CareOregon Behavioral Health System Integration (BHSI)

Provider Frequently Asked Questions (*Rev 11.30.2023*)

Overview

This document provides answers to questions most frequently submitted by Behavioral Health Providers regarding the CareOregon Behavioral Health System Integration (BHSI) project, which has a go-live date of 10/1/2023.

If you have additional questions not answered in this document, please submit them through the provider question form.

This FAQ document will be updated and published monthly as new questions are submitted.

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Section 1: General

Does the CareOregon Behavioral Health System Integration apply to Health Share Behavioral Health services/providers?
Yes – All authorizations and claims for Health Share Members are moving from PH TECH / CIM to CareOregon Connect (Connect) for claims and authorizations for dates of service 10/1/2023 and beyond.

If a Provider only providers substance use disorder (SUD) services, will they be included in this system transition?
Yes, all SUD and Mental Health notifications of treatment, authorizations, and claims are included in this change to Connect.

Section 2: Eligibility

Why would Mental Health eligibility in MMIS (Medicaid Management Information System) look different than Connect eligibility?
Members with Mental Health only coverage were setup in Connect with an effective date of 10/1/2023, therefore MMIS eligibility may show a different effective date.

- For clients who have Mental Health only coverage through CareOregon, when looking for member eligibility in Connect, enter an effective date of 10/1/2023 or after.

Will a member's physical AND behavioral health coverage still be available to verify in CIM?
Information regarding Health Share eligibility in CIM and your access to that information is not changing. If you have access to see Health Share eligibility now, you will continue to be able to see Health Share/CareOregon behavioral and physical health eligibility information beyond the 10/01/2023 transition.

Will 270/271 batch eligibility verification be available after 10/1/2023?
There is no change to how providers may use Health Share's CIM portal for eligibility checks, including the use of 270/271s. See Health Share CIM Portal, which include CIM links and PH TECH support information.

How can we learn more about 270/271 batch eligibility verification if we are interested in setting this up?
For information on how to establish the 270/271 real time eligibility verification process, please contact PH TECH EDI (Electronic Data Interchange) Support via email at EDI.Support@PHTECH.COM, or by calling 503.584.2169 Opt. 1 and the EDI Team.

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Are there other ways you can verify a member's Health Share of Oregon eligibility after 10/1/2023?
Eligibility can be verified through Connect (*the preferred method for accessing Connect is through OneHealthPort*).
Medicaid/Oregon Health Plan (OHP) providers can also access Oregon's Medicaid Management Information System (MMIS) Provider Portal to verify real-time eligibility for OHP members. This state-managed provider portal can be helpful in confirming CCO (Coordinated Care Organization) assignment of a member when there is more than one CCO in a given service area and can also confirm a member's benefit coverage type. The MMIS Provider Portal login is available at: https://www.or-medicaid.gov. For more information about the state managed MMIS Provider Portal, visit:
OHA (Oregon Health Authority) Oregon Medicaid Provider PortalHA Oregon Medicaid Provider Portal
These options will not include the member's detailed physical health plan coverage (e.g., will show Health Share of Oregon as the plan, not Health Share/Kaiser, or Health Share/Providence, etc.). Those additional details will remain in CIM as outlined above.

Section 3: Notifications of treatment (Level of Care) and Prior Authorization (PA)

NEWLY UPDATED: What changes should Case Rate Providers expect for method of payment related to Medication Management services starting 10/1/2023?
Effective 10/1/23, CareOregon is changing the method of payment for Medication Management services for Case Rate (CR) providers in the metro region. The new method of payment will be a capitated payment and move away from fee-for-service (FFS) reimbursement. With BHSI we have an opportunity to promote better data integrity with QIIP metrics and reporting, thus we are making this change and moving the medication management services under the case rate notifications of treatment.

Change Break Down:

From	To
Medication Management notifications of treatment running concurrently with Assessment Plus 2/Level A-D notifications of treatment for the same member	One notification of treatment (Assessment Plus 2/Level A-D) for all services, including medication management.
FFS payment for medication management claims/notifications of treatment	Capitated payment based on 2022 claims volume adjusted for 2023 rates. 1/12th paid monthly with a semi (2x year) annual true-up

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	to assure full earning potential. Please note there will be no recoupment if fee for service equivalent (FFSE) of medication management encounters is below capitated amount.

Providers have expressed concerns and asked for additional clarification on the change in method of payment for Medication Management services for Case Rate (CR) providers in the metro region. We are addressing those as they arise and will be working to assure a smooth transition for those providers. CareOregon is looking to assure that there are no negative consequences with this change. Below are responses to top concerns received.

1) What if a person sees a LMP for services initially rather than a QMHP?

Provider encounters initial LMP service(s) under an Assessment Plus 2 notification of treatment. If another provider type (e.g., QMHP or QMHA) then begins providing services, their claims would be submitted under the same Assessment Plus 2 notification of treatment and/or a new Level A-D Case Rate notification of treatment once the assessed level of care (LOC) is confirmed.

2) What if a person only ever sees an LMP for medication management?

Obtain an Assessment Plus 2 notifications of treatment to encounter the initial service(s). Medication management only service delivery meets criteria for LOC A and subsequent LMP encounters would be submitted under a LOC A notification of treatment.

3) How will this affect the Risk Corridor?

The medication management services will trigger a case rate payment if they are the initial or only claim submitted against a case rate notification of treatment. This case rate payment is in addition to the 1/12 capitated payment. However, the FFSE for medication management services and/or case rate payments for notifications of treatment with only LMP encounters will not count towards the Risk Corridor and CareOregon does not consider this to be an overpayment. Updates to Risk Corridor reporting are under development and details will be shared as soon as possible.

4) Additional Guidance:

Med Management FFS providers who need to submit NoT should submit NoT under the Connect service type MH General Outpatient effective for DOS 10/01/2023

Nonpar providers and contracted providers listed on our MH No Auth Provider list will not need to send in any NoT/Auth for Med Management FFS effective DOS 10/01/2023

In CIM, Authorization numbers are generated automatically and available right away for service types that are not clinically reviewed. Will requests for authorizations be immediately available in the new system setup?
The authorization number that will need to be submitted on claims will not be available immediately. You will get an initial confirmation number and notification of approval at time of submission; however, the request may take up to an hour to generate an authorization number, labeled as a "Request Number." Once Connect updates, the authorization number is the number that needs to be submitted on claims.

In Connect, what is the difference between the Auth/NoT Confirmation# vs. Request #?
The Confirmation # equals the Request #, just missing the "CC." Providers have asked whether the Confirmation number is the same as the Request number. If you have received an auto approved Confirmation number, this is the true Request # (Auth/NoT) and providers can just add the "CC" to the beginning of this number. *Providers do not need to check back in 4 hours for the Request number.* FYI: CareOregon recently updated Connect with a message to inform providers of this information.

- Example: Confirmation # = Auth/Notification# 155555. Once it is loaded into our claims system it will send a response to CareOregon Connect under Request# CC155555. The response takes up to 4 hours to complete.

When is it required to fax a facesheet to CareOregon for notification of an Acute Admission?
Providers that send notifications of acute admissions via Collective/Point Click Care do not need to fax facesheets advising of acute admissions. All other providers will need to fax a facesheet to CareOregon to notify us of an acute admission.

Will SUD IOP claims be required to be sent on a UB04 starting 10/1/2023?
No.

What happens if an authorization is submitted into CIM for dates of service 10/01/2023 and beyond?
These authorizations will be automatically returned with a "VOID" status and will not allow for claims payment. All authorizations for dates of service 10/01/2023 and beyond must be submitted in CareOregon's Connect provider portal to be reviewed, considered, and/or auto-approved.

Have there been any changes to Level of Care (LOC) category for IOP?
The options for IOP will remain the same and there are Service Types in Connect for each (SUD, MH, DBT and Eating Disorder). You will select "SUD" or "MH" first, and then pick the IOP service type being requested. There will be no changes to the clinical criteria that are in place now.

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Are there any changes to the SUD modifier or procedure code requirements (e.g., are we still to use H codes)?
There are no changes to these requirements.

With the combination of the Adult and Child outpatient authorizations, will the system be set up to assign the correct rate based on age?
Our claims processing system will be set up to pay the correct case rate based on the member's age as of the date of service reflected on the claim. Age is calculated in months:

- Child = 0 to 215 months (0-17 years)
- Adult = 216 months+ (18+ years)

[INPATIENT ONLY] Currently, we have scenarios where we receive two separate CareOregon authorizations for a single episode of care. One authorization is for secondary coverage for the initial dates of service covered by Medicare, and then a second authorization for primary coverage for the dates of service after the member's Medicare benefits are exhausted. Will this process continue? If yes, how should we submit these claims if only 1 Authorization # can be on a claim?
For CareOregon members who are dually enrolled, only a single authorization is required for both programs. Even if Medicare benefits are exhausted during the episode of care, the authorization will continue to cover the Medicaid-only portion of the service.

For authorizations that span over the 10/1/2023 transition date, will we be able to submit claims with the original authorization number from CIM?
CIM authorizations spanning 10/1/2023, will be migrated into Connect along with the CIM authorization number. Providers will submit claims for dates of service 10/01/2023 and beyond using that original CIM authorization number.

The full authorization number will be required on all claims for dates of services 10/1/2023 and beyond. This will be a change for some providers who have not submitted authorization numbers on claims in PH TECH.

Will CareOregon authorizations include maximum dollars?
CareOregon will no longer be using authorizations to set maximum dollars, like we see in CIM today. Our Utilization Management team will instead enter in the number of units approved and the system will be configured to pay current rates based on the appropriate fee schedule.

Will service types be changing?
Service Types will be combined and simplified in Connect. The number of service types will be reduced by approximately 30%. A Service Type Crosswalk for Current (PH TECH) to 10/1/2023 forward (Connect) can be found in the Appendix at the end of this BHSI FAQ.

Is the authorization number required on the claim?
Yes, the authorization number must be submitted on the claim for appropriate processing and payment. *Claims must be billed with one authorization per claim*.

Connect will provide a "request number." This is the number that must be in the prior authorization box on the claim. Below are details related to the authorization submission process for providers who submit professional and institutional claims:

- Electronic submissions, the "Request Number" issued by CareOregon Connect should be listed in REF02 field of Loop 2300 in the REF-Prior Authorization segment as in this example: REF*G1*12345678~, where the number "12345678" is the Request Number from Connect.
- 1500 paper claim submissions, list the "Request Number" in Box 23 – Prior Authorization Number.
- UB04 paper claim submissions, list the number in Box 63 – Treatment Authorization Codes.

Go-Live transition: We understand that routing authorization numbers accurately to claims is a barrier for some providers. For a limited time only, *CareOregon will attempt to find a matching authorization for claims submitted without an authorization number listed. We intend to keep this in place through June of 2024 to support our providers through this transition.*

- If a matching authorization cannot be located or if there is more than one approved authorization that could be a match for the service, CareOregon will deny the claim. If a claim denial is issued for this reason, the provider would need to adjust or rebill their claim with the correct authorization for the service.
- Providers should continue to work towards accurate reporting of authorization numbers on claims to ensure the most seamless processing and payment. Providers currently submitting authorizations on claims should continue to do so.

When submitting an authorization request, will providers need to add each diagnosis and CPT code individually in Connect?
You will not have to enter CPT/HCPCS code or Diagnosis code as these are not mandatory fields in Connect.

When a provider submits a notification of services at one location, will the authorization continue to be active and valid for all locations?
Our current understanding is that it will be active for all locations if the TIN is the same, even when the National Provider Identifier (NPI) is different.

- *As an example, if the billing/pay-to provider on an authorization is Joes Very Good Counseling (NPI 123456789 – TIN 123456789) and a claim comes in with Joes Very Good Counseling (NPI 987654321 TIN 123456789) the auth will cover both locations.*

Will authorization forms be available online for providers to fax in requests?
For dates of service 10/1/2023 forward, authorizations and notifications should be entered into Connect. There will continue to be a fax option, but faxed submission of authorization forms will be the exception. Printable authorization forms will be available on our webpage.

With CareOregon taking over Withdrawal Management authorizations, will there be any change in the process for requesting the authorizations, or the duration of the authorization?
The notifications for Withdrawal Management will auto-approve and there should be no need to close the first notification to submit an additional notification even if it is in the date range of the first one submitted.

Will we be able to submit requests for Applied Behavioral Analysis (ABA) authorizations online after the transition?
Yes. ABA will be one of the service types that can be selected in Connect.

Section 4: Referrals and Care Coordination

How will the referral to care coordination process change?
There will not be any change to the process of referring to care coordination. The network should continue to refer to care coordination either by calling customer service, or using our care coordination referral form (Care Coordination Referral Form- HSO (careoregon.org)) and emailing ccreferral@careoregon.org

Will we be able to see other open authorizations or diagnosis codes history in Connect?
Authorizations for dates of 10/1/2023 and beyond will be in Connect. Authorizations for dates of service prior to 10/1/2023 will be in CIM. In Connect, providers see only their own authorizations and notifications, as permissions are established by TIN. There is a dashboard where you can drill into each authorization to see details including effective date, requesting and servicing provider, member ID, request number, submission date, diagnosis, procedures, and any entered additional remarks or attachments.

There is an advanced search function where you can select from various filters and a list of authorizations are displayed, each of which you can drill into to see the details. For Connect tutorials see link: Authorization Advanced Search Tutorial - Connect

Will the Level D and ICM authorization structure change in this transition?
There is currently no plan to change the Level D/ICM referral process. We are developing a workflow in Connect that is similar to the current workflow in CIM. Our Utilization Management team will continue to work with our BH Navigation Team in processing and triaging the notifications and referrals to ICM providers.

Section 5: Clearinghouse and Claims Submission

NEWLY UPDATED: Will the AS and AF modifiers be required?
AS should not be billed to CareOregon with behavioral health codes.
AF can be billed but is not required and does not drive rate of reimbursement. Providers status/credentials are built into claims system and claims will pay based on their status.

NEWLY UPDATED: What is a Delegated Provider Roster?

- *What:* The Delegated Organizational Provider Roster is a tool used by CareOregon's Provider Data team for terming, updating and adding providers. The Provider Roster Template was updated in October 2023 and can be found online: Delegated Provider Roster. (Please replace old versions)
- *Who*: Providers who signed an agreement with CareOregon to delegate their credentialing are contractually obligated to send a complete roster
- *Why:* Information provided in the roster is used to ensure accurate rate assignment for this subset of Providers
- *Where:* Rosters should be emailed to **BHProviderDataUpdates@careoregon.org**
- *When:* Rosters must be submitted by the 10th calendar day of each month. If updates need to be expedited, please send bi-weekly.

NEWLY UPDATED: Have there been any updates to Telehealth guidelines?
Yes, Additional modifiers have been added as payable.
Any claims denied with GT, FQ, 93 or 95 modifiers that are appropriate for telehealth have been reprocessed by CareOregon as of end of November 2023. Providers do not need to resubmit.

If we provide behavioral health services in specialty and physical health settings, how will rates and authorization requirements be identified for Behavioral Health services administered in a Physical Health location (BHiPC)?
If you provide both types of behavioral health services, you must indicate on your provider roster submission if the rendering provider is primarily 'Specialty Behavioral Health' or 'Primary Care/Specialty Physical Health'. Authorization/Notification will only be required if rendering provider is designated as 'Specialty Behavioral Health', and rates will be assigned accordingly.

As of October 2023, a *newly updated version of the Provider Roster Template* can be found online: Delegated Organizational Provider Roster Template. *Please replace old versions.*

What are the Telehealth guidelines?
Telehealth Guidelines:

- CPT/HCPCS code sets which allow modifier 95 or GT for telehealth services will be allowed.

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- Modifiers GT, 95, 93, and FQ will continue to be allowed indefinitely.
- Audio only visits: Temporary through 12/31/2024 - Certain telehealth visits can be delivered using audio-only technology (such as a telephone) if someone is unable to use both audio and video (such as a smartphone or computer). The inability to use video needs to be documented in the chart note.
- Permanent: Behavioral/mental telehealth services can be delivered using audio-only communication platforms.
- Outpatient clinic visits, preventative E/M visits via telehealth should not be billed.
- Telehealth modifiers should be used with POS 02 or 10.

When claims are pended in Connect, what should we expect with Remark Codes and Processing Timeline?
Claims may take up to 30-45 days to process. Remark codes and notes on pended claims do not necessarily indicate a claim will be denied. Pended claims go through many edit checks such as: eligibility, authorizations, etc. This is a normal part of claims processing, and no action is needed by the provider.

Will the GB modifier be required in Connect?
GB modifiers will not be required once we have transitioned to Connect, for dates of service 10/1/23 and after.

Will the transition to Connect change claims reprocessing turnaround time?
CareOregon strives to process 99% of appeals and reopening requests within 90 days and we staff with the objective of meeting that target. There are situations where an appeal could take more than 120 days, especially if a medical necessity determination is required, but most appeals are completed within 90 days.

Will the option to submit claims via Direct Data Entry (DDE) be available?
CareOregon does not offer direct data entry of claims in the Connect provider portal. Claims with dates of service 10/01/2023 and after will need to be submitted through a clearinghouse or on a paper form.

Many clearinghouses offer direct data entry solutions, allowing you to key information into an online claim form which is then converted to an electronic claim for submission to payors. Electronic claims are preferred for the most accurate and timely processing experience.

What is the Electronic Payor ID # that Behavioral Health claims should be routing to effective 10/1/2023?
The Payor ID is 93975, through Change Healthcare. Claims with dates of service 10/1/2023 and forward should route to this Payor ID.

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Will we still be able to submit claims via direct 837 (without a Clearinghouse)?
CareOregon set up an option for Providers to submit 837s directly to Connect using the Change Health Care Portal. Impacted providers received instructions on how to set this up prior to go-live.

Where can Providers find the technical specification (e.g., header values) for 837 files submitted from a Provider's Clearinghouse to CareOregon's Clearinghouse (Change Healthcare)?
Providers should contact their Clearinghouse for support with 837 file format from Clearinghouse to Clearinghouse.

If a Member has a physical health discharge on the same date as a behavioral health admit, will CareOregon be able to differentiate between the services when split claims with the same date come from the same location?
If the same Provider renders services for a physical health discharge on the same day as a behavioral health admit, they will need to distinguish that it is not a duplicate charge by using proper coding on the claim.

Will paper claims still be accepted?
Yes, we will continue to accept paper claims if the claims are legible. Use original red/white claim forms with black typed content, keep content within the form fields, do not use rubber stamps for fields and do not highlight text. Paper claims for dates of service 10/1/2023 and after will need to be mailed to CareOregon at the following address: CareOregon PO Box 40328 Portland, OR 97240-0328. (This address is also listed on the CareOregon website.)

After 10/1/2023, when a paper claim is submitted by mail, will Providers still receive a mailed letter in response to paper claims that need to be corrected?
Yes, CareOregon will continue to process mail and send a reject letter back to the Provider on any claim that requires correction (e.g., missing information, or handwritten claims where all or part of the claim is not legible).

Will this system in any way facilitate coordination of billing with Medicare for Members who have both Medicaid and Medicare?
Yes, if a Health Share Member is also enrolled in CareOregon Advantage for Medicare, CareOregon will process the secondary claim under Health Share after the Medicare claim is finalized. You do not need to submit a secondary Medicaid claim to CareOregon after receiving the CareOregon Advantage remittance advice.

If the Member has Original Medicare as primary, CMS will send CareOregon crossover claims to process for secondary Medicaid benefit determination. You do not need to submit a Health Share Medicaid claim after receiving the Original Medicare remittance advice.

Will per diem claims still need to be billed under a provider (instead of a facility)?
Our claims processing system will be configured to allow facilities as rendering provider for specific procedure codes, as allowed by OHA.

Should Providers use the Member's Health Share of Oregon ID or CareOregon ID number via Connect for billing?
The Member's OHP Member Number is used by Health Share and CareOregon to identify a Member. Providers should bill using the Member's OHP Member ID number.

Section 6: Claim Status, Adjudication and Payment

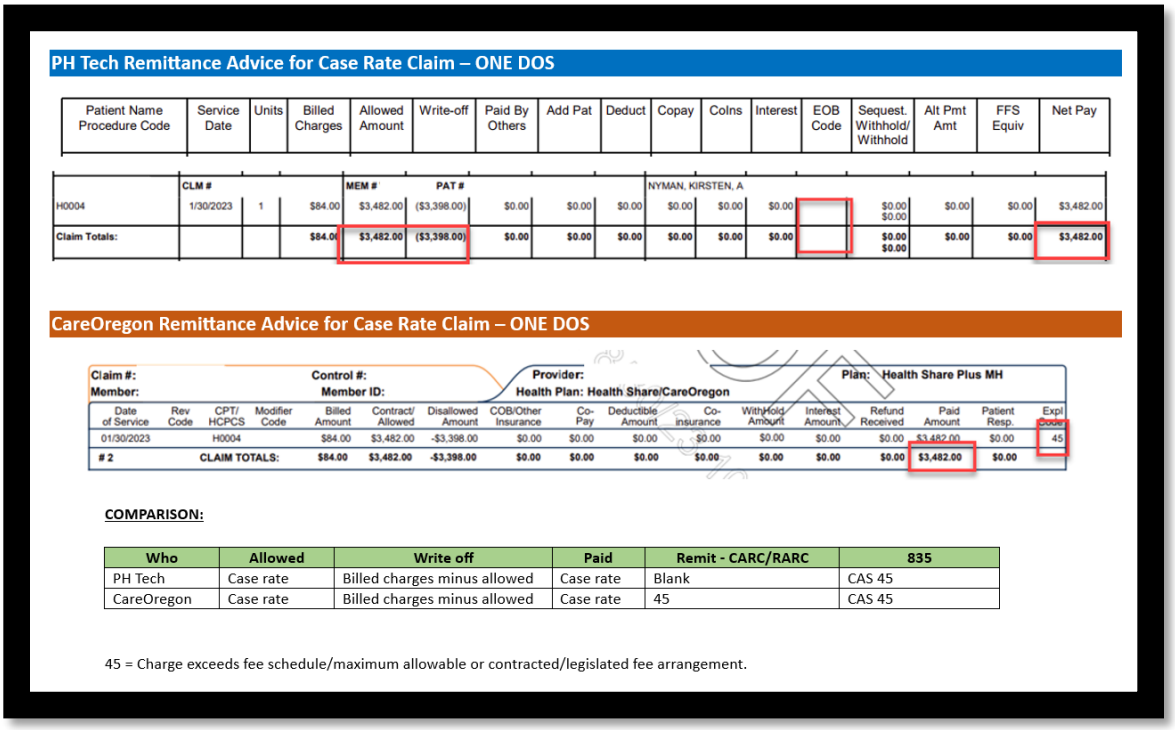
In the past, we have been able to submit reports to Provider Relations to get bulk updates on a list of claims when we are experiencing a more global issue with a large volume. Will that still be an option?
Yes, please contact your Provider Relations Rep to work through any global claim issues. Provider Relations can triage the root cause and engage internal resources, such as a Provider Claims Liaison, to assist in problem solving and issue resolution.

In Connect, are we going to be able to send an electronic message for reprocessing claims or correcting authorizations and/or still submit ZenDesk tickets?
Messaging / email functionality / ZenDesk tickets will not be available initially in Connect. All support needs can be directed to our Customer Service Team at (503)416-4100 or 800-224-4840, option 3 for Providers. CareOregon is reviewing options to support message functionality for our entire network as a future enhancement, however this will not be available on 10/1/2023.
The Provider Customer Service Team is staffing up and providing additional training to team members in advance of the 10/1 go live. Contracted Providers also have access to their Provider Relations Support (PRS) representative who will continue helping with escalated / global claim issues, like the triage and resolution support that is currently in place today via the CIM ZenDesk.

Since there will not be a messaging function in Connect, how many inquiries will we be able to make in one call to CO Provider Customer Service?
The current limitation is 3 inquiries per phone call. We recommend utilizing Connect for claim inquiries: to obtain claim status, paid amounts, check numbers, paid dates, and similar needs. If you have claim discrepancies, questions or need adjustments to authorizations, a phone call to Customer Service will be needed. Our Customer Service team has been adding more staff since April in preparation for the transition of work that will occur on 10/1/2023. We have also increased training efforts to cross-train our staff on Metro BH processes to help alleviate wait times and make the phone call process as convenient as possible.

Will the Remittance Advice display Coordination of Benefits (COB) differently in Connect?
For claims with primary insurer(s) including Medicare and private insurance, the total benefits that a member receives from CareOregon and the other insurer(s) cannot exceed what the CareOregon normal benefit would have been by itself. CareOregon calculates our total payment to the other insurer's payment total to determine the payable benefit which is then redistributed on all lines of the billed claim.

What will a Case Rate Remittance Advice look like in Connect?
The following is a sample remittance advice where a case rate payment has been made, showing how the payment looks today from PHTECH and how it will look like when paid through Connect. Note the similarities – both will show Case Rate payments with negative adjustments because the payment amount exceeds the billed charges. One difference is that the Connect Remittance will show an EOB code of 45 to explain the adjustment between the billed charges and the payment.



PH Tech Remittance Advice for Case Rate Claim – ONE DOS

Patient Name / Procedure Code	Service Date	Units	Billed Charges	Allowed Amount	Write-off	Paid By Others	Add Pat	Deduct	Copay	Coins	Interest	EOB Code	Sequest. Withhold/ Withhold	Alt Pmt Amt	FFS Equiv	Net Pay
	CLM #			MEM #	PAT #				NYMAN, KIRSTEN, A							
H0004	1/30/2023	1	$84.00	$3,482.00	($3,398.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00 $0.00	$0.00	$0.00	$3,482.00
Claim Totals:			$84.00	$3,482.00	($3,398.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00 $0.00	$0.00	$0.00	$3,482.00

CareOregon Remittance Advice for Case Rate Claim – ONE DOS

Claim #: Control #: Provider: Plan: Health Share Plus MH
Member: Member ID: Health Plan: Health Share/CareOregon

Date of Service	Rev Code	CPT/ HCPCS	Modifier Code	Billed Amount	Contract/ Allowed	Disallowed Amount	COB/Other Insurance	Co-Pay	Deductible Amount	Co-insurance	Withhold Amount	Interest Amount	Refund Received	Paid Amount	Patient Resp.	Expl Code
01/30/2023		H0004		$84.00	$3,482.00	-$3,398.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,482.00	$0.00	45
# 2		CLAIM TOTALS:		$84.00	$3,482.00	-$3,398.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,482.00	$0.00	

COMPARISON:

Who	Allowed	Write off	Paid	Remit - CARC/RARC	835
PH Tech	Case rate	Billed charges minus allowed	Case rate	Blank	CAS 45
CareOregon	Case rate	Billed charges minus allowed	Case rate	45	CAS 45

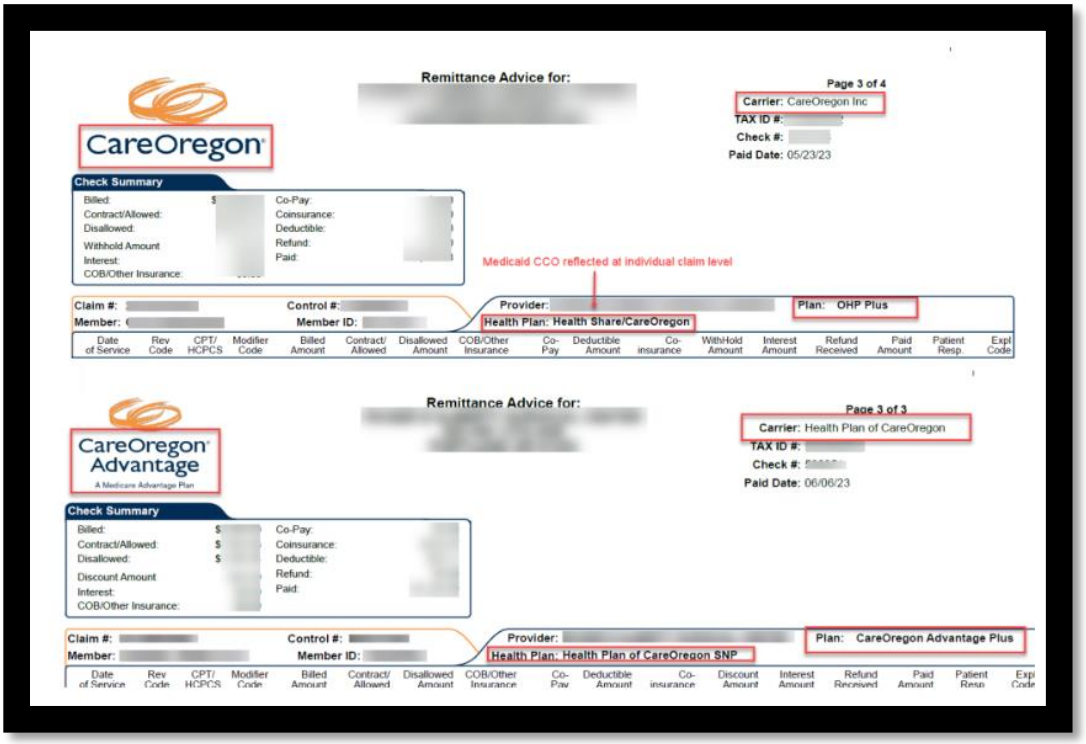
45 = Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Where can we see the CareOregon name on the Remittance Advices (RA) to identify coverage types (e.g., Medicare/Medicaid)?

- The RA distinguishes Medicaid from Medicare and are paid on separate remittance advices. The CareOregon Medicaid remittance advice includes all CCOs and at the top of each claim the CCO name is reflected in a field labeled "Health Plan" (e.g., Health Share/CareOregon).
- The CareOregon Medicare plan RA is branded CareOregon Advantage, at the top of each claim the field labeled "Health Plan" contains "Health Plan of CareOregon SNP". The

CareOregon Advantage checks/images of checks also show "CareOregon Advantage A Medicare Advantage Plan".

- Here is a visual example of where to look for this information in the Remittance Advice:



Will there be any changes after the 10/1 transition in COB payments?
There will be no difference in secondary payment. The same benefit will be paid out on secondary claims pre and post 10/1

Is there anything I should know about COB after the 10/1 transition?
The overall calculation may look different on CareOregon's EOB/ Remits.

- CIM calculates the secondary payment line by line based on the primary EOB
- CareOregon calculates the secondary payment based on the total payment made on the primary EOB
- In both instances, the same payment will be issued.

How is COB calculated?
If CareOregon's payment is equal to or less than the other insurer's payment, the benefit is zero. If CareOregon's payment is greater than the other insurer's payment, CareOregon pays the difference, but does not exceed the member's responsibility.

Should we expect a delay in payments during this transition?
It is our goal to transition with minimal to no disruption to payments.

On 10/1/2023, will all Health Share/CareOregon Behavioral Health claims activity migrate to the same platform currently used for Jackson Care Connect (JCC), Columbia Pacific (CPCCO), Health Share/CareOregon, and CareOregon Advantage (COA) members?
Yes, all claims processed by CareOregon for JCC, CPCCO, Health Share of Oregon, and CareOregon Advantage members will be handled in Connect for dates of service 10/01/2023 and beyond.

What is EFT (Electronic Funds Transfer) payment?
EFT stands for electronic funds transfer, which includes Automated Clearinghouse (ACH), where payment is deposited directly into your bank account, and virtual credit card.
You may receive EFT payments in one of several ways:

- Enroll in ACH using the CareOregon sponsored ePayment Center online portal that offers payment solutions for Providers. There are no fees charged for ACH payments using this enrollment method.
    - CareOregon is no longer processing paper ACH enrollment forms. All requests for ACH payment directly from CareOregon must be made using the CareOregon sponsored ePayment Center.
- CareOregon has also partnered with Zelis to offer their electronic payment options via the Zelis Network. You can enroll with Zelis Payments for ACH or virtual credit card using their portal. This is an optional value-added payment solution that some Providers prefer. Fees may apply to this option.

Who can sign-up to receive direct EFT payments from CareOregon?
All Providers submitting claims to CareOregon may enroll for CareOregon ACH ePayment, without a fee.

If we already have Electronic Funds Transfer (EFT) with CareOregon, do we still need to update that for Behavioral Health payments? Are there any fees?
CareOregon is transitioning our Automated Clearinghouse (ACH) Electronic Funds Transfer options for all Providers. This is happening at the same time as the BHSI transition. Our goal is to have all Providers currently enrolled in ACH with us registered through our new CareOregon ePayment Center (ePC) by 08/15/2023. If a Provider is not enrolled with CareOregon ACH now, they can register in the CareOregon ePC. Enrolling in this service is a no fee option for ACH payment.
For more information and details on how to enroll, please follow this link: Electronic Payment & Electronic Remittance Advice FAQs (careoregon.org). As an alternative, CareOregon also offers the option to use the Zelis Payment Network for ACH or virtual credit card payments. Providers are not required to use the Zelis Payment Network. If a Provider decides to enter a relationship directly with Zelis, you may incur a cost.

What will the workflow be for monies owed to PH TECH after the transition since PHTECH will not have future remits from which to deduct any refunds? Will they accept paper checks?
Refunds for dates of service prior to 10/01/2023 will still go to PH TECH through the runout period (which is TBD). PH TECH will accept paper checks for refunds.

[GLOBAL CASE RATE PROVIDERS ONLY:] What level of care do we submit for medication only clients who are not engaged in therapy?
The member still needs to meet criteria for one of the A-D levels of care. Please refer to levels of care clinical criteria that begin on pg. 31 of our Behavioral Health provider manual: BH Provider Manual (careoregon.org) and our sample Level of Care forms which can be found on our website: CareOregon - Metro area behavioral health providers. A covered diagnosis on the prioritized list and a need for medication management for a medication regime that is more complicated than what is generally provided in primary care meets the clinical criteria for Level A for youth and adults.

[GLOBAL CASE RATE PROVIDERS ONLY:] Are you going to change how you pay case rates? Can we have a unique HCPCS like T1041?
CareOregon is not intending to make significant changes to the case rate process. We are currently testing case rate payment functionality and are always looking for ways to enhance timeliness and predictability. We will share submission and payment details as soon as they are finalized.

[GLOBAL CASE RATE PROVIDERS ONLY:] In the LOC Crosswalk, we will no longer be using the "Medication Management for CR Providers" authorization type as of 10/01/2023 dates of service. How will we submit claims for those services and how will we get reimbursed for those services?
Claims for medication management services provided by case rate Providers will be submitted under a Member's Assessment Plus Two and/or Global Level A-D authorization. Providers will be issued a monthly payment outside of claims beginning in October of 2023 for these services. The payment will be a monthly lump sum payment for all Members equal to $1/12^{th}$ of your total fee for service claims received for all "Medication Management for CR Providers" authorizations for 2022 dates of service, valued at the higher CareOregon fee schedule effective 1/1/2023. Payments will also include a quarterly reconciliation process to ensure Providers are reimbursed for medication management service utilization beyond 2022 utilization. These payments will be in addition to the case rate payments you will receive via claim submission. More details to come.

Section 7: Connect (Provider Portal) and OneHealthPort Access

What is Single Sign On (SSO) in OneHealthPort and does it work with Connect?
Once you are logged into OneHealthPort you should be able to go between any payor system that is associated with OneHealthPort SSO and not have to log out and back into an individual payor system. You can log into Connect and other SSO systems through OneHealthPort. Here is the link to more information: SSO Home | OneHealthPort

Is Connect available through OneHealthPort?
Yes, access to Connect is available via OneHealthPort or directly through CareOregon. If you do not have access, you can request an account for your organization. The easiest way to access Connect is through OneHealthPort. Here is a link to OneHealthPort: https://www.onehealthport.com/

If we are not already using Connect and/or OneHealthPort, how soon should we start setting up our logins?

- *Contracted Providers* can get access immediately for Connect under OneHealthPort. If you login prior to the system conversion Connect will not have all your information loaded yet, but you can start exploring. You will need to work directly with OneHealthPort to set up system access if you do not already have logins.
- *Non-Participating Providers* can get access through OneHealthPort anytime; however, if you have never billed a claim to CareOregon your Provider record/TIN# will not be in our claims system so you will not see any of your clinics information in Connect. You will need to work directly with OneHealthPort to set up system access if you do not already have logins.

If I already access OneHealthPort, do I need to update my sign-in details to get into Connect?
Our understanding is that OneHealthPort login details will carry over. However, each Provider will need to confirm with OneHealthPort that they also have access to Connect.

When logging into Connect through OneHealthPort, can you access information for *any* Provider associated with your Tax Identification Number (TIN)? Or would that require logging out and back in when switching between Providers (as is currently required in CIM)?
Once you are logged into OneHealthPort, if CareOregon recognizes your TIN, you will be able to access Connect without logging out and back in.

Is Connect different than GSI (Aerial)?
GSI is a platform used for care management/care coordination and is different than Connect that allows the entry of authorizations and notifications of treatment.

Section 8: Reporting

NEWLY UPDATED: Where will we get claim and authorization reports after the transition?
The Authorization and Claims Reports are available in Connect, on demand in a .csv format.

NEWLY UPDATED: Will we still have reporting capabilities on authorizations that contain most or all the same fields as CIM has for referral reports?
The referral auth report in Connect will not have the same fields as the current CIM Authorization report, however it will have all the same Authorization data. Parameters include Date selections - Service Start Date Begin, Service Start Date End, Requesting Provider, Servicing Provider, Servicing Provider specialty, Service Type, Level of Care, and Member Specific or "All" Members Status of Authorizations.
Since 10/1/23 Go Live, we have received input from Providers that additional data fields in these reports. CareOregon is researching options for incorporating requested data into these reports.

In the new environment, will there be a compatible report option to the Case Rate Risk Corridor and Global Utilization Reports?
We are working on replicating the risk corridor and global utilization reports. More details to come soon.

In CIM, Providers can find payment amounts based on a batch number and then can produce excel reports from the claims search function. Will similar advanced search functionality based on batch be available in Connect?
You can download a copy of a Provider remittance advice from Connect or the CareOregon ePayment Center (ePC) in a PDF to view all claims in the same payment batch. In general, the Remittance Advice (RA) will have any applicable remark and reason codes listed for each claim. A PDF of the RA can be viewed and downloaded in Connect. Additionally, Providers enrolled in the CareOregon ePayment Center can also access RAs (Remittance Advice) there.

Section 9: Contracting

How will Behavioral Health in Primary Care (BHiPC) claims be processed for dates of service beyond 10/01/2023?
If a Provider has a BHiPC contract amendment and they submit claims using an NPI used solely for their primary care setting, then no authorization is needed, and the rates stated in the amendment will be applied.
For Providers who submit these claims using an NPI that is also used in specialty behavioral health settings, an accurate payment will be based on the standard, monthly roster submission (must be submitted by the 10th of each month).

As of October 2023, a *newly updated version of the Provider Roster Template* can be found online: Delegated Organizational Provider Roster Template. *Please replace old versions.*

Will the Provider roster process be the same in Connect?
This process will stay the same.

Once a Providers credentialing comes through, PH TECH automatically reprocesses any claims for a Provider that were denied while pending credentialing. Will this continue to happen?
Yes, from the time of credentialing effective date, all claims will be reprocessed for correct reimbursement.

Where do we get access to our fee schedules and authorization rules for 10/1/2023 and forward?

- CareOregon authorization rules and standard fee schedules for contracted Providers are now available in Connect.
- Provider specific fee schedules for contracted Providers will continue to be included in your contract with CareOregon.
- Fee schedules and authorization rules for non-participating Providers will be available on our website.

Is anything expected to change with credentialing for the other CCOs (for contracted Provider, not COA)?
Nothing is expected to change for credentialing.

Where can Providers find guidelines for how to add Providers for dates of service 10/1/2023 and after?

- For the following provider data updates, please send your request to mailto:bhproviders@careoregon.org. (*Please only send inquiries to this email that fit the criteria, below):*

- Providers changing demographics (address, name changes, phone number, licensure, etc.)
- OHA Provider Enrollment process/updates (3108, 3975, 3974)
- TIN changes (W9)

- When the CareOregon Provider Data team receives a claim, a Provider Information Form (PIF), and/or any other communication about adding a Provider for reimbursement, we will update that data in our claims processing system.
- If a Provider sends in a claim and any provider NPIs (National Provider Identifier) listed *do not* have an active Oregon Medicaid Provider ID number, the claim will be denied with the remark code N767 (OHA requires all Providers to be enrolled in the member's Medicaid program - OHP). The Provider will also receive a letter with details on the steps needed to obtain an Oregon Medicaid Provider ID number. Once this process is complete, the claim can be reprocessed.

Section 10: Training and Support

Will the Behavioral Health Provider Manual be updated?
The Behavioral Health Provider Manual for 10/1/2023 forward can be found online at BH Provider Manual 10/1/2023 forward. The BH Provider Manual (for dates of service prior to 10/1/2023) will continue to be available online at BH Provider Manual Prior to 10/1/2023.
Who can we contact for support?
Information for how who to contact for support can be found online at the CareOregon Metro Area Behavioral Health Provider website: CareOregon - Metro Behavioral Health Provider Website

- *BHSI Transition:* See details for who to contact regarding services provided before and after 10/01 in our BHSI Who to contact for help? quick guide
- *Provider Portal:* For most needs, we recommend using CareOregon Connect, our online provider portal. This includes topics such as, but not limited to, submitting authorization requests, reviewing authorization and claim status, viewing/retrieving remittance advice, requesting PCP (Primary Care Physician) changes, viewing member rosters and member eligibility.
- *Provider Customer Service:* Reach out to our Provider Customer Service Team at 800-224-4840 (option 3) for questions regarding the online provider portal, billing and authorization inquiries, claim and authorization appeals, general CareOregon guidelines and questions that the portal cannot answer.
- *Provider Relations Specialist:* If you have further questions, you can contact the provider relations specialist assigned to you.

Will CareOregon offer training to Providers on how to run reports and navigate the Connect system?
Yes, CareOregon hosted Live Provider trainings online late August through mid-October 2023. There are a variety of video and written training materials and resources, including a recording of a Live Provider Connect training, currently available online at: CareOregon - Metro area behavioral health providers.

How are you going to support us during our EHR (Electronic Health Record) reconfigurations needed to support the BHSI transition?
CareOregon continues to evaluate the impact of this system change on our Provider partners to fully understand your support needs. We will continue to share information, provide training, and support Providers through this transition. If you have specific questions about your EHR reconfiguration needs, please submit them through the provider question form.

Section 11: Service Type Crosswalk (Appendix)

CareOregon Behavioral Health Service Type Crosswalk – Mental Health Service Category PH Tech to Connect Effective 10/1/2023			
Prior to 10/1/2023	10/1/2023 Forward	Prior to 10/1/2023	10/1/2023 Forward
ABA Assessment 7/1/16 ABA Treatment – 7/1/16 ABA IBU	Applied Behavior Analysis ABA	Assessment Plus Two Crisis Stabilization Assessment	Assessment Plus Two
Crisis Services	Crisis Services CMHP	Crisis Stabilization Treatment	Crisis Stabilization Treatment
Foster Care Crisis Response and Coordination	Child Welfare Resource Support Network	Supported Employment	Supportive Employment
EASA FFS EASA Case Rate	Early Assessment and Support Alliance EASA	Adult Respite Child Respite 7/1/16	Respite
CANS Assessment – FFS 7/1/16 DBT 7/1/16 Medication Management FFS Outpatient FFS Assessment 7/1/16 Outpatient FFS 7/1/16	MH General Outpatient	Medication Management for CR Providers	Services previously under this service group have been combined with Service Types: Levels A-D and Assessment plus Two
Eating Disorder Partial-IOP	Eating Disorder Partial IOP	Eating Disorder Residential	Eating Disorder Residential
Eating Disorder 7/1/16 Eating Disorder Less Intensive OP	Eating Disorder Treatment	ECT Anesthesia Fees 7/1/16 ECT Treatment 7/1/16	Electroconvulsive Therapy ECT
Transcranial Magnetic Stimulation (TMS)	TMS Transcranial Magnetic Stimulation	Psych Testing and Consultation 7/1/16	Psychological Testing
Partial Hospital-IOP 7/1/16	Partial Hospital IOP	DBT IOP	DBT IOP
Oregon Intercept 7/1/16 Community Based Int Treatment HBS	Intensive Treatment HBS	Child Sub-Acute 7/1/16	Subacute
Day Treatment 7/1/16	PDTS Psychiatric Day Treatment Services	PRTS/Sub-Acute Case Rate PRTS/Sub-Acute FFS	PRTS Psychiatric Residential Treatment Services
ACT	Assertive Community Treatment ACT	Culturally Specific	Culturally Specific
Level A Child Global Level A Adult Global Level A Child FFS 7/1/16 Level A Adult FFS 7/1/16	Level A	Level B Child Global Level B Adult Global Level B Child FFS 7/1/16 Level B Adult FFS 7/1/16	Level B
Level A Adult Global SPMI	Level A Adult SPMI	Level B Adult Global SPMI	Level B Adult SPMI
Level C Child Global Level C Adult Global Level C Adult 7 Child FFS 7/1/16 Level C Adult FFS 7/1/16	Level C	Level C Adult Global SPMI	Level C Adult SPMI
Level D Adult ICM Global	Level D Adult ICM	Level D Adult TAY Global	Level D Adult TAY
Level D Child Initial HBS Global	Level D Child	Level D HBS Global	Level D Child

CareOregon Behavioral Health Service Type Crosswalk – Substance Use Disorder Service Category PH Tech to Connect Effective 10/1/2023	
Prior to 10/1/2023	10/1/2023 Forward
Assessment & Transition	SUD Assessment
General Outpatient – Adult General Outpatient – Child	SUD General Outpatient
MAT OTP MAT Induction Only MAT OBOT MAT OTP Medication Assisted Treatment (MAT) MAT	SUD Medication Assisted Treatment OTP
Adult A&D Residential Treatment 7/1/16 Child A&D Residential Treatment 7/1/16 Parent/Child A&D Residential Treatment 7/1/16 Dual Diagnosis Adult Residential Dual Diagnosis Youth Residential Medically Monitored A&D Residential 7/1/16	SUD Residential
Day Treatment SUD- Adult Day Treatment SUD – Child	SUD Day Treatment
IOP – Adult IOP – Child	SUD IOP Intensive Outpatient
Withdrawal Management WM FFS	SUD Withdrawal Management