Behavioral Health Utilization Management
Procedure Handbook

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Behavioral Health Utilization Management
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A manual for CareOregon behavioral health providers serving Columbia Pacific CCO members

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Introduction

The utilization management (UM) guidelines in this document explain the process CareOregon uses in the authorization of behavioral health services for Columbia Pacific CCO members. The purpose of this handbook is to guide providers in the submission of requests for authorization of covered services and to inform providers of the criteria used by CareOregon in the review process.

Columbia Pacific CCO (CPCCO) is one of the coordinated care organizations for Clatsop, Tillamook and Columbia counties. CPCCO is a wholly owned subsidiary of CareOregon (CareOregon, Inc. is the sole member of the LLC). As such, most of the functions performed by CPCCO are performed by CareOregon. Therefore, the Vision and Mission are shared.

Our Vision: Healthy communities for all individuals, regardless of income or social circumstances.

Our Mission: Inspire and partner to create quality and equity in individual and community health.

Guidelines – values and principles

Values

CareOregon promotes resilience in and recovery of its members. We support a system of care that promotes and sustains a person's recovery from a mental health condition by identifying and building upon the strengths and competencies within the individual to assist them in achieving a meaningful life within their community.

Individuals are to be served in the most normative, least restrictive, least intrusive, and most cost-effective level of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history, individual voice and choice, and extent of family and community supports.

Principles

1. Treatment planning incorporates the principles of resilience and recovery:
   - Employs strengths-based assessment
   - Individualized and person-centered
   - Promotes access and engagement
   - Encourages family participation
   - Supports continuity of care
   - Empowering
   - Respects the rights of the individual
   - Involves individual responsibility and hope in achieving and sustaining recovery
   - Uses natural supports as the norm rather than the exception
2. Policies governing service delivery are age and gender appropriate, culturally competent, evidence-based and trauma informed, attend to other factors known to impact an individual's resilience and recovery, and align with the individual's readiness for change. The goal is for the individual to have access to all services that are clinically indicated. Positive clinical outcomes are more likely when clinicians use evidence-based practices or best clinical practices based on a body of research and as established byprofessional organizations.
3. Treatment interventions should promote resilience and recovery as evidenced by:
   - Maximized quality of life for individuals and families.
   - Success in work and/or school.
   - Improved mental health status and functioning.
   - Successful social relationships.
   - Meaningful participation in the community.

4. When multiple providers are involved in the care of our members, it is our expectation that regular coordination and communication occurs between these providers to ensure coordination of care. This could include sharing of service plans, joint sessions, phone calls or team meetings.

Medical necessity criteria

CareOregon defines medical necessity and medical appropriateness consistent with both the Oregon Administrative Rules and nationally recognized evidence-based standards (InterQual). All services provided to Oregon Health Plan Medicaid recipients must be medically appropriate and medically necessary. For all services, the individual must have a diagnosis covered by the Oregon Health Plan which is the focus of treatment, and the presenting diagnosis and proposed treatment must qualify as a covered condition-treatment pair on the Prioritized List of Health Services.

Medically appropriate services are those services which are:

- Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service.
- Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment.
- Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan.
- The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to the individual.
- Not provided solely for:
  - the convenience of the recipient, the recipient's family, or the provider of the services or supplies.
  - recreational, research or data collection purposes.
  - the purpose of fulfilling a legal requirement placed on the recipient.

Medically necessary services are those services that are required by a member to address one or more of the following:

- The prevention, diagnosis or treatment of a member's disease, condition or disorder that results in health impairments or a disability
- The ability for a member to achieve age-appropriate growth and development
- The ability for a member to attain, maintain or regain independence in self-care, ability to perform activities of daily living or improve health status
- The opportunity for a member receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice.

A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically necessary services are covered services.

In addition to the above foundational definitions, the determination of medical necessity is also made by CareOregon on an individual basis using InterQual criteria. Requests for services are reviewed by Masters-level behavioral health clinicians and/or psychiatrists. If a requested service is denied, reduced when previously authorized, or authorized in amount, duration or scope other than what was requested, the decision to do so will be made by a clinician with clinical expertise in the specific condition.

Prior authorization for Behavioral Health Treatment

Most determinations for standard prior authorization requests are made within 14 calendar days of the date of the request. In the event a covered behavioral health condition may result in imminent danger to the member's life, health or ability to function, prior authorization can be requested as Expedited, and a decision will be made within 72 hours. Both standard and expedited requests can be extended an additional 14 calendar days for review if the member or provider requests it, or if CareOregon can demonstrate that additional time for the review is in the member's best interest. Some specific levels of care operate under more specific turnaround times per OHP rule, and CareOregon abides by those requirements. Please see the table below for full details of turnaround times and authorization length. If the request for services is approved, CareOregon will notify the requesting provider and give the date of the next medical necessity review, if applicable. If the request for a prior authorization is denied, CareOregon will send a Notice of Adverse Benefit Determination (NOABD) to the member and the requesting provider. If the services denied had previously been authorized, the effective date of the denial will be 10 calendar days from the date of the determination to deny. There is no prior authorization for urgent or emergent care.

Levels of service and practice guidelines

Level of Care	Initial Authorization Length	Continued Stay Length	Utilization Management Turn Around Time
Applied Behavioral Analysis (ABA)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Eating Disorder Programs Treatment: Residential and Partial Hospitalization	30 days	30 days	14 calendar days
Electroconvulsive Therapy (ECT)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Mental Health Intensive Outpatient Treatment (IOP)	Dependent upon clinical circumstances; generally 14 days	Dependent upon clinical circumstances; generally 14 days	14 calendar days
Mental Health Partial Hospitalization	Dependent upon clinical circumstances; generally 7- 14 days	Dependent upon clinical circumstances; generally 7- 14 days	14 calendar days
Neuropsychological Testing	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Psychiatric Day Treatment Services (PDTS)	90 days	30 days	7 business days
Psychiatric Residential Treatment Services (PRTS)	30 days	30 days	3 calendar days
Psychological Testing	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Subacute Treatment: Youth	7 days	Dates and units entered per provider request/clinical need	Next business day
Transcranial Magnetic Stimulation (TMS): Adult	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days

Submitting requests for authorizations

Connect Provider Portal
Providers can access patient eligibility, prior authorizations and claims/payment information through our Provider Portal (Connect). It makes it easy for you to:

- Submit treatment authorization requests.
- Check detailed claim status.
- Review remittance advices.
- View authorizations on the detailed, line level.
- Check detailed eligibility and member information, including primary care provider (PCP) assignment, other insurance and benefits.
- Create and print PCP rosters.
- Search and verify ICD-10, CPT, HCPC, revenue codes and modifiers.

Providers who do not have access to Connect should contact CareOregon Provider Customer Service at 503-416-4100.

Requests for Initial Authorizations
Providers can submit a Prior Authorization request and supporting clinical documentation to CareOregon via the Connect Provider Portal at least two weeks prior to the expiration date of the current authorization. Not all services require authorization. Please see Levels of Service grid for details. If the provider believes that ongoing services are clinically indicated, the provider will submit an assessment and services plan indicating the member's current level of functioning, the frequency, duration and clinical justification of the proposed services, as well as the anticipated benefit of those services. Other supporting clinical documentation is welcomed at the provider's discretion. CareOregon UM staff will review the documentation and consult with the provider as needed to confirm that the request is for treatment of a covered diagnosis; that medical necessity of the services is demonstrated; and to enter an authorization for services as approved, including the documentation of the above.

Required elements of a request for Initial and Ongoing services are as follows:

- Identification of beneficiary (member information)
- Name of beneficiary's physician, or lead clinical provider
- Date of admission (to program or service)
- If application for Medicaid is made after admission to the program, date of application of and authorization for Medicaid
- Plan of Care
- Reason and plan for the services

Requests for Ongoing Treatment Authorizations
Providers can submit a Prior Authorization request and supporting clinical documentation to CareOregon via the Connect Provider Portal at least two weeks prior to the expiration date of the current authorization. Some levels of care should be submitted on a different timeline according to the turnaround time for review of that service type; see the Authorization table for details. These processes will repeat as needed for the duration of treatment, including until the member no longer needs those services, the clinical picture necessitates a referral to other more appropriate services, or medical necessity is no longer evidenced, and the current services are denied.

Obtaining a second opinion
A second opinion by a qualified healthcare professional is available with or without an authorization. CareOregon arranges for second opinions when CareOregon determines that providers are unavailable or inadequate to meet a member's medical need.

Acute psychiatric inpatient

Authorization process
CareOregon gathers admission information from Collective, Oregon's statewide electronic census. Authorizations are generated by CareOregon and a clinical review for medical necessity of the inpatient services is begun on the day of, or next business day after, day of admission. For facilities with remote EPIC or other EHR access capability, remote access is used to review clinical records. When remote access is not available, clinical documentation indicating medical necessity of the admission shall be submitted via fax to CareOregon. CareOregon's behavioral health UM team is available as follows:

	Contact Information
Initial and concurrent authorizations	Phone: 503-416-3404 Fax: 503-416-1720 UM staff are available Monday through Friday, 8 a.m. to 5 p.m. Requests made after hours: CareOregon will review the admission record for medical necessity and contact hospital UR staff on the next business day after the admission.

Minimum record requirements
In the event of the admission of a CPCCO member to a hospital for mental health treatment or to a mental health hospital, the health record shall include, at the minimum:

- Name of the member/potential member
- Name of the member's physician
- Date of admission
- Dates of application for and authorization of benefits
- Plan of care
- Justification of emergency admission
- Reasons and plan for continued stay
- Initial and subsequent continued stay review dates
- Other supporting material the utilization review committee believes is appropriate

Medical necessity criteria
CareOregon uses InterQual criteria to determine the presence of medical necessity based on the clinical documentation provided with each request. In some instances, local resources, community agreed-upon standards or regional consensus best practices inform medical necessity instead.

Eligibility is not determined until after admission
If the member is still admitted when eligibility is determined, CareOregon will confirm eligibility and review clinical for medical necessity of inpatient services. If approved, authorization will be retroactive to the day of admission. If the member has already discharged when eligibility is determined, UM staff will make an authorization determination within 30 calendar days of notification of the admission.

Requests for Continued Stay Authorizations
For facilities where remote EHR access is available, CareOregon UM staff will access the record on the day of concurrent review and perform the review. Hospital UR will notify CareOregon if the member is discharging prior to the scheduled day. For facilities without remote EHR access, Hospital UR will fax updated clinical information in legible written format to CareOregon UM.

Once clinical information has been received and reviewed, CareOregon UM staff will contact hospital UR staff via phone to request additional information, if needed, or to notify of the determination. If no additional information is needed, CareOregon UM staff will determine the number of days authorized and the date of the next review.

Medical unit transfers
When a member transfers to a medical care unit and remains there past midnight, it is the responsibility of the hospital to notify CareOregon that the member is no longer on the inpatient psychiatric unit. The psychiatric inpatient episode of care will be ended as of midnight.

Should the member need to return to psychiatric acute care following the medical stay, the Initial Authorization process outlined above is followed.

When a member transfers to a medical service and returns to psychiatric acute care within the same business day, the authorization is not ended, and a prior authorization is not required before continuing the current psychiatric episode of care.

Discharge procedures
Hospitals will inform CareOregon UM staff of known or tentative discharge date and/or estimated length of stay, along with details of disposition/discharge plan. Hospital UR staff will notify of actual discharge date on the same business day as the discharge.

CPCCO is financially responsible for post stabilization care services obtained within or outside of its network of contracted providers that are pre-approved by a plan provider or other organization representative. Charges to members for post stabilization care shall not be greater than what the charge would have been to a member who received the services through an in-network provider. Planning for post stabilization care should begin upon admission to inpatient care.

Institution for mental diseases (IMDs)
CareOregon will abide by and authorize according to OAR rules for IMDs as noted in OAR Chapter 410-141-3000 (39) and 410-141-3160 (21).

Referrals to long term care (LTC)
When the CPCCO Exceptional Needs Care Coordinator determines that an individual is appropriate for LTC, the referral packet is completed, signed and routed to CareOregon UM staff for review. CareOregon UM staff, in consultation with the CareOregon Medical Director, review and make the determination before routing the signed referral packet to OHA for final determination. For Medicaid members, if approved for LTC, CareOregon continues to be responsible for payment for acute care until discharge. For children and youth, the state is responsible for payment for acute care after 7days, taking responsibility on day 8.

Determination for admission to LTC per OAR 309-091-0015
State hospital level of care is determined appropriate when:

- The individual's condition or symptoms have not improved in an acute care setting despite having received a comprehensive psychiatric and medical assessment, and treatment with medications for at least 7 days at an adequate dose; and
- The individual continues to require hospital level of care services, as evidenced by failure to meet the state hospital's criteria for readiness to transition.

Prior to referral for admission to a state hospital, the individual should have received:

- A comprehensive medical assessment to identify conditions that may be causing, contributing to or exacerbating the mental illness;
- Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the mental illness; and
- There must be evidence of additional treatment and services having been attempted, including:
  - Use of evidence-based or promising psychosocial interventions which were delivered in relevant culturally competent, strength-based, person-centered and trauma-informed manners and which adequately treated the assessed and/or expressed needs of the individual. Treatments should include members of the individual's family, support network and Peer Delivered Services, unless the individual doesn't consent.
- Documentation of ongoing review and discussion, by hospital staff, ENCC and Care Oregon, of options for discharge to non-hospital levels of care; and
- Documentation of services and supports attempted by the ENCC to divert an individual from acute admission and establish treatment and recovery in a non-hospital setting.

To make a referral for admission to a state hospital, the responsible party shall ensure the following documentation is provided:

- Request for OSH and PAITS Services form
- Community Questionnaire form, to include the OSH discharge plan, developed by the responsible party
- Patient demographic information
- Civil Commitment documents, to include Commitment Judgment or Order, and pre-commitment investigations; or guardianship orders, or health care representative forms
- History and Physical and Psychosocial assessment, if available
- Progress notes, from admission, Medication Administration Record; labs and other diagnostic testing
- Involuntary Administration of Significant Procedures documentation, if applicable.

Referral is received and reviewed by CareOregon UM team. If approved, determination is sent to the responsible party (ENCC) and OHA.

Prior to referral for admission to a state hospital, the individual should have received:

- A comprehensive medical assessment to identify conditions that may be causing, contributing to, or exacerbating the episode behavioral illness and associated symptoms;
- Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the episode of behavioral illness and associated symptoms;
- Treatment in an acute setting within the parameters of the most recent version of the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders;
- Attempts at additional treatment and services, including:
  - Use of evidence-based or promising psychosocial interventions which were delivered in relevant, culturally competent, strength-based, person-centered and trauma-informed manners, which adequately treated the assessed and/or expressed needs of the individual;

- When requested by the individual, treatments should include members of the individual's family, support network and/or peers;
- Documentation of ongoing review and discussion of options for discharge to non- hospital levels of care; and/or
- Documentation of services and supports attempted by the responsible party to divert admission and establish treatment and recovery in a non-hospital setting.

Outpatient mental health services – child, adolescent and adult

Outpatient services do not require authorization. Adolescents age fourteen and older may request service admission without parent/guardian consent, in accordance with applicable ORS 109.675[1]

Access

CPCCO members have open and direct access to agencies and licensed independent practitioners on the provider panel. Members can access treatment by contacting contracted providers directly, being referred from an allied agency, or by calling Care Oregon member Customer Service for help identifying and accessing a behavioral health provider most likely to be appropriate to their needs. Providers are required to offer members an intake assessment within two weeks from the date of request.

Screening and emergent/urgent response

Providers will screen all referrals to assess the urgency of the presenting situation and will respond within appropriate timelines as defined in these guidelines and relevant OAR. The provider may determine, based on member presentation, that an alternative provider is a more clinically appropriate match and may refer the member to another CPCCO paneled provider. Either may be accessed by calling CareOregon member Customer Service or by contacting a provider directly. Members identified as needing emergent/urgent services will be provided services within the following timelines, in accordance with OAR 410-141-0220:

- Emergency services mean health services from a qualified provider to evaluate or stabilize an emergency condition that are provided immediately or as indicated in initial screening. An emergency condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.
- Urgent care services are defined as health services that are medically appropriate and immediately required to prevent serious deterioration of a member's health that are a result of unforeseen illness or injury within 72 hours or as indicated in initial screening.

Contact Customer Service:
503-416-4100 or 800-224-4840
TTY: 711
Hours: 8 a.m. to 5 p.m.
Monday-Friday

careoregon.org

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