Behavioral Health
Metro Area Provider Manual

CareOregon®

Contents

Values & Principles

Values

CareOregon promotes resilience in and recovery of our members. We support a system of care that promotes and sustains a person's recovery from a mental health condition or substance use disorder (SUD) by identifying and building upon their strengths and competencies in order to assist them in achieving a meaningful life within their community.

Members 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.

Practice guidelines are intended to ensure appropriate and consistent utilization of mental health and SUD services and to provide a frame of reference for clinicians in providing services to individuals enrolled in Health Share. The guidelines offer a best practice approach and are not intended to be definitive or exhaustive.

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 session, phone calls or team meetings.

Principles

1. Service planning incorporates the principles of resilience and recovery, and:
    a. Employs strengths-based assessment
    b. Is individualized and person-centered
    c. Promotes access and engagement
    d. Encourages family participation
    e. Supports continuity of care
    f. Empowers the member
    g. Respects the rights of the individual
    h. Involves individual responsibility and hope in achieving and sustaining recovery
    i. 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 individuals' resilience and recovery and align with the individual's readiness for change, with the goal of ensuring that individuals have access to services that are clinically indicated.
3. Positive clinical and recovery outcomes are more likely when clinicians use evidence-based practices or best clinical practices based on a body of research and as established by professional organizations.

4. Treatment interventions should promote resilience and recovery as evidenced by:
    a. Maximized quality of life for individuals and families
    b. Success in work and/or school
    c. Improved mental health status and functioning
    d. Successful social relationships
    e. Meaningful participation in the community
    f. Increase in housing stability
    g. Increased abstinence from alcohol and/or drugs

Contractual Compliance with Provider Manual

CareOregon shall make this Provider Manual available to providers electronically. **As part of their Provider Participation Agreement with CareOregon, the provider agrees to comply with the applicable policies and procedures set forth in this Provider Manual and that compliance is necessary to meet the obligations under the provider's agreement with CareOregon.**

Glossary

General Terms

CIM (Community Integration Manager): the database in which eligibility, authorizations and claims reside for specialty behavioral health services for Health Share members.

PH Tech (Performance Health Technology): PH Tech is the third party administrator for CareOregon who processes specialty behavioral health claims for Health Share members.

Clean/Valid claim: A claim which is submitted in the correct format with all required information. The Medicare claims processing manuals for the *HCFA 1500* and *CMS 1450* should be consulted for additional information.

Provider Category Terms

Contracted Providers: Providers who hold a contract with CareOregon to provide mental health and/or substance use disorder services to Health Share members. Also referred to as "in-network providers."

Outpatient Fee for Service Mental Health Providers (aka OP FFS MH providers): Providers who receive reimbursement on a fee for service basis. Prior authorizations from CareOregon are required for all services provided by OP FFS MH providers. CareOregon refers members to these providers for specialty services that are not available with other contracted providers.

Fee for Service Level of Care Mental Health Providers (aka FFS LOC MH providers): Providers who receive reimbursement on a fee for service basis, issue provider submitted authorization and complete level of care assessments.

Case Rate Level of Care Mental Health Providers (aka CR LOC MH providers): providers who receive reimbursement on an episodic basis, issue provider submitted authorization and complete level of care assignments.

Non-Contracted Single-Case Agreement Providers: Providers who hold a one-time, member-specific single-case agreement that enables providers to receive reimbursement for services delivered to an individual member. Prior authorizations from CareOregon are required for all services provided by non-contracted single-case agreement providers.

Authorization Terms

Appeals: A request by a member, or members' authorized representative, for a review of a notice of action/adverse benefit determination.

Authorization: A member-specific approval to a provider to deliver services, which is entered into PH Tech's community integration manager (CIM) and allows for billing.

Authorization Amount: The dollar amount that CareOregon approves for provider submitted authorization and authorizations entered into CIM.

Authorization Increase Request: The request and clinical review process that providers engage in with CareOregon for determination of whether funds will be added to an existing authorization amount (based on medical necessity).

Claim: A bill that the provider submits to PH Tech in order to receive payment for services rendered.

Did Not Meet Medical Necessity Criteria: This refers to a scenario whereby the clinical information provided did not meet either the admission criteria or continued stay criteria.

Encounter: A single, individual service rendered.

Exceptional Needs Service: A service which requires a prior authorization.

Initial Provider Submitted Authorization: A contracted provider's first authorization for services to a Health Share member, when entered into PH Tech's CIM. Or, CareOregon has authorized services that require prior authorization.

Notice of Adverse Benefit Determination: A written notice to the member or member's representative and provider regarding a decision to reduce, suspend, deny or terminate previously authorized or requested services.

Re-Authorization: Outpatient re-authorizations for services rendered, also known as "concurrent review" or "continued stay."

Provider Submitted Authorization: The information that any contracted outpatient case rate provider or contracted outpatient fee for service provider enters into CIM to indicate that the provider will bill for services rendered to a member. The provider submitted authorization may automatically approve in CIM, and a provider can submit claims with respect to that provider submitted authorization.

Request Additional Clinical Information: For the purposes of clinical review, CareOregon Utilization Management staff request clinical information that is current, valid and congruent with the member's level of functioning at the time of the request. When a request for additional clinical information is made, the provider shall submit their clinical documentation, which should include a brief description of the member's current clinical presentation, response to interventions, prognosis and description of need for continuation/extension of services. Requested additional information should be received as soon as possible and within three business days to avoid an unnecessary denial due to lack of information.

CareOregon Clinical Practice Guidelines

CareOregon, through its Quality Committee, reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses.

Metro Area Behavioral Health Clinical Practice Guidelines can be found at *careoregon.org/providers/best-practice-guidelines* via the CareOregon website.

Paper copies of these guidelines will also be made available upon request. Please call CareOregon Customer Service at 503-416-4100 and ask to speak to someone in our Quality Assurance Department.

Utilization Management Criteria for Behavioral Health

Many services require a *prior authorization* from CareOregon including, but not limited to:

Mental Health

- *Applied Behavioral Analysis (ABA) Services - Youth*
- Assertive Community Treatment
- Community-Based Intensive Treatment (CBIT) - Youth
- Crisis Stabilization - Youth
- Day Treatment
- Eating Disorder Treatment - Residential, PHP, IOP
- Electro-Convulsive Therapy (ECT)
- Outpatient Mental Health Treatment with an Outpatient Fee for Service Mental Health provider
- Single-Case Agreements with Non-Contracted providers
- Intensive Case Management
- Partial Hospitalization
- Psychiatric Day Treatment Services - Youth
- Psychiatric Residential Treatment Services - Youth
- Psychological Testing
- Sub-Acute Services - Youth
- Transcranial Magnetic Stimulation

Substance Use Disorder (SUD)

- *Non-Formulary Medication Assisted Treatment*
- *Residential Treatment*
- *Day Treatment*

The complete Metro Area Utilization Management Procedure Handbook will be made available to the provider network on December 18, 2019 (and will become effective on January 1, 2020) via the CareOregon website: *careoregon.org/bhproviders*

Access

Behavioral Health

Urgent behavioral health treatment appointments should be scheduled within 24 hours. For urgent/emergent situations, other appropriate services may include referral to the local county crisis service or to a hospital emergency department as necessary to prevent injury or serious harm. In an emergency situation, if a provider is unable to schedule an appointment that occurs within 24 hours, the provider is to make a referral to the appropriate county crisis services or nearest emergency department.

Routine behavioral health treatment appointments should be scheduled as follows:

- Within seven days of request, see patient for an intake assessment.
- Within 14 days, see the patient for second appointment (sooner if clinically indicated).
- Within 48 days of request, see the patient three additional times.

Appointments must be therapeutic in nature and expand beyond administrative activities.

Specialty Behavioral Health providers are to ensure patients have timely access to covered specialty behavioral health services. If providers cannot meet these time frames, the member must be placed on a wait list and provided interim services within 72 hours of being placed on a wait list.

Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance abuse disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135.

If care cannot be provided according to the time frames listed here, the provider must contact CareOregon Care Coordination services, which will help place the member in the appropriate care setting.

The following populations require immediate assessment and intake. If interim services are necessary, treatment at the appropriate level of care must start within 120 days from placement on a wait list:

- Pregnant women
- Veterans and their families
- Women with children
- Unpaid caregivers
- Families
- Children ages birth through five years
- Individuals with HIV/AIDS or tuberculosis
- Individuals at the risk of first episode psychosis
- Children with serious emotional disturbance
- I/DD population

For IV drug users, immediate assessment and intake is required. Admission must occur within 14 days of request, or if interim services are necessary, admission must commence within 120 days from placement on a wait list.

For opioid use disorder and medication assisted treatment, assessment and intake are required-within 72 hours.

Additional information regarding member access to services are described in OAR 410-141-3515.

Substance Use Disorders

When a provider receives a request for outpatient services, an initial service appointment will be offered within seven calendar days.

For urgent/emergent situations, other appropriate services may include referral of the member to local county crisis services or to a hospital emergency department as necessary to prevent injury or serious harm.

If the member prefers to seek services elsewhere due to wait times, the provider must offer referral information to other appropriate providers within CareOregon's provider network, including name of the provider, address or general location and phone number. The provider will also educate the member on how to contact CareOregon Customer Service for further assistance.

For providers who hold a certificate of approval: Per OAR 309-019-0110 (5) (e), the provider's policies and procedures shall prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.

Out-of-Office Planning for Independent Practitioners

Single-case agreements are not issued to cover a second provider when the authorized provider will be out of the office/unavailable. It is the practitioner's responsibility to check with their licensing board on how to address this issue within their practice in line with their board requirements. Solo practitioners may partner with other providers in their area who are also part of CareOregon's provider network to cover services to members when necessary. It is the responsibility of the provider to make coverage arrangements and contact CareOregon to request prior authorizations for the covering provider. Health Share members may be directed to the Mental Health Crisis Clinics/Crisis Services for support when their providers are not available.

Members' Rights

Provider must notify members of their rights at time of intake. Member rights, including grievance, appeal and contested case hearing procedures and timeframes, are included in the Health Share Member Handbook on the Health Share website, as well as in the *CareOregon Provider Manual* under OHP Member Rights and Responsibilities.

Members have the right to:

- Be free from discrimination on the basis of health status, the need for health services, race, color, national origin, language spoken, religion, sex, sexual orientation, gender identification, marital status, age or disability and the right to complain about discrimination.

- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand.
- Be actively involved in the development of treatment plans if covered services are to be provided and to have family involved in such treatment planning.
- Request and receive a copy of his or her own health record (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion.

Declaration for Mental Health Treatment

Participating providers who hold a certificate of approval must document in a prominent part of the medical record whether the CareOregon member has been offered an opportunity to complete a Declaration for Mental Health Treatment form. Declarations for mental health treatment information is available in the *Health Share Member Handbook* and in the provider's contract.

Member Assignment & Termination

Members may choose to receive care from any contracted provider who has the capacity to meet the individual's assessed behavioral health treatment needs. Once the member has made a successful connection with the provider, as evidenced by an authorization for routine services, the individual will be considered "enrolled." For all enrolled members, the provider will have the responsibility to assist members to access services by providing outreach, office- and/or community-based appointments, engagement techniques and other methods likely to improve the chances that those in need will receive services.

A provider may not refuse to provide services to any member meeting medical necessity criteria. If there are reasonable clinical reasons why the provider is unable to provide services that otherwise are a good fit for the member, arrangements for service to be received at an alternative agency is the mutual responsibility of the member, the provider and CareOregon.

The provider will continue to maintain responsibility for any member with an open authorization, including providing post-hospital follow up. The only circumstances that would terminate the provider's responsibility for a member with an open authorization are one or more of the following circumstances:

- The member has transferred services to another provider, and the new provider has confirmed that they have accepted the member.
- The provider and member have agreed that the member no longer needs formal behavioral health services and has an established natural system of support that is likely to meet their ongoing needs. The provider will be available to reopen the member's treatment plan or provide aftercare services, as clinically appropriate.

- The provider has documented consistent efforts to engage the member over a period of time determined by clinical best practice which have not been successful, and the member is not judged to be at risk for requiring a higher level of care.
- The member moves out of the area and referral has been made to a receiving agency.
- The member dies.
- The member requests termination of services with the provider.

Except for these identified scenarios, case rate providers are expected to continue to provide medically necessary services for the duration of the authorization period and may not terminate the individual from treatment while the member has benefits through Health Share. Providers must work with CareOregon directly for any exceptions to these requirements.

Transfers

Providers shall make all reasonable efforts to provide services to members with an open service authorization and address any member-reported concerns related to service delivery. This may include accommodating reasonable requests to transition to a new clinician (within the same provider agency) or adjust treatment approach(es) to be more aligned with the treatment needs of the member.

If a member with an open service authorization requests a transfer of services to another contracted behavioral health provider, the provider will cooperate with the member and assist in making transfer arrangements with the new provider and CareOregon. The current provider is responsible for determining the best course of action.

Care Integration & Coordination

Coordination with Physical Health

CareOregon expects coordination of care and exchange of protected health information between the physical health care provider and the behavioral health provider to address physical and behavioral health needs, when indicated. As a best practice, behavioral health providers are responsible for informing the primary care provider (PCP) of the member's entry into behavioral health treatment after an appropriate release of information has been signed (when required). The amount of information to be disclosed "must be limited to that information which is necessary to carry out the purpose of the disclosure" [42 C.F.R. §2.13(a)]. Thus, information shared between physical and behavioral health providers will vary depending on the different purposes for which different recipients are being allowed access to the information, and each release of information must be individualized accordingly.

Providers are also responsible for informing the PCP of any significant change in the member's mental status or medications.

CareOregon supports a model of care — such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare, or wraparound for children with behavioral health disorders — that emphasizes prevention and routine care. As a best practice, providers determine if the member has a PCP and assist the member to receive routine health exams with their PCP even when there is not an immediate health concern.

Members with No Identified PCP

The amount of assistance given to a member by a provider in obtaining a PCP or identifying their assigned PCP will be based on the functioning level of the member and the member's need for assistance. Either CareOregon or the provider will encourage members receiving outpatient level of care services who disclose that they have no PCP to call their Physical Health Plan's Customer Service Department to find out the process for obtaining a PCP. If the member is a child or adolescent, their parent or guardian will be encouraged to obtain a PCP for their youth.

Clinicians providing behavioral health services and supports to Health Share members with severe and persistent mental illness (both adult and child/adolescent) are expected to take an active role in seeking PCP services for their members.

Members with no insurance coverage for physical health care will be provided with information about "safety net" clinic alternatives.

Members with Chronic Disease

Members or their guardians are asked to identify any current or chronic medical conditions as part of the assessment.

If such a medical disease or disorder is identified, the provider will follow the procedures outlined above to determine if the member is receiving care for this condition from a PCP or a medical specialist.

If a member identifies a significant physical disease or disorder for which the member is not receiving treatment, the provider will encourage and/or assist the member to obtain necessary treatment as appropriate. When a member with a significant medical disease or disorder is receiving behavioral health treatment, the provider is encouraged to monitor the member's compliance with their medical treatment plan.

Member Complaints

CareOregon members have the right to file complaints in accordance with Oregon Administrative Rules (OAR) and Centers for Medicare and Medicaid Services (CMS) guidelines. CareOregon encourages members and providers to resolve complaints, problems and concerns directly with those involved. However, CareOregon provides formal procedures for addressing complaints and problems when they cannot be resolved otherwise.

If they are not resolved, OHP members have the right to request a hearing by OHA through its hearing process. Members may call the Customer Service Department of their CCO to file their complaint.

Resolving Complaints at the Provider's Office

Members who have complaints about a specific provider, clinic staff or the provider site in general should contact the clinic manager for help in addressing the issue.

Mental health providers are required to address complaints consistent with Grievances and Appeals sections as required by Oregon Administrative Rules 309-019 and 309-022.

If a member remains dissatisfied with the provider's response to the complaint, the member should contact their CCO's Customer Service Department.

Providers may contact CareOregon Customer Service Department for help in resolving members' complaints.

Resolving Complaints at CareOregon

CareOregon Customer Service logs received complaints and facilitates the member complaint process. Other staff in units such as Care Coordination, Pharmacy, DME, Authorizations and the Senior Medical Director are involved in the process when appropriate.

CareOregon Quality Assurance monitors and analyzes all complaints documented by Customer Service and follows up with appropriate parties until the issue is resolved.

Oregon Health Plan Complaint Forms

If a CareOregon OHP member is uncomfortable contacting CareOregon, he/she may submit a complaint to the OHA using Oregon Health Plan Complaint Form 3001 or contact the OHP Client Services Unit at 800-273-0557 (TTY 711).

OHP Complaint Forms are available online at OHP Client Services Unit:
aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3001.pdf

Provider Crisis Response Requirements

All behavioral health providers (regardless of organizational size or number of members served) will be required, at minimum, to provide members with the phone number to the crisis line associated with the county in which the member resides, and coordinate care with the crisis line as needed. Crisis line information for the metro area is provided on the CareOregon website.

Provider agencies will have a crisis response system for members enrolled in their program. At a minimum, the provider agency will have a clinician available by phone for consultation at all times, including after regular business hours. This individual shall be familiar with the member or shall have the ability to access relevant information about the member to assist in crisis response.

Enrolled members who come to the attention of a crisis line shall be referred to their current provider for crisis response during normal business hours. If a member who is enrolled with one of the local provider agencies comes to the attention of a crisis program, the team will contact the provider directly and request assistance in responding to the situation.

Interpreter Services

Interpreter services are a covered benefit for Health Share members at no cost to the provider. Per your agreement with CareOregon, Oregon Administrative Rules and federal regulations, members have the right to receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand. Details for accessing interpretation services can be found online in the *CareOregon Provider Manual*.

Privacy and Confidentiality of Member Information & Records

Protecting the privacy and confidentiality of member information and records is a paramount responsibility. To that end, providers are required to have policies and procedures in place that ensure that member records are secured, safeguarded and stored in accordance with the requirements of the Provider Participation Agreement, as well as all applicable federal and state laws and regulations, including ORS 413.171, ORS 414.679, OAR 410-120-1360; OAR 943-014-0300 to 0320, OAR 943-120-0000 to 0200 and OAR 410-141-0180.

In addition to the above, any provider, whether a facility or individual, which holds itself out as providing (and does provide) alcohol or drug abuse diagnosis, treatment or referral for treatment must comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. That rule only allows information protected by Part 2 to be shared if the provider obtains a written consent from the member prior to treatment. Such consents must include a description of all entities to which the protected member records will be disclosed, including to which entities those records may also be re-disclosed. In addition, the consent must state the purpose of the disclosure, which is "payment and health care operations." Given the nature of CareOregon's provider network and its relationship with the county behavioral health divisions in Multnomah, Clackamas and Washington counties, all providers should ensure that consent forms developed pursuant to 42 CFR Part 2 specifically state that protected records may be disclosed for payment and health care operations to each the following entities:

- CareOregon, Inc.
- Clackamas County Behavioral Health Division
- Multnomah County Behavioral Health Division
- Washington County Behavioral Health Division
- Health Share of Oregon
- Performance Health Technology (PH Tech)

All of the entities above require access to protected records for the purposes of billing and payment as well as utilization management and care coordination. CareOregon will conduct compliance audits to ensure that 42 CFR Part 2 consent forms adhere to the above requirements.

Health Related Services, Flexible Options, Mental Health Providers

Per OAR 410-141-3000 (38), health-related services, flex options (HRSF) are cost-effective services offered to an individual member to supplement covered benefits. Flexible services lack any traditional billing or encounter codes (including physical, dental or behavioral health), are not encounterable, and may not be reported for utilization purposes.

In accordance with OAR 410-141-3150, the following criteria must be met for the use of HRSF by Contracted providers.

Requirements for HRS-Flex Options

- Items and services requested must not be otherwise Medicaid reimbursable and/or encounterable.
- All community and external resources have been pursued, or adequate documentation of no other funding source is available and/or exists to cover the cost of the service or item (e.g., community-based organizations, AMHI, ENCC).
- All flexible services and supports must be related to a treatment goal and documented in the member's treatment plan or medical record.
- Flexible services and supports must not be used for the sole purpose of reducing costs or member cost containment.
- Flexible services must be designed to improve health quality, increase the likelihood of desired health outcomes in a manner that can be objectively measured and produce verifiable results and achievements and be based on evidence-based medicine, widely accepted best clinical practice and/or criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations.
- Urgent requests must be submitted at least two to three business days prior to the date an item or service is needed. All non-urgent requests will be reviewed within 10-15 business days of receiving a completed request form.

The treatment plan must clearly identify the current clinical justification (i.e., behavioral issue, psychosocial stressor and/or functional impairment including intervention to address goal) for the use of flexible services and explain how the specific service or item will address/ameliorate the identified issue/stressor/impairment.

Providers should contact CareOregon to request authorization for flexible services, as described in the *flexible services resource document* available on the CareOregon website.

HRS-Flexible Options Grievance Requirements

HRS-Flex fund outcomes are subject to the grievance provisions of OAR 410-141 3225.

Members, their representatives, and providers will receive a written outcome regarding flex fund requests. The written outcome informs the member, their representative and provider of the member's right to file a grievance in response to the outcome. The member may file the grievance orally or in writing with either CareOregon, Health Share or OHA. Members have no appeal or hearing rights in regard to a flexible services outcome.

Provider Fee Schedules

CareOregon maintains regional provider fee schedules. Regular updates to fee schedules are posted in CIM and providers will be notified at least 30 calendar days in advance (or as soon as possible) of revisions and updates to the regional provider fee schedules.

Billing, Service Authorization & Claims Management

CareOregon standards related to authorization and claims processing and payment follow the requirements in OAR Chapter 410-120 and 410-141.

CareOregon works with a third party administrator, Performance Health Technology (PH Tech), for authorization and claims management. The community integration manager (CIM) is the online tool offered by PH Tech for the submission and management of service authorizations; it can also be used to manage adjudicated claims. Instructions for accessing CIM can be obtained by visiting *help.phtech.com*.

Third Party Liability

As Medicaid is the payer of last resort, state and federal guidelines require:

- Reporting of all third party liability (TPL) sources for clients who are covered by other health insurance; and
- Providers must bill all other insurance resources before billing Medicaid. A provider is not required to bill fee for service Medicare as the primary insurer for services or items not covered by Medicare or for services provided by a non-Medicare approved provider type.

All providers must make every reasonable effort to obtain and report TPL information for the members they serve, and to bill TPL before billing CareOregon.

To ensure accurate processing and correct payment of secondary claims, providers must include a copy of the explanation of benefits (EOB) from the primary payer when CareOregon is the secondary payer. claims for which CareOregon is the secondary payer must be received within 365 days of the date of service and must include the primary payer's EOB.

Upon receipt of valid secondary claims, for claims with primary payers including Medicare and private insurance, the total benefits that a member receives from CareOregon and the other medical plan cannot exceed what CareOregon's normal benefit would have been by itself. For members with other primary payers, CareOregon compares our payment to the other carrier's payment to determine the amount payable.

- If CareOregon's payment is equal to or less than the other carrier's payment, the benefit is zero (see examples #1 and #2).
- If CareOregon's payment is greater than the other carrier's payment, CareOregon pays the difference, but does not exceed the member's responsibility (see example #3).

	Example 1	Example 2	Example 3
Total billed	$100	$100	$100
Other plan paid	$40	$40	$24
Member responsibility	$60	$60	$76
CareOregon normal benefit	$80	$0	$65
CareOregon pays	$40	$0	$41

Confirming Member Eligibility

Per OAR Chapter 410-141, providers are required to confirm new and current member benefits and eligibility prior to providing all services. Failure to confirm member eligibility may result in the provider not being reimbursed, should the member be ineligible for services.

Additionally, as Medicaid is the payer of last resort, providers must check member benefits and eligibility to confirm if the member has other coverage prior to billing CareOregon. If it is determined that the member has other coverage, provider must bill the primary payer prior to billing CareOregon.

Member eligibility should be confirmed using the OHA Medicaid Portal, MMIS. Review *OHP Provider Web Portal-Eligibility* for more detailed information regarding logging into MMIS and checking member eligibility.

Claims Submission Process

Providers may submit claims to PH Tech within timely filing guidelines via paper or electronic data interchange (EDI). The preferred method of claims submission is EDI. For EDI support, please email edi.support@phtech.com.

EDI Payer IDs for accepted clearinghouses	Payer ID for CORTEX EDI – HSOCC, CMHO1, CX034 or CX032 Payer ID for GATEWAY EDI – VMMH1 or 16259 Payer ID for OFFICE ALLY – CCMMH, VMMH1 or WCHHS Payer ID for RelayHealth – 77122

Please limit claims to services provided by one provider per claim. Please limit claims to services covered by one authorization per claim. If your agency provides services to Health Share members for both mental health and SUD, please limit each claim to services for only mental health or only SUD services.

When claims are submitted for services offered within a facility/office setting (not in the community), the actual address of the service location must be included on the claim.

For paper claims submissions, please send mail to:

CareOregon Behavioral Health
PO Box 5490
Salem, OR 97304

Claims Adjudication

Claims are reviewed by PH Tech at the time of receipt to determine whether they meet the definition of a valid claim as stated in OAR Chapter 410-120. Claims received for payment of covered health services rendered to an eligible member must:

1. Contain all relevant information for processing without requiring additional information from the provider or from a third party.
2. Be received within the time limitations described in the following section, "Claims Timely Filing Deadlines."

All Health Share claims are adjudicated in accordance with the Oregon Health Authority Health Evidence Review Commission Prioritized List of Health Services and the Centers for Medicare and Medicaid Services National Correct Coding Initiative (NCCI).

Additional information and the current prioritized list can be found on the Oregon Health Authority website: *oregon.gov/oha/hsd/ohp/pages/index.aspx*

Additional information and some of the National Correct Coding Initiative edits can be found on the following websites:
cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
medicaid.gov/medicaid/program-integrity/ncci/index.html

Claims Timely Filing Deadlines

Per OAR Chapter 410-141, CareOregon requires both participating and non-participating providers to submit valid claims for all mental health and substance use disorder (SUD) services within 120 calendar days of the date of service. A claim is considered valid if it contains all relevant information for processing, without requiring any additional information from the provider or from a third party. If a valid claim is not received by PH Tech within 120 days, it is not considered timely and will be denied for timely filing.

Exceptions to the 120-day timely filing rule include:

- Eligibility issues such as retroactive enrollments or dis-enrollments.
- When Medicare or other third-party resources are the primary payer.

Exceptions do not include failure of the provider to verify the member's eligibility at the time of service.

Post-Service Claim Reconsiderations

For CIM users:

Please send a request through CIM by emailing careoregonbhclaims@phtech.com with the subject line "Post-Service Claim Reconsideration." Please attach and complete the *Post-Service Claim Reconsideration form* along with any necessary documents to support your request within the claim in CIM.

For non-CIM users:

Please send a request using the *Post-Service Claim Reconsideration form*.

Please fax to:
BH Claims Reconsiderations
503-566-9801

Please mail to:
Attn: BH Claims Reconsiderations
PO Box 5490
Salem, OR 97304

Claims Reprocessing Deadlines

Providers shall submit a claim to be reprocessed or corrected (see Corrected Claims below) to PH Tech within 365 calendar days from the original adjudication date.

Claims Reprocessing Communications

Providers are encouraged to continue to use the email link within CIM for the following types of communication (this list is not exhaustive):

- Providers requesting adjustment to authorization information
- Providers relaying information about patient/member eligibility (retro changes)
- Claim status questions
- Provider questions concerning how decisions are made to process and pay claims, including fee schedule, benefits, edits, etc.
- Providers requesting to VOID a claim

Member Billing Regulations

Providers shall accept the agreed-upon contractual rate as payment in full for services rendered. In accordance with OAR Chapter 410-120, members shall not be billed for:

- Missed appointments.
- Services and treatments that have been denied by the payer due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).
- Any copayment, coinsurance or deductible.

Providers may only bill a member in the following situation:

- The member did not inform the provider of OHP coverage, enrollment in Health Share, or third-party insurance coverage at the time of or after a service was provided. Therefore, the provider could not bill the appropriate payer, obtain prior authorization, and/or submit claims within timely filing limits. The provider must verify eligibility and document attempts to obtain coverage information prior to billing the member.
- The member became eligible for benefits retroactively but did not meet all other criteria required to receive the service.

- A third-party payer made payments directly to the member for services provided.
- The member is receiving the limited Citizen Alien Waived Emergency benefit package (CAWEM). These members may be charged for services which are not part of the benefit. The provider must document that the member was informed in advance that the service would not be covered.
- The member has requested a continuation of benefits during a contested case hearing process, and the final decision was not in the favor of the member. The member shall be billed for any charges incurred for the denied service on or after the effective date on the Notice of Adverse Determination or Notice of Appeal Resolution. The provider must complete the *OHP 3165 form* prior to providing these services.

Members may elect to privately pay for services in exceptional circumstances:

- For covered services, the provider may bill the member if the provider informs the member in advance of the following:
  - The provider documents in writing, signed by the member or the member's representative, indicating that the provider gave the member the information described below, that the client had an opportunity to ask questions, obtain additional information and consult with the client's caseworker or client representative and that the client agreed to privately pay for the service. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to Health Share or a third-party payer that is subject to the agreement.
- The agreement must include:
  - That the requested service is a covered service, and the appropriate payer would pay in full for the service; and
  - The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay and that the member cannot be billed for an amount greater than the amount the payer would pay; and
  - The member knowingly and voluntarily agrees to pay for the covered service.
- For non-covered services, a provider may bill a member provided the following:
  - Prior to delivering the non-covered service, the *OHP 3165 form* is signed by the member; and
  - There is evidence of the *OHP 3165 form* in the member's file and available upon request.

Oregon Medicaid Enrollment for Claims Processing

All providers, both organizational and individual, who will appear on a claim as a submitting, rendering or attending provider, must be enrolled in Oregon Medicaid and be issued an Oregon Medicaid enrollment number by the Department of Medical Assistance Programs (DMAP) **in order to be reimbursed for services rendered**. This number is commonly referred to as a "DMAP number." Furthermore, clinicians must be enrolled as the correct provider type, in order to render services. For example, a clinician who is both an LPC and a CADC must be enrolled in Medicaid with two separate enrollment numbers, one for mental health and one for SUD in order to provide both services.

For more information regarding DMAP and NPI identification numbers, please see the *CareOregon Provider Manual* and reference the section titled **DMAP ID Number.**

Corrected Claims

Providers shall submit corrected claims to PH Tech within 365 calendar days from the original adjudication date.

Providers should not submit email requests to change required data elements to a claim. PH Tech will not accept changes submitted either via direct email or via email link in CIM. Instead, providers are required to submit a corrected claim reflecting needed changes either by paper or electronically (EDI), as applicable. Below is a list of example data elements that cannot be changed based on email submitted either directly to PH Tech staff or via CIM link (this list is not exhaustive):

- Provider name/Tax ID/NPI
- CPT code
- Billing provider name/Tax ID/NPI
- Modifier
- Plan/provider/billing provider/location address
- Diagnosis pointer
- From and to dates of service
- Units
- Diagnosis code
- National drug code (NDC)

Provider Data Management

CareOregon behavioral health providers are contractually responsible for notifying CareOregon of changes to their staff, addresses and billing data. Processes for submitting provider rosters, adding or removing practitioners, adding or changing address and changing provider billing data are outlined herein.

Requirements for All Contracted Providers

Submitting Address Changes

Providers shall notify CareOregon of **any change** to a provider's office location(s) or administrative address at least **30 calendar days** in advance of the effective date.

Changes to current office locations, or additions of a new office location, shall be reported using the *Provider Address Addition/Relocation form*. If a provider is closing an office and it is not being relocated, providers shall compete the *Provider Address Closure form***.** Changes to any administrative addresses (i.e., billing, mailing, credentialing), shall be reported using the *Provider Administrative Address Update form*.

Completed forms and supporting documents should be sent to bhproviders@careoregon.org at least **30 calendar days** prior to your address change or addition.

Failure to submit notice at least 30 days in advance of a change may result in inaccurate data in the Provider Directory.

Submitting Changes to Provider Billing Data

CareOregon must be notified at least 45 calendar days prior to any changes to a provider's billing data, including tax identification number (TIN), Organizational National Provider Identification (NPI) number and/or organizational name.

Failure to submit notice at least 45 days in advance of a change may result in claims or authorization processing errors.

To notify CareOregon of a change to your billing data, please complete and submit the *Provider Billing Data Change form* to bhproviders@careoregon.org.

Requirements for Delegated Organizationally Contracted Providers

Submitting Provider Rosters

In order to ensure network accuracy, **delegated organizationally contracted providers*** must regularly submit full practitioner rosters to CareOregon.

Providers must use the *Delegated Organizational Provider Roster template* to submit practitioner information each quarter to CareOregon in Excel format. Documents received in any other format will not be accepted. The *Delegated Organizational Provider Roster* must be submitted to CareOregon at bhproviders@careoregon.org by the **first Friday of each quarter (January, April, July and October)**.

Adding a New Practitioner to a Delegated Organization

Currently contracted delegated organizational providers who need to add a newly-hired and credentialed practitioner to their CareOregon contract in order for claims to be processed correctly must complete an *Adding New Practitioner to an Organization form* and submit to provider.contracts@phtech.zendesk.com.

Prior to sending the above information, delegated organizational providers* are responsible for credentialing their practitioners in order to meet the Medicaid regulations stated in the Provider Manual.

*In order to be considered a Delegated Organizational Provider you would need to have a Credentialing Delegation exhibit included with your CareOregon contract. If you do not have a Credentialing Delegation exhibit, you must have your provider credentialed by CareOregon to have claims processed correctly.

Information should be provided for each practitioner who will treat CareOregon members and submit claims under the organizational provider.

Please note: In order for authorizations and claims to process correctly, all individual practitioners within a group must be loaded into CIM.

Updating/Terming a Current Delegated Practitioner with an Organization

A currently contracted organizational provider who needs to update (i.e., name change) or indicate the termination of an existing practitioner should send notification and details of the change or term to PH Tech at provider.contracts@phtech.zendesk.com.

The practitioner's name and NPI must be included along with description of change or termination notice.

Credentialing & Re-Credentialing Requirements

CareOregon's Credentialing Department can be reached at credentialing@careoregon.org.

Organizational Providers

Initial Credentialing

An organizational provider with an active CareOregon contract has undergone an initial credentialing process and been approved by CareOregon's committees to provide services. If you have already been approved by Health Share, your credentialing will be grandfathered and accepted by CareOregon until you are due for re-credentialing.

Re-Credentialing

CareOregon re-credentials organizations every three years. At the time of re-credentialing, CareOregon will notify the provider.

Ongoing Expectations

For participation in the CareOregon provider network, organizations shall maintain the following credentialing documentation in paper or digital form as applicable to the scope of their contracted services. Any changes to the status of credentialing documentation (examples: expiration without renewal, restrictions or other changes) must be immediately reported to CareOregon.

As applicable, active health care accreditation for all locations providing services under the contract with CareOregon. Examples of accreditation include, but are not limited to:

- CARF accreditation
- Joint Commission accreditation

As applicable, active licensure for locations providing services under the contract with CareOregon. Examples of licensure include, but are not limited to:

- Current certificate of approval from the Oregon Health Authority for all locations that provide outpatient mental health or substance use disorder services and have unlicensed practitioners providing services
- Current DEA for locations that provide covered maintenance and withdrawal management services
- Current OHA licensure(s) for locations that provide covered adult residential treatment services
- Current DHS licensure(s) for any facility that will be providing covered child residential treatment services
- Current opioid treatment program certification for locations that provide medication-assisted treatment to Health Share members
- Any other current health care related licensure granted to any facility that provides covered services to CareOregon members

Active liability insurance showing:

- Professional liability coverage, with at least $1M per occurrence/$3M aggregate coverage
- A policy on restraint and seclusion that ensures members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion

Organizations' Responsibility to Oversee License and Unlicensed Practitioners

For Organizations with a Credentialing Delegation Exhibit in their CareOregon Agreement: Organizational providers that hold a contract with CareOregon that includes a Credentialing Delegation exhibit *are responsible for processing and approving credentialing* for their individual employed and contracted practitioners who are providing services to CareOregon members. Resources regarding credentialing practitioners are available by contacting credentialing@careoregon.org.

For Organizations WITHOUT a Credentialing Delegation Exhibit in their CareOregon Agreement:
Organizations that do not hold a Credentialing Delegation exhibit *will require credentialing by CareOregon* of their licensed providers. CareOregon has agreed to honor the credentialing that the contracted provider groups have completed of their providers prior to January 1, 2020, but re-credentialing of all providers will be completed by CareOregon.

For practitioners' re-credentialing: CareOregon will reach out 90 days in advance to request the required re-credentialing documents.

For new practitioners: Any newly-hired licensed practitioners will need to be credentialed in-house by CareOregon. To initiate this process, a completed Oregon Practitioner Credentialing Application (OPCA) needs to be sent to credentialing@careoregon.org or faxed to 503-416-3665 to start the credentialing process.

- *Link to OHA website to obtain a blank OPCA*
- *Link to checklist of elements required by CareOregon*

Individual Providers (Solo Practitioners Directly Contracted)

Initial Credentialing

An individual provider with an active CareOregon contract has undergone the initial credentialing process and been approved by CareOregon to provide services. If you have already been approved by Health Share, your credentialing will be grandfathered and accepted by CareOregon until you are due for re-credentialing.

Re-Credentialing

CareOregon re-credentials individuals every three years and will notify the provider at time of re-credentialing.

Other Expectations

For participation in the CareOregon network, providers shall maintain the following credentialing documentation in paper or digital form as applicable to the scope of their contracted services:

- Active liability insurance with professional liability coverage with at least $1M per occurrence/$3M aggregate coverage
- Active licensure. Must have appropriate licensure for fulfilling scope of contracted services
- If applicable, current DEA. The DEA must be registered in the state providing services and have appropriate clearance for fulfilling scope of their contracted services

Any changes to the status of credentialing documentation (examples: expiration without renewal, restrictions or other changes) must be immediately reported to CareOregon.

Fraud, Waste & Abuse

All participating CareOregon provider clinics must adopt and implement an effective compliance program, which must include measures that prevent, detect and correct non-compliance with Centers for Medicare and Medicaid Services (CMS) program requirements and fraud, waste and abuse. Training and education must occur annually, at a minimum, and must be a part of new employee orientation, new first tier, downstream and related entities and new appointment to a chief executive, manager or governing body member.

CMS fraud, waste and abuse training can be found on our website at careoregon.org/providers/support

Provider Audits

CareOregon is committed to promoting quality improvement, payment integrity and minimizing fraud, waste and abuse. CareOregon may periodically perform pre-payment claim audits and audits of paid claims which may call for records and clinical documentation to be submitted for review for HEDIS or other quality program initiatives, risk management purposes or payment integrity monitoring and oversight practices. CareOregon may use extrapolation to establish the results of an audit's findings.

As a CareOregon contracted provider, refusal to cooperate with the medical record review as part of the audit process, peer review requirements, corrective action plans or otherwise being unable to meet provider qualifications and requirements may result in contract termination.

Overpayment Recoveries

When an overpayment is identified from any source — including but not limited to various audits and/or notification from the provider — CareOregon uses an auto-debit method to recover funds. This process involves reversing the appropriate group of claims and future claims payments are automatically debited until the outstanding overpayment balance is settled. The most efficient way for a provider to notify CareOregon of an overpayment is to call our Customer Service team as soon as the overpayment is found and no later than 60 days from the date of discovery. Our Customer Service team will obtain all required information, including why the overpayment occurred. They can be reached Monday-Friday 8 a.m. to 5 p.m. at 800-224-4840.

If, as a result of an audit, claims you submitted to CareOregon cannot be validated based on medical records and/or are not clinically indicated, those claims payments will be considered overpayments, subject to recovery by CareOregon on behalf of the Oregon Health Authority and CMS. Please handle overpayment disputes as outlined in this manual and your provider agreement.

Required Submissions

Provider Access Report

CareOregon providers who provide outpatient behavioral health services shall submit access reporting data by the 15th of each month. The data collected is intended to capture (on average) how many days out providers are currently scheduling the third next available non-urgent outpatient behavioral health assessment appointments.

"Third next available appointment" is defined as the length of time (in days) between the day a patient makes a request for an assessment appointment and the third available appointment. The third next available appointment is used rather than the next available appointment since it is a more sensitive reflection of true appointment availability.

CareOregon providers who provide ABA services shall submit access reporting data by the 15th of each month. That data collected is intended to capture (on average) how many days out providers are currently scheduling intake appointments and how long it is taking for services to begin.

CareOregon providers will be required to respond to the **Monthly Access Report survey** by the 15th of each month.

For more information on how to submit the report please contact Behavioral Health Providers: bhproviders@careoregon.org

Additional Reports as Requested

CareOregon may request additional reports from providers that are not specifically named herein. Providers must submit these reports in a timely manner.

Mental Health Outcomes

The following information on outcomes applies to all CareOregon providers contracted to offer mental health outpatient services under the case rate or fee for service level of care model.

Feedback-Informed Treatment: Description, Participation and Standards

Feedback-informed treatment (FIT) (also referred to as outcomes-based care, PCOMS, routine outcomes monitoring and measurement-based care) can be described as:

"A pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery" (Bertolino, B., & Miller, S. (eds.) (2011). The ICCE Feedback Informed Treatment and Training Manuals. Chicago, IL: ICCE Press)

Essentially, this can be distilled down as the process of:

1. Regularly and formally gathering client feedback about their level of distress (or wellness) and about the alliance between the client and the helper.
2. Using that data to inform treatment.
3. Engaging in deliberate practice to help foster professional development.

FIT puts the client's voice at the center of services as an active participant and driver of the treatment process. Engaging in FIT processes allows clinicians and agencies to capture and tangibly demonstrate the good work they are doing with clients and notifies clinicians when clients are not benefiting so that treatment can be augmented as needed. In short, it is a client-centered process that helps care providers ensure that as many people benefit from services as possible.

Providers are expected to use a CareOregon-approved outcomes instrument to aid in treatment planning and overall provision of services. All providers contracted January 2018 or later who are contractually required to implement FIT may self-select either the Outcomes Rating Scale (ORS) and Session Rating Scale (SRS) or the ACORN as their outcomes tool.

Providers contracted prior to January 2018 may continue to use their previously selected tool.

If a provider contracted prior to January 2018 would like to switch their FIT outcomes tool, they may select either the ORS/SRS or the ACORN. It is the expectation that providers will participate in FIT initiatives, utilize the identified outcomes tool with their member population and that they are able to report on their outcomes to CareOregon. Providers who are interested in FIT support, would like information about learning opportunities or have other FIT-related questions should contact a Behavioral Health Outcomes Specialist.

Case Rate Level of Care Mental Health Providers

Performance Expectations

A key element of health care transformation is moving away from paying for volume to paying for value. The fee for service payment model may create an incentive to provide as many services as possible, while case rates support a shift in focus to achieving outcomes.

Case rates are meant to provide flexibility to the provider and member, in order to ensure that mutually established treatment outcomes are met. Ultimately, case rates will contribute to achieving the Triple Aim of better care, better health and lower costs.

Case rates are an AVERAGE payment for all of the members served at a given level of care. By definition, some individuals will require MORE care and some will require LESS care in order to achieve the intended outcomes.

Case rates are NOT a fixed budget for an individual member.

Performance expectations include, but are not limited to, the following:

- The provider shall maintain required access for routine, urgent and emergent appointments within timelines per the access requirements outlined in the Access Report.
- The provider shall ensure follow-up care for members after discharge from a hospital for mental illness within seven calendar days of hospital discharge.
- The provider shall complete an annual audit of its decision-making process to ensure consistent application of review criteria for level of care authorization decisions, taking into account applicable utilization management guidelines (see the CareOregon Metro Area Utilization Management Procedure Handbook, to be posted on the website December 18, 2019, and will become effective January 1, 2020) and consultations with requesting practitioners as appropriate.
- The provider shall ensure members are receiving the frequency and intensity of service that is clinically indicated by the member's level of care and current clinical presentation and functioning. CareOregon may periodically coordinate with providers to ensure services are available to align with the frequency and intensity that the member requires.
- The provider shall improve outcomes by using approved outcomes tools to track progress and adjust treatment accordingly.

- The provider shall provide 24-hour, seven-day-a-week telephonic or face-to-face crisis support coverage.

Case rate level of care provider staff make level of care determinations for all services that are delivered within the Level A-C outpatient levels of care. The results of the clinician's evaluation of level of care needs could result in one of the three outcomes.

The clinician at the case rate provider agency determines that the client's presentation

1. Does not meet the threshold for treatment at any of the outpatient levels of care.
2. Results in the clinician assigning one of the outpatient levels of care (A-C), which they can self-authorize.
3. Results in the clinician submitting a request for a service that requires prior authorization.

Risk Corridor Reconciliation Process

A risk corridor will be calculated to evaluate case rate payments in relation to the fee for service equivalent value of the encounterable services. There will be one risk corridor effective each fiscal year with an 70 percent floor and a 125 percent ceiling. The risk corridor will be calculated annually. Fee for service equivalents are identified on the regional fee schedule. Please note that if a provider's usual and customary billed rate is lower than CareOregon's fee for service equivalent, then the provider's usual and customary billed rate will be used to calculate the risk corridor.

Alternative Payment Confidentiality Requirements

Pursuant to section 9.6 of CareOregon's Provider Participation Agreement, all information on the case rate (alternative payment) system is considered "Confidential Business Information." This information includes all elements related to the case rate system including, but not limited to: case rate/risk corridor reports, authorization utilization report, case rate payment amounts and the case rates technical assistance manual.

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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