CareOregon

Health-Related Services
Flexible Services Funding Request

Health-Related Services Policy

These services are provided instead of or as an adjunct to benefits and are intended to improve health delivery and member health and lower costs. Flexible services are likely to be cost-effective alternatives to covered benefits and are likely to generate savings. These services may effectively treat or prevent physical, oral, or behavioral health conditions, improve health outcomes, and prevent or delay health deterioration. Flexible services are consistent with the member's treatment plan as developed by the member's care team and documented in the member's medical record as specified in OAR 410-141-3180.

Eligibility

To be considered for Health-Related Services, the member must be enrolled in the Oregon Health Plan for primary or secondary coverage. Any services or items reviewed as Health-Related Services must be consistent with the member's treatment plan as developed by the member's care team and documented in the member's medical record. If the item or service has an OHP billing or encounter code, we will not be able to review this is a health related service.

3rd Party Resources

CareOregon also requires that other resources within the community be pursued first, Health-Related Services should only be used when no other funding source is available to cover the cost of the item(s) or services(s) purchased. As a last resort, CareOregon may provide a partial amount of the cost to supplement the amount of the item or service along with additional support from other resources.

Requesting Party

Any Health-Related Services request must come from the primary care team. The primary care team consists of any medical provider with direct access to the member's primary care plan and medical records. The primary care team may include but is not limited to: primary care physician team, specialists, surgeons, mental health provider, dental provider, or hospital discharge planner.

It is important to note that while the primary care team must sign and agree to Health Related Services request form requirements, other parties may be involved in the process of developing the request and advocating for member needs. Member advocates for Health-Related Services may include but are not limited to: Population Health Partnerships direct service staff, case workers and managers, social services agencies, and family members.

Time Frame

All urgent requests must be submitted 24 business hours prior to needed item/service requested.

Non-Urgent requests must be submitted at minimum 7-10 business days prior to the needed item/ service requested.

Required Documents

All Health-Related Services requests must include:

1. A complete request form,
2. Medical records or chart notes supporting the request
3. And information regarding all third party resources sought prior to Health-Related Services request.

Please note that third party resources must be pursued before a Health-Related Services request will be considered.

Procedure

1. Requestor (primary care team along with member advocates as needed) completes the request form.
2. Requestor includes medical documentation, cost estimate for requested items, and the member's treatment plan as it relates to the item or services requested.
3. Triage Coordinator will prepare for and conduct a clinical review and engaged with the requestor for additional information as needed.
4. Clinical Review panel will review request.
    a. If the request is over $250, a Medical Director will participate in the clinical review of the requested item or service.
5. If approved or denied, a written outcome letter will be sent to both the requestor and the CareOregon member.
6. The primary care team commits to updating the member's health record with the written outcome letter and request form. The request form and written outcome letter will also be uploaded to the member's profile on PreManage by CareOregon staff.

Barriers to Request Approval

1. Request form is incomplete.
2. CareOregon is unable to reach requestor.
3. Medical documentation is not attached to the request form.
4. The member's treatment plan as it relates to the item or service is not included with the request form.
5. The request is not signed by the primary care team.
6. Alternate community resources were not sought prior to Health-Related Services request.
7. The item has an OHP billing code.
8. The member is not enrolled in OHP for primary or secondary coverage.

Payment & Delivery Method

CareOregon manages direct payment for item and/or service(s) requested on behalf of the member and requesting provider.

If the request is an item, and if appropriate, we require the requesting party provide 3 quotes from various vendors to provide a cost estimate.

1. If approved for the requested item, CareOregon will purchase the item on behalf of the member.
2. CareOregon will contact the member directly with delivery information and require the member to be present for the estimated delivery date and timeframe.
3. The member is required to sign a waiver contract releasing CareOregon liability for maintenance once the item is delivered and installed.
4. If the member resides in an apartment complex or public housing unit, the member is required to inform the property management of the delivery and coordinate for access to the building and unit.

CareOregon®

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Request Information

CCO ☐ health share Health Share of Oregon ◯ Columbia Pacific CCO ◯ Jackson Care Connect™

Date ____ / ____ / ____
Month *Day* *Year*

Member Name _____

DMAP ID# _____

DOB _____

Is the member currently engaged with care management, Transitions Specialist, or a Health Resilience Specialist? ☐ **Yes** ◯ **No** ◯ **N/A**

Item/Service Requested	Vendor/Source	Date Needed	Duration of Services	Cost

Is this a one-time cost? ☐ **Yes** ◯ **No**

If this is an ongoing cost, please explain how long CareOregon is being asked to cover.

_____

If member is unable to receive equipment, is there someone available who is able to do this? ☐ **Yes** ◯ **No** ◯ **N/A**

If member is unable to maintain equipment, is there someone who is able to do this? ☐ **Yes** ◯ **No** ◯ **N/A**

If yes, please list name/relationship to member:

Name _____ **Relationship** _____

A release of liability may need to be signed by the member upon delivery of equipment.

The Agency/Provider acknowledges the use of these alternative funding resources as a last resort. What other sources of funding did you consider? Attach provider recommendation or medical record substantiation for this resource.

State or Covered Benefit (including Medicare) ☐
Agency/Provider Existing Programs ☐
Community Partners ☐

List alternative funding resources pursued. If none, please explain.

Please continue on the next page.

What is the member's treatment plan? How does this item/service relate the described treatment plan?

How will this health related service/item improve the member's health outcome or prevent deterioration?

How will the cost of this health-related service offset future medical costs for this member?

What is the sustainability plan? What is the plan after this item/service is paid for? What is the follow up?

Requesting Agency/Provider _____ **Phone** _____

Individual Completing Form _____ **Phone** _____

Requesting Provider Signature _____

CareOregon Administrative Use Only

Finance Code _____ **Prior health-related funds expended for this client, year to date** _____

Date Approved/Denied _____

Approved by Clinical Review Committee _____ **Date** _____

Approved by Program Manager _____ **Date** _____

Approved by Medical Director _____ **Date** _____

Fax completed forms to **ATTN Toni Wood** at **503.416.4728**.or mail to ATTN Toni Wood, CareOregon, 315 SW Fifth St #900, Portland, OR 97204