degree of need, the dentist is consulted.

C. Appointment scheduling

1. Emergent dental care
   The member is seen or treated within 24 hours. Members calling or walking into the office with emergent problems are put in immediate contact with a clinical staff member.
   If the dental condition requires treatment not available in the office, the member is sent to the appropriate facility or specialty dentist immediately. Referrals are provided if necessary.
2. Urgent dental care
   Urgent care is made available within one to two weeks depending on the member's condition.
3. Routine care
   A member with routine care needs is scheduled for an appointment within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason, which would make access longer than 12 weeks appropriate.

MONITORING ACCESS:

ODS periodically conducts telephone surveys to assess the access of our members for appointments and 24-hour after-hours access for dental emergencies. The purpose of the survey is to monitor compliance with the following rules:

- Oregon administrative rule 410-141-0220 for the Oregon Health Plan
- Board of Dentistry's rule 818-012-0010 under "Unacceptable Patient Care"

These rules require that the licensee provide or arrange for emergency treatment for established patients.

The after-hours survey is conducted between 6 p.m. and 7 a.m. to identify what type of coverage is in place. The expectation is that the dentist will have one of the following:

- An answering service that is able to reach the patient's primary dentist or an on-call dentist; or
- The patient's primary dentist office message will instruct an established patient to call a listed after-hours telephone number that will reach the primary dentist or an on-call dentist. The after-hours number is also called to determine whether the patient can leave a message.

Dentists who do not meet the criteria above are notified and must become compliant in order to continue as an OHP participating provider with ODS.

MEMBER RIGHTS AND RESPONSIBILITIES

A copy of these rights and responsibilities is also available to members in the Dental Member Handbook they receive from ODS upon enrollment.

MEMBERS HAVE THE RIGHT TO:

1. Be treated with dignity and respect.
2. Be treated by participating providers the same as other people seeking dental care benefits to which they are entitled.
3. Select or change primary care dentists (PCD).
4. Have a friend, family member or advocate present during appointments and at other times as needed within clinical guidelines.
5. Be actively involved in creating treatment plans.
6. Be given information about conditions, covered services and non-covered services in order to make an informed decision about proposed treatment(s).
7. Consent to treatment or refuse services and be told the consequences of the decision, except for court-ordered services.
8. Receive written materials describing rights, responsibilities, benefits available, how to access services and what to do in an emergency.
9. Have written materials explained in a manner that is understandable.
10. Receive necessary and reasonable services to diagnose the presenting condition.
11. Receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and are medically appropriate.
12. Receive covered preventive services.

13. Have access to urgent and emergency services 24 hours a day, seven days a week.
14. Receive a referral to specialty providers for dentally appropriate covered services.
15. Have a clinical record maintained that documents conditions, services received and referrals made.
16. Have access to one's own clinical record, unless restricted by law, and request and receive a copy of their records and request that they be amended or corrected.
17. Transfer a copy of their clinical record to another provider.
18. Execute a statement of wishes for treatment (Advanced Directive), including the right to accept or refuse dental treatment and the right to obtain a power of attorney for healthcare.
19. Receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations.
20. Know how to make a complaint or appeal about any aspect of care or the plan.
21. Request an Administrative Hearing with Health Systems.
22. Receive interpreter services.
23. Receive a notice of an appointment cancellation in a timely manner.
24. Receive covered services under OHP, which meet generally accepted standards of practice, as is dentally appropriate.
25. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation and to report any violations to ODS or to the Oregon Health Plan.
26. Post-stabilization services after an emergency department visit.
27. A second dental opinion.

MEMBERS HAVE THE RESPONSIBILITY TO:

1. Choose, or help with, assignment to a provider or clinic, once enrolled.
2. Treat all providers and their staff with respect.
3. Be on time for appointments made with providers and call in advance either to cancel if unable to keep the appointment or if expected to be late.
4. Seek periodic dental exams, check-ups and preventive care from the member's dentist.
5. Use the member's dentist or clinic for diagnostic and other care except in an emergency.
6. Obtain a referral to a specialist from the general dentist before seeking care from a specialist.
7. Use urgent and emergency services appropriately and notify ODS within 72 hours of an emergency.
8. Give accurate information for the clinical record.
9. Help the provider obtain clinical records from other providers. This may include signing a release of information form.
10. Ask questions about conditions, treatments and other issues related to their care that they do not understand.
11. Use information to decide 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.
14. Tell providers that the member's dental care is covered under the Oregon Health Plan before services are received and, if requested, show the provider the Division Medical Care identification form.
15. Tell the authority worker of a change of address or phone number.
16. Tell the Authority worker if she becomes pregnant and notify the Authority worker of the birth of the child.
17. Tell the Authority worker if any family members move in or out of the household.

18. Tell the Authority worker if there is any other insurance available.
19. Pay for non-covered services received under the provisions described is OAR 410-120-1200 and 410-120-1280.
20. Pay the monthly OHP premium on time if so required.
21. Assist in pursuing any third-party resources available and to pay ODS the amount of benefits paid from an injury from any recovery received from that injury.
22. Bring issues, complaints or grievances to the attention of ODS.
23. Sign an authorization for release of dental information so that ODS can get information pertinent and needed to respond to an administrative hearing request in an effective and efficient manner.

SECLUSION AND RESTRAINT POLICY

In accordance with Federal law, we recognize that each patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

A ***restraint*** is (a) any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (b) a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

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

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members or others from harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. In addition, the nature of the restraint or seclusion must take into consideration the age, medical and emotional state of the patient. Under no circumstances may an individual be secluded for more than one (1) hour.

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

ODS requires their participating OHP dentists to have a policy and procedure regarding the use of seclusion and restraint as required under the Code of Federal Regulations and also requires the provider to provide ODS a copy of their policy upon request.
(42 CFR, 438.100, be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation)

MEMBER DISMISSAL AND DISENROLLMENT GUIDELINES

DEFINITIONS

- Dismissal is when a member is removed from the care of their general dentist.
- Disenrollment is when a member is removed from their OHP dental plan.

REQUIREMENTS

ODS must follow the guidelines established by Health Systems regarding disenrolling members from the plan. ODS encourages members and their providers to resolve complaints, problems and concerns at the clinic level.

KEY POINTS WHEN CONSIDERING DISMISSING A MEMBER

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

- Timely, early communication
- Thorough documentation of events, problems and behaviors
- A plan generated by the dental office to attempt to address the problem or concern
- Use of contracts and case conferences
- Consideration of mental health diagnoses whenever dismissing or requesting disenrollment of a member

WHEN CAN A MEMBER BE DISMISSED?

A member may be dismissed from a dentist's office or disenrolled from ODS only with just cause. The list of just causes, identified by Health Systems, includes but is not limited to:

- Missed appointments
- Drug-seeking behavior
- Committing or threatening an act of physical violence directed at a dental provider, office staff, clinic, property, other patients, or ODS staff
- Dismissal from dentist by mutual agreement between the member and the provider
- Agreement between provider and ODS that adequate, safe and effective care can no longer be provided
- A fraudulent or illegal act committed by a member, such as permitting someone else to use their Health Systems Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises

IF A DENTIST DETERMINES TO DISMISS A MEMBER

When the clinic management moves to dismiss a member, a letter is sent to the member informing of the dismissal, with a copy sent to ODS. Dentists are asked to provide urgent care for the dismissed member for 30 days following notification of the member. ODS Customer Service Representatives work with the member to establish a new dentist.

WHEN A MEMBER CANNOT BE DISMISSED

Oregon Administrative Rule 410-141-0080 states that members shall not be dismissed from a dentist or disenrolled from ODS solely because:

- The member has a physical, intellectual, developmental, or mental disability.
- There is an adverse change in the member's health.
- The provider or ODS believes the member's utilization of services is either excessive or lacking.

- The member requests a hearing against a provider or ODS.
- The member exercises their option to make decisions regarding their dental care, with which the provider or the plan disagrees.
- The member engages in uncooperative or disruptive behavior as a result of their special needs.

CAUSE FOR REQUEST FOR DISENROLLMENT
ODS requests immediate disenrollment when notified about any of the following circumstances:

- Disruptive, unruly or abusive behavior.
- The member commits a fraudulent or illegal act, such as permitting someone else to use their Medical ID Card, altering a prescription, or committing a theft or another criminal act on any provider's premises.
- The member commits or threatens an act of physical violence directed at a dental provider, office staff, property, clinic, other patient, or ODS staff.
- Missed appointments.

Send copies of relevant documentation, including chart notes and a police report, to ODS. ODS contacts Health Systems and requests immediate disenrollment.

MISSED APPOINTMENT POLICY

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 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 needs to have members sign an acknowledgement of the office policy.

When a member misses an appointment, the provider's office should attempt to contact the member to reschedule and notify ODS Customer Service of the missed appointment. ODS Customer Service will contact the member and educate them on the importance and expectation of keeping appointments and the necessity of advance notice of cancellation. A form has been included in the back of this handbook and on our website that your office can mail or fax to ODS Customer Service for your convenience.

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 them of the dismissal. A copy of the dismissal letter should be sent to ODS Customer Service 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. The patient will be asked to select a new provider. ODS requests disenrollment of a member after that member has been dismissed from two providers for missed appointments in a 12-month period.

MEMBER COMPLAINTS AND APPEALS

COMPLAINTS

A complaint is an expression of dissatisfaction to ODS or a provider about any matter that does not involve a denial, limitation, reduction or termination of a requested covered service. Examples of complaints include, but are not limited to, access to providers, waiting times, demeanor of dental care personnel, quality of care and adequacy of facilities. Providers are encouraged to resolve complaints, problems and concerns brought to them by their ODS patients. If a complaint cannot be resolved, inform the member that ODS has a formal complaint procedure. Members' complaints must be made to ODS Customer Service. If a member is not satisfied with the way ODS handles the complaint, the member has the right to file a complaint with the OHA Ombudsman's Office.

APPEALS

An appeal is a request by an ODS member or the member's representative to review an ODS decision to deny, limit, reduce or terminate a requested covered service or to deny a claim payment. Member appeals must be made to ODS in writing within 45 days of the decision. If the member calls ODS Customer Service, the member must follow up with a written appeal. Providers may also appeal on behalf of the member with the member's permission. The member also has the right to file an Oregon administrative hearing request with Health Systems.

RESOLVING COMPLAINTS AND APPEALS AT ODS

The ODS appeal staff facilitates the member complaint and appeal processes and seek input from appropriate parties, such as the provider, dental consultant or care coordination staff to reach decisions about the complaints and appeals. The appeal staff sends a written resolution to the member or the member's representative within five days of receipt of a complaint and within 14 days of receipt for an appeal.

STATE OF OREGON ADMINISTRATIVE HEARING PROCESS

- Health Systems has an appeal process for members who are dissatisfied with ODS's response to an appeal of a denial, limitation, reduction or termination of a requested covered service or denial of claims payment. This is the state of Oregon Administrative Hearing process.
- When ODS denies, limits, reduces or terminates a requested covered service, or denies a claim payment, the ODS Notice of Action letter outlines the member's right to file an appeal with ODS and the appeal timelines. The letter also informs the member of the right to request a state of Oregon Administrative Hearing and the timelines if the member continues to be dissatisfied with the ODS appeal decision.
- Members may obtain more information about this process by contacting their Authority worker or contacting the ODS OHP Customer Service department at 503-243-2987 or toll-free at 800-342-0526.

Below are the methods in which a member can submit a Complaint or Appeal to ODS OHP:

Write
Member Appeal Unit
ODS P.O. Box 40384
Portland, OR 97240

Fax
503-412-4003
Attention: Appeals Unit

Telephone
ODS OHP Customer Service 503-243-2987 or toll-free at 800-342-0526 (TTY 711)

OHP Complaint Form
A member may file a complaint or appeal using an OHP Complaint Form 3001. The form can be found online at: http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf.

SUBMITTING CLAIMS

ACCEPTABLE CLAIM FORM

Please file all claims using the most recent ADA Dental Claim form. If you would like information on billing claims electronically, please contact our Electronic Data Interchange (EDI) department at 1-800-852-5195 or 503-228-6554.

TIMELY FILING GUIDELINES

ODS requests that all eligible claims for covered services be received in our office within three months after the date of service. Claims received later than 12 months after the date of service shall be invalid and not payable.

If a payment disbursement register (PDR) is not received within 45 days of submission of the claim, the billing office should contact ODS Customer Service or check Benefit Tracker to verify that the claim has been received. Please verify if your initial claim was received prior to submitting a duplicate. When submitting a claim electronically using an electronic claims service or clearing house, check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

All information required to process a claim must be submitted in a timely manner (e.g., clinical notes, X-rays, chart notes). Any adjustments needed must be identified and the adjustment request received within 12 months of the date of service.

CORRECTED BILLINGS

All claims submitted to ODS as corrected billings to previously submitted claims need to be clearly marked in the remarks section of a paper claim as a "corrected billing," or noted on the electronic claim. In addition, dental records need to accompany the corrected billing if the change involves a change in procedure or the addition of procedure codes.

ELECTRONIC CLAIMS SUBMISSION

Providers can reduce administrative time shorten turnaround time by submitting claims electronically.

ODS is able to accept claims from the following electronic connections:

- DMC (Dentist Management Corporation)
- APEX EDI
- CPS (Claims Processing System)
- EHG (EDI Health Group, Inc.)
- TESIA/PCI Corp.
- QSI (Quality System Incorporated)

The EDI Department at ODS will work with your office to advise you of the options available.

For information on setting up this process, please call or write:
Moda Health
EDI Department
601 SW Second Ave.
Portland, OR 97204
503-228-6554
800-852-5195
Email: edigroup@modahealth.com

DENIALS AND APPEALS OF PREDETERMINATIONS, REFERRALS AND PAYMENT

DENIALS
When ODS denies a service or referral, a written notice of action is mailed to the member and requesting provider.

The notice of action includes the following information:

- Service requested
- Reason for denial
- Member's appeal rights and instructions
- Member's right to file an OHP administrative hearing request and instructions

APPEALS
Letters denying authorization or referral inform members they have a right to file an appeal and/or an OHP administrative hearing request. Appeals must be submitted to ODS in writing. Providers can also appeal on behalf of the member. Members would need to indicate in writing that they want the provider to appeal on their behalf.

An appeal may be requested as follows:

Write
Member Appeal Unit
ODS P.O. Box 40384
Portland, OR 97240

Fax
503-412-4003

Telephone
ODS OHP Customer Service 503-243-2987 or 800-342-0526 (TTY 711)

Oregon Health Plan Complaint Form
Complaint forms are available on the ODS website at:
www.modahealth.com/pdfs/grievance_form_ohp.pdf

An appeal must be requested within 45 days of the date on the member's notice of action letter. The appeal will be processed by the ODS appeal staff, who seek input from appropriate parties, such as the provider or the ODS dental consultant to reach an informed decision about the appeal. The decision to uphold the denial or approve the requested service is communicated in writing to the member, PCD or requesting provider and specialist (when applicable) within five days of receipt of a complaint and within 14 days of receipt of an appeal.

The member also has the right to request an administrative hearing through Health Systems. The ODS denial letter informs the member on how to request an administrative hearing.

Claims indicating treatment beyond which a claims auditor is trained to review, or where special information has been furnished by the treating dentist, are reviewed by the ODS dental consultant. The consultant reviews the information submitted and determines if a service is within the covered benefits specified in the OHP contract. Contract benefit determination is made following the consultant's review.

COORDINATION OF BENEFITS

OHP will always be secondary to all other insurance coverage. If the member has private insurance, that carrier's Explanation of Benefits (EOB) should be submitted with the claim as soon as the EOB is received. Exceptions to this rule include Indian Health Services or Tribal Health Facilities and Veterans Administration plans.

CALCULATING COORDINATION OF BENEFITS
As secondary payer, ODS issues benefits when the primary carrier paid less than the ODS OHP allowed amount for each procedure. Payment is the difference between ODS OHP total allowed amount and the primary carrier's total payment.

If the primary plan's payment is more than the ODS allowed amount, no additional benefit will be issued. All remaining balances, including primary plan deductibles and/or co-insurances, are to be included in the provider discount. The deductible and/or co-insurance may be collected when treatment is performed by a Delta Dental Provider who does not participate in the ODS OHP network.

PREDETERMINATION OF BENEFITS

A predetermination of benefits gives the provider a response to an inquiry regarding benefits, is based on current history and eligibility at the time the predetermination is processed, and is subject to change.

A current ADA form may be submitted with the following information:

- The request for predetermination box at the top of the form should be checked.
- The appointment date fields should be blank.
- Use current ADA codes for all procedures proposed.

Predeterminations are an option for partials, dentures, and third molar extractions. **Predeterminations are not a guarantee of payment**.

BENEFIT TRACKER (BT)

Benefit Tracker (BT) is a free online service designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims status information and patient eligibility directly from ODS.

There are many benefits to using Benefit Tracker.

- Find benefit information.
- Access the most up-to-date information at the most convenient times for you, whether it's during office hours or after hours.
- Use benefit information to quickly determine the best treatment plan for your patient.
- Check the latest claims status of a patient or use the search filters to find the status of older claims.
- Print out hard copies for patient files, statement plan presentations and easy updates to plan benefit software.

BENEFIT TRACKER CONTACT INFORMATION

Registration and additional information can be obtained by contacting our Benefit Tracker Administrator or by accessing the ODS website at www.modahealth.com/dental/.

Benefit Tracker Administrator
601 SW Second Ave.
Portland OR 97204
877-337-0651 (choose option 1)
Email: ebt@modahealth.com

BILLING THE MEMBER

State and federal regulations prohibit billing OHP members for OHP covered services. Providers must inform OHP members of any charges for non-covered services prior to the services being rendered.

The following are examples of when members cannot be billed.

- For covered services that were denied due to a lack of referral
- For covered services that were denied because the member was assigned to another general dentist other than the one who rendered the services
- For services that are covered by ODS or OHP – this includes balance billing the member for the difference between the ODS allowed amount and the provider's billed charges.
- For broken or missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the member.

There are very limited circumstances when a provider may legally bill an OHP member:

1. A provider may bill a member if the service provided is not covered by OHP and the member signed a waiver before services were rendered.
   - The waiver must be the Health System's approved waiver located in the back of this handbook.
   - The waiver must be written in the primary language of the member.

2. A provider may also bill a member if the member did not advise the provider that they had Medicaid insurance and attempts were made to obtain insurance information.
   - The provider must document attempts to obtain information on insurance or document a member's statement of non-insurance.
   - Merely billing or sending a statement to a member does not constitute an attempt to obtain insurance information.
   - **For a complete description of the rules, please refer to the General Rules, 410-120-1280 at:** www.oregon.gov/oha/healthplan/Pages/general-rules.aspx

PROFESSIONAL REVIEW

The professional review department reviews selected claims to determine if a service is necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. When a claim is selected for review, your office will be notified via a letter. You can then send in the clinical, referencing the claim number on the letter. It is important to send the recommended information and ensure your X-rays are of diagnostic quality and clearly labeled to expedite the process.

By selecting claims randomly and based on practice and billing patterns (focused review), we are able to reduce the number of codes requiring 100 percent review. Supporting documentation such as X-rays are usually needed on only a portion of all claims, and we recommend reviewing the following sections *Professional Review Procedure Codes* and *Clinical Review Requirements* for specific clinical submission guidelines.

When a claim is selected for review, additional information from the treating dentist may be requested. All pertinent information should be submitted when requested by professional review. Re-evaluation requests made by your office are handled in the same manner; however, claims are not re-evaluated in the absence of additional, pertinent information.

PROFESSIONAL 100% REVIEW PROCEDURE CODES

The following list of procedure codes will always go through the Professional Review process, requiring clinical documentation for benefit determination.

To expedite the processing of your claim, it is requested you submit the clinical information with your initial claims submission using the Clinical Review Requirements on the following pages. Our Clinical Review Requirements outline the necessary documentation and/or clinical information required for review of specific procedure codes.

DIAGNOSTIC	ENDODONTICS	ORAL SURGERY	ORAL SURGERY	ADJUNCTIVE SERVICES
D0310	D3331	D7251	D7770	D9211
D0472	D3332	D7261	D7911	D9212
D0473	D3333	D7270	D7912	D9440
D0474	D3346	D7287	D7960	D9610
D0480	D3351	D7340	D7963	D9612
D0502	D3352	D7350	D7970	D9630
RESTORATIVE	D3353	D7490	D7971 D7980	D9920
D2751	D3354 D3410 D3430	D7530	D7981	
D2752	**PERIODONTICS**	D7540	D7982	
D2980	D4920	D7550	D7983	
	PROSTHODONTICS	D7560	D7990	
	D5211	D7670		
	D5212			

CLINICAL INFORMATION REQUIREMENTS

Please refer to the *Professional 100% Review Procedure Codes* list in this handbook for a list of procedure codes that will always require documentation for payment determination. Information provided below includes codes that are not on the 100% review list. The Submission Request information is for your office to use as a guideline in the event a claim is randomly selected for Professional Review.

The below requirements are necessary for our professional review team to adequately determine necessity. Chart notes should always include diagnosis and justification for all treatment rendered.

DIAGNOSTIC SERVICES: D0100-D0999		
Code	**Description of Service**	**Submission Request**
D0140	Limited Oral Evaluation – Problem Focused	Chart notes regarding the necessity of the treatment rendered including the diagnosis. Include any additional diagnostic information to assist in determining benefits.
D0220, D0230	Periapical X-Rays	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0310	Sialography	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0320	Temporomandibular Joint Arthrogram	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0321	Temporomandibular Joint Films	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
D0472, D0473, D0474, D0480, D0486, D0502	Accession of tissue, gross examination, preparation and transmission of written report, other oral pathology procedures, by report	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.

SPACE MAINTENANCE D1510 – D1525		
Code	**Description of Service**	**Submission Request**
D1510, D1515, D1520, D1525	Space Maintainers	Please specify the teeth being replaced and the teeth being clasped. Include detailed narrative regarding the reason this treatment is being done instead of a bilateral removable partial denture.
CROWNS D2390 - D2799		
Code	**Description of Service**	**Submission Request**
D2390	Resin-based composite crown, anterior	Current periapical radiographs and chart notes outlining necessity.
D2710, D2712, D2751, D2752	Crowns – single restorations only	Current radiographs (periapical radiographs are preferred), intraoral photographs if available. Chart notes outlining necessity, symptoms and diagnosis. It is preferred that panoramic radiographs are NOT submitted for anterior crowns.
D2980	Crown Repair	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
BUILDUP/POSTS: D2950 - D2957		
Code	**Description of Service**	**Submission Request**
D2950, D2951, D2954, D2955, D2957	Core buildup for single restorations	Current periapical radiographs. Intra-oral photo, if available. Chart notes outlining diagnosis, or completion date of RCT. If replacement crown, periapical radiographs and/or photos after existing crown removed, Per the ADA, buildups should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.

ENDODONTICS: APEXIFICATION D3351-D3353		
Code	**Description of Service**	**Submission Request**
D3310, D3320, D3330	Endodontic Therapy	Current periapical radiographs with chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3331, D3333	Obstruction and root repair	Pre-operative and post-operative periapical radiographs, if applicable, with chart notes regarding the necessity of the endodontic procedure.
D3332	Incomplete root canal	Please provide chart notes indicating why this tooth is inoperable or unrestorable.
D3346	Retreatment of Previous Root Canal Therapy – anterior	Current periapical radiographs and chart notes. Please also indicate the type of final restoration being placed after completion of the endodontic treatment.
D3351, D3352, D3353	Apexification/recalcification procedures	Current periapical radiographs and chart notes. Please also indicate the reason for treatment and if apexification/ recalcification procedure is the first step of root canal therapy.
D3410, D3430	Retrograde Filling	Pre-operative and post-operative periapical radiographs, if applicable, and chart notes regarding the necessity of the endodontic procedure.

PERIODONTAL PROCEDURES: D4211-D4268		
Code	**Description of Service**	**Submission Request**
D4210, D4211	Gingivectomy	Periodontal charting (probing done within past 12 months), diagnosis, bitewing X-rays, and chart notes regarding the necessity of the periodontal treatment, and date of last active periodontal therapy, if applicable.
D4341, D4342	Periodontal scaling and root planing	
D4910	Periodontal maintenance	
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	Chart notes regarding necessity, and any additional diagnostic information to assist in determining benefits.
D4920	Unscheduled dressing change	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

PROSTHETICS: D5213 - D5214		
Code	**Description of Service**	**Submission Request**
D5211, D5212	Removable prosthetic services	Current periapical radiographs, periodontal charting done within past 12 months and definitive treatment plan for entire mouth. Please indicate missing teeth to be replaced and teeth to be clasped, as well as any additional teeth that will be extracted.
D5820, D5821	Interim Partial Denture	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
BIOPSY: D7285-D7410		
Code	**Description of Service**	**Submission Request**
D7285, D7286, D7287, D7288, D7410, D7440, D7450, D7460, D7465	Surgical procedures	Pathology report indicating specific location of tissue. Services performed on the lip, cheeks or tongue are not covered.
ORAL AND MAXILLOFACIAL SURGERY: D7111- D7997 (EXCLUDING BIOPSY)		
Code	**Description of Service**	**Submission Request**
D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7490,	Oral and maxillofacial surgery	Current periapical X-rays and chart notes regarding the necessity of the treatment. Include any additional diagnostic

D7510, D7530, D7540, D7550, D7560, D7960, D7963, D7971		information to assist in determining benefits.
D7320, D7340, D7350, D7471, D7520, D7670, D7770, D7910, D7911, D7912, D7970, D7980, D7981, D7982, D7983, D7990, D7997	Oral and maxillofacial surgery	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.
ADJUNCTIVE PROCEDURES: D9910- D9940		
Code	**Description of Service**	**Submission Request**
D9211, D9212, D9310, D9440, D9610, D9612, D9630, D9920, D9930	Adjunctive procedures	Chart notes regarding the necessity of the treatment. Include any additional diagnostic information to assist in determining benefits.

Information required only when clinical is requested.

Photographs are always beneficial in determining cracked teeth, build-ups, crowns and anterior restorations.

DENTAL RECORDS STANDARDS

CLINICAL RECORDS
The provider is required to:

- Have all active dental records available for ODS.
- Have a filing system that provides retrievable dental records.
- Maintain dental records for seven years after the date of service for which claims are made.
- Participating OHP providers are required to release requested information to ODS according to OAR 410-141-0180 (3).

FRAUD AND ABUSE

It is the policy of ODS that its employees and providers 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 of health care services to ODS members and payment for such services to providers. Complete descriptions of the applicable federal and state laws are listed at the bottom of this policy.

Two common types of healthcare fraud are member fraud and provider fraud. Examples of member fraud include:

- Using someone else's coverage or allowing someone besides the member to use the member's insurance card or coverage to receive treatment
- Filing for claims or medications that were never received
- Forging or altering bills or receipts

Examples of provider fraud include:

- Billing for services or procedures that were not provided
- Performing medically unnecessary services in order to obtain insurance reimbursement
- Incorrect reporting or unbundling of procedures or diagnoses to maximize insurance reimbursement
- Misrepresentations of dates, description of services or subscribers/providers

TO ENSURE THAT AS A PROVIDER YOU ARE NOT THE VICTIM OF HEALTHCARE FRAUD, TAKE THE FOLLOWING PRECAUTIONS:

- Always ask for photo identification of new patients. Take a copy and put it in his/her chart. If you are able to take a photo of your patients, do so.
- Make sure to have a signature on file in the patient's handwriting.
- Thoroughly check the PDR that ODS sends you. Make sure as you review the PDR that the dates, patient and services are correct. Also, make sure this was an appointment the patient actually attended — it is not uncommon for criminals to bill for services not received and ask for the payment to be sent to them.

ODS has a fraud, waste and abuse prevention, detection and reporting plan that applies to all ODS employees and providers. ODS has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees.

This plan includes operational policies and controls in areas such as claims, predeterminations, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and ODS employee education, human resource policies and procedures, and corrective action plans to address fraud, waste and abuse activities. Verified cases of fraud, waste or abuse are reported to the appropriate regulatory agency. ODS reviews and revises its Fraud and Abuse policy and operational procedures annually.

If you suspect you are the victim of fraud or if you suspect a member is committing fraud, please call ODS immediately at 877-372-8356. ODS will investigate all reports of fraud to protect our providers and members.

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. ODS assures the anonymity of complainants to the extent permitted by law.

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, and upcoding (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 10 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.

Qui Tam and Whistleblower Protection Provisions: The False Claims Act contains 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 60 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.

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.

STATE LAWS:
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 that 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 that 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 Healthcare Payments: A person commits the crime of making a false claim for healthcare payment when the person: (1) knowingly makes or causes to be made a claim for healthcare payment that contains any false statement or false representation of a material fact in order to receive a healthcare payment; or (2) knowingly conceals from or fails to disclose to a healthcare payer the occurrence of any event or the existence of any information with the intent to obtain a healthcare payment to which the person is not entitled, or to obtain or retain a healthcare 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: ODS 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 healthcare 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.

CONFIDENTIALITY

Confidentiality of member information is extremely important. All healthcare providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Acts (HIPAA) transactions must adhere to the HIPAA privacy and security regulations. There may be state and federal laws that provide additional protection of member information.

Providers must offer privacy and security training to any staff that have contact with individually identifiable health information. All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disc or optical media formats.

Health information contained in dental or financial records is to be disclosed only to the patient or the patient's personal representative—unless the patient or the patient's personal representative authorizes the disclosure to some other individual (e.g., family members) or organization. The permission to disclose information and what information may be disclosed must be documented in either verbal approval or written authorization. Health information may be disclosed to other providers involved in caring for the patient without the patient's or patient's personal representative's written or verbal permission. Patients must have access to, and be able to obtain copies of, their dental 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. Employees (including physicians) shall not have unapproved access to their own records or records of anyone known to them who is not under their care.

Confidentiality of Protected Health Information: ODS and provider each acknowledge that it is a "Covered Entity," as defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) adopted by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"). Each party shall protect the confidentiality of Protected Health Information (as defined in the Privacy Rule) and shall otherwise comply with the

requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of medical information.

ODS staff adheres to HIPAA-mandated confidentiality standards. ODS protects a member's information in several ways:

- ODS has a written policy to protect the confidentiality of health information.
- Only employees who need to access a member's information in order to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.

RELEASE OF INFORMATION

In general, information about a member's health condition, care, treatment, records or personal affairs may not be discussed with anyone unless the reason for the discussion pertains to treatment, payment or plan operations. If member health information is requested for other reasons, the member or the member's healthcare representative must have completed an authorization allowing the use or release of the member's protected health information (PHI). The form shall be signed by the patient or their personal representative and must be provided to ODS for their records.

Release forms require specific authorization from the patient to disclose information pertaining to HIV/AIDS, mental health, genetic testing, drug/alcohol diagnosis or reproductive health.

For your convenience, a sample authorization form has been included at the back of this provider manual. A current authorization form and instructions on how to complete the form can be downloaded from the ODS website at www.modahealth.com/members/forms?dn=ods.

QUALITY IMPROVEMENT

PROGRAM GOALS

The goal of the ODS Dental Quality Improvement (QI) program is to ensure delivery of appropriate, cost-effective and high-quality oral healthcare to ODS members.

PROGRAM OBJECTIVES

ODS QI program objectives are to:

- Implement review processes to facilitate the evaluation of dental aspects of care, such as:
  - Use of services
  - Adequacy of dental record keeping
  - Operation and outcome of referral process
  - Access (the appointment system, after-hours call-in system, etc.)
  - Grievance system
  - Encounter data management
- Continuously evaluate and identify opportunities for improvement of:

- The quality of dental care and service delivery
- Barriers to services at the plan and practitioner level
- Communication within the organization, and between the organization and its practitioners and members
- Progressively improve member care through communication of QI activities to members and practitioners

- Identify and address continuing education needs of practitioners and members.
- Ensure compliance with regulatory requirements.

ODS meets these objectives by focusing on QI projects that have a significant impact on the oral health of plan members and have measurable outcomes in terms of quality of life.

QI COMMITTEE
The Dental Quality Improvement Committee (DQIC) has operational authority and responsibility for the ODS Dental Quality Improvement Program. It reviews and evaluates the quality of dental care and services provided to ODS dental members.

SCOPE OF SERVICE
ODS defines an annual QI work plan. This includes the processes that will be measured and monitored. Major plan components include the processes involved with quality outcomes, use of services and access. The scope of service includes any and all regulatory requirements, including internal and external quality review activities, for which ODS ensures access to dental records, information systems, personnel and documentation requested by the state division of medical assistance programs.

Member-specific or provider-specific data are considered confidential and treated according to the ODS confidentiality and privacy policy.

DENTAL HEALTH PROMOTION AND EDUCATION

ODS provides health promotion and education information for ODS members and their families. The brochures listed below are available for your patients on the ODS website. You may print copies of these brochures for your patients or contact the ODS Healthcare Services department at 503-948-5548, 877-277-7281 or by email at careprograms@odscompanies.com for a supply. (A sample of these brochures is included in this manual.)

"Your Guide to Immediate Dentures"
This brochure educates members on how to take care of immediate dentures and what to do after surgery.

"Dental Health During Pregnancy"
This flyer informs pregnant women of the importance of taking care of their teeth while they are pregnant.

"Take Time for Teeth"
This brochure educates parents about caring for their young child's teeth in order to prevent early childhood caries.

TOBACCO CESSATION

"Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco." — Public Health Service (PHS) Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update

ODS asks that all providers take an active part in tobacco cessation by helping members who are ready to quit tobacco to find the resources available to them.

OHP members have benefits for tobacco cessation services through their OHP medical plan.

Please help your patients who use tobacco by doing the following:

Ask

Ask about tobacco use at every visit.

Implement a system in your clinic that ensures that tobacco-use status is obtained and recorded at every patient visit.

Advise

Advise all tobacco users to quit.

Use clear, strong and personalized language. For example:
"Quitting tobacco is the most important thing you can do to protect your health."

Assess

Assess readiness to quit.

Ask every tobacco user if he/she is willing to quit at this time.

- If willing to quit, provide resources and assistance (go to Assist section).
- If unwilling to quit at this time, help motivate the patient:
  - Identify reasons to quit in a supportive manner.
  - Build patient's confidence about quitting.

Assist

Assist tobacco users with a quit plan.

Assist the smoker to:

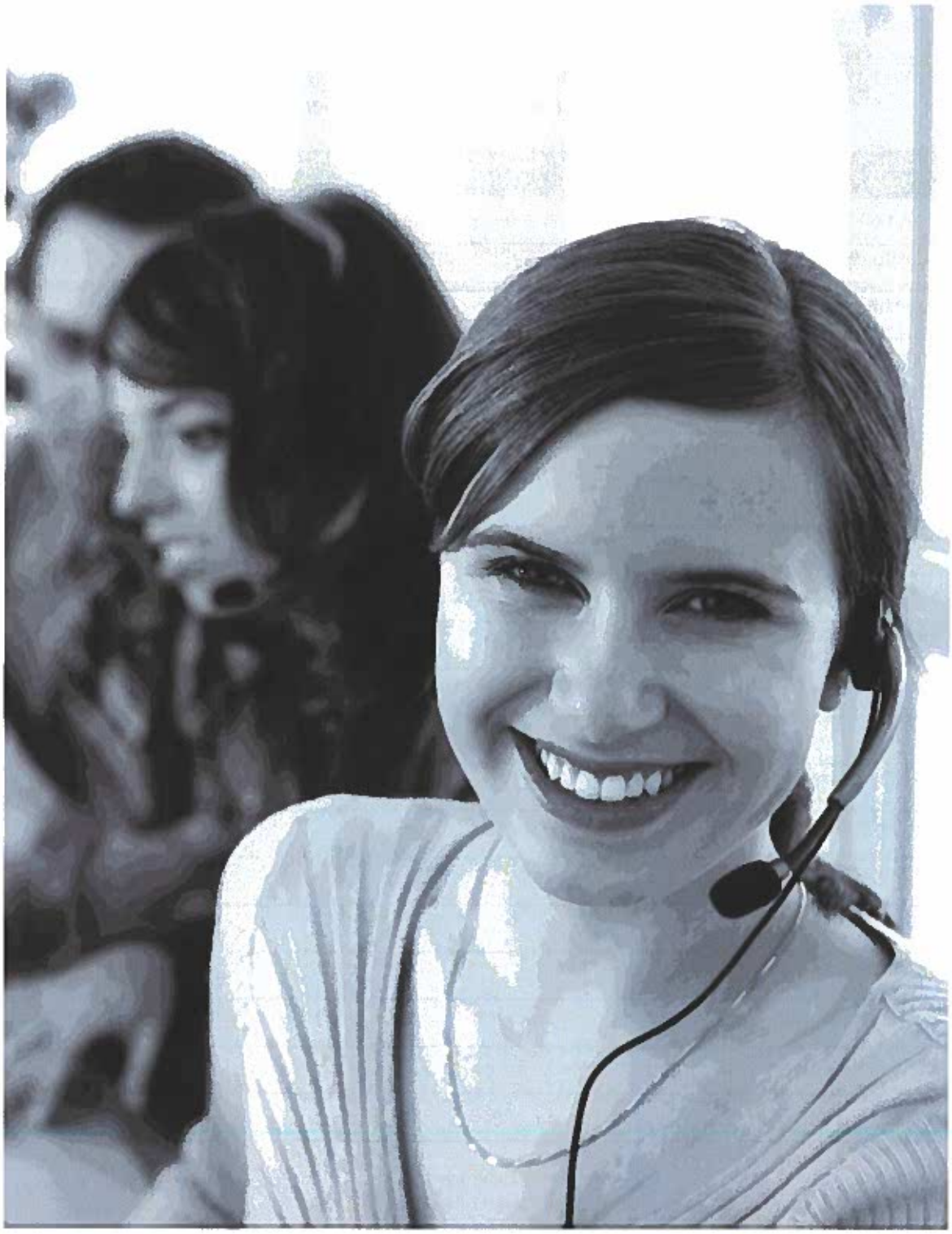
- Set a quit date, ideally within two weeks.
- Remove tobacco products from their environment.
- Get support from family, friends and coworkers.

Refer

Refer OHP members:

- To their medical plan to arrange for quitting.
- To the Oregon Tobacco Quit Line
  Call these numbers for free from anywhere in Oregon:
  1-800-QUIT-NOW (1-800-784-8669)
  Español: 1-877-2NO-FUME (1-877-266-3863)
  TTY: 1-877-777-6534
  Or register online at: www.quitnow.net/oregon/ The Quit Line is open seven days a week, 4 a.m. to 12 a.m. (Pacific Time)

FORMS, BROCHURES AND DOCUMENT SAMPLES



INTERPRETER REQUEST FORM

Community Health, Inc.

Interpreter Request Form – Passport to Languages

Oregon Health Plan - Dental
Today's Date:
Appointment Date:
Appointment Start Time:
Appointment Length (total):
Language:
Interpreter Preference (if applicable):
Recipient ID:
Patient Name:
Patient Date of Birth:
Patient Phone Number:
Other Patients included in Appt (name, recipient ID, date of birth):
Provider/Facility Name:
Street Address:
City, State and Zip:
Phone Number:
Fax Number:
Contact Person:
Special Requests:

ODS Community Health, Inc.

800-342-0526 503-243-2987 Fax 503-765-3297

Interpreters are scheduled based on availability. For best availability, please request interpreters by fax or phone call to Dental Customer Service no less than 48 hours prior to the appointment.

OHP DENTAL REFERRAL REQUEST FORM

When submitting a referral request, please follow these instructions and submit all requested information in accordance to the type of referral being completed. Incomplete request forms and/or information may result in a denial of the referral. Detailed instructions by specialty, including information required for each referral type, is indicated below.

General instructions for the referral form:

1. Verify your patient's OHP ID number and current enrollment with OHP Plus or Standard plan.
2. Enter the most current name and address that you have on file for your patient. Please note that ODS will send all correspondence to your patient at the address on file in the ODS OHP system and will notify you of an address discrepancy.
3. Enter complete referring dentist/clinic information. ODS OHP requests a fax number for the referring provider for communication purposes.
4. When requesting sedation, indicate the type of sedation you are requesting, member's history of sedation, reason for the sedation request and if hospital access is needed. Sedation requests should be placed in the comments section of the referral form.

PEDIATRIC

Some OHP pediatric providers have an age restriction for the members they treat. If a pediatric provider is not available for your patient, ODS will contact the referring dentist and provide him or her with a list of general dentists who are able to treat your patient comfortably.

ENDODONTIC

Root canal therapy is now only covered in conjunction with a final restoration that is ***covered*** under the OHP plan. The following is required for completion of an endodontic referral:

- Tooth number
- Treatment plan for final restoration
- CDT code for final restoration

ORAL SURGERY

When requesting a referral for OHP Plus members for the extraction of third molars or when requesting a referral for OHP Standard members for all extractions, the following information is required for EACH tooth. Teeth must be symptomatic to be eligible for extraction:

- Tooth number
- Pain level on a scale of 1-10, with 10 the most painful
- Swelling and/or bleeding
- Tooth-specific narrative or chart notes
- X-ray(s), all teeth for which a referral is requested must be visible

PERIODONTAL

Please note that OHP benefits are very limited for periodontal services. ODS requests general dentists attempt to treat their patients for covered services such as root planing and full-mouth debridement in their office prior to requesting a specialist referral. All periodontal referrals require the following:

- History of periodontal scaling and root planing within the last two years
- Periodontal charting (pockets must be at least 5mm in two or more quadrants)

Completed referral forms can be submitted by mail or fax (please see referral form for address and fax number). ODS customer service representatives can also take the referral information over the telephone. Please contact the customer service department at (800) 342-0526 with questions.

OHP dental referral request form

FOR ODS USE ONLY
ODS CSR call/fax received by _____
Referral to _____
Eligibility _____
Date Received _____
Date Completed _____

Please read instructions before completing
Note: Incomplete forms may result in denial of referral.

SECTION 1 | *Patient information*

Plan ☐ Plus ☐ Standard	Is emergency treatment needed? ☐ Yes ☐ No	OHP client ID no.
Patient last name	First name	MI
Date of birth	Patient phone	
Address Street	City	State ZIP code

SECTION 2 | *Referral information*

Name of referring dentist and/or clinic				Contact name
Address Street		City	State	ZIP code
Office phone	Office fax			
Type of referral: ☐ ENDO ☐ Oral surgery ☐ PERIO ☐ PEDO ☐ Special needs/general dentist				
Date of last appointment with refering provider ____ / ____ / ____				Is patient experiencing any pain? ☐ Yes ☐ No

Tooth no.	Pain level (1-10)	Swelling?	Infection?	Notes
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

Has pain relief been provided? ☐ Yes ☐ No	Any medication given? ☐ Yes ☐ No	Please list the medications given to the patient or any other pain relief provided

X-rays available: ☐ PA ☐ Bitewings; how many? _____ ☐ FMX ☐ Panoramic film

Please indicate how the X-rays will be submitted. ☐ NEA; NEA no. _____

☐ Emailed to ohpdentalcoordinator@odscompanies.com ☐ Mailed to the attention of the OHP Dental Coordinator at 601 SW 2nd Ave Portland, OR 97204

Note: If X-rays are not submitted with original request, referral may be denied. Tooth needing treatment must be visible on film.

For ENDO referral, are canals of tooth/teeth: ☐ Curved ☐ Calcified Final Restoration: _____

For PERIO referral, date of last root planing and scaling: ____ / ____ / ____ Bone Loss? ☐ Yes ☐ No *(please attach perio charting)*

Additional comments

PLEASE SEND COMPLETED FORMS TO:

MAIL: ODS Community Health, Inc., Attn: OHP Dental Coordinator, 601 SW 2nd Ave Portland, OR 97204
EMAIL: ohpdentalcoordinator@odscompanies.com **FAX:** 503-765-3297

If you have questions, please contact ODS Community Health, Inc. toll free at 800-342-0526. (TTY users, please dial 711.)
www.odscompanies.com

Member Authorization - Release of Personal Health Information to ODS

Member authorization allows the healthcare provider to use/disclose protected health information to ODS (Oregon Dental Service, ODS Health Plan, Inc. and/or ODS Community Health, Inc.)

(Member Name) Last	**First**	**M.I.**
ID Number		
DOB		
Employer or Group Name		
Group Number		

I authorize:_____
(Name of healthcare provider(s)/entity(ies) disclosing information.)
to use and disclose a copy of my protected health information to: **ODS**

for the purpose of:_____
(Describe each purpose of the use/disclosure.)

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes) and any personal or medical information related to the purpose of this authorization.

I authorize the release of (initial one option):
_____ All protected health information, OR
_____ The most recent two years of protected health information, OR
_____ Specific information _____

I understand that the Healthcare Provider needs my specific authorization to release information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case. (Initial all that apply. Leaving a space blank indicates that no information about the item is to be released.)

_____ HIV/AIDS test or result information and related records
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment or referral information

(continued on next page)

ODS Community Health, Inc.

OHP 01/2006

OHP General Authorization: Disclosure to ODS Form 1 of 2

MEMBER AUTHORIZATION — RELEASE OF PERSONAL HEALTH INFO

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in a health plan or eligibility for health benefits.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this Authorization, please send a written statement to ODS Community Health, Inc., Privacy Office at 601 S.W. 2nd Avenue, Portland OR, 97204 and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will be in force and effect until the following (check one):

☐ Date: _____ (not to exceed 24 months), OR

☐ Event: _____

(The event will be limited to 24 months maximum.)

I have reviewed and I understand this Authorization.

Signed _____ Date _____
(Individual)

-OR-

Signed _____ Date _____
(Individual's representative)

Relationship to Member: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*
*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

INSTRUCTIONS: ALL RELEVANT FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID. MEMBER SHOULD RETAIN A COPY OF THE SIGNED ORIGINALS.

Mail the signed originals to: ODS Community Health, Inc.
Privacy Office
601 S.W. 2nd Avenue
Portland, OR 97204

OHP 01/2006

OHP General Authorization: Disclosure to ODS Form 2 of 2

MISSED APPOINTMENT

NOTIFICATION FORM

Member Name: _____ Member ID#: _____

Dentist Name and Address: _____

Office Phone: _____ Office Fax: _____

TO REPORT A MISSED APPOINTMENT
Complete the following and fax this form to ODS.

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other _____

Date of missed appointment: _____
Reason Member gave for the missed appointment: _____
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other _____

**See back to report additional missed appointments

TO REPORT A DISMISSAL DUE TO MISSED APPOINTMENTS
Attach copies of the following to this form and fax all to ODS.
☐ Your office dismissal for missed appointments policy (signed by the Member) **and**
☐ Your dismissal letter to the Member.

Fax this form if applicable, and any necessary dismissal attachments to ODS Attn: Customer Service at (503) 765-3297 after each missed appointment.

Oregon Administrative Rule 410-141-0080(2) (a) (A) (i)
Missed appointments: The number of missed appointments is to be established by the Provider or PHP. The number must be the same as for commercial Members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the OHP Member in receiving services.

ADDITIONAL MISSED APPOINTMENTS

The number of additional missed appointments allowed prior to dismissal is set by your office for missed appointments policy.

Date of missed appointment: ________________
Reason Member gave for the missed appointment: ____________________
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other ____

Date of missed appointment: ________________
Reason Member gave for the missed appointment: ____________________
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other ____

Date of missed appointment: ________________
Reason Member gave for the missed appointment: ____________________
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other ____

Date of missed appointment: ________________
Reason Member gave for the missed appointment: ____________________
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other ____

Date of missed appointment: ________________
Reason Member gave for the missed appointment: ____________________
Indicate your attempts to assist the Member in receiving services: ☐ Rescheduled appointment,
☐ Referred Member to case worker for help with transportation,
☐ Member is being dismissed, referred Member to ODS to find another dentist,
☐ Other ____

Fax this form if applicable, and any necessary dismissal attachments to ODS Attn: Customer Service at (503) 765-3297 after each missed appointment.

DENTAL HOSPITAL REFERRAL

If a patient needs dental treatment in the hospital, a hospital referral form needs to be submitted to the medical carrier prior to treatment being rendered. An example form has been included, or you can access the form and save to your desktop at: http://dhsforms.hr.state.or.us/Forms/Served/OE3301.pdf

Dental Hospital Referral

Caller Name	Date of call	Coverage Verified
Dentist Name	Phone	Fax
Address		
Client Name	ID#	Date of Birth
Parent/Guardian Name	Client Phone	
Address		
Medical Plan Name	Phone	Contact Name
PCP Name	PCP Phone	
Hospital Facility Requested	Date(s) Requested	
Patient special needs (i.e. interpreter, etc.)		

Clinical Information

Give a detailed description of the dental treatment needed (or a copy of the treatment plan can be attached if it details treatment needed)

Give a detailed explanation why a dental hospitalization is being requested. In the explanation state whether office oral sedation was used, and the results. Also, list other important information contributing to the need for hospitalization, such as the condition of the teeth/mouth, physical or mental disability, behavior issues, etc.

For use by Medical Plan Staff

Date services approved	Referral #
Dates referral valid	Approved by
Comments	

OMAP 3301 (5/06)

INSURANCE NOTIFICATION FORM

Insurance Notification Form

Providers. Use this form to report information about Medicaid clients (including Oregon Health Plan) who are covered by other insurance.

THE ODS COMPANIES FOR INSURANCE & BUSINESS SERVICES

Private Health Insurance

Date: _____

Policyholder name: _____ Date of birth: / /

Insurance company name: _____ Phone: ( )

Insurance company address: _____

Private Health Insurance ID no. (include any alpha prefix): _____

Group number: _____ Policyholder's SSN: _____

People covered by this insurance (use additional sheets if necessary):

Individual Detailed Health Information

Name	DOB	Medicaid Case #	Start Date	End Date	Social Security Number

Name of provider or person submitting this report: _____

Contact Person: _____ **Phone:** ( )

Comments:

Please return this form to the ODS Community Health Insurance Group.
If you have questions, please contact ODS Community Health Customer Service.

Medical:
By fax: (503) 765-3570
By Mail: PO Box 3550, Portland, OR 97208
Customer Service: (888) 788- 9821

Dental:
By Fax: (541) 962-2171
By Mail: PO Box 40384, Portland, OR 97240
Customer Service: (800) 342-0526

OHP Client Agreement to Pay for Health Services

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

Provider Section

① Healthcare services requested:

Procedure codes (CPT/HCPCS):

② Expected date(s) of service:

③ Condition being treated:

④ Estimated fees $ to $

Check one: ☐ There are no other costs that are part of this service.

☐ There may be other costs that are part of this service, and you may have to pay for them, too. Other procedures that usually are part of this service may include:

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

⑤ As your provider:

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

Provider Name: NPI:

Provider Signature: Date:

OHP Client Section

⑥ Client Name: DOB: Client ID#:

⑦ I understand:

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

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

Client (or representative's) signature: Date:

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

® Witness signature: Date:

Witness name:

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

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

DMAP 3165 (Rev. 11/1/13)

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

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

① ***Check to make sure the service is not covered***
DMAP, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and/or Hearing***
Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

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

③ ***Check to see if there are other ways to get the service***
Ask your provider if:

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

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

④ ***Ask about reduced rates and discounts***
Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***
You may find another provider who will charge you less for the service.

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

Questions?

- Call ODS Customer Service at 800-342-0526, TTY 711 or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at:

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html

DMAP 3165 (Rev. 11/1/13)

IMMEDIATE DENTURE BROCHURE

What is a reline and when will a denture need one?

A loose denture makes it harder to chew and may cause irritation, sores or infection in your mouth. If your denture is loose, have your dentist check it. You may need a temporary reline or a laboratory reline.

- A temporary reline is done in the office while you wait. It is usually done during the healing phase. The dentist adds a soft material that bonds to the underside of the denture. This material helps keep the denture close and comfortable. It is removed when a laboratory reline is needed.
- A laboratory reline depends on how many teeth were removed, your health and many other factors. Most people are ready for a permanent laboratory reline in six to eight months, when the healing has completed. You need to leave your dentures with the dentist for up to eight hours. The dentist removes any temporary relines and makes an impression of the space between your gums and the denture. A permanent reline is then made with the same type of material used to make the pink portion of your denture.
- A reline generally does not change how the denture or your face looks. A reline does not make a lower denture fit "tighter," but it fits the tissue closer and better.

Care of your dentures

Dentures, like natural teeth, must be cleaned to keep your mouth healthy and odor free.

- Brush the surfaces of your denture inside and out morning and night. Brush with the solution from denture cleanser soaking solutions, liquid soaps or special toothpaste designed for dentures.
- After the first night, store your dentures in water or denture cleanser soaking solution when you are not wearing them. This helps keep the shape and prevents drying out.
- Don't adjust or repair a denture yourself. You can permanently damage the denture and cause harm to the tissue in your mouth.
- Don't use hot water on your denture. It will warp.
- Don't use scouring powders on your dentures, as they can remove the denture materials or roughen the surface.
- Don't use abrasive cleaners or bleach to remove stains. They can change the color of gum colored acrylic.

ODS

www.odscompanies.com

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Your guide to immediate dentures

What are immediate dentures?

Immediate dentures are dentures that are placed in your mouth right after your teeth are extracted. The shape of your mouth changes quickly for about a month. As the healing process continues, your gums, which support the denture, will shrink. Changes can continue for several months. During this time, it is important that you keep your dentist office appointments for adjustments. Following are tips to help you adjust to, and take care of your immediate denture.

What to do right after surgery

Day 1
Keep your head up. Take your medication and rest. Put gentle biting pressure on your denture during the first four hours. Use cold packs to reduce swelling.

Eat soft healthy foods such as mashed potatoes, soups, eggs or cottage cheese. Drink cool liquids. Be careful with hot foods. The plastic part of the denture may not allow you to feel hot food in some areas of your mouth.

Don't remove your denture during the first 24 hours. There may be some oozing of blood. The denture acts as a bandage to protect the extraction sites and helps to control bleeding and swelling.

Day 2
The dentist removes your denture and makes any needed adjustments. The dentist shows you how to remove and clean it.

Day 3-4
(or until your stitches are removed)
Remove your denture three to four times a day and gently rinse your mouth with warm saltwater (1/2 teaspoon salt in 8 ounces of warm water). Lightly brush your denture at the same time, and then place in your mouth.

Getting used to your denture

- A new denture is uncomfortable for the first several weeks. It may feel loose while the muscles of your cheeks and tongue learn to hold it in place. Saliva may increase. You may feel minor irritation or soreness. You may bite your cheeks or tongue as you learn to use your new denture.
- It takes practice and patience to eat with dentures. Start with soft foods cut into small portions. Chew slowly and use both sides of your mouth at the same time to keep the denture from moving out of place. Don't bite with your front teeth. That causes your denture to tip and come loose. As you adjust to the denture, add other types of foods until you're back to your normal diet.
- Speaking with a new denture takes time and practice. Read aloud and repeat difficult words in front of the mirror. Speak slowly to help reduce muffled, blurred or thickened speech. You may lisp or whistle your "s" when you first try to talk. Your denture may sometimes slip out of place when you laugh, cough or smile. Put it back in place by gently biting down and swallowing.
- Although your denture is custom made to fit your mouth, your dentist may suggest using a denture adhesive while you get used to wearing it. Keep in mind that a denture adhesive is only a temporary fix.

Denture facts

- A lower denture is never as "tight" as an upper denture. The lower denture doesn't have the "suction" to keep it in place like the upper one does. The lower denture is held in place by the muscles of the lips, tongue and cheeks. It should not "pop" out of place, but it does not have a tight feeling. It usually takes four to five times longer to master a complete lower denture compared to an upper denture.
- Getting used to a denture takes time and patience. Remember, your gum tissue changes, not your denture. For some patients, many visits to the dentist for adjustments are needed.
- A big gain or loss in body weight can change the fit of your denture.

Yearly dental checkup

After you adjust to wearing a denture, see your dentist yearly for a complete checkup.

TAKE TIME FOR TEETH BROCHURE

ODS

Happy mouth, healthy child

Did you know that healthy teeth and a healthy mouth can help your baby become a healthy child? By following some simple steps you can make a big difference in your child's health

BIRTH TO SIX MONTHS

- Gently wipe your baby's gums and teeth with a clean, soft cloth after every feeding.
- Ask your doctor about giving your baby fluoride.

ONE YEAR

- Get your baby used to using a regular cup instead of a bottle or "sippy" cup by his or her first birthday.
- At one year of age, help your baby use a toothbrush. You will need to brush your baby's teeth to make sure they are clean.
- Speak with your dentist if you see white or brown spots on your baby's teeth.

TODDLERS

- At age two or three, the last of your child's baby teeth are coming in.
- Try to make good oral care fun for your child. Turn on music and brush together.
- Help your child brush twice a day. Toothpaste can be used starting at age two, or when your dentist recommends it.
- Floss your child's teeth daily to help prevent the build-up of plaque.

over ›

HEALTHY HABITS FOR LIFE

- Give your child healthy snacks, and limit sweet snacks and drinks.
- Visit the dentist every six months.
- Brush and floss twice a day.

REMEMBER:

- Decay is preventable. The bacteria that causes decay is usually passed from mother to child through saliva.
- Avoid contact from your mouth to your baby's bottles, pacifiers or sippy cups. This passes the bacteria to your baby.
- Always hold your baby when bottle feeding.
- Never put your baby to bed with a bottle.
- Never put soda or juice in a bottle.

YOUNG CHILDREN

- At age six or seven, most children start to lose baby teeth and get permanent teeth.
- To help keep baby teeth and permanent teeth healthy, have your child rinse with water after every meal and brush at least twice every day.
- You will need to check to make sure your child brushed for at least three minutes and cleaned thoroughly.
- Encourage healthy snacks that are low in sugar. Sugary juices and sodas are harmful to your child's teeth and cause tooth decay.

PRE-TEENS AND TEENS

- By age 13, most teens have about 28 permanent teeth.
- Sports and energy drinks, soda and junk food stain and damage teeth.
- Let your teen know that good oral hygiene helps prevent bad breath, missing teeth and stains.
- Encourage your child to drink plenty of water and carry a toothbrush, floss and toothpaste with them.

DID YOU KNOW?

It is important to help children brush their teeth until they can write in cursive. That is when the muscles they use to brush their teeth are coordinated enough to do it on their own.

If you need the name of a dentist or have questions about your coverage, please call ODS Customer Service at 800-349-0526. Or, visit www.odscompanies.com/ohp.

ODS

Una boca feliz, un niño sano

¿Sabía usted que una boca y dientes sanos pueden ayudar a su bebé a ser un niño sano? Tomando algunas medidas sencillas, usted puede marcar una gran diferencia en la salud de su hijo.

DESDE EL NACIMIENTO HASTA LOS SEIS MESES DE VIDA

- Frote suavemente las encías y los dientes del bebé con un trapo suave y limpio después de cada vez que come.
- Pregúntele al médico si puede darle flúor al bebé.

AL AÑO DE VIDA

- Haga que el bebé se acostumbre a usar una taza común en lugar de un biberón o de una taza con tapa sorbete, aproximadamente cuando cumpla el primer año de vida.
- Cuando tenga un año, ayude al bebé a usar un cepillo de dientes. Deberá cepillar los dientes del bebé para asegurarse de que estén limpios.
- Hable con el odontólogo si ve manchas blancas o marrones en los dientes del bebé.

NIÑOS PEQUEÑOS

- A los dos o tres años de vida, a los niños les salen los últimos dientes de leche.
- Intente que el buen cuidado bucal sea divertido para su hijo. Ponga música y cepíllense los dientes juntos.
- Ayude a su hijo a cepillarse los dientes dos veces por día. Se puede comenzar a utilizar pasta dental a partir de los dos años o cuando lo recomiende el odontólogo.
- Use hilo dental en los dientes de su hijo diariamente para ayudarlo a evitar la acumulación de placa.

Ver al dorso ›

HÁBITOS SALUDABLES PARA TODA LA VIDA

- Dele a su hijo bocadillos saludables y limite la cantidad de bocadillos y bebidas dulces.
- Visite al odontólogo cada seis meses.
- Cepíllese los dientes y use hilo dental dos veces por día.

RECUERDE:

- La caries se puede evitar. Las bacterias que la causan generalmente se transmiten de madre a hijo a través de la saliva.
- Evite el contacto entre su boca y los biberones, los chupones o las tazas con tapa sorbete del bebé. Esto transmite las bacterias a su hijo.
- Siempre sostenga al bebé en brazos cuando le dé el biberón.
- Nunca ponga al bebé en la cama con un biberón.
- Nunca coloque refrescos o jugo en el biberón.

NIÑOS

- A los seis o siete años, a la mayoría de los niños se les comienzan a caer los dientes de leche y les salen los dientes permanentes.
- Para ayudar a tener dientes de leche y permanentes sanos, haga que su hijo se enjuague la boca con agua después de cada comida y que se cepille los dientes al menos dos veces por día.
- Usted deberá controlarlo para asegurarse de que se cepille los dientes durante tres minutos, como mínimo, y que se limpie meticulosamente.
- Aliente los bocadillos saludables que tengan bajo contenido de azúcar. Los jugos y los refrescos con azúcar son dañinos para los dientes de su hijo y causan caries dental.

PREADOLESCENTES Y ADOLESCENTES

- A los 13 años, la mayoría de los adolescentes tienen aproximadamente 28 dientes permanentes.
- Las bebidas energéticas y deportivas, los refrescos y la comida chatarra manchan y dañan los dientes.
- Infórmele a su hijo adolescente que una buena higiene bucal ayuda a evitar el mal aliento, la caída de dientes y las manchas.
- Aliente a su hijo a beber mucha agua y a llevar un cepillo de dientes, hilo y pasta dentales.

¿SABÍA USTED?

Es importante ayudar a los niños a cepillarse los dientes hasta que puedan escribir en letra cursiva. Ese es el momento en el que los músculos que utilizan para cepillarse los dientes tienen la coordinación suficiente como para hacerlo por sí mismos.

Si necesita el nombre de un odontólogo o si tiene preguntas sobre su cobertura, llame a Servicio al Cliente de ODS al 800-342-0526 o visite www.odscompanies.com/ohp.

DENTAL HEALTH DURING PREGNANCY FLYER

ODS

Pregnancy and your teeth

Taking care of your teeth is especially important while you are pregnant. The health of your teeth and gums can affect the health of your baby.

TAKE CARE OF YOUR TEETH AND TAKE CARE OF YOUR BODY

Your oral health matters. As an ODS member, you can see your dentist every six months for a cleaning. You can get an additional cleaning in your third trimester even if you have already had a two cleanings in the past twelve months. Your dentist will help make sure your mouth is healthy, which will help you have a healthy baby.

X-rays can be taken if necessary, even if you are pregnant. Just ask your dentist to use a lead apron with a thyroid collar when taking X-rays. Going to the dentist is safe during pregnancy.

YOUR MOUTH MATTERS, BECAUSE:

- Germs in your mouth can be passed on to your baby while you are pregnant.
- Gum disease is linked with premature delivery and low-birthweight babies.

YOU HAVE SUPPORT

If you can't find a ride to or from a dental appointment, call your local Department of Human Services (DHS) office or DHS worker one week before. You'll find those numbers on your medical care ID form.

EAT HEALTHY AND TAKE CARE OF YOUR TEETH

Here are a few tips to help you have a healthy pregnancy:

- Be sure to include foods high in calcium and Vitamin D in your diet.
- Snacking during the day can cause more tooth decay. Try to limit sweet snacks.
- Brush your teeth after eating.
- Remember to brush twice a day and floss every day.
- Stop smoking. Smoking can cause dental problems and hurt your baby.

If you currently smoke and would like help to quit, call the Oregon Tobacco Quit Line at 800-QUIT-NOW (800-784-8669) or visit www.oregonquitline.org.

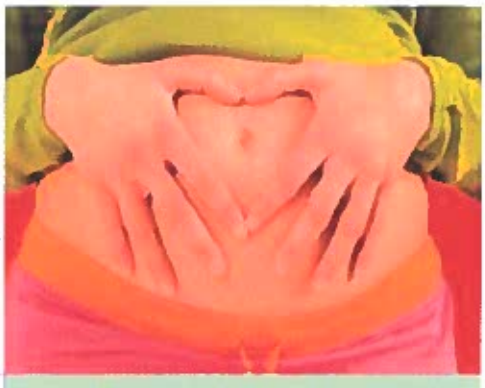
If you need the name of a dentist or have questions about your OHP coverage, call ODS Customer Service at 800-342-0526 or visit us online at www.odscompanies.com/ohp

Insurance products provided by Oregon Dental Service and ODS Health Plan, Inc.

DENTAL HEALTH DURING PREGNANCY FLYER (SPANISH)

ODS

El embarazo y los dientes



Cuidarse los dientes tiene una importancia especial cuando usted está embarazada. La salud de los dientes y las encías puede afectar a la salud del bebé.

CUÍDESE LOS DIENTES Y EL CUERPO

Su salud bucal es importante. Como miembro de ODS, usted puede visitar al odontólogo cada seis meses para hacerse una limpieza. Puede obtener una limpieza extra en el tercer trimestre, si ya se ha realizado dos limpiezas durante los últimos doces meses. El odontólogo la ayudará a asegurarse de que su boca esté sana, lo cual la ayudará a tener un bebé sano.

Se pueden tomar radiografías si es necesario, incluso si está embarazada. Sólo solicítele al odontólogo cuando se saque una radiografía, que utilice un "delantal de plomo" con un cuello que proteja la glándula tiroides. Visitar al odontólogo durante el embarazo es seguro.

SU BOCA ES IMPORTANTE PORQUE

- Los gérmenes que se encuentran allí pueden transmitirse al bebé durante el embarazo.
- Se relaciona a la enfermedad de las encías con el parto prematuro y con bebés que tienen bajo peso al nacer.

USTED TIENE AYUDA

Si no puede trasladarse hacia o desde una cita con el odontólogo, llame a la oficina local del Departamento de Servicios Sociales (DHS, por sus siglas en inglés) o a un empleado de dicho departamento, con una semana de anticipación. Encontrará los números de teléfono en el formulario de identificación de atención médica.

Si necesita el nombre de un odontólogo o si tiene preguntas sobre su cobertura de OHP llame a Servicio al Cliente de Ods al 800-342-0526 o visítenos en Internet en www.odscompanies.com/ohp

TENGA UNA DIETA SALUDABLE Y CUÍDESE LOS DIENTES

Aquí tiene algunos consejos para ayudarla a tener un embarazo saludable:

- Asegúrese de incluir en su dieta alimentos con altos contenidos de calcio y de vitamina D.
- Comer bocadillos durante el día puede producir más caries. Intente limitar los bocadillos dulces.
- Cepíllese los dientes después de comer.
- Recuerde cepillarse los dientes dos veces por día y usar hilo dental todos los días.
- Deje de fumar. Fumar puede ocasionar problemas dentales y dañar al bebé.

Si actualmente fuma y desea abandonar el hábito, llame a la línea para dejar de fumar "Oregon Tobacco Quit Line" al 800-QUIT-NOW (800-784-8669) o visite www.oregonquitline.org

Productos de seguro suministrados por Oregon Dental Service y ods Health Plan, Inc.

CONTACT INFORMATION

Send Dental Claims to:
ODS Dental Claims
PO Box 40384
Portland, OR 97204

Send Complaints and Appeals to:
ODS
Attn: Appeals Unit
P.O. Box 40384
Portland, OR 97240
Fax: 503-412-4003

OHP Customer Service:
Provides information regarding benefits, eligibility, claim status, etc.
503-243-2987
800-342-0526
dentalcasemanagement@modahealth.com

Dental Professional Relations:
Provides information regarding contracts and fee schedules
503-265-5720
888-374-8905
Fax: 503-243-3965
dpr@modahealth.co

Benefit Tracker (BT):
Provides registration and assistance for utilizing this online resource
877-337-0651, (choose option 1)
ebt@modahealth.com

Electronic Data Interchange:
Provides information regarding electronic billing and NEA
503-228-6554
800-852-5195
edigroup@modahealth.com

Health Systems MMIS System and AVR
(Provides information for OHP and eligibility requirements)
MMIS: https://www.or-medicaid.gov/ProdPortal/Default.aspx

Automated Voice Response: 866-692-3864

The most recent version of this handbook is available online at
www.modahealth.com/dental/handbooks.shtml

moda

Questions? Visit modahealth.com or contact
Customer Service at 800-452-1058 or
Professional Relations at 888-374-8905.

601 S.W. Second Ave.
Portland, OR 97204-3154

EXHIBIT B

Oregon Health Authority

OHP Client Agreement to Pay for Health Services

Oregon HEALTH PLAN

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

Provider Section

① Health care services requested:

Procedure codes (CPT/HCPCS):

② Expected date(s) of service:

③ Condition being treated:

④ Estimated fees $ to $

Check one: ☐ There are no other costs that are part of this service.

☐ There may be other costs that are part of this service and you may have to pay for them, too. Other procedures that usually are part of this service may include:

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

⑤ As your provider:

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

Provider Name: NPI:

Provider Signature: Date:

OHP Client Section

⑥ Client Name: DOB: Client ID#:

⑦ I understand:

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

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

Client (or representative's) signature: Date:

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

⑧ Witness signature: Date:

Witness name:

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

Client – Keep a copy of this form for your records

EXHIBIT C

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

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

① ***Check to make sure the service is not covered***
DMAP, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and or Hearing***
Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

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

③ ***Check to see if there are other ways to get the service***
Ask your provider if:

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

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

④ ***Ask about reduced rates and discounts***
Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***
You may find another provider who will charge you less for the service.

Additional costs

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

Questions?

- Call ODS Customer Service department at 800-342-0526, TTY 711, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

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

EXHIBIT C

TILLAMOOK COUNTY HEALTH DEPARTMENT
801 PACIFIC
TILLAMOOK, OREGON 97141
503-842-3900

MRN NUMBER:_____ **RECEIPT NO:** _____
PATIENT NAME:_____ **APPOINTMENT DATE:**_____
DOB:_____ **PHONE:**_____ **APPOINTMENT TIME:**_____
PROVIDER:_____ **CO-PAY:**_____ **DMAP:**_____

DIAGNOSTIC AND PREVENTIVE	CODE
Periodic Oral Eval-*1 annually*	D0120
Limited Oral Eval-*1 annually*	D0140
Comprehensive Oral-*1annually*	D0150
Extensive Oral Eval-*1 annually*	D0160
Comp Perio Eval	D0180
Intraoral-complete	D0210
Intraoral-Periapical 1st	D0220
Intraoral-Periapical ea addl	D0230
Intraoral Occlusal	D0240
Bitewings-Single Film	D0270
Bitewings-Two Films	D0272
Bitewings-Four Films	D0274
Panoramic Film	D0330
[illegible]	D0340
Prophylaxis-Adult	D1110
Prophylaxis-Child	D1120
Fluoride-Child/Adult	D1208
[illegible]	D1320
Sealant-Per Tooth	D1351
Dry Socket-FU	D9930
[illegible]	D9940
[illegible]	D9941
ENDONTICS	
[illegible]	D3120
[illegible]	D3140
[illegible]	D3150
Therapeutic Pulpotomy	D3220
Pulpal Debride, prime / Perm	D3221
Pulpectomy (Apico)	D3410
Root Canal Therapy-Ant	D3310
Root Canal Therapy-Bicuspid	D3320
PERIODONTICS	
Perio scaling/root planing quad	D4341
LLQ LUQ RLQ RUQ	
Full mouth debridement	D4355
Periodontal Maintenance Proc.	D4910
ORAL SURGERY	
Single Tooth	D7140
Ea. Addl. Tooth	D7111
Root Removal-Exposed Roots	D7250
Surgical Extraction	D7210
Soft Tissue Impaction	D7220
Removal-Partial bony	D7230
Removal-Completely Bony	D7240
I & D Abscess	D7510

RESTORATIVE-AMALGAM	TOOTH	SURFACE	CODE
Amalgam-1surface, Primary/Permanent			D2140
Amalgam-2surfaces, Primary/Permanent			D2150
Amalgam-3 surfaces, Primary/Permanent			D2160
Amalgam-4+ Surfaces,Primary/Permanent			D2161
RESIN RESTORATIONS	TOOTH	SURFACE	CODE
Resin-based Composite 1 surface anterior			D2330
Resin-based Composite 2 surface anterior			D2331
Resin-based Composite 3 surface anterior			D2332
Resin-based Composite 4+ surface anterior			D2335
Resin-based Composite 1 surface post.			D2391
Resin-based Composite 1 surface post.			D2392
Resin-based Composite 1 surface post.			D2393
Resin-based Composite 1 surface post.			D2394
Resin Crown-Anterior			D2390
Recement Crown			D2920
Sedative Filling			D2940
CROWNS-SINGLE RESTORATION ONLY			
Stainless Steel-Primary			D2930
Stainless Steel-Permanent			D2931
Recement fixed Partial Denture			D6930

PROCEDURE:_____

DIAGNOSIS	
521.2	Abrasion
523.0	Acute Gingivitis plaque induced
523.01	Acute Gingivitis non plaque induced
523.33	Acute Periondtis
526.5	Alevolitis(Dry Socket)
522.6	Chronic Apical Perio.
523.40	Chronic Periodontitis,unspecified
521	Dental Caries
523.8	Other specified Diseases
520.6	Disturbance in Eruption
522.1	Necrosis of the Pulp
522.4	Origin
522.7	Periapical Abscess
522	Pulpitis
522.8	Radicular cyst
522.5	Sinus
V72.2	Dental Examination

PLEASE ASSIGN APPROPRIATE DIAGNOSIS

Patient Consent to Treatment (Consentiamiento de Tratamiento)

I hereby agree to performance of such treatment that is, in the opinion of the attending physician, deemed necessary to the patient named above. I understand that I am financially responsible to the Provider for all charges incurred. (Estoy de acuerdo con los tratamientos curales el docot crea necesarios por el cliente nombrado. Entiendo que yo soy resonsible por todos los cargos.)

A $26.00 fee will be charged for missed appointments. A $25,00 efectuará cargos para cualquier citas perdidas.

*Patient Signature (La Firma del Paciente)*_____ _____*Date(Fecha)*_____

	TILLAMOOK COUNTY HEALTH DEPARTMENT POLICY AND PROCEDURE	Number: A-E	Revision/ Reviewed: original	Page: 1 of 4
		Effective Date: July 16, 2014		
		Approved By: Marlene Putnam		

EXHIBIT D

Cultural and Linguistic Policy

1. PURPOSE

Tillamook County Health Department (TCHD) will provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

2. POLICY

Tillamook County Health Department follows the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Governance, Leadership, and Workforce:

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care obtained from www.ThinkCulturalHealth.hhs.gov website in cooperation with U.S. Department of Health and Human Services Office of Minority Health.

3. PROCEDURE

Governance, Leadership and Workforce

TCHD staff references two internal policies, "Communication with Persons of Limited English Proficiency" and "Communicating Information to Persons with Sensory Impairments".

County of Tillamook recruits diverse individuals that are responsive to the county population.

TCHD conducts a mandatory cultural diversity training to review effective communication skills for all staff on an annual basis.

Communication and Language Assistance

Cultural

Tillamook County Health Department shall provide for communication with limited English-proficient persons, including current and prospective patients, family, interested persons, et al, to ensure them an equal opportunity to benefit from services. The procedures outlined below will ensure that information about services, benefits, consent forms, waivers of rights, financial obligations, etc., are communicated to limited English-proficient persons in a language which they understand. Patients will be informed that communication services are provided without cost.

- All new employees during orientation will receive instructions on how to communicate with limited English-proficient persons.
- When patients register with the clinic, the staff will note in registration the additional needs of the patient to insure effective communication. Patients will be informed that the services are provided without cost.
- When a translator is needed the nursing staff or provider is responsible for contacting one of the in-house translators if one is available who speaks the needed language.
- If a staff translator is not available or there is none for the needed language, arrangements will be made to provide such translators. The nursing staff or provider is authorized to use the language line to obtain a translator.
- When the clinic's service area from which the majority of its patients are drawn includes one or more national origin minority groups with at least 100 persons with limited English-proficiency (LEP), the clinic will provide consent forms, waivers of rights and information about services, benefits, requirements, etc., in languages other than English to serve the clinic patient population.
- Annually, the clinic will hold a cultural diversity training to review effective communication skills for all staff.

Refer to Tillamook County Health Department policy, "Communication with Persons of Limited English Proficiency".

Linguistic

Tillamook County Health Department will take such steps as are necessary to ensure that qualified persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice concerning benefits or services, and written material concerning waivers or rights or consent to treatment. All aids needed to provide this notice, for example, sign-language interpreters, readers, etc. are provided without cost to the person being served.

When patients register with the clinic, the staff will note in the comment field in registration noting additional needs of the patient to insure effective communication. Patients will be informed that the services are provided without cost.

For Person with Hearing Impairments

- Qualified sign-language interpreter: To obtain a qualified sign-language interpreter to communicate, both verbal and written information, for persons who are hearing-impaired and who use sign-language as their primary means of communication.

- Written materials: All program information will be provided to hearing-impaired persons in writing. Printed materials and writing materials are available.

- State Relay System: Staff will access the Voice Carry Over system by dialing 711Voice Carry Over (VCO) which allows hard of hearing users to speak directly to a hearing person. When the hearing person speaks to you, a CA will type the other party's communication.

For Persons with Visual Impairments

- Reader: Staff will communicate the content of written materials concerning benefits, services, waivers of rights, and consent-to-treatment forms by reading them out loud to visually impaired persons.

For Persons with Manual Impairments

- Personal assistance: Staff will be available to assist individuals as may be required.
- Special equipment: Special equipment (e.g., wheelchairs, walkers, canes, etc.) will be available to assist individuals as may be required.

The basic rights of human beings for independence of expression, decision, and action and concern for personal dignity and human relationships are always of great importance. During sickness, however, their presence or absence become vital, deciding factors in survival and recovery. Thus, it becomes a prime responsibility for the clinic to assure that these rights are preserved for its patients.

In providing care/services, the clinic has the right to expect behavior on the part of the patients, their relatives and friends, which, considering the nature of the illness, is reasonable and responsible.

This statement does not presume to be all-inclusive. It is intended to convey the clinic's concern about the relationship between the medical professionals and patients, or their parent or legally designated representatives; and to emphasize the need for the observance of the rights and responsibilities of patients.

Refer to Tillamook County Health Department's policy, "Communicating Information to Persons with Sensory Impairments".

Engagement, Continuous Improvement and Accountability

TCHD conducts annual Strategic Planning meetings with staff, community and Health Council members. Needs assessments are utilized during the Strategic Planning process in preparation for planning for future development of expanded clinic services for all patients. This includes development of staff skills and on-going trainings.

TCHD conducts Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient surveys on a six month basis. Survey results are reviewed by the Quality Assurance Committee, Health Council and staff.

Patients have the right to conflict and grievance resolution as outlined in Tillamook County Health Department policy, "Patient Grievance Policy". TCHD also utilizes "Speak Up/Speak Out" comment boxes for patients to submit their comments/concerns confidentially.

Community partners and contracted services are expected to comply with the standards that TCHD has set to comply with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

4. CONTROL

The Administrator will review this policy on an as-needed basis to ensure appropriateness and accuracy.

EXHIBIT E

Chronic Pain Management

1. PURPOSE

The purpose of this policy is to:

1. To address the safe and effective treatment of patients with chronic pain at the Tillamook County Health Department and Family Health Centers. **The highest priority is PATIENT SAFETY.**
2. To ensure that our clinics and providers are in compliance with Oregon Board of Medical Examiner Administrative Rules (OAR 847-015-0030) and the ORS 851-056-0000 – 851-056-0026: Clinical Nurse Specialist and Nurse Practitioner Authority to Prescribe and Dispense regarding the use of controlled substances/opiate pain medications for chronic, non-malignant pain.
3. To provide a standard set of rules to reduce misuse and abuse of controlled substances or other medications in selected clients.
4. To set standards for the routine prescribing and refilling of opiates and other controlled substance and for the documentation of these activities.

2. BACKGROUND

The patients of the Tillamook County Health Department and Family Health Centers have a right to a comprehensive assessment of their chronic pain including physical, mental health and alcohol and drug assessment. Providers have the responsibility to diagnose and manage chronic pain, including developing a care plan which is **safe**, legal, minimizes the opportunity for diversion and facilitates improved patient functioning and sense of well-being.

3. POLICY

This policy addresses the safe and effective prescribing of opiates to patient with chronic pain.

Contraindications for treating with opiates (i.e. by policy cannot prescribe):

1. Any history of diversion
2. Opiate risk score: high risk: >90% chance of developing problematic behaviors. Not a suitable candidate for long-term opioid treatment.
3. No Behavioral health screening done for new patients.
4. Undertreated Behavioral Health condition as defined:
    a. If PHQ>15 and:
        i. No active treatment for active diagnosis
        ii. No engagement with Behavioral Health if initiated
        iii. Diagnosis not clear or defined
    b. History of suicide attempt in past 2 years
    c. History of suicide attempt with pills anytime
5. Patient currently in Methadone Maintenance
6. No functional improvement noted after trial or chronic use
7. Lack of a complete work up for pain diagnosis
8. History of misuse/ overuse, such as
    a. Receiving multiple prescriptions from multiple different sites/ providers
    b. Increased ER use for obtaining opiates

c. Previous dismissal and/or opiate agreement violation with another system, clinic, provider; specifically regarding opiates

9. Active substance use (including the use of Marijuana or alcohol) as defined as any mood altering substances or non-prescribed medication use in the past 24 months. If an established patient is currently using marijuana, they will need to obtain a Marijuana Card within 6 months from an outside provider or stop using Marijuana.
10. No non-medication therapies tried (must be at least 2 different modalities done in the past 12 months)
11. Controlled Substance Overview Committee did not review and approve

3. PROCEDURE

New Patients

A. Prior to initiating treatment for chronic pain:

1. Prior to initiating treatment for chronic, non-malignant pain with opiate pain medications, the provider must ensure that all conditions set forth in the Oregon State Board Of Medical Examiner (BME) rules or the Oregon Board of Nursing regarding diagnosis, informed consent and written documentation have been met and are documented in the chart.

2. In addition, the following must be done:
   a. Refer all new patients to the Controlled Substances Oversight Committee before initiation and/or continuation of chronic opiate treatment. Exceptions to this include:
      - Hospice and/or end-of-life care
      - Any acute pain treatment (defined as </ 3 months)
      - Prescribing of </ 10 mg equivalent of MSO4 (e.g. 2 hydrocodone daily)
      - If PCP feels continuation of opioid prescribing is clinically appropriate and has:
        a. Contacted the prior prescribing provider
        b. Submitted for an urgent review via the Controlled Substance Oversight Committee.

   b. Refer all new patients for a Behavioral Health and RN assessment, because chronic pain is strongly linked to mental health and substance abuse issues; this requires at least 2 visit. Evaluation will include:
      - Screening for depression and/or other mental health issues (Appendix E: Patient Wellness Questionnaire)
      - Functional assessment if appropriate (Appendix D: Oswestry Low Back Pain Disability Questionnaire)
      - History of prior evaluation and treatment for chronic pain
      - Opioid Risk Assessment (Appendix F: ORT)
      - Screening for alcohol, drug, and gambling addiction (Appendix E: Patient Wellness Questionnaire)
      - BHP assessment of risk/benefit to patient in prescribing opiates

   c. Obtain UDS

   d. Sleep Risk Assessment (Appendix C: STOP BANG)

   e. Complete medical history related to pain complaints.

f. Review of all outside records obtained through submission of ROI to all prior prescribing providers (not records brought by patient to appointment from prior providers).
g. Check Oregon Prescription Drug Monitoring Program web site (www.orpdmp.com).

B. Work Flow New Patients (See Appendix B: Guidelines Flowchart)

1. First visit: obtain UDS, ROI's, required forms, medical history, chronic pain program and refer to BHP
2. BHP completes assessment and refer chart back to PCP
3. PCP then completes other work, such as review of outside records, H & P, checking Oregon Prescription Drug Monitoring Program
4. At this point, if provider feels patient may be a candidate for opiate pain management, provider refers chart to Controlled Substance Oversight Committee for review.

D. Non-Opioid Treatment

1. Prior to beginning chronic pain treatment with opioids, use patient self-management strategies and other treatment:
   a. Create a plan of treatment with patient that incorporates non-opioid intervention which includes the following:
      a. Patient lifestyle improvement: exercise, weight loss, etc
      b. Behavioral Therapist: support/education groups, case management, psychotherapies
      c. Physiotherapy modalities
      d. Treatment goals outlining pain and functional expectations
      e. Possible steps to achieve these goals
      f. Scheduled periodic monitoring and what monitoring will include
      g. As needed, discussion regarding the risks and benefits of any opioid treatment and refer the patient to the Controlled Substance Oversight Committee for review for opioid treatment

C. Controlled Substance Oversight Committee approved Patients Requirements

1. Patient must review and sign provider-completed Opiate and Controlled Substance Medication Agreement and Material Risk Notice. Review may be done by RN, BHP or Provider. Consent needs to be scanning into the patient's EMR in Epic
2. Create FYI in EPIC
3. Use one of the following medications: oxycodone, hydrocodone, or extended-release morphine not to exceed the following ceiling doses of the equivalency of 90 mg Morphine sulfate. Methadone may be continued for established patients already taking it at not more than the ceiling dose recommended.

Drug	Equianalgesic Dose	Adult starting dose/day	Ceiling dose/day (as single agent)
Morphine	30 mg	30 mg	90 mg
Codeine	200 mg	60-120 mg	180 mg
Hydrocodone	30 mg	10-20 mg	90 mg
Oxycodone	20mg	10-20 mg	60 mg
Methadone (Established Patients Only)	10mg (chronic)	5-15 mg	30 mg
Hydromorphone (Established Patients Only)	5 mg	5-10 mg	22.6 mg

D. Choosing Appropriate Opioid Therapy

1. Preferred medications:
   a. Preferred short-acting agents: Oxycodone and Hydrocodone.
   b. Preferred long-acting agents: extended release morphine.
   (Note: Use Tramadol with extreme caution because of medication interactions. Medication interactions should be assessed carefully (using electronic medication interaction checking) before prescribing Tramadol)

2. Avoid Use of the Following Agents for Chronic Non-Cancer Pain
   a. Meperidine (Demerol).
   b. Combination agonists and mixed agonists/antagonists such as butorphanol (Stadol), dezocine (Dalgan), nalbuphine (Nubain) and pentazocine (Talwin).
   c. Fentanyl patch secondary to high-risk of misuse and abuse, high-risk of overdose, difficult to wean off, and dose effects may last longer than 24 hours.
   d. Parenteral medications.

3. Maximum Dose Threshold
   a. Total opioid dose, long-acting plus short-acting medications, should not exceed 120 mg morphine oral equivalents per day.
   b. All patients being prescribed more than 120 mg morphine dose equivalents (total opioid dose) per day require review via the controlled substance committee.

4. Concomitant Medication Use
   a. Acetaminophen: exercise caution when prescribing opioid-acetaminophen combination drugs to ensure that total daily dose of acetaminophen does not exceed 4.0 grams or, in persons with liver disease/impairment, 2.0 grams.

   b. Benzodiazepines: Caution is advised regarding concomitant use of benzodiazepines. For appropriate prescribing, see the Appropriate Prescribing of Benzodiazepines Policy and Procedure.

   c. Medical Marijuana: For patient on both marijuana and a narcotic (grandfathered under our previous policy), we will no longer continue this regimen; patient must choose either marijuana or opioid pain medications

   a. Promethazine (Phenergan): Caution is advised with concomitant use of opioids and promethazine.
      1. Use in new patients is discouraged.
      2. Established patients on opioids and Phenergan should be reevaluated for alternative nausea measures
      3. Patient requests for Phenergan by name should raise suspicion of opioid abuse/dependence.
      4. Alternatives for nausea include hydroxyzine pamoate, metoclopropamide, ondansetron, and prochlorperazine.

   b. Carisoprodol (Soma): Use is strongly discouraged due to abuse and diversion risk and lack of evidence of benefit.
   c. Chronic Use of Skeletal Muscle Relaxants (methocarbamol, cyclobenzaprine, etc.): Use is discouraged due to lack of evidence of benefit and risk of adverse events.

   d. Chronic Use of Zolpidem (Ambien): Use is discouraged due to lack of evidence of benefit and risk of adverse events and dependence.

e. Barbiturates: DO NOT use due to additive sedating effects.

f. Quetiapine (Seroquel): Use is discouraged due to abuse risk secondary to "high street value" for its known sedative and anxiolytic qualities. Report of abuse, including intranasal administration of pulverized pills, is increasing. Recommend mental health evaluation to determine appropriate ongoing use of medication.

Established Patients on Opiates for Non-Malignant Chronic Pain

1. Discontinue opiates (taper or stop) for patients with first violation of his/her opiate agreement. Refer any patient to CSOC if you would like to offer the patient a "second chance."
2. Screen patient using SBIRT for alcohol and drug use.
3. Review with the patient the new Controlled Substance Medication Agreement and Material Risk Notice and have patient sign agreement
4. Review history for prior suicide attempts, depression and treatment for depression, polypharmacy, psycho-social or medical issues that might put patient at risk for overdose or adverse drug interactions, use of marijuana, benzodiazepine or stimulant use.
5. Review history for reason for use of opiates. Opiates are not indicated for fibromyalgia, chronic low back or neck pain, or chronic headaches, including migraines.
6. Consider the long term effects and side effects of opiates in young patients, under age of 40.
7. Perform UDS every 3-6 months
8. Advise patients that we have added pill counts to our Opiate agreement and get their written consent.
9. Perform pill counts at least every 3-6 months
10. Respond to every opiate violation
11. For patients who are taking more than the new maximum recommended dose of opiates, begin the discussion for tapering their dose slowly over the next several months
12. For patients taking a non-recommended opiate, advise the patient that we will be exchanging the current medication for a recommended medication if appropriate.
13. For patient on both marijuana and a narcotic (grandfathered under our previous policy), advise the patient that we will no longer continue this regimen; patient must choose either marijuana or narcotic pain medications
14. Similarly for patients on both benzodiazepines and opiates, advise patient that this combination of medications is high risk. Discuss other options with the patients and, consult with Mental or Behavioral health provider, if benzodiazepine was prescribed by him/her to create new care plan.
15. Methadone: although we do not recommend initiating therapy with Methadone, it may be safest to continue patients on Methadone, at no more than the ceiling dose (~20mg/day), than to try to change them to another agent. That said there are several other requirements for patients taking Methadone.
    a. Check www.QTDrugs.org for drug interactions with Methadone may cause QT prolongation.
    b. Obtain an EKG every year. If QT is 450-499 msec, consider changing to alternative medication; if QT is >/=500 msec, change to an alternative medication.
    c. Avoid use in patients with structural heart disease.
    d. Evaluate patient for polypharmacy.
    e. Check for drug-drug interactions using UpToDate and avoid combination if interaction is "C," "D," or "X."
    f. Avoid other CNS depressant drugs, especially Benzodiazepines
    g. Have patient sign the Methadone consent and Methadone Material Risk Notice in addition to the regular Opiate and Controlled Substance Medication Agreement.
    h. Discuss Non-Opioid Treatment
        1. Create a plan of treatment with patient that incorporates non-opioid intervention which includes the following:

a. Patient lifestyle improvement: exercise, weight loss, etc
b. Behavioral Therapist: support/education groups, case management, psychotherapies
c. Physiotherapy modalities
d. Treatment goals outlining pain and functional expectations
e. Possible steps to achieve these goals
f. Scheduled periodic monitoring and what monitoring will include
g. As needed, discussion regarding the risks and benefits of any opioid treatment and refer the patient to the Controlled Substance Oversight Committee for review for opioid treatment

Follow Up Visits

1. Patients will be scheduled for periodic follow up visits to assess safety and progress toward treatment goals. Nurses, medical assistants, and other support staff can assist with follow up monitoring by assessing progress toward treatment goals and noting problems with medication. These visits will included
   a. Watching for opioid adverse effects, including problems with affect and sedation
   b. Remember that exacerbations of chronic pain are expected and should not automatically result in a dose increase
   c. Remind patients that chronic pain ebbs and flows
   d. Pill Count
   e. Reinforces realistic expectations of opioid benefits

Contract/Agreement Violations

1. Provider should respond to every violation of the agreement, including no shows, and document response in chart.
   a. Violations most likely to predict abuse:
      1. Stealing or borrowing drugs from another patient
      2. Obtaining drugs from a non-medical source
      3. Concurrent abuse of related illicit drugs
      4. Injecting drugs meant for oral use
      5. Multiple unsanctioned dose escalations
      6. Loss or theft of prescriptions
   b. Violations less likely to predict abuse:
      1. Aggressive complaining about the need for higher doses
      2. Drug hoarding during periods of reduced symptoms
      3. Requests for specific drugs
      4. Unsanctioned dose escalation one or two times
      5. Unapproved use of the drug to treat other symptoms
      6. Reporting unexpected CNS effects
2. Any violation of the agreement should prompt careful reassessment of appropriateness of opiate prescription; discontinuation is best choice. Refer patient to CSOC if there is any question Opiate Management of Specific Contract/Agreement Violations
3. Early refill request or running out and getting supply from outside provider
   a. Evaluate patient for appropriate level of pain control; patient may need dose escalation
   b. Evaluate for opiate abuse and discontinue if appropriate
   c. Consider psychiatric evaluation; patient may be abusing medication to relieve psychiatric symptoms
   d. Counsel patient that repeated, abrupt withdrawal from pain medication which results from early exhaustion of drug supply can compromise good pain management

e. Patients with genuine pain issues and intractable abuse of prescription opiates are sometimes effectively managed through methadone maintenance; consult with medical director of methadone maintenance program

4. Presence of drugs of abuse in urine
   a. A positive screen for drugs of abuse is rarely a false positive
   b. Refer for A&D counseling/ treatment
5. Absence of prescribed drug in urine
   a. Absence of short-acting opiate in urine does not necessarily mean patient is not taking the medication, especially with oxycodone, or when patient uses low doses or takes medication intermittently; if diversion is a concern, see below.
   b. Absence of long-acting opiate in urine is presumptive evidence that patient has not taken the drug or patient may have run out early and should be evaluated as above or patient may not be taking regularly, in which case a long-acting medication may not be appropriate or patient may be diverting medication (see below) and medication should be discontinued
6. Suspected diversion
   a. Documented sale of prescription drugs should result in immediate and permanent termination of all prescriptions for scheduled drugs
7. For unsubstantiated reports or absence of drug in urine:
   a. Increase frequency of UDS
   b. Prescribe only long-acting opiate which can be reliably monitored in the urine
   c. Utilize mid-month, random (without prior notification) recall to the clinic for pill counts and UDS. Less than expected number of pills coupled with a negative UDS is presumptive evidence of diversion and medication should be discontinued.

Weaning Opiates

1. Opiates must be weaned after chronic use. In general patients who have been on regular doses of opiates for over a month should be weaned. Opiate withdrawal symptoms are uncomfortable but not dangerous
   a. Decrease dose by 10% per week for long-acting opiates, 15% per week for short acting
   b. Consider use of Clonidine to minimize side effects (0.1mg – 0.2mg po q 6 hrs), such as anxiety, agitation, muscle aches, sweating, runny nose and cramping. Use cautiously because it may cause hypotension.
   c. For nausea and vomiting, may use Ondansetron (Zofran®), prochlorperazine, or metoclopramide. Do not use Ondansetron with Methadone or other medications which prolong QT interval and cause Torsades de Pointes.
   d. For diarrhea, bismuth subsalicylate may be used
   e. For muscle aches, NSAID's may be used.
   f. For insomnia, trazadone may be used at low doses.
   g. Anticipate increased need for behavioral health support during this process
   h. Provide careful written instructions, documented in the record, as to how to wean down on opiates.

Side Effect Management

1. Constipation
   a. Patient education with emphasis on diet and lifestyle factors.
   b. Prescribe a stool softener such as docusate and a laxative such as senna, MOM, bisacodyl, magnesium citrate, lactulose or sorbitol to take as needed.
   c. Constipation due to chronic opiate use should be viewed as a serious but preventable potential side effect; if ignored, it may result in obstipation and bowel perforation.
2. Nausea/vomiting

   a. Titrate slowly.
   b. Add or increase non-opioid or adjuvant analgesic so that opioid dose can be reduced.
   c. Prochlorperazine, ondansetron (Zofran®), and metoclopramide may be helpful. Do not use Ondansetron with Methadone or other drugs which may prolong QT interval and cause Torsades de Pointes.
   d. Avoid Phenergan.
   e. Tolerance typically develops within 5-10 days of treatment.
3. Histamine reactions (urticaria, sneezing, worsening of asthma, and pruritus)
   a. Add or increase non-opioid or adjuvant analgesic so that opioid dose can be reduced.
   b. Premedication with diphenhydramine 25-50 mg po may help.
4. Mental confusion/sedation
   a. Reduce dose of opiate; reduce or discontinue other medications that may be contributing to the somnolence
   b. Eliminate concomitant, nonessential CNS depressants.
   c. Sedation is a common side effect during the first few days of opioid use and upon subsequent increases in dose. It typically resolves quickly.
   d. Sudden severe sedation often precedes respiratory depression and is a warning sign to decrease the dose or increase the dosing interval.

Indications for a UDS in addition to routine screening every 3-6 months include:

1. Ask about unauthorized use of substances prior to obtaining sample. Self-disclosure of substance abuse is always preferable to obtaining a UDS.
2. Do not obtain a UDS without informed consent (included in Opiate and Controlled Substance Medication Agreement).
3. Perform UDS under following circumstances
   a. Requests for early refills
   b. Lost, stolen or damaged prescriptions
   c. Controlled substance prescriptions obtained or solicited from multiple providers
   d. ER visits to obtain controlled substances
   e. Requests prescriptions of controlled substances by brand name
   f. Requests escalating doses of controlled substances without clear indication
   g. Reluctance to sign ROI from former providers
   h. History regarding substance use is vague or contradictory
   i. Appears intoxicated in clinic
   j. Fails to keep follow up appointments
   k. Fails to engage in care for other chronic illnesses or in preventive health needs
   l. Fails appointments for diagnostic exams or specialty consultation

Other Resources:

Appendix A: Opiate and Controlled Substance Medication Agreement
Appendix B: Guidelines Flowchart
Appendix C: STOP BANG
Appendix D: Oswestry Low Back Pain Disability Questionnaire
Appendix E: Patient Wellness Questionnaire
Appendix F: Opioid Risk Assessment
Appendix G: Material Risk Notice
Appendix H: Non-Opioid Treatment-Treatment Effectiveness Tool and Options

4. CONTROL

This policy will be reviewed by the Controlled Substance Oversight Committee and Medical Director periodically for accuracy and effectiveness of the guidelines.

Appendix A: Opiate and Controlled Substance Medication Agreement

I, _____, have agreed to use controlled substance medication(s) as part of my treatment for _____. I understand that medication(s) may not eliminate my symptoms but may reduce them and improve what I am able to do each day.

I understand the following guidelines for continuing care for pain treatment or other chronic condition requiring the use of controlled substances under the care of the Tillamook County Health Department and Family Health Centers:

1. I understand that I have the following responsibilities:
   - I will take medications at the dose and frequency prescribed.
   - I will not increase or change how I take my medications without the approval of this health care provider.
   - I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
   - I understand that refills will be made only when I am due to run out of medication. No early refills will be given.
   - I will obtain all refills for these medications only at _____ pharmacy (phone number:_____),
   - I will not request any pain medications or controlled substances from other providers including dentists, specialist, and emergency rooms and will inform this provider of all other medications I am taking.
   - I will inform my other health care providers that I am taking these medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
   - I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
   - I will keep medications only for my own use and will not share or sell them to others. I will keep all medications away from children, preferably in a locked location.
   - I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.
   - I will obtain past medical records as requested by my provider.
   - I will bring my medications to each visit in their original containers and agree to pill counts.
   - I understand these medications may impair my ability to operate machinery, such as driving a car or riding a bicycle. If I drive while impaired, I am breaking the law and may be subject to punishment for this offense.

2. I will not use illegal, street drugs, alcohol, marijuana or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other:_____

If in treatment, I will request a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I agree to submit a sample of my own urine or have my blood drawn, whenever requested, at any time for the duration of my treatment with opiates to test for opiates and drugs of abuse. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I will be responsible for the cost of this testing.

4. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.

5. I have received Oregon's Material Risk Notice for opiates and understand that these medications have benefits and risks – including tolerance, physical dependence, addiction – and bad results with over-dosage (including death).

   - I understand these drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
   - I am aware:

     For Men: Opiates may decrease testosterone levels resulting in a change in sexual desire and/or function.

     For Women: If I plan to become pregnant or believe I am already pregnant, I will inform my provider. A newborn could be dependent on opiates and there are always risks of birth defects (although generally not due to opiates).

6. I give permission to my prescribing provider to discuss all diagnostic and treatment details with dispensing pharmacists or other professional who provide my health care for purposes of maintaining accountability and improving treatment.

6. I understand that this provider may stop prescribing the medications listed if:

   - I do not show any improvement in pain or my activity has not improved.
   - I do not adhere to the conditions of this agreement
   - I do not keep appointments with the Behavior Health Provider as recommended
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.

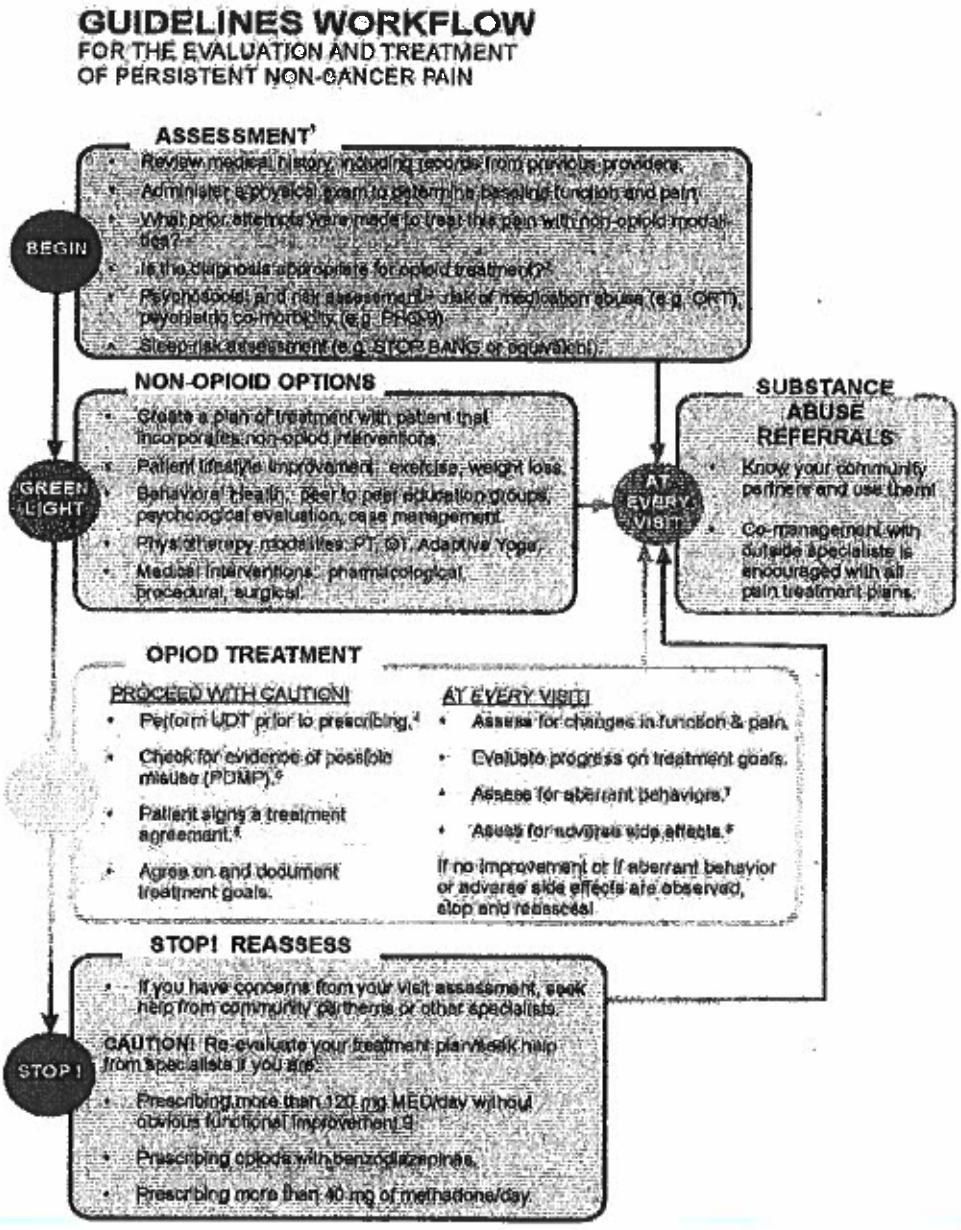
- My behavior is inconsistent with the responsibilities outlines above, ***which may also result in being prevented from receiving further care from this clinic.***

I have read and understand the above Opiate and Controlled Substance Agreement

Signed:_____ Date:_____

Provider:_____ Date:_____

Appendix B: Guidelines Flowchart



Appendix C: STOP BANG

Ask your patient to answer the following questions to determine if he or she is at risk of obstructive sleep apnea.

S (snore)	Have you been told that you snore?	YES	NO
T (tired)	Are you often tired during the day?	YES	NO
O (obstruction)	Do you know if you stop breathing, or has anyone witnessed you stop breathing while you are asleep?	YES	NO
P (pressure)	Do you have high blood pressure, or are you on medication to control high blood pressure?	YES	NO

If the patient answered *yes* to two or more questions on the STOP portion, he or she is at risk of obstructive sleep apnea.

To find out if the patient is at moderate to severe risk of obstructive sleep apnea, he or she should complete the BANG questions below.

B (BMI)	Is your body mass index greater than 28?	YES	NO
A (age)	Are you 50 years old or older?	YES	NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.	YES	NO
G (gender)	Are you a male?	YES	NO

The more questions the patient answers yes to, the greater his or her risk of having moderate to severe obstructive sleep apnea.

Appendix D: Oswestry Low Back Pain Disability Questionnaire

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but manage most of my personal care
- o I need help every day in most aspects of self-care
- o I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives extra pain
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- o I can lift very light weights
- o I cannot lift or carry anything at all

Section 4 – Walking*

- o Pain does not prevent me walking any distance
- o Pain prevents me from walking more than 2 kilometers
- o Pain prevents me from walking more than 1 kilometer
- o Pain prevents me from walking more than 500 meters
- o I can only walk using a stick or crutches
- o I am in bed most of the time

Section 5 – Sitting

- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me sitting more than one hour
- o Pain prevents me from sitting more than 30 minutes
- o Pain prevents me from sitting more than 10 minutes
- o Pain prevents me from sitting at all

Section 6 – Standing

- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing for more than 1 hour
- o Pain prevents me from standing for more than 3 minutes
- o Pain prevents me from standing for more than 10 minutes
- o Pain prevents me from standing at all

Section 7 – Sleeping

- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain I have less than 6 hours sleep
- o Because of pain I have less than 4 hours sleep
- o Because of pain I have less than 2 hours sleep
- o Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9 – Social life

- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- o Pain has restricted my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10 – Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

Fairbank JC, Couper J, Davies JB. The Oswestry Low Back Pain Questionnaire. Physiotherapy 1980; 66: 271-273

Appendix E: Patient Wellness Questionnaire

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things in the past **2 weeks**	0	1	2	3
2. Feeling down, depressed, or hopeless in the past **2 weeks**	0	1	2	3
If you answered "YES" to one of the above questions, please continue to the questions below.				
3. Trouble falling/staying asleep, or sleeping too much in the past **2 weeks**	0	1	2	3
4. Feeling tired or having little energy in the past **2 weeks**	0	1	2	3
5. Poor appetite or overeating in the past **2 weeks**	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, in the past **2 weeks**	0	1	2	3
7. Trouble concentrating on things in the past **2 weeks**	0	1	2	3
8. Moving or speaking slowly, or being fidgety or restless in the past **2 weeks**	0	1	2	3
9. Thoughts of hurting yourself or that you'd be better off dead in the past **2 weeks**	0	1	2	3
If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____			

Nutrition:

Within the past 12 months we worried whether our food would run out before we got money to buy more.	Often true	Sometimes true	Never true	Don't know, or refused
Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	Often true	Sometimes true	Never true	Don't know, or refused

Ask yourself:

Does my partner give me space to be with friends or family?	Yes	NO	NA
Does my partner shame or humiliate me in public or in private?	Yes	NO	NA
Does my partner support my decisions about if or when I want to have children?	Yes	NO	NA
Does my partner threaten me, hurt me or make me feel afraid?	Yes	NO	NA

Please list a safe phone number where you can be reached: _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

Men: How many times in the past year have you had 5 or more drinks in a day?	None	1 or more
Women: How many times in the past year have you had 4 or more drinks in a day?	None	1 or more

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	None	1 or more

Appendix F: Opioid Risk Assessment

OPIOID RISK TOOL PATIENT FORM

Name:_____Age:_____

		Mark Each Box That Applies	Score if Female	Score if Male
1. Family History of Substance Abuse	• Alcohol	☐	1	3
	• Illegal Drugs	☐	2	3
	• Prescription Drugs	☐	4	4
2. Personal History of Substance Abuse	• Alcohol	☐	3	3
	• Illegal Drugs	☐	4	4
	• Prescription Drugs	☐	5	5
3. Age (Mark Box if 16-45 years)		☐	1	1
4. History of Preadolescence Sexual Abuse		☐	3	0
5. Psychological Disease	• Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia	☐	2	2
	• Depression	☐	1	1

Total Score _____Risk Category_____

Low Risk 0-3

Moderate Risk 4-7

High Risk >7

Appendix G: Material Risk Notice

This will confirm that you,_____, have been diagnosed with the following condition(s) causing you chronic intractable pain:_____.
I have recommended treating your condition with the following controlled substances:_____.
In addition to significant reduction in your pain, your personal goals from therapy are:

_____
_____

Alternatives to this therapy are:

_____
_____

Additional therapies that may be necessary to assist you in reaching your goals are:

_____
_____

Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to:

Central Nervous System: Sleepiness, decreased mental ability and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.

Cardiovascular: Irregular heart rhythm from mild to severe.

Respiratory: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.

Gastrointestinal: Constipation is common and may be severe. Nausea and vomiting may occur as well.

Dermatological: Itching and rash.

Endocrine: Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.

Urinary: Urinary retention (difficulty urinating).

Pregnancy: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth

Drug Interactions: With or altering the effect of other medications cannot be reliably predicted.

Tolerance: Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect.

Physical dependence and withdrawal: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flu-like

symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (opiates) need to be slowly weaned (tapered off) under the direction of your physician.

Addiction (Abuse): This refers to abnormal behavior directed toward acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.

Allergic reactions: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (initial one):

_____was satisfied with that explanation and desired no further information

_____requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks.

PATIENT SIGNATURE_____Date:_____

Explained by me and signed in my presence.

PHYSICIAN SIGNATURE_____ Date:_____

Appendix H: Non-Opioid Treatment-Treatment Effectiveness Tool and Options

Patient Lifestyle	Physiotherapy Interventions
›Healthy sleep management › Weight reduction › Diet/nutrition › Stress reduction › Exercise	›Functional therapies - Physical therapy (PT) - Occupational therapy (OT) - Passive modalities
Behavioral Interventions	**Medication Interventions**
›Educational groups - Preventive - Support - Peer-to-peer/Living Well workshops - Shared medical appointments › Psychotherapy - Individual counseling - Group therapy - Cognitive behavioral therapy › Supportive care - Case management › Substance abuse treatment - Residential - Outpatient - Medication-assisted treatment referral › Trauma-informed care - PTSD screening - Domestic violence screening - Child abuse screening	› Non-opioid medications that may aid in chronic pain management - NSAIDS, acetaminophen - Tricyclic antidepressants (neuropathic pain) - Anti-epileptics (neuropathic pain) - Antidepressants (treating underlying depression) - Topical medications › Minimally invasive surgical procedures - Nerve blocks, steroid injections - Interventional treatments: ablations, restorative injections, stimulators, implantable devices - Surgical treatment › Complementary and alternative treatments - Manipulation therapy - Massage therapy - Acupuncture

HIPAA Business Associate Agreement **EXHIBIT F**

This Business Associate Agreement (the "Agreement") is entered into as of July 1, 2015, (the "Effective Date") by and between Tillamook Family Dentistry (the "Covered Entity") and Tillamook County Health Department, (the "Business Associate"), (collectively, the "Parties").

WHEREAS, Tillamook Family Dentistry is a "Covered Entity" as that term is defined in the Health Insurance Portability and Accountability Act, Privacy Standards and Security Standard, 45 C.F.R. Parts 160, 164 (the "Privacy Standards");

WHEREAS, Tillamook County Health Department, is a "Business Associate" as that term is defined in the Privacy Standards and Security Standard, and will have access to Protected Health Information ("PHI") from the Covered Entity;

WHEREAS, pursuant to the Privacy Standards and Security Standard, the Business Associate must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI and must also comply with certain provisions as required under the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"); and

WHEREAS, the Parties wish to enter into this Agreement to comply with the requirements of the Privacy Standards, the Security Standards, and the HITECH Act.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

ARTICLE 1

DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms are defined in the Privacy Standards and Security Standards (45 C.F.R. Parts 160, 164) and the HITECH Act (Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009)).

1.2 All PHI that is created or received by the Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display, by Covered Entity or its operating units to Business Associate on Covered Entity's behalf shall be subject to this Agreement.

ARTICLE II

PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

2.1 Except as limited by 45 C.F.R. 164.504(e), or as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity (check applicable provision):

X For the following specific purposes:
Federally Qualified Health Center (FQHC) Dental Services

☐ As specified in the following agreement between Business Associate and Covered Entity:

See Professional Services Agreement and Modification:

2.2 Except as otherwise limited in this Agreement, Business Associate may also use PHI as follows (check any or all that apply:

X For the proper management and administration of Business Associate
X To carry out the legal responsibilities of Business Associate
X To provide data aggregation services to Covered Entity

2.3 Business Associate may not use or disclose PHI if such use or disclosure would be a violation of the Privacy Standards if don by Covered Entity.

2.4 Any use or disclosure of PHI by Business Associate must comply with the minimum necessary policies and procedures of the Covered Entity. This includes limiting the use or disclosure to a limited data set as defined by the Privacy Rule; unless the Business Associate or Covered Entity, as applicable, determines that a limited data set s not practicable.

2.5 If Business Associate and Covered Entity are also a party to any other agreement, any use or disclosure of PHI by Business Associate must be consistent with such agreement. In the event of any inconsistency between the provisions of the Agreement and the provisions of any other agreement between the parties, the terms of this Agreement shall govern.

2.6 Business Associate agrees it will not use or further disclose PHI other than as permitted or required by this Agreement or as required by law. Business

Associate may not use or disclose PHI if such use or disclosure would be a violation of other applicable law.

ARTICLE III

RESPONSIBILITIES OF BUSINESS ASSOCIATE

3.1 Safeguards. Business Associate agrees to use appropriate physical, administrative or technical safeguards to prevent use or disclosure of PHI other than as permitted by this Agreement or HIPAA.

3.2 Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

3.3 Reporting. Business Associate agrees to report to Covered Entity, in writing, any use of disclosure of PHI in violation of HIPAA of which it become aware within 10 days of the Business Associate's discovery of such unauthorized use and/or disclosure. If Business Associate becomes aware of a breach of any unsecured PHI in the Business Associate's possession, (i.e. PHI that has not been rendered unusable, unreadable or indecipherable to unauthorized individuals), and the breach does not meet the exceptions given in Section 13402 of Title XIII of the HITECH Act, Business Associate shall notify affected individuals as required and shall comply with notification requirement sot the Secretary of the Department of Health and Human Services. Business Associate shall notify Covered Entity of any breach of unsecured PHI as soon as possible, but in no event later than 60 calendar days after discovery.

3.4 Subcontractors. In the event that Business Associate is permitted by law to provide PHI to an agent, Business Associate agrees to ensure that its agents, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees, in writing, to the same restrictions and conditions that apply to Business Associate with respect to such information.

3.5 Right of Access. Business Associate agrees to make PHI available to the Covered Entity or to an individual as directed by the Covered Entity in accordance with the access of individuals to PHI provisions of the Privacy Standards as set for the in 45 C.F.R. § 164.524 in a time and in a manner that are mutually agreeable to the Parties. Additionally, if the Business Associate maintains PHI in an electronic health record, it shall provide a copy of such record in an electronic format upon request.

3.6 Right of Amendment. Business Associate agrees to make PHI available for amendment and to incorporate any amendments to PHI as directed or agreed to by the Covered Entity in accordance with the amendment of PHI provisions of the Privacy Standards as set forth in 45 C.F.R. § 164.526 in a time and manner that are mutually agreeable to the Parties.

3.7 Right to Accounting of Disclosures. Business Associate agrees to make an accounting of disclosures of PHI in the format provided by Covered Entity to Business Associate. Business Associate shall make this information available to Covered Entity, or to an individual directly if requested by the individual (with notice to Covered Entity), as necessary for the Covered Entity to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and the HITECH Act.

3.8 Books and Records. Business Associate agrees to make internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to Covered Entity and/or the Department of Health and Human Services in a time and manner that are mutually agreeable to the Parties and to the Secretary for purposes of determining the Covered Entity's compliance with the Privacy Standards.

3.9 Security Provisions. Business Associate will take the following measures:

3.9.1 Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the Security Rule in accordance with 45 C.F.R § 164.308, 164.310, 164.312 and 164.316;

3.9.2 Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect the electronic PHI;

3.9.3 Develop and enforce appropriate policies, procedures and documentation standards, including designation of a security official; and

3.9.4 Report to the Covered Entity any security incident (as defined in 45 C.F.R. § 164.304) of which it becomes aware, as well as any breach of unsecured PHI as discussed in Section 3.3 above. The Parties agree that the breach notification requirements of Section 3.3 satisfy any notice requirements of Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but unsuccessful security incidents, for which no additional notice to Covered Entity shall be required.

ARTICLE IV

TERM AND TERMINATION

4.1 Term. This agreement shall become effective on the Effective Date and shall terminate when all of the PHI provided by Covered Entity to Business associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 4.2 and 4.3.

4.2 Termination. If either party fails to perform any material obligation pursuant to this Agreement, and (i) cure of the failure to perform the material obligation is possible and the failure to cure continues for a period of 30 days after the breaching party is notified in writing by the non-breaching party of said failure to perform, or; (ii) cure is not possible, then the non-breaching party, may also terminate any other agreement between the parties that involves the use or disclosure of PHI, in the event that Business Associate fails to perform any material obligation pursuant to this Agreement. In addition, Covered Entity may terminate this Agreement without cause upon thirty days written notice to Business Associate.

4.3 Effect of Termination. Upon termination of this Agreement, for any reason, Business Associate or Covered Entity shall, as directed by Covered Entity or Business Associate, return or destroy all PHI received from, or created or received by Business Associate or Covered Entity, on behalf of either Party that either Party still maintains in any form and retain no copies of such information. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate or Covered Entity. If return or destruction is not feasible, Business Associate or Covered Entity shall provide to the other Party notification of the conditions that make return or destruction infeasible. If Covered Entity or Business Associate is in agreement that return or destruction is not feasible, then Covered Entity or Business Associate will agree to extend the protections of this Agreement to the information and to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, for as long as Business Associate or Covered Entity maintains such PHI.

ARTICLE V

MISCELLANEOUS

5.1 Indemnification. Business Associate shall indemnity and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

5.2 Regulatory Reference. A reference in this Agreement to a section in the Privacy Standards, Security Standards or the HITECH Act means the section as in effect or as amended.

5.3 Preemption. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the Privacy Standards, Security Standards or HITECH Act, as amended, the Privacy Standards, Security Standards and the HITECH Act shall control. In the event of an inconsistency between the provisions of the Privacy Standards, Security Standards, the HITECH Act and other applicable confidentiality laws, the provisions of the more restrictive rule will control.

5.4 Independent Entities. None of the provisions of this Agreement is intended to create, nor shall any be construed to create, any relationship between the Parties other than that of independent entities contracting with each other solely to effectuate the provisions of the Agreement.

5.5 Severability. The invalidity or unenforceability of any term or provision of this Agreement shall not affect the validity or enforceability of any other term or provision.

5.6 Amendments. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Standards, Security Standard, the HITECH Act and any future regulations, statutes or other guidance concerning HIPAA or HITECH that may affect this Agreement.

5.7 No Third-Party Beneficiaries. This Agreement shall not in any manner whatsoever confer any rights upon or increase the rights of any third-party.

5.8 Survival of Terms. The obligations of Business Associate under Article II and III of this Agreement shall survive the expiration, termination, or cancellation of this Agreement and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

5.9 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Standards, Security Standards and the HITECH Act.