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TITLE: TRANSITION OF CARE

DEFINITIONS:
Member: An Oregon Health Plan client enrolled with Health Share of Oregon.

Priority Populations: Individuals with Serious and Persistent Mental Illness, children 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems and/or have a Serious Emotional Disturbance diagnosis, individuals in medication assisted treatment for Substance Use Disorder, pregnant women and parents with dependent children, children with neonatal abstinence syndrome, children in Child Welfare, IV drug users, individuals with substance use disorder in need of withdrawal management, individuals with HIV/AIDS, individuals with tuberculosis, veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the intellectual and development disability population, and other prioritized members.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering Provider, or bills, obligates and receives reimbursement on behalf of a rendering Provider, also termed a billing Provider.

Subcontractor: An entity that has entered into a contract with Health Share of Oregon to perform designated work under the Health Plan Services Contract.

Transition of Care: The period of time after the effective date of enrollment with the receiving Coordinated Care Organization, during which the receiving Coordinated Care Organization must provide continued access to care.

PURPOSE:
To ensure Members who meet the definition of Priority Populations and are transitioning care from Health Share of Oregon (Health Share) to another Coordinated Care Organization, or from another Coordinated Care Organization to Health Share are provided continued access to the same Providers and treatment plan for continuity of care, as defined in Oregon Administrative Rule 410-141-3860 and 410-141-3870.

POLICY:
I. Members in the Priority Populations as defined and as listed below require active case management to ensure transitions do not adversely impact the Members' current plan of care.
   - Medically fragile children
   - Breast and Cervical Cancer Treatment Program Members
   - Members receiving CareAssist assistance due to HIV/AIDS
   - Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and
   - Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization (see Attachment A – Eligible Population)

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

II. When a Member's care is being transferred to Health Share, Health Share and Subcontractors will make every reasonable effort within the laws governing confidentiality (including but not limited to ORS 414.679) to coordinate the transfer of the Member into the care of the Subcontractor's participating Provider network. The Transition of Care period lasts for ninety (90) days for members who are dually eligible for Medicaid and Medicare, or for other members, the shorter of thirty (30) days for physical and oral health and sixty (60) days for behavioral health, or until the enrollee's new primary care Provider, oral or behavioral health Provider reviews the Member's treatment plan.

III. The receiving Subcontractor shall ensure that any Member meeting the definition for Transition of Care has access to care from their previous Providers until the transition period ends.

A. The receiving Subcontractor will allow the Member to continue receiving services by honoring any written documentation of prior authorization of ongoing covered services from the Member's previous Provider, nor shall there be a service delay if written documentation of prior authorization is not available in a timely manner regardless of whether the Provider participates in the receiving Subcontractor's network, until one of the following occurs:
    i. The minimum or authorized prescribed course of treatment has been completed; or
    ii. The reviewing Provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified Provider.

B. The Subcontractor is responsible for continuing the entire course of treatment with the Member's previous Provider in the following situations:
    - Prenatal and postpartum care;
    - Transplant services through the first-year post-transplant;
    - Radiation or chemotherapy services for the current course of treatment; or
    - Prescriptions with a defined minimum course of treatment that exceeds the Transition of Care period.

C. While the Member continues to receive services from the Member's previous Provider, the receiving Subcontractor will reimburse the non-participating Providers at no less than Medicaid fee-for-service rates.

D. If the Subcontractor determines to not authorize a service authorization request, the Subcontractor will follow all rules outlined in OAR 410-141-3835 and provide the Member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR §438.404 and OAR 410-141-3885.

E. The receiving Subcontractor is not responsible for paying for inpatient hospitalization or post hospital extended care for which a predecessor Coordinated Care Organization or Subcontractor was responsible under contract.

IV. After the Transition of Care period ends, the receiving Subcontractor is responsible for care coordination and discharge planning activities. The Subcontractor is required to approve claims for which it has received no written documentation during the Transition of Care time period, as if the services were prior authorized.

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V. Subcontractors are required to include accountability for achieving successful Transition of Care in their hospital and specialty medical services contracts. Subcontractor is accountable for care coordination and discharge planning activities to assist Members to transition out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the State Hospital.
   A. Subcontractors will participate with the Member and treatment team in discharge planning activities and support warm handoffs (as defined under OAR 309-032-0860(30)) between levels or episodes of care. Specific requirements for care coordinator participation in transition and discharge planning are listed in OAR 410-141-3865.
   B. Subcontractors coordinate transitions to Medicaid-funded long-term care services and supports, after post-hospital extended care is exhausted, by communicating with local Department offices when Members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.

PROCEDURE:

I. When it is the transitioning Coordinated Care Organization, Health Share will ensure Subcontractor provides the following data and information to the receiving Coordinated Care Organization following the file layout specifications in Attachment B within twenty-one (21) calendar days of the Member's effective date with the receiving Coordinated Care Organization in a HIPAA compliant format:
   - Current prior authorizations and pre-existing orders;
   - Prior authorizations for any services rendered in the last 24 months;
   - Current behavioral health services provided;
   - List of all active prescriptions;
   - Current ICD-10 diagnoses; and
   - Current care plan

II. Health Share monitors Transition of Care as part of delegation oversight to ensure Members receive comprehensive transitional care and improved the Members' experience of care and outcomes as it relates to transitions between hospitals and long-term care.

III. Health Share distributes information on the process for Members requiring Transition of Care to Subcontractors through contracts and policies. Subcontractors are required to provide the same information to Providers within their networks.

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

ATTACHMENTS:
Attachment A: Prioritized Population Codes
Attachment B: Transition of Care File Layouts

REFERENCES:
Health Plan Services Contract
Oregon Administrative Rules 410-141-3710, 3850, 3860, 3865, 3870 Oregon Administrative Rule 410-120-1295
42 CFR 438.62 (b)

DocuSigned by:
Mindy Stadtlander
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Mindy Stadtlander, COO

6/12/2023
Date

Department: Delegation and Quality Oversight	**Author:** Alex Covington, Delegation and Quality Oversight Manager
Effective Date: October 2019	**Review Frequency:** Every 2 years
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☒ *Required by Health Plan Services Contract*

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ATTACHMENT A
TRANSITION OF CARE ELIGIBLE POPULATIONS

Priority Conditions with a HEDIS Value Set or Defined by Simple Codes

Condition	Look back time period *(months)*
Acute Myocardial Infarction or Cardiac	3
ALS	24
Asthma*	6
Bone Marrow Transplant	12
Cerebral Palsy	12
Chemotherapy and Radiation Therapy	6
Chronic Heart Failure	6
Cirrhosis	12
COPD* or Emphysema	6
Cystic Fibrosis	6
Dementia	6
Depression*	12
Diabetes with Long Term Complications	3
Eating Disorders*	12
Hemophilia*	6
High Risk Pregnancy	9
HIV*	6
Intellectual and Developmental Disabilities	12 (for 0-18)
Immunocompromised State*	12
Neurodevelopmental Disorders	12 (for 0-18)
Organ Transplant, Kidney or Other	12
Pervasive Developmental Disorder	6
Psychotic or Bipolar Disorders	6
Pulmonary Hypertension	6
Rheumatalogical Conditions*	3
Seizure Disorders	3
Sickle Cell Anemia, HB-S Disease	12
Stage III-IV Kidney Disease, ESRD, or Dialysis	6
Thoracic Aortic Aneurysm	6
Traumatic Brain Injury	6 (for 0-18)
Tuberculosis (active)	6
Ulcerative Colitis or Crohn's Disease*	6

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All conditions are identified through the associated HEDIS value sets, with supplementary identifications (*) identified below:

* Asthma defined using the HEDIS definition for inclusion in the denominator for condition related metrics
* COPD defined using the HEDIS definition for inclusion in the denominator for condition related metrics
* Depression – defined using a partial list from HEDIS value set "Depression or Other Behavioral Health Condition" where the description of the code contains the word "depression". Only members with an inpatient claim in the last 12 months were included. Or in combination with pregnancy (excluding delivery) or diabetes (diabetes combo may include a lot of people, consider reviewing separately)
* Immunocompromised State – Includes HEDIS value sets for "Immunocompromised State" as well as "Severe Combined Immunodeficiency"
* Eating Disorders – claim in last 6 months with diagnosis code F50.xx
* Hemophilia – claim in last 6 months with diagnosis D66
* High Risk Pregnancy – claim in the 9 months prior to date of transition with a diagnosis of O90.90 and still assumed pregnant on date of transition
* HIV – HEDIS value sets for "HIV", "HIV Disease", or "HIV Types 2"
* Pulmonary Hypertension – claim in last 6 months with diagnosis I270, I271
* Rheumatalogical Conditions – includes the HEDIS value sets for "Rheumatoid Arthritis" and "Disorders of the Immune System"
* Ulcerative Colitis or Crohn's Disease – claim in last 6 months with diagnosis code K50.xx or K51.xx

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Priority Conditions with Non-Standardized Definitions

Condition/Treatment	**Look back time period *(months)***
Autism Spectrum Disorder and receiving Applied Behavioral Analysis (ABA)	6
Behavioral Health Medications (3+ psychotropic meds or at least 1 antipsychotic)	12
Dyadic Treatment for Children Under 5 Years of Age	6
Hepatitis C w/Rx Only	6
HIV with Rx claim only	6
Overdose or suicide attempt	6
Substance Use Disorder (SUD) with Medication Assisted Treatment (MAT)	3
SUD without MAT	6
Transgender	6

* ABA – claim in last 6 months with Diagnosis F840 and CPT in 99366, 99368, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T
* Hepatitis C w/Rx Only – NDC value in: 00003001101, 00003021301, 00003021501, 61958180101, 59676022507, 59676022528, 61958220101, 61958150101, 00074308228, 61958220101, 00074309301, 00074309328, 61958220101, 00006307401, 00006307402
* Overdose – Inpatient claim in last 6 months for diagnosis T50991, T50991A, T50991D, T50991S (unintentional, limit to over age 5) or T50992, T50992A, T50992D, T50992S (intentional)
* SUD without MAT – claim in last 3 months
    - OTP: Hedis NDC list "MAT for Opioid Abuse or Dependence Medications" or NDC in 62756097083, 00054018913, 65162041503, 50383093093
    - OBOT: Procedure code in H0020, H0033, T1502, J2315, J0574, J0571, J0572 modifier01 = HG
* SUD, without MAT – claim in last 6 months but does not have a MAT claim in last 6 months
    - ProcedureCD in (90849, 90853, 90887, 97810, 97811, 97813, 97814, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, H0001, H0002, H0004, H0005, H0006, H0010, H0011, H0012, H0013 ,H0014, H0015, H0016, H0048, H2010, T1006, T1007) and (Modifier01CD in (HF) or Modifier02CD in (HF))
    - ProcedureCD in (H0018, H0019) and Modifier01CD in (UA, HB)
    - ProcedureCD in (H0038) and Modifier01CD in (HB, HF, UA)
    - ProcedureCD in (H0038) and Modifier01CD = HQ and Modifier02CD in (HB, UA)
* Transgender – Procedure codes: 55970, 55980, 57111, 55899, 55175, 55180, 54125, 57335, 56625, 56805, 53410, 53411, 53412, 53413, 53414, 53415, 53416, 53417, 53418, 53419, 53420, 53421, 53422, 53423, 53424, 53425, 53426, 53427, 53428, 53429, 53430, ICD-10 F-64

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Priority Places of Service

Priority Places of Service
13: Group Home
31: Skilled Nursing Facility
32: Nursing Facility
34: Hospice
Intensive Outpatient Treatment
Day Treatment
51: Inpatient Psychiatric Facility
55: Residential Substance Abuse Treatment Facility
56: Psychiatric Residential Treatment Center
Long Term Acute Care Hospital
NICU stay longer than 14 days
PICU stay longer 3 days

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

ATTACHMENT B
TRANSITION OF CARE FILE LAYOUTS GUIDE

File Layout Key

Field Name: Short name of the field
Description: The longer more descriptive name of the field
Type: Character = alphanumeric, Number = numeric
Length: Size of the field in number of characters/digits

Claims File Record Types

Record types may vary between Claims, Prior Authorization, and Plan of Care files, but what is consistent for each is the presence of the beginning 'P' record and ending 'T' record.

P Record - The 'P' is the first record in the file and contains information about the health plan number and name. A P record will only occur once per file at the beginning.

H Record - The 'H' record identifies a claim header and contains header level claim fields. Each claim reported in the file will begin with an H record. H records will occur for as many claims as there are to report in the file.

D Record - The 'D' record contains information for each detail relating to the claim. Every H (header) record will have one or more detail records.

T Record – The 'T' record will be the last line of the file. It contains the total number of claims reported. A T record will only occur once per file at the end.

EXAMPLE of what these records will look like in a Claims file named File1 where 2 claims are reported and each claim has 3 details.

```
File1:
P999999          CCO NAME INC                                    MB000000
HM7019179000000  DATA  DATA  DATA
D120190617  DATA  DATA  DATA
D220190617  DATA  DATA  DATA
D320190617  DATA  DATA  DATA
HM7019179000000  DATA  DATA  DATA
D120190613  DATA  DATA  DATA
D220190613  DATA  DATA  DATA
D320190613  DATA  DATA  DATA
T000002
```

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Pharmacy Claim File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains information about the header record for each individual claim sent.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
Claim Type	Identifies the type of claim	Character	1
ICN	Claim unique internal control number	Character	13
Member ID	Recipient's Oregon Medicaid ID	Character	12
Last Name	The last name of the member associated with the Member ID number.	Character	20
First Name	The first name of the member associated with the Member ID number.	Character	15
Provider ID	Billing provider ID	Character	15
Prescribing Prov	Prescribing provider ID	Character	15
MCO Billing Prov	On encounter claims, this is the ID of the provider who billed the CCO.	Character	15
Prescription Num	Number assigned by a pharmacy to identify the drug dispensed to a member	Character	12
Refill Qty	Number of refills on the prescription billed.	Character	2
RX Date	Date the drug prescription (Rx) was either filled or written.	Number YYYYMMDD	8
Disp Date	Date pharmacy dispensed the drug to the member.	Number YYYYMMDD	8
Days Supply	Number of days a prescribed drug should last a member.	Number	9
DAW Code	This field indicates the reason, if any, that a brand name drug was dispensed.	Character	1
DUR Interven	The response of the pharmacist to the DUR message.	Character	2
DUR Outcome	The response of the pharmacist to the DUR message.	Character	2

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Emergency	Indicates whether service was provided as a result of an emergency situation.	Character	3

D Record

The 'D' record contains information about all existing details of each individual claim sent

Field Name	Description	TYPE	LENGTH
Record Type	'D' - Detail Information	Character	1
Detail Number	The detail number of a claim record.	Number	4
NDC	National Drug Code	Character	11
Dispense Qty	Number of units of a drug dispensed to a member. Format 99999999.99	Number	10

T Record

A 'T' record will be the last line of the file. It contains totals for number of claims sent.

Field Name	Description	TYPE	LENGTH
Record Type	'T' - Trailing Record with total number of claims	Character	1
Total Claims	Number of records sent (H records)	Number	6

Dental Claim File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains information about the header record for each individual claim sent.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
Claim Type	Identifies the type of claim	Character	1
ICN	Claim unique internal control number	Character	13
Member ID	Recipient's Oregon Medicaid ID	Character	12
Last Name	The last name of the member associated with the Member ID number.	Character	20
First Name	The first name of the member associated with the Member ID number.	Character	15

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Provider ID	Billing provider ID	Character	15
Rend Prov ID	Rendering/Performing Provider ID	Number	15
MCO Billing Prov	On encounter claims, this is the ID of the provider who billed the CCO.	Character	15
PAN	Identification for a member assigned by a provider. (Patient Account Number)	Character	38
Diagnosis X8	Header diagnosis codes list starting with sequence 1. (*7 char per code in a single field ordered starting with sequence 1 through 8 on the claim*)	Character	56
POS	Place of Service where service was rendered.	Character	2
Accident	Indicates whether the service was provided as a result of an accident.	Character	1

D Record

The 'D' record contains information about all existing details of each individual claim sent

Field Name	Description	TYPE	LENGTH
Record Type	'D' - Detail Information	Character	1
Detail Number	The detail number of a claim record.	Number	4
FDOS	First Date of Service on the claim.	Number YYYYMMDD	8
Tooth	The tooth number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.	Character	2
Surface 1	Code which indicates the tooth surface of a particular tooth.	Character	8
Surface 2	Code which indicates the tooth surface of a particular tooth.	Character	8
Surface 3	Code which indicates the tooth surface of a particular tooth.	Character	8
Surface 4	Code which indicates the tooth surface of a particular tooth.	Character	8
Surface 5	Code which indicates the tooth surface of a particular tooth.	Character	8
Quadrant	The quadrant of the mouth that the procedure on the claim is related to.	Character	2
Procedure	Detail procedure code	Character	6
Diagnosis Ind	Detail Diagnosis Indicator	Number	8
Units Billed	Number of units billed by the provider	Number	6

T Record

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

A 'T' record will be the last line of the file. It contains totals for number of claims sent.

Field Name	Description	TYPE	LENGTH
Record Type	'T' - Trailing Record with total number of claims	Character	1
Total Claims	Number of records sent (H records)	Number	6

Institutional Claim File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains information about the header record for each individual claim sent.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
Claim Type	Identifies the type of claim	Character	1
ICN	Claim unique internal control number	Character	13
Member ID	Recipient's Oregon Medicaid ID	Character	12
Last Name	The last name of the member associated with the Member ID number.	Character	20
First Name	The first name of the member associated with the Member ID number.	Character	15
PAN	Identification for a member assigned by a provider. (Patient Account Number)	Character	38
MRN	Code representing the Medical Record Number.	Character	50
Type of Bill	Header Type of Bill Code.	Character	3
FDOS	Header From Date of Service	Number YYYYMMDD	8
TDOS	Header To Date of Service	Number YYYYMMDD	8
Provider ID	Billing provider ID	Character	15
Facility ID	Facility provider ID	Character	15
Attend Prov	Attending Provider ID	Character	15
Other Prov 1	Performing/Operating Provider ID	Character	15
Other Prov 2	Other Physician ID	Character	15

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

MCO Billing Prov	On encounter claims, this is the ID of the provider who billed the CCO.	Character	15
Admit Date	The date the patient was admitted to the facility for care.	Number YYYYMMDD	8
Admit Time	The time that the member was admitted to the facility for care.	Character	4
Admit Type	Code indicating the type of this admission.	Character	1
Admit Source	Indicates the source of admission.	Character	1
Discharge Hour	Indicates the hour of discharge	Number	4
Pat Status	Header patient status code	Character	2
Condition codes X11	Condition codes (*2 bytes per code in a single field starting with sequence 1 through 11 on the claim*)	Character	22
Occurrence code 1	Occurrence code 1	Character	2
Occurrence FDOS 1	Occurrence 1 FDOS	Number	8
Occurrence Through 1	Occurrence 1 Through date	Number	8
Occurrence code 2	Occurrence code 2	Character	2
Occurrence FDOS 2	Occurrence 2 FDOS	Number	8
Occurrence Through 2	Occurrence 2 Through date	Number	8
Occurrence code 3	Occurrence code 3	Character	2
Occurrence FDOS 3	Occurrence 3 FDOS	Number	8
Occurrence Through 3	Occurrence 3 Through date	Number	8
Occurrence code 4	Occurrence code 4	Character	2
Occurrence FDOS 4	Occurrence 4 FDOS	Number	8
Occurrence Through 4	Occurrence 4 Through date	Number	8
Occurrence code 5	Occurrence code 5	Character	2
Occurrence FDOS 5	Occurrence 5 FDOS	Number	8
Occurrence Through 5	Occurrence 5 Through date	Number	8
Occurrence code 6	Occurrence code 6	Character	2
Occurrence FDOS 6	Occurrence 6 FDOS	Number	8
Occurrence Through 6	Occurrence 6 Through date	Number	8
Occurrence code 7	Occurrence code 7	Character	2
Occurrence FDOS 7	Occurrence 7 FDOS	Number	8
Occurrence Through 7	Occurrence 7 Through date	Number	8
Occurrence code 8	Occurrence code 8	Character	2
Occurrence FDOS 8	Occurrence 8 FDOS	Number	8
Occurrence Through 8	Occurrence 8 Through date	Number	8
Primary Diag	The primary diagnosis code (diagnosis sequence 1)	Character	7
Diagnosis X27	Header diagnosis codes list starting with secondary. (*7 char per code in a single field ordered starting with sequence 2 through 28 on the claim*)	Character	189

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Admit Diag	Admit diagnosis code (diagnosis sequence 'A')	Character	7
Principle ICD procedure	The principal ICD procedure (ICD Procedure Sequence 1)	Character	7
Principle ICD procedure date	The principal ICD procedure Date (ICD Procedure Sequence 1)	Number	8
Other ICD Proc 1	Other ICD procedure code 1 (sequence 2)	Character	7
Other ICD Proc 1 Date	Other ICD procedure date 1 (sequence 2)	Number	8
Other ICD Proc 2	Other ICD procedure code 2 (sequence 3)	Character	7
Other ICD Proc 2 Date	Other ICD procedure date 2 (sequence 3)	Number	8
Other ICD Proc 3	Other ICD procedure code 3 (sequence 4)	Character	7
Other ICD Proc 3 Date	Other ICD procedure date 3 (sequence 4)	Number	8
Other ICD Proc 4	Other ICD procedure code 4 (sequence 5)	Character	7
Other ICD Proc 4 Date	Other ICD procedure date 4 (sequence 5)	Number	8
Other ICD Proc 5	Other ICD procedure code 5 (sequence 6)	Character	7
Other ICD Proc 5 Date	Other ICD procedure date 5 (sequence 6)	Number	8
Other ICD Proc 6	Other ICD procedure code 6 (sequence 7)	Character	7
Other ICD Proc 6 Date	Other ICD procedure date 6 (sequence 7)	Number	8

D Record

The 'D' record contains information about all existing details of each individual claim sent

Field Name	Description	TYPE	LENGTH
Record Type	'D' - Detail Information	Character	1
Detail Number	The detail number of a claim record.	Number	4
Revenue Code	Detail revenue code	Character	4
NDC or description	National Drug Code	Character	11
NDC UOM	This is the NDC Unit of Measure for the Claim Detail.	Character	18
NDC Qty	This is the NDC Quantity for the Claim Detail.	Number	11
HCPCS	Detail procedure code	Character	6
Modifier 1	Procedure code modifier 1	Character	2
Modifier 2	Procedure code modifier 2	Character	2
Modifier 3	Procedure code modifier 3	Character	2
Modifier 4	Procedure code modifier 4	Character	2
FDOS	Detail From Date of Service	Number YYYYMMDD	8
Units Billed	Detail units billed	Number	9

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

T Record

A 'T' record will be the last line of the file. It contains totals for number of claims sent.

Field Name	Description	TYPE	LENGTH
Record Type	'T' - Trailing Record with total number of claims	Character	1
Total Claims	Number of records sent (H records)	Number	6

Professional Claim File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains information about the header record for each individual claim sent.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
Claim Type	Identifies the type of claim	Character	1
ICN	Claim unique internal control number	Character	13
Member ID	An assigned number which uniquely identifies a recipient.	Character	12
Last Name	The last name of the member associated with the Member ID number.	Character	20
First Name	The first name of the member associated with the Member ID number.	Character	15
Provider ID	Billing provider ID	Character	15
Ref Prov ID	Provider ID of the Referring Provider billed on the claim	Character	15
MCO Billing Prov	On encounter claims, this is the ID of the provider who billed the CCO.	Character	15
Accident	Indicates whether the service performed was as a result of an accident.	Character	1
Accident Date	Date of accident.	Number YYYYMMDD	8
Diagnosis X12	Header diagnosis codes list starting with sequence 1. (*7 char per code in a single field ordered starting with sequence 1 through 12 on the claim*)	Character	84

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

PAN	Identification for a member assigned by a provider. (Patient Account Number)	Character	38

D Record

The 'D' record contains information about all existing details of each individual claim sent

Field Name	Description	TYPE	LENGTH
Record Type	'D' - Detail Information	Character	1
Detail Number	The detail number of a claim record.	Number	4
Rend Prov ID	Detail rendering provider ID	Number	15
NDC	National Drug Code	Number	11
NDC UOM	This is the NDC Unit of Measure for the Claim Detail.	Character	18
NDC Qty	This is the NDC Quantity for the Claim Detail.	Number	11
FDOS	Beginning date of service on the claim detail	Number YYYYMMDD	8
TDOS	Ending date of service on the claim detail	Number YYYYMMDD	8
POS	Place of Service where service was rendered.	Character	2
Emergency	Indicates whether the service was provided as result of emergency situation	Character	3
Procedure	Detail procedure code	Character	6
Modifier 1	Procedure code modifier 1	Character	2
Modifier 2	Procedure code modifier 2	Character	2
Modifier 3	Procedure code modifier 3	Character	2
Modifier 4	Procedure code modifier 4	Character	2
Diagnosis Ind	Detail diagnosis indicator	Number	8
Units Billed	Number of units billed by the provider.	Number	9
EPSDT Ref	EPSDT referral/treatment information	Character	1
EPSDT/ Fam Plan	EPSDT or Family Planning indicator	Character	1

T Record

A 'T' record will be the last line of the file. It contains totals for number of claims sent.

Field Name	Description	TYPE	LENGTH
Record Type	'T' - Trailing Record with total number of claims	Character	1
Total Claims	Number of records sent (H records)	Number	6

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Plan of Care (POC) Extract File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains header POC information.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
Client ID	Client this POC is for	Character	8

D Record

The 'D' record contains information for each POC Line Item

Field Name	Description	TYPE	LENGTH
Record Type	D' - Detail Information	Character	1
Service Authorization Number	The unique identifier assigned to the service line item.	Character	10
Rendering Provider ID	The ID of the rendering provider.	Character	15
Referring Provider ID	The ID of the referring provider.	Character	15
Service Code Type	Identifies the type of service on the line item. Selectable values are Procedure Code and Revenue Code.	Character	15
Service Code	The code identifying the line item service.	Character	6
Modifier 1	A code used in combination with a procedure code to provide additional information.	Character	2
Modifier 2	A code used in combination with a procedure code to provide additional information.	Character	2
Modifier 3	A code used in combination with a procedure code to provide additional information.	Character	2
Modifier 4	A code used in combination with a procedure code to provide additional information.	Character	2
Effective Date	The date the service line item is effective.	Number YYYYMMDD	8
End Date	The date the service line item is no longer effective.	Number YYYYMMDD	8
Units	The number of units of the service.	Number	5

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Unit Qualifier (Description)	The description of the type of units (what the units represent).	Character	20
Frequency (Description)	Frequency for this type of unit	Character	20
Status	The current status of the service authorization line item.	Character	20
Used Units	The quantity of units that have been used to pay a claim.	Number	5
Balance Units	The quantity of units remaining and available to be used by claims.	Number	5
Date Approved	Date POC Approval Status was assigned (AUDIT TRAIL)	Number YYYYMMDD	8

T Record

A 'T' record will be the last line of the file. It contains totals for number of POC sent.

Field Name	Description	TYPE	LENGTH
Record Type	T' - Trailing Record with total number of POC	Character	1
Total POC	Number of records sent (H records)	Number	6

Prior Authorization (PA) Extract File Layout

P Record

The 'P' record contains information about the receiving CCO Provider.

Field Name	Description	TYPE	LENGTH
Record Type	'P' (Batch Record)	Character	1
PHP OMAP Provider Number	The PHP OMAP provider number entered on the claim header.	Character	15
PHP	Name of PHP (submitter)	Character	50
Trading Partner Number	Internal application identifier for the trading partner.	Character	15

H Record

The 'H' record contains header PA information.

Field Name	Description	TYPE	LENGTH
Record Type	'H' – Header Information	Character	1
PA Assignment	This is used to categorize PA requests.	Character	30
PA Number	Prior Authorization number	Character	9
Provider ID	The requesting provider's identification number. The provider ID entered can be either the National Provider Identifier (NPI) or the Medicaid ID (MCD).	Character	15
Referring ID	The referring provider's identification number. The provider ID entered can be either the National Provider Identifier (NPI) or the Medicaid ID (MCD).	Character	15

DocuSign Envelope ID: FC20D803-CC45-449C-BEFD-BD4FB47B2EF0

Current ID	This is the Recipient's Medicaid identification number.	Character	8

I Record

The 'I' Diagnosis Code record indicator.

Field Name	Description	TYPE	LENGTH
Record Type	'I' (Diagnosis Record)	Character	1
Diagnosis Code	ICD Diagnosis Code associated with the PA. **(SYSTEM ALLOWS UP TO 20 PER PA).**	Character	7

V Record

The 'V' Internal Text record indicator.

Field Name	Description	TYPE	LENGTH
Record Type	'V' (Internal Text)	Character	1
Internal Text -Date Entered	This is the date the internal text comment was originally added.	Number YYYYMMDD	8
Text delimiter	Three single quotes	Character	3
Internal Text - Description	This is the internal free form text entered by the user.	Character	<= 1000
Text delimiter	Three single quotes	Character	3

D Record

The 'D' record contains information for each PA Line Item.

Field Name	Description	TYPE	LENGTH
Record Type	'D' - Detail Information	Character	1
Line Item	A two character field that uniquely identifies each service line of the PA. This field is automatically populated with the next available line item value for the PA. Line Item values range from 01 through 99.	Character	2
Authorized Eff. Date	The date the line item service is authorized to begin.	Number YYYYMMDD	8
Authorized End Date	The date the line item service is authorized to end.	Number YYYYMMDD	8
Status	Identifies the current status of the line item. Selectable values are determined by the statuses contained within the PA Decision Status code table (T_PA_LINEITEM_STAT).	Character	20
Date Approved	Date PA Approval Status was assigned (AUDIT TRAIL)	Number YYYYMMDD	8
Service Provider ID	The service provider's identification number. Either the National Provider Identifier (NPI) or the Medicaid ID (MCD).	Character	15
Service Type Code	This field identifies the type of service on the line item. Selectable values are NDC Code, ICD-PROC, Procedure Code and Revenue Code.	Character	14

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Procedure Code	The HCPCS code that identifies a procedure.	Character	6
NDC Code	The National Drug Code used to uniquely identify a drug.	Character	10
ICD-Proc	The ICD procedure code that identifies a surgical procedure.	Character	7
Revenue Code	The code that identifies a specific accommodation or ancillary service.	Character	4
Modifier 1	A code used in combination with a procedure code to provide additional information regarding the procedure.	Character	2
Modifier 2	A code used in combination with a procedure code to provide additional information regarding the procedure.	Character	2
Modifier 3	A code used in combination with a procedure code to provide additional information regarding the procedure.	Character	2
Modifier 4	A code used in combination with a procedure code to provide additional information regarding the procedure.	Character	2
Authorized Units	The amount of authorized units for the service on the line item.	Character	9
Quantity Used Units	This field indicates the number of units used by claims on the line item. This is a calculated field	Number	9

R Record

The 'R' record hold reason code information.

Field Name	Description	TYPE	LENGTH
Record Type	'R' - Reason record marker	Character	1
Reason Code	The code that identifies the reason for the line item decision.	Character	4
Text delimiter	Three single quotes	Character	3
Reason Code Description	The descriptive text associated with a reason code. This field is display only based on the reason code selected in the Reason Code field.	Character	<= 500
Text delimiter	Three single quotes	Character	3

T Record

A 'T' record will be the last line of the file. It contains totals for number of POC sent.

Field Name	Description	TYPE	LENGTH
Record Type	T' - Trailing Record with total number of PAs	Character	1
Total PA	Number of records sent (H records)	Number	6

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Envelope Sent	Hashed/Encrypted	5/30/2023 | 10:17 AM
Certified Delivered	Security Checked	6/12/2023 | 08:48 AM
Signing Complete	Security Checked	6/12/2023 | 08:49 AM
Completed	Security Checked	6/12/2023 | 08:49 AM

Payment Events	Status	Timestamps