ATRIO™
HEALTH PLANS

Medicare Advantage Provider Manual

www.atriohp.com

TABLE OF CONTENTS

HISTORY OF ATRIO HEALTH PLANS

Incorporated in 2004, ATRIO is a fully licensed Healthcare Service Contractor (HCSC) by the State of Oregon. ATRIO operates as a collaborative effort between independent physician associations and hospital organizations contracted with the state of Oregon to administer the Oregon Health Plan: Cascade Comprehensive Care, Inc. (CCC) in Klamath County, Umpqua Health, LLC in Douglas County, Oregon Health Management Services (OHMS) in Josephine and Jackson Counties, and WVP Health Authority in Marion and Polk Counties. The primary goal of ATRIO is to keep local attention and control while providing member healthcare.

ATRIO has been offering Medicare Advantage plans since 2005. ATRIO currently offers PPO plans with and without prescription drug coverage, along with Special Needs Plans for individuals dually eligible for Medicare and Medicaid services.

ATRIO's goal is to link exceptional clinical focus with operational excellence. The relationship with providers demonstrates mutual respect with the expectation that ATRIO will fulfill expectations to providers and members by delivering effective and excellent healthcare. ATRIO understands the needs and concerns of its contracted providers, and strives to foster open communication to improve provider satisfaction while simultaneously improving the quality of patient care and service.

All providers and facilities listed in the ATRIO Provider Directory at http://www.atriohp.com/Provider-Directory.aspx are in-network for ATRIO members, regardless of service area location. CMS requires that Medicare Advantage members must live in the service area of their plan in order to be eligible for coverage.

This manual provides critical information regarding ATRIO's in-network provider responsibilities. It coincides with existing provider contractual agreements. However, if any information in this manual is inconsistent with provider contractual agreement terms, the provider contractual agreement will govern.

ATRIO's website at www.atriohp.com has a useful provider search for in-network specialists. If ATRIO is unable to locate a contracted provider within the network, the Provider Relations Department will aid the member and his/her provider(s) in identifying and contracting with an out-of-network provider for the care needed. For information about contracting with ATRIO, contact the Contracting Department at ATRIOcontracting@atriohp.com. For questions about any aspect of this manual or suggestions regarding improvements for future editions, please contact the Provider Relations staff at ProviderRelations@atriohp.com.

CONTACT INFORMATION

ATRIO Health Plans
2965 Ryan Drive SE
Salem, OR 97301

Provider Customer Service:
(**541) 672-8620**

Provider Services Help Desk:
(855) 204-2964

Provider Relations Department:
ProviderRelations@atriohp.com

Prior Authorization Phone #:
(**541) 672-8620**

Prior Authorization Requests Fax: **(866) 440-9525**

Prior Authorization Email:
MedicareMM@atriohp.com

Pharmacy Authorization Requests Fax: **(858) 790-7100**

Pharmacy Customer Service:
(541) 492-5131

Douglas County

Umpqua Health, LLC
(Formerly Architrave Health, LLC)
1813 W Harvard Ave, Suite 431
Roseburg, OR 97471

Josephine / Jackson Counties

Oregon Health Management Services
1867 Williams Highway
Grants Pass, OR 97527

Klamath County

Cascade Comprehensive Care, Inc.
2909 Daggett Ave, Suite 200
Klamath Falls, OR 97601

Marion / Polk Counties

WVP Health Authority
2995 Ryan Drive SE
Salem, OR 97301

CONTRACTING & CREDENTIALING

EXCLUDED PROVIDERS

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

ATRIO CREDENTIALING

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

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

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

PROVIDER DIRECTORY UPDATES

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

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

CMS Mandate:

Managed Care Manual Chapter 4, sec. 110.2.2

CREDENTIALING TERMINATION

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

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

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

CREDENTIALING AFTER A TERMINATION

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

LOCUM TENENS

A Locum Tenens arrangement is made when a participating provider must leave his or her practice temporarily due to illness, vacation, leave of absence, etc. The Locum Tenens is a temporary replacement for that provider for a specified amount of time.

The Locum Tenens physician does not have to be enrolled in the Medicare Advantage program or be in the same specialty as the physician for whom he or she is filling in, but the Locum Tenens must have a National Provider Identifier (NPI) and possess an unrestricted license in the state in which he or she is practicing.

A Locum Tenens physician cannot be used to cover expansion or growth in a practice. Medicare beneficiaries must seek to receive services from the regular physician, and services *may not* be provided by the Locum Tenens over a continuous period of more than 60 days (with the exception of a Locum Tenens filling in for a physician who is a member of the armed forces called to active duty.)

Billing claims with a Modifier Q6 indicates the provider is Locum Tenens. ATRIO will monitor all claims that come in with Q6 modifier to ensure they are processed within the Locum Tenens claim guidelines.

A Locum Tenens that provides services for a participating provider for up to 60 days does not require credentialing. If the Locum Tenens leaves the practice and then returns to the practice for an additional cycle, a new 60-day cycle will be allowed before credentialing is required.

However, if the Locum Tenens provides coverage longer than 60 consecutive days, the applicable practitioner's credentialing application will be mandatory for claims consideration. Locum Tenens claims billed after the 60-day period without completion of credentialing will be denied.

Submitted claims must include the name of the Locum Tenens, or the servicing provider, and will be processed according to member's benefits and contractual guidelines.

OFFICE VISIT ACCESSIBILITY

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

TYPE OF SERVICE TIME STANDARD

Non-urgent or routine care
- Symptomatic: within 7 days (1 week)
- Asymptomatic: within 30 days (4 weeks)

Urgent care
- Schedule as medically appropriate, within 72 hours

Emergent care
- Immediate assessment or referral for treatment

Preventative care
- Within 30 days (4 weeks)

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

Return telephone call from provider's office
- Routine calls: by close of the business day
- Urgent calls: within 4 hours

PROVIDER RIGHTS & RESPONSIBILITIES

PROVIDER RIGHTS

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

PROVIDER RESPONSIBILITES

- Treat all members with respect and courtesy;
- Respond promptly to members' questions and document communications with members as appropriate;
- Comply with all the legal and professional standards of care, ethics, conduct and behavior applicable to health maintenance organizations, their employees and their network providers;
- Provide all members with information concerning the benefits available to them;
- Ensure members have reasonable access to the services to which they are entitled to under their plans;
- Ensure that member requests for access to medical records and information pertaining to their care are responded to in a timely manner;
- Provide members the opportunity to make informed decisions concerning their medical care, including providing information about withholding resuscitative service, forgoing or withdrawing life-sustaining treatment, or participating in investigation studies or clinical trials. Health care providers, as required by law, shall obtain informed consent;
- In making clinical decisions concerning a member's medical care, an ATRIO network provider shall not discriminate based on how the provider or provider network would be financially compensated, or by whether a particular treatment or course of care would be covered by the member's plan;
- Avoid denying, limiting, or adding conditions to any coverage of offered services to a member based on any condition related to the member's health status;
- Agree to accept ATRIO's payment in full for services, and agree to bill ATRIO for all services rendered;

- Accept only coinsurance, deductibles, co-payments and non-covered services charges from members. Providers must “write off” all other charges, and must hold the member harmless for any remaining balances;
- Arrange for the provision of covered services during normal office hours or as otherwise necessary to provide reasonable access to services by members. Providers will arrange for call coverage for medically necessary services on a 24-hour per day, seven day per week basis;
- Return telephone calls from members within a reasonable length of time. The length of time should be appropriate to the members stated condition;
- Provide call share group listing to ATRIO Health Plans including any updates to the call share group;
- Meet and be able to provide documentation of completion of federal fraud, waste and abuse requirements at ATRIO’s request;
- Comply with provisions of the Americans with Disabilities Act (ADA). ADA Accessibility Guidelines for Buildings and Facilities (ADAAG);
- Be prepared to meet the special needs for members who need language interpretation; and
- Ensure physical access to provider offices. Practitioners must provide the following:
    - Street level access or accessible ramp into facility;
    - Wheelchair access to the lavatory;
    - Corridor railings; and
    - Elevators operable from a wheelchair.

ATRIO RIGHTS & RESPONSIBILITIES

ATRIO RIGHTS

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

ATRIO RESPONSIBILITIES

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

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

- Be treated with respect and in a manner that recognizes their need for privacy and dignity;
- Receive assistance in a prompt, courteous, responsible and culturally competent manner;
- Be provided with information about their health care benefits, exclusions, and limitations of the plan, and any charges for which they may be responsible;
- Receive a Notice of Privacy Practices regarding Protected Health Information (PHI);
- Refuse the release of identifiable PHI, except when such release is required by law;
- Have complete confidentiality involving medical diagnosis, treatment or care received from any ATRIO contracted provider;
- Be informed by their physician or other medical care provider of their diagnosis, prognosis and plan of treatment in terms that are understood;
- Have discussions with their provider regarding appropriate or medically necessary treatment options regardless of cost or benefits;
- Expect ATRIO not to interfere with any contracted health provider's discussion regarding treatment options whether covered or not;
- Be provided with access to a directory of contracted providers, to select a Primary Care Provider and to change the Primary Care Provider for any reason;
- Be informed by their physician or other medical care provider about any treatment they may receive;
- Be provided information on all alternate treatments available and their potential values and risks;
- Have their medical care provider request their consent for all treatment, unless there is an emergency and they are unable to sign a consent form and their health is in serious danger;
- Refuse treatment, including any experimental treatment, and be advised of the probable consequences of their decision;
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes;
- Express a complaint about ATRIO's notification, their provider(s) or the care they have received and to receive a response in a timely manner;
- Initiate the grievance procedure if they are not satisfied with ATRIO's decision regarding a complaint; and
- Receive timely access to medical records.

MEMBER RESPONSIBILITIES

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

Did you know?

Definition of "clean claim"

A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

Some of the most common reasons for claim rejections are:

Lack of completed data fields

Missing documentation

Incorrect Member Information (name, ID, birth date, etc.)

Incorrect Provider Information (name, address, NPI, Tax ID, etc.)

Incorrect Insurance Provider Information (Wrong policy number, name, etc.)

Incorrect or mismatched DX and/or CPT codes

Timely filing

CLAIMS SUBMISSION

ATRIO will pay clean claims according to CMS Medicare Advantage Regulations within 30 days from receipt of a clean claim.

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

ELECTRONIC CLAIMS SUBMISSION

CLINICAL INTEGRATION MANAGER (CIM)

ATRIO uses the Clinical Integration Manager (CIM) to document communication with members and their providers. Once a provider office signs up for access and receives a provider log in, username and password, he/she will be able to access specific patient information.

Access for provider offices include the following abilities:

- Submitting authorizations or checking status of authorizations
- Verification of eligibility for patients
- Emails to nurse case managers, Provider Customer Service and Claims staff
- View existing claims
- Messages
- Voucher viewing

Providers may access the Provider Login through http://www.atriohp.com/Providers.aspx. Click "Provider Login" and then the link to "Clinical Integration Manager (CIM)"

To receive access to the Provider Portal, please email Support@phtech.com or call (503) 584-2169, option 2.

Please provide email address, office name, address and phone number to receive username and password.

REQUIREMENTS FOR ELECTRONIC PRINT IMAGE CLAIMS

Carrier Section must read:

ATRIO Health Plans
Claims Administration
PO Box 5490
Salem, OR 97304

CMS-1500 submissions:

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

UB-04 submissions:

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

ELECTRONIC CLAIMS SUBMISSION- ELECTRONIC DATA INTERCHANGE (EDI)

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

ATRIO EDI Support for Transmission and Clearinghouse questions:

- Email: EDI.Support@phtech.com
- Phone: (503) 584-2169 Opt. 1

Did You Know?

In order to ensure faster service and timely payment, providers are encouraged to consider submitting claims electronically.

Please contact EDI Support at 503.584.2169 - Opt. 1, or email EDI.support@phtech.com

PAPER CLAIMS SUBMISSIONS

Professional Form:

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

Institutional Form:

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

Dental Form:

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

Paper claims must follow these guidelines:

- Providing a correct and complete Plan/Carrier name on the claim form increases the ability to process the claim without extra handling and delay
- All required fields of the paper claim form must be completed with valid information. It is essential that the information entered on the claim align in the appropriate boxes
- As a rule, ATRIO will use the information found in the Medicare Claims Processing Manual to determine required fields
- To ensure Optical Character Recognition (OCR) scanning process functions with the highest level of accuracy, all claim forms must be the same size, scale, and alignment as the standard professionally printed version of the form
- Paper claims that are completely typed or printed are accepted. Claims that are completely handwritten are accepted. Individual claims that contain a combination of these methods *will not* be accepted
- A label, correction tape, or other editing media may not be used to change or edit information in a required field
- Labeled or stamped information on a claim, (i.e. “Tracer”, “Corrected Claim”, provider signatures, etc.) are considered informational and can be accepted on both handwritten and typed claims

- Paper claims with attached documentation that is not standard size (8.5”x11”) cannot be scanned or processed without extra handling. This will delay processing of the claim. It is strongly encouraged that providers submit standard size documentation
- In accordance with HIPAA, attachments submitted with a claim may not contain information for individuals who are not the member indicated on the claim
- In order to be accepted, ambulance claims should have complete pick-up and drop-off locations, including street address, city, state, and zip code information on the claim, and/or attached documentation

ATRIO Health Plans

Claims Administration

PO Box 5490

Salem, OR 97304

To purchase forms from the U.S. Government Printing Office:

Call (866) 512-1800

PRIOR AUTHORIZATION ON CLAIM FORM

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

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

- If ATRIO is the secondary payer, please include the primary payer’s explanation of benefits (EOB)
- Please include any additional documentation required under the terms of the provider’s contract for review of authorization

RESUBMISSION OF CORRECTED CLAIMS

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

CLAIMS BILLING REQUIREMENTS

TIMELY FILING OF CLAIMS SUBMISSIONS

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

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

INCORRECT PAYMENT RECOVERY

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

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

In all cases, ATRIO will provide a refund request voucher to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. The standard request notification provides 90 calendar days for the provider to send in the refund, request further information or dispute the overpayment. Once 90 days has passed, payment will be automatically recouped from the provider.

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

BALANCE BILLING

IN-NETWORK PROVIDERS

- Providers *may* collect co-payments, coinsurance and deductibles as appropriate from members
- Providers *may not* charge, or otherwise seek payment from ATRIO members for covered services, in the event of non-payment by ATRIO
- Under no circumstances will providers bill or seek payments from an ATRIO member for a service for which payment is denied or reduced because failure of the provider to comply with utilization management requirements
- Only services that are reasonable and necessary under original Medicare program standards are covered
- Members may seek and accept financial responsibility for non-covered services

- Providers and hospitals that balance bill for non-covered services are obligated to provide prior written notice to ATRIO's members detailing their potential liability. This must include a good faith estimate of the costs
- Providers shall hold-harmless any Dual Eligible members whose Part A & B expenses have been covered up to the full allowable of the State Medicaid Agency

OUT-OF-NETWORK PROVIDERS

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

COORDINATION OF BENEFITS

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

MOTOR VEHICLE ACCIDENT (MVA)

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

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

THIRD PARTY LIABILITY (TPL)

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

Some examples of Third Party Liability may include:

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

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

HOSPITAL ACQUIRED CONDITIONS & NEVER EVENTS

HOSPITAL ACQUIRED CONDITION (HAC)

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

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

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

NEVER EVENTS

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

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

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

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

PROVIDER APPEALS

Appeals/Grievance Address and Phone/Fax Numbers

ATRIO Health Plans: A&G
2965 Ryan Drive SE
Salem, OR 97301
Phone: (877) 672-8620, option 3
Fax: (866) 339-8751

Based on CMS rules, contracted provider appeals are not allowed. Please refer to the "Provider Reconsideration" section for guidance on payment issues. Non-contracted providers may appeal on their own behalf if they sign a Waiver of Liability (WOL). When a non-contracted provider signs a Waiver of Liability, and the denial is upheld, they agree not to bill the member for the services in question.

If a member is impacted financially, he/she has the right to appeal. The provider may act as an authorized representative on the member's behalf with a signed Appointment of Representative statement (AOR.) *Please see Member Appeal Section below*.

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

Appeal forms are located on ATRIO's website at:

http://www.atriohp.com/Providers.aspx

NON-CONTRACTED PROVIDER PAYMENT APPEALS

A non-contracted provider may appeal a payment on his or her own behalf with a Waiver of Liability (WOL).

Requests for appeals must include:

- Member name
- Address
- Member number
- Reasons for appealing
- Request for either a standard or expedited appeal
- Any evidence included for review, such as medical records, doctor's letters, or other information that may support why the service or item is necessary

NON-CONTRACTED STANDARD APPEALS

A non-contracted Medicare provider must file a payment appeal request either verbally or in writing within 60 calendar days of the date of the adverse organization determination.

Non-contracted provider appeals received verbally through ATRIO's Customer Service Center still will be sent to the appealing provider for signature. ATRIO's review of the appeal begins with the receipt of the signed appeal request. Requests for reconsideration after 60 calendar days must show good cause in order for ATRIO to accept the untimely request. Examples of good cause include, but are not limited to:

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

If the extension is granted, ATRIO will respond with a decision in writing within 60 days.

NON-CONTRACTED EXPEDITED APPEALS

Non-contracted provider payment appeals are not subject to any expedited timeframes in the appeal process.

PAYMENT DISPUTES

If Medicare non-contracted providers or suppliers dispute the original payment of claims, a dispute may be sent to ATRIO to be reviewed by appropriate staff for Medicare lines of business only, per CMS guidelines. Payment disputes may be emailed to providerrelations@atriohp.com.

Any payment disputes must be received within 120 days from the date the payment was initially received by the provider or supplier.

ATRIO's Payment Review Determination of the payment dispute will generally be provided within 30 days from the time the payment dispute is first received.

If a provider has exhausted ATRIO's internal dispute process, but still maintains he/she have not been reimbursed fairly, a complaint may be filed through 1-800-Medicare (1-800-633-4227). Additionally, other actions may be taken that the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

MEMBER APPEALS

The member, member's representative, or a provider acting on behalf of the member and with the member's written consent, may file an appeal. Providers do not have appeal rights through the member appeals process. If the member wishes to use a representative, then he/she must complete an Appointment of Representative (AOR) statement, and both must sign the AOR statement. The form is located on ATRIO's website under the "Resources and Support" tab.

Requests for appeals must include:

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

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

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

ATRIO ensures that decision-makers on appeals and/or grievances were not involved in previous levels of review or decision-making when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal involving clinical issues; the appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

For concerns regarding a decision, action or statement by the member's provider, ATRIO encourages the member to discuss these concerns with the provider. If the member remains dissatisfied after discussing the concern with the provider, then he/she may contact the Customer Service department at (877) 672-8620 option 3 for assistance.

MEMBER STANDARD APPEAL

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

ATRIO will respond accordingly:

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

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

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

REVERSAL OF DENIAL OF A STANDARD PRE-SERVICE APPEAL

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

AFFIRMATION OF DENIAL OF A STANDARD PRE-SERVICE APPEAL

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

- For members with Part C, ATRIO will notify the member or his/her representative with a written explanation for the final determination. The complete case file will be sent to the Independent Review Committee (IRE) contracted by CMS. The IRE has 30 calendar days from receipt of the case to issue a final determination;
- For members with Part D, appeals must be initiated by the member or a representative in order to be sent to the IRE;
- ATRIO will notify the member of the decision to affirm the denial and send the case to the IRE. The IRE will notify the member and ATRIO of the final determination; and
- In the event the IRE agrees with ATRIO, the IRE will provide the member further appeal rights

If the IRE overturns the denial, the IRE notifies the member or representative in writing of the decision

EXPEDITED APPEAL PROCESS

To request an expedited pre-service appeal, a member or a provider must submit an oral or written request within 60 days of the event or incident.

A request to expedite an appeal will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which ATRIO makes a less than fully favorable decision to the member. In light of the short time frame for deciding expedited reconsiderations, a provider does not need to be an authorized representative to request an expedited reconsideration on behalf of the member.

RESOLUTION OF AN EXPEDITED APPEAL

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

REVERSAL OF DENIAL OF AN EXPEDITED APPEAL

If ATRIO overturns its initial action and/or the denial, ATRIO will notify the member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

AFFIRMATION OF DENIAL OF AN EXPEDITED APPEAL

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

- Submit a written explanation for a final determination with the complete case file to the IRE contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE

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

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

APPEAL LEVELS

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

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

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

If the answer to the appeal is favorable at any stage of the appeals process after Level 2, ATRIO must send the payment requested to the member or to the provider within 60 calendar days.

CONTRACTED PROVIDER RECONSIDERATIONS

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

Reconsiderations may be mailed to:

ATRIO Health Plans
Provider Reconsiderations
3025 Ryan Drive SE
Salem, OR 97301

Or by email to ProviderRelations@atriohp.com

WHEN CAN A CONTRACTED PROVIDER REQUEST A RECONSIDERATION?

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

HOW OFTEN CAN A CONTRACTED PROVIDER REQUEST A RECONSIDERATION?

Providers can only make the request once when there is no additional information provided for the request. ATRIO must receive the request within 60 calendar days of the denial notification date.

Untimely filing is 61 or more days. If the provider believes they have filed their case within the appropriate time frame, he/she may submit documentation-showing proof.

ATRIO has 60 calendar days to review the payment denial request. Other timelines may be based on individual contracts.

Necessary documentation is required for all cases. It is the responsibility of the provider to provide the requested documentation within 60 calendar days of the denial to re-open the case.

REVERSAL OF DENIAL

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

AFFIRMATION OF DENIAL

Denials will not be overturned for providers who failed to comply with ATRIO protocols. Providers will receive a notice of decision in writing. The criteria used to make the denial decision for medical necessity will be within the letter provided. If it is believed that a policy, action or decision of ATRIO is incorrect, please contact the Customer Service department at (877) 672-8620, option 3 for assistance.

GRIEVANCE PROCESS

The member, or member's representatives acting on the member's behalf, may file a grievance. A grievance is any complaint that does not involve a request for a coverage determination, or an appeal.

If the member wishes to use a representative, then he/she must complete an Authorized Representative Form (ARF.) The form is located on ATRIO's website.

Some examples of grievances are:

- Provider Service including, but not limited to:
  - Rudeness by provider or office staff
  - Refusal to see member (other than in the case of patient discharge from office)
  - Office conditions
- Services provided by ATRIO including, but not limited to:
  - Hold time on telephone
  - Rudeness of staff
  - Involuntary disenrollment from ATRIO
  - Unfulfilled requests
- Services provided by ATRIO including, but not limited to:
  - Difficulty getting an appointment
  - Wait time in excess of one hour
  - Handicap accessibility

Standard grievance requests may be made either verbally or in writing within 60 calendar days of the date of the incident and/or when the member was aware of the incident. ATRIO will respond within 30 days from receipt of grievance.

STANDARD GRIEVANCE

Members or member's representatives shall be notified of the decision as expeditiously as the case requires, based on the member's health status, but no later than 30 calendar days after the date ATRIO receives the oral or written grievance, consistent with applicable federal law. ATRIO will send a closure letter upon completion of the grievance review. The member or the member's representative may request up to a 14-calendar day extension. ATRIO may also initiate an extension if it can justify the need for additional information and if extension is in the member's best interest. In all cases, extensions must be well documented. ATRIO will provide prompt written notification regarding ATRIO's policy that allows a 14-calendar day extension on a grievance case.

The Grievance Department will inform the member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing
- All grievances related to quality of care will include a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO)

For any complaint submitted to a QIO, ATRIO will cooperate with the QIO in resolving the complaint. ATRIO will provide all members with written information about the grievance procedures/process available to them, as well as the complaint processes. ATRIO will provide written information to members and/or their appointed representative(s) about the grievance procedure at:

(a) Initial enrollment

(b) Upon involuntary disenrollment initiated by ATRIO

(c) Upon the denial of an member's request for an expedited review of a determination or appeal

(d) Upon the member's request and annually thereafter. ATRIO will provide written information to members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal for appropriately reviewing and resolution.

EXPEDITED GRIEVANCE

A member, or member's representative, may request an expedited grievance. ATRIO may decide not to expedite a review, expedite an appeal, or invoke an extension to a review. The grievance will be conducted to ensure that the decision to not apply an expedited review period or extend a review period does not jeopardize the member's health. Expedited grievances are orally responded to within 24 hours of receipt. After an oral notification within 24 hours, ATRIO will send a written notice within 3 business days.

Questions or Concerns?

ATRIO Health Plans
2965 Ryan Drive SE
Salem, OR 97301

(877) 672-8620

UTILIZATION MANAGEMENT

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

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

PRIOR AUTHORIZATION/ORGANIZATION DETERMINATION

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

Authorization Request Forms are available and located in ATRIO's website under "Prior Authorizations."

Providers may submit requests for authorization by:

- Faxing a properly completed Inpatient, Outpatient, or Ancillary Services Authorization Request Form;
- Requesting, via telephone, selected services, including urgent requests; or
- Submitting information through CIM.

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

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

CONCURRENT REVIEW

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

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

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

Initial concurrent review is obtained by ATRIO on the first business day following admission to determine appropriateness of the level of care:

- Observation care may be appropriate when testing or re-evaluation is needed to determine the patient's diagnosis and care needs, and/or Observation is needed to determine whether a patient's response is adequate
- Inpatient admission, or transition to inpatient from observation care, is generally indicated when a condition is diagnosed requiring a long-term stay (greater than 24-48 hours) or intensive monitoring is needed for a condition

If the Nurse Case Manager is unable to make a determination, the case is referred to the ATRIO or SAC (Service Area Contractor) Medical Director. Notification to the providers and the members of approval status for observation or inpatient is within 48 hours of receipt date (excluding weekends and holidays).

DISCHARGE PLANNING

ATRIO identifies and provides the appropriate level of care, as well as medically necessary support services for members upon discharge from an inpatient setting. Discharge planning begins upon notification of the member's inpatient status to facilitate continuity of care, post-hospitalization services, and referrals to a skilled nursing facility or rehabilitation facility. ATRIO will evaluate for lower levels of care, and maximize services in a cost-effective manner. As part of the utilization management process, ATRIO will provide for continuity of care when transitioning members from one level of care to another. The discharge plan will include a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. The basis for this will be the information received from the institution and/or providers caring for the member.

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

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

RETROSPECTIVE REVIEW

A retrospective review is any review of care or services that have already been provided.

Services provided by ATRIO may require prior authorization for payment. However, if Prior authorization is overlooked and submitted retroactively, those requests for authorization of payment will be reviewed as provided below. Retroactive requests not meeting the criteria provided is cause for denial of payment by ATRIO.

Requests for retroactive approval should occur infrequently, and providers are required to seek approval in advance.

ATRIO will consider approval of retroactive requests due to other unique circumstances. Documentation of the circumstances that reasonably prevented the provider from seeking prior approval from ATRIO must accompany the retroactive request. The time limit for retroactive request is four months.

PRIOR AUTHORIZATIONS AND REFERRALS

MEDICARE PRIOR AUTHORIZATION GRID

https://www.atriohp.com/Providers.aspx, current Medicare Prior Authorization grid, is within the Prior Authorizations drop down menu.

REFERRALS

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

AUTHORIZATIONS

Prior authorizations are required for Medicare Advantage Plans.

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

ORGANIZATION DETERMINATION (PRIOR AUTHORIZATION) TIMELINES

STANDARD ORGANIZATION DETERMINATION

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

EXPEDITED ORGANIZATION DETERMINATION

A member, member's representative, or any provider may request that ATRIO expedite an organization determination when there is belief that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

ATRIO will provide the member or member's representative with prompt oral notification within 24 hours regarding the denial of an expedited organization determination and the member's rights, and will subsequently mail to the member or member's representative, within three calendar days of the oral notification, a written letter that:

- Explains that ATRIO will automatically transfer and process the request using the 14 calendar day period for standard organization determinations;
- Informs the member of the right to file an expedited grievance if they disagree with the organization's decision not to expedite the determination, and provides instructions about the expedited grievance process and its time frames; and
- ATRIO's organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. ATRIO will notify requesting providers verbally via telephone or via fax of the authorization.

In the event of an adverse determination, ATRIO will notify the member or the member's representative (if appropriate) in writing and provide written notice to the provider.

PRACTICE GUIDELINES

To promote quality care, patient safety and the most appropriate use of health care sources, ATRIO follows the McKesson evidence-based InterQual Clinical Guidelines.

InterQual Guidelines are developed using the industry's most rigorous evidence-based methodology. With nearly 40 years of development, InterQual was the first to provide health care organizations with trusted evidence-based, decision-support criteria. Each content update or addition undergoes review by multiple experts from across the country, as well as an additional round of validation review by independent physicians from each relevant discipline. InterQual examines databases, such as PubMed, the Library of Congress, and the Cochrane Library, and follows national guidelines of organizations such as the Joint Commission, URAC, NCQA, and the Centers for Medicare & Medicaid Services.

ATRIO uses Medicare coverage criteria and InterQual Clinical Care Guidelines as the basis for care management decisions. ATRIO medical directors and review nurses also consider individual clinical circumstances and the capabilities of the local delivery system while reviewing care management determinations. For more information about the McKesson InterQual, please visit their website.

QUALITY IMPROVEMENT

MEDICARE QIO REVIEW PROCESS OF SNF/HHA/CORF TERMINATIONS

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

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

the date coverage is expected to end, by noon (12 p.m.) of the day before coverage ends.

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

CHRONIC CARE IMPROVEMENT PROGRAM (CCIP)

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

Beginning in 2012 CMS required that each MA plan conduct a CCIP focused on reducing and/or preventing cardiovascular disease. Implementation over a five-year period has supported the National HHS Initiative Million Hearts Campaign's goal to prevent one million heart attacks and strokes by 2017.

ATRIO seeks to align its CCIP efforts with the national Million Hearts campaign by supporting good cholesterol management for all members.

Included in ATRIOs CCIP are all-plan members with a diagnosis of diabetes between the ages of 40-75 years, and all-plan members with a diagnosis of ASCVD—males aged 21-75 years and females aged 40-75. Identified members and their prescribers are sent a once year letters outlining the importance of statin (HMG-CoA reductase inhibitors) adherence.

QUALITY IMPROVEMENT PROGRAMS

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

CASE MANAGEMENT

ATRIO case managers are experienced healthcare professionals. The case managers can provide guidance and support for a variety of disease and health related conditions. Case management services may range from answering a relatively simple question to developing a comprehensive assessment of the member's condition, determination of available benefits and resources, and the development and implementation of a plan of care with performance goals, monitoring and scheduled case management follow-up.

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

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

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

SNP MODEL OF CARE

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

- MOC 1—Description of the SNP Population
- MOC 2—Care Coordination
- MOC 3—Provider Network
- MOC 4—MOC Quality Measurement and Performance Improvement

ACTION REQUIRED

It is a CMS requirement that all network and out-of-network providers who are routinely seen by SNP beneficiaries complete initial and annual SNP MOC trainings. Please access the training and associated attestation at the ATRIO website, under the "provider education" drop down. Once providers complete the SNP MOC training, they are required to attest they have completed the training. Providers should maintain their training records and make those training records available to ATRIO when requested. Cooperation and assistance in this process is a CMS requirement, as well as ensuring that the highest quality of care is being provided to ATRIO's SNP members.

TRANSITIONS OF CARE (TOC)

ATRIO makes special effort to coordinate care when SNP members move from one health care setting to another, such as discharge from a hospital. Without coordination, such transitions often result in fragmented and unsafe care for older or disabled members, and the particularly vulnerable SNP beneficiary. ATRIO designed its program with the intent to minimize risks associated with health care transitions.

ATRIO's TOC program consists of the identification of planned or unplanned transitions of care for SNP members. A TOC program introduction letter is sent to the member and primary care provider, including the nurse case manager and point of contact's information, as well as the TOC specific ICP (Individualized Care Plan.) Appropriate case management activities will follow as identified.

ATRIO's TOC program reporting is conducted throughout the year and is presented to the QA Committee on a regular basis. Quality Improvement efforts revolve around the identification of barriers and gaps in care and the implementation of mitigation plans and corrective action strategies.

HEALTH RISK ASSESSMENT (HRA)

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

ATRIO's senior clinical staff, Quality Assurance Committee and Chief Medical Officer annually review the HRA process, as well as annually, or more frequently, review and approve any changes to HRA's.

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

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

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

ATRIO attempts to conduct the initial HRA for new SNP members within 30 days of enrollment. During the 30 days, ATRIO will send two HRA letters. If there is no response, ATRIO will follow up with telephone calls. ATRIO will make a good faith effort to conduct the HRA within 90 days of the effective date of enrollment, and annually thereafter.

MEMBER PROGRAMS

ATRIO offers health improvement programs as enhancements to the total benefit package. These programs help ATRIO members live healthier lives, and strive to reinforce and support treatment plans with providers.

SMOKING CESSATION CLASSES

ATRIO case managers provide outreach in order to direct members to local, online and telephonic smoking cessation options. These include counseling services provided by a qualified physician or other Medicare-recognized practitioner. There is no copay for the smoking cessation counseling service.

Medicare members, both SNP and PPO, can receive assistive Part D medications (e.g., Chantix, bupropion) with their copay. Please refer to the appropriate formulary for medications, tier levels and copays.

HEALTHY LIVING CLASSES

Some ATRIO plans cover attendance to a plan approved evidence based health promotion program for members with chronic conditions. For example, programs such as the Chronic Disease Self-Management Program (licensed through Stanford University) and other similar evidence-based programs are covered.

Some plans also cover general nutritional education through classes and/or individual counseling. See plan benefits for coverage and/or limits.

GYM MEMBERSHIPS

Some ATRIO plans include a fitness benefit to pay for gym memberships. Please see individual plan benefits for coverage and/or maximum allowable for the year.

HEDIS

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

CMS rates plans on a one to five-star scale, with five stars representing the highest quality and one star representing the lowest quality. A summary score is provided as an overall measure of a plan's quality. The Star Ratings measures span five broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process. Plans scoring four stars or higher are eligible for CMS payment incentives. These payment incentives are critical for ATRIO to deliver high quality services.

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

In order to report HEDIS data each year, ATRIO scans medical records for review. These scanned records are used for both HEDIS hybrid data and for Risk Adjustment medical record reviews (see Risk Adjustment). In addition, by scanning the medical record each year, ATRIO has immediate access to historical records for CMS audits.

ATRIO expects providers to:

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

For more information, please visit the website.

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

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

RETROSPECTIVE CHART REVIEWS

ATRIO performs chart reviews of member records to ensure all relevant diagnoses obtained from compliant documentation sources are reported to CMS. The purpose of this initiative is to capture diagnoses that were either not reported via claims data, or the condition reported in claims data was not coded to the highest degree of specificity based on compliant chart documentation.

IN-HOME COMPREHENSIVE HEALTH EVALUATIONS

In an effort to ensure complete and accurate documentation of all medical conditions on an annual-basis, ATRIO is pleased to offer in-home comprehensive health evaluations for all members. These evaluations are performed by licensed medical providers (physicians, nurse practitioners or physician assistants) trained to evaluate for all current and chronic medical conditions. A copy of the report is sent to the member's Primary Care Provider (PCP). Not only does this program provide the PCP with a "birds-eye view" of their patient's living environment, but also serves as a detailed summary of conditions sometimes treated by multiple specialists. Each report is reviewed through a quality assurance process by a professional coder, ensuring accuracy and documentation compliance prior to reporting diagnosis codes to CMS.

RISK ADJUSTMENT PROGRAM

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

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

DOCUMENTATION AND CODING REQUIREMENTS

- Record the patient's name and date of service on each page of the chart
- Ensure the medical record is complete and legible
- Use subjective, objective, assessment, and plan (SOAP) note format when applicable
- Clearly indicate that all diagnoses were addressed and reported
- Report codes only if they were actively addressed (not merely appearing on a problem list)
- Chronic conditions being medically managed should be reported, even if they are not the principle reason for the patient's visit that day. This can be done when reviewing, updating or reconciling a patient's medication list;
- Contributory and co-morbid conditions should be reported if they affect the ongoing care for the patient and were addressed at the visit but not if the condition is inactive or immaterial
- Update all acute and chronic diagnoses with the current status and treatment plan in the progress notes
- On the claim, include the ICD-10-CM code of every diagnosis assessed, treated or considered in the medical decision making for the encounter
- Include the provider's signature and credentials (either handwritten or electronic) on each chart entry. Dictated/transcribed entries also require the provider's signature (either handwritten or electronic). Stamped signatures are not acceptable
- Use only standard medical abbreviations

ADVANCE DIRECTIVES

In every new member packet, ATRIO sends out an Advance Directive packet from Oregon Health Decisions.

PHARMACY

For health plans that include a prescription drug benefit, a comprehensive pharmacy services program is provided that includes formulary management, drug prior authorization, step therapy requirements, drug quantity limitations and a specialty drug program.

PHARMACY NETWORK

ATRIO contracts with MedImpact to access a nationwide network of pharmacies. For a comprehensive list of in-network pharmacies please visit our website at www.atriohp.com/pharmacy-locator. MedImpact's authorization process can be located online at https://mp.medimpact.com/partdcoveragedetermination.

FORMULARIES

ATRIO uses two formularies for the Medicare Advantage line of business: 1) for PPO plans and 2) for Special Needs Plans (SNP). These formularies are updated on a monthly basis. Medicare formularies are located at http://www.atriohp.com/Medicare/Member-Tools-Resources.aspx.

To find out which formulary applies to a patient's pharmacy plan, refer to their ATRIO member ID card to verify what benefit plan they are on, and use the appropriate formulary. The PPO Formulary is a tiered formulary that consists of six tiers. Generic versions of drugs are generally available for the lowest costs. Preferred brands are available at a higher cost, and non-preferred brands for an even higher cost. Specialty drugs are available at the highest cost. The PPO formulary also includes a zero cost tier that consists of select preferred generic drugs for hypertension, diabetes and cardiovascular disease as well as Part D vaccines. The SNP formulary also covers Part D vaccines at zero cost. All other formulary generic and brand medications will process according to the members level of subsidy. For more information regarding the copays for both PPO and SNP, please refer to the formulary. For Medicare plans, non-formulary drugs are not covered. To suggest an addition to a formulary, please mail a written request to:

Chairperson, Pharmacy & Therapeutics Committee
MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

DRUG PRIOR AUTHORIZATION AND STEP THERAPY GUIDELINES

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

Prior authorization and step therapy guidelines are based on current medical evidence. ATRIO will review and update the guidelines regularly in order to accommodate new drugs and changing recommendations. The MedImpact Pharmacy and Therapeutics (P&T) Committee approves all guidelines and formulary changes. The P&T voting members are providers and pharmacists outside of MedImpact. In addition, Medicare prior authorization and step therapy guidelines are reviewed and approved by CMS. Providers can access the current Medicare prior authorization and step therapy guidelines on the ATRIO website or at MedImpact.

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

DRUG QUANTITY LIMITATIONS

Quantity limitations are in place for certain drugs. These limitations include specific quantities over defined time periods. The drug limitations help manage utilization and drug costs, reduce overall healthcare costs, and provide sound, cost effective drug therapies. Quality limitations also prevent fraud, waste and abuse of medications.

The drugs on the formularies will have a limit on the quantity allowed in a 30-day period, and claims can only be considered for this limited amount. Limiting quantities helps ensure that members are using these products appropriately and in a safe manner, according to the FDA-approved dosing guidelines.

If clinical indications warrant a quantity above the limit, please fill out the appropriate form, available on the website, under "Prior Authorization Requirements." Please be aware, although a patient may obtain more medication than the specific dispensing limit, they may be responsible for the cost of the additional quantity.

SPECIALTY DRUGS

Medicare members can use any pharmacy in the network, but ATRIO's preferred specialty network is encouraged.

COVERAGE DETERMINATIONS AND EXCEPTIONS

Exceptions to standard formulary coverage and utilization management rules can be handled using the same prior authorization process indicated above. Formulary exceptions require that a member has tried all formulary drugs available prior to the exception request.

Once a standard request for a drug is received, a written notification of the determination, or a request for more information, is sent to the prescriber as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request. This includes weekends and holidays. Decisions and requests for more information are communicated to prescribers via fax. Decision notifications are delivered to members via a written letter.

If the clinical circumstances warrant an expedited review, and the member's health will be jeopardized by the standard review timelines, please indicate that the request is 'URGENT' or "Expedited". Expedited determinations decisions are communicated verbally and via fax to the prescriber and written letters are sent to members. Expedited determinations will be reviewed within 24 hours.

REPORTING FRAUD, WASTE AND ABUSE

HIPAA VIOLATIONS AND OTHER NON-COMPLIANCE

COMPLIANCE OFFICER

Chris Norman
Phone: (971) 304-0068
Email: compliance@atriohp.com

ATRIO WEBSITE

http://www.atriohp.com/Providers.aspx

PRINTABLE/ONLINE FORM FOR REPORTING

http://www.atriohp.com/documents/Forms/Code-of-Conduct-Printable-Form.pdf

ANONYMOUS MAILBOX

ATRIO Health Plans
PO Box 12645
Salem, OR 97309

CHAIRMAN OF THE BOARD AUDIT COMMITTEE

Chairman of the Board of Directors
ATRIO Health Plans
2965 Ryan Dr. SE
Salem, OR 97301

OFFICE OF INSPECTOR GENERAL (OIG)

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

By TTY: 1-800-377-4950

By E-Mail: HHSTips@oig.hhs.gov

By Physical Mail:

US Department of Health and Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS)

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

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

MEDICAL RECORD ACCESSIBILITY AND HIPAA

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

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

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

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

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

The Notice of Privacy Practices is posted at www.atriohp.com, and is available to all members. If there are any questions or concerns about ATRIO's policy, please contact Customer Service at (541) 672-8620.

NOTICE OF PRIVACY PRACTICES

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

PRIVACY COMMITMENT

ATRIO respects the privacy and confidentiality of Protected Health Information (PHI.) ATRIO will maintain PHI confidentiality in a responsible and professional manner. PHI includes any information regarding healthcare of the member that can identify the member as the recipient of the healthcare services. ATRIO is required by law to maintain the privacy of PHI, provide the member with a privacy notice, abide by the terms of the notice, and to notify the parties involved if a breach of unsecured PHI should occur.

HOW ATRIO MAY USE MEMBER INFORMATION

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

- **For Treatment**: ATRIO may use or disclose information with health care providers who are involved in member health care. For example, information may be shared to create and carry out a plan for individual treatment.
- **For Payment**: To make sure that claims are paid correctly, and the member receives the benefits they are entitled to, ATRIO may use and disclose PHI to determine plan eligibility and responsibility for coverage and benefits. For example, ATRIO may use information to facilitate payment for the care a member receives from health care providers, to coordinate benefits with other plans and facilitate the adjudication or subrogation of health care claims. ATRIO may also use or disclose PHI to review health care services for medical necessity, appropriateness of care or justification for charges, and to facilitate utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review.
- **For Health Care Operations**: ATRIO may use or disclose information during the course of running the healthcare business. These include operational activities such as quality assessment and improvement, performance

measurement and outcomes assessment; health services research; and preventative health, disease management, case management and care coordination. ATRIO may share member information with partners who perform business functions. Information will only be shared if there is a business need to do so, and if the business partner agrees to protect the information.

ADDITIONAL TYPES OF DISCLOSURES:

- State and federal agencies who regulate ATRIO. (For example, the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services, and the Oregon Department of Financial Regulation)
- Authorized public health agencies. For instance, ATRIO may report concerns to the Food and Drug Administration regarding prescription drug and medical device problems
- Appropriate authorities, if there is belief that the member is a victim of child abuse or neglect, domestic violence or other crimes
- The appropriate agencies, if it is believed there is a serious health or safety threat to the member, or others
- Health oversight agencies for activities authorized by law, including audits, criminal investigations, licensure or disciplinary actions
- Law enforcement agencies for identification and location of a suspect, fugitive, material witness, crime victim or missing person
- A court or administrative agency in response to a search warrant, subpoena or other lawful process
- Coroners, funeral directors, medical examiners and organ procurement entities, and for research in limited cases
- Military authorities and authorized federal officials for intelligence, counterintelligence, and other national security activities
- The extent necessary to comply with laws relating to worker's compensation or other similar programs
- To a public or private entity authorized by law to assist in disaster relief efforts

USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

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

Some examples include:

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

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

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

PRIVACY RIGHTS

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

- **Right to request limits on uses or disclosures of PHI**. The member has the right to ask that ATRIO limit how their information is used or disclosed. They must make the request in writing and describe what information they want to limit and to whom they want the limits to apply. While ATRIO may honor the request for restrictions, it is not required that they agree to these restrictions. The member can request that the restriction(s) be terminated in writing or verbally.
- **Right to request confidential communications.** The member has the right to ask that ATRIO share information in a certain way or in a certain place. For example, the member may ask ATRIO to send information to their work address instead of their home address. All reasonable requests will be considered, and must be agreed to if the member states they would be in danger if the request were not granted.

- **Right to See and Get Copies of Records**. Members have the right to inspect and obtain a copy of information that is maintained about them in a designated record set. However, they may not be permitted to inspect or obtain a copy of information that is:
    - Contained in psychotherapy notes
    - Compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding
    - Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provisions of access to the individual would be prohibited by law or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2)

  Additionally, in certain other situations, ATRIO may deny the request to inspect or obtain a copy of information. If that request is denied, ATRIO will notify the member in writing and will provide them with a right to have the denial reviewed. ATRIO may require that the request for information be made in writing. A response to the request will be made no later than 30 days after receipt. If additional time is needed, ATRIO will inform the member of the reasons for the delay and the date of completion of the request, which will be no more than 30 additional days. If a copy is requested, it will be provided to the member in the form and format requested if the information is readily producible in that format. ATRIO will charge a reasonable fee based on copying and postage costs. The member may request a copy of the portion of the enrollment and claim record related to an appeal or grievance, free of charge.
- **Right to Request a Correction or Update of Records**. The member has the right to ask ATRIO to amend information that is maintained in a designated record set. ATRIO may require that the request be in writing and that a reason for the request is provided. ATRIO will respond to the request no later than 60 days after receipt. If ATRIO is unable to act within 60 days, they may extend that time by no more than an additional 30 days. If they need to extend this time, they will notify the member of the delay and the date the request will be completed. If ATRIO makes the amendment, the member will be notified that it was made, and will then obtain an agreement to share the amendment with the relevant persons the member has identified. ATRIO will notify these persons, including their business associates, of the amendment. If the request to amend is denied, ATRIO will notify the member in writing of the reason for the denial. The denial will explain the right to file a written statement of disagreement. ATRIO has a right to rebut member statements. However, the member has the right to request that the written request, the written denial and the statement of disagreement be included with their information for any future disclosures.
- **Right to Get a List of Disclosures**. The member has the right to receive an accounting of certain disclosures of their information made by ATRIO during the six years prior to the request. ATRIO will include all the disclosures except for

those about treatment, payment, and health care operations, and certain other disclosures (such as any the member requested.) ATRIO will provide one accounting a year for free but will charge a reasonable, cost-based fee if another is requested within 12 months.

- **Right to choose someone to act in place of the member**. If the member has given someone medical power of attorney, or if someone is a legal guardian, that person can exercise the rights and make choices about the member's health information. ATRIO will make sure the person has this authority and can act on behalf of the member before any action is taken.
- **Right to get a paper copy of this notice.** The member has the right to ask for a paper copy of this notice at any time.

HOW TO CONTACT ATRIO TO REVIEW, CORRECT OR LIMIT PHI

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

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

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

EXERCISING RIGHTS

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

COMPLAINTS

Private & Confidential Mailing Address:

1050 25th St. SE PMB#12645
Salem, OR 97301

Toll Free: (877) 672-8620

TTY: (800) 735-2900

Fax: 541-672-8670

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

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

The office may be contacted at:

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

Phone: 1-877-696-6775

Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

CORPORATE CODE OF CONDUCT

I. CODE OF CONDUCT

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

II. STANDARDS OF CONDUCT

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

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

ATRIO employees are asked to review this information carefully. If an employee is directed to do something that is or believed to be contrary to the ethical and legal representations of this code, they are required to report the incident to the Chief Compliance Officer, any member of management or directly to the Audit & Compliance Committee of the ATRIO Board or to the Board of Directors. Failure to adhere to these standards can result in criminal and civil penalties. Those actions found to defraud local and/or state health care programs may exclude the offending individuals from participation in these healthcare programs.

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

CONFLICT OF INTEREST

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

These interests may include:

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

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

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

ATRIO has a Conflict of Interests Policy that shall be given to each Employee and member of ATRIO’s Board of Directors. This policy outlines the expectations and requirements regarding Conflicts of Interest in more detail.

CONFIDENTIALITY/PRIVACY

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

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

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

EMPLOYEE RELATIONS: EQUAL OPPORTUNITY EMPLOYER/HARASSMENT

ATRIO values the skills, assets and talent each employee brings to the organization. ATRIO is determined to provide an equal opportunity environment, and will comply with all laws, regulations and policies regarding personnel actions. It is policy to provide equal opportunity without regard to race, religion, color, national origin, age, gender, disability, marital status, veteran status or any other characteristics protected by federal, state or local laws. ATRIO does not discriminate against anyone with a disability regarding terms of employment and will make reasonable accommodations for the disability or special needs of an employee when the condition allows ATRIO to do so.

ATRIO employees have the right to work in an environment that is safe and free of harassment or discrimination. All employees will treat one another with respect, courtesy and fairness and any behavior contrary to this expectation is subject to disciplinary action. ATRIO will not tolerate any sexual, racial, ethnic, religious or other forms of harassment and will address any complaints in the most expedient manner possible. Workplace violence such as robbery, assault (physical or verbal) and other crimes committed by a current, future or former employee will not be tolerated. Employees will not bring firearms, explosive devices or other weapons or dangerous material to the office or workplace.

Every employee is responsible to ensure that the work environment is safe and any one that is a witness to any form of violence, harassment or discrimination is required to report the incident to the Chief Compliance Officer.

FRAUD, WASTE AND ABUSE

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

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

If ATRIO employees are asked to do something they believe is contrary to this Code, state and federal law and the regulatory requirements in which we operate, they should report the incident/occurrence to any member of management, the designated Chief Compliance Officer or CEO. All reports will be handled confidentially and as expeditiously as possible. Further action based on the investigation will be taken by the Audit & Compliance Committee, in accordance with state and federal requirements.

III. REPORTING/INVESTIGATION AND RESPONSE

ATRIO has a confidential disclosure program for all employees to report known or suspected conduct or activities by any person engaged in the performance of duties for ATRIO that violates the Code/Standards of conduct or any state or federal law. This program may also be used for individuals who are uncertain whether an action violates the Code and would like to communicate with the company on a confidential basis.

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

Questions or concerns about potential compliance issues or violations may be addressed to any of the following:

- Supervisors or managers
- Chief Compliance Officer
- The CEO
- Chairman of the Audit Committee

- Any Board of director member
- Website reporting at http://www.atriohp.com
- Confidential mailbox – 1050 25th Street SE, PO Box 12645,Salem, OR 97301

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

Prompt, appropriate and confidential investigation will be conducted for any good faith report. The Chief Compliance Officer will coordinate any findings from the investigations and will share the complaint and investigation with the Audit & Compliance Committee to ensure a complete review. Once a reported violation is researched through the investigation process the Chief Compliance Officer, in coordination with the Audit & Compliance Committee, will initiate any corrective action.

IV. EMPLOYEE RESPONSIBILITIES

- To act with honesty and integrity and in full compliance with the Code/Standards of Conduct;
- Promote honest and ethical behavior within the company;
- Avoid conflicts of interest or if one is possible to disclose the potential conflict for further evaluation;
- To comply with all state and federal rules and regulations;
- Respect the confidentiality of all information acquired in the course of my work and to not disclose information that violates the Confidentiality/Privacy policy of the company;
- To report any violations of this Code/Standards of Conduct or any violations of local, state or federal law;
- To disclose any indictment or potential indictment with regard to a felony, a misdemeanor involving fraud or dishonesty; or any crime punishable by imprisonment for more than one year; and
- To disclose any exclusions by the Department of Health and Human Services (DHHS) Officer of the Inspector General (OIG) or General Services Administration (GSA), or other entity as required.

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

www.atriohp.com