CareOregon Behavioral Health System Integration (BHSI)

Provider Frequently Asked Questions (*Rev 5.24.2023*)

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 this system change apply to Health Share Behavioral Health services/providers?
Yes – All authorizations and claims for Health Share Members are moving from PHTECH CIM to CareOregon Connect for claims and authorizations for dates of service 10/1/2023 and beyond.

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

Section 2: Eligibility

How do you verify a Member's Health Share of Oregon eligibility after the 10/1/2023 change?
Eligibility can be verified through CareOregon's Connect portal (preferred method to Connect is through OneHealthPort). Eligibility can also continue to be verified through CIM.

Medicaid providers can also access Oregon's Medicaid Management Information System (MMIS) Provider Portal to verify real-time eligibility for Oregon Health Plan (OHP) members. This state managed provider portal can be helpful in confirming CCO assignment of a client when there are more than one CCOs in a service area and can also confirm the type of benefit coverage a client has. The MMIS Provider Portal login is available at: https://www.or-medicaid.gov. For more information about the state managed MMIS Provider Portal, see Oregon Health Authority : Oregon Medicaid Provider Portal : Oregon Health Plan : State of Oregon.

Does that mean that verification of a member's physical health plan will happen in CIM still? And will we still see the CareOregon BH eligibility line for someone who has Kaiser OHP as their physical health plan in CIM?
Information regarding Health Share eligibility in CIM3 and your access to that information as a BH provider is not changing. If you are set up to see Health Share eligibility now, you will continue to be able to see the CareOregon BH eligibility and the IDS, Physical Health Plan, information beyond the 10/01/2023 transition.

Will 270 / 271 batch eligibility be available after 10/1/2023?
There is no change to how providers may use Health Share's CIM3 for eligibility checks, including the use of 270/271s. See https://www.healthshareoregon.org/providers/provider-portal and posted Provider Portal FAQs which include CIM links and PHTECH support information.

Can you access information for anyone associated with your Tax Identification Number (TIN) when you access CareOregon Connect through OneHealthPort? Or will we need to log out and log back in when switching between providers, like we do currently in CIM?
Once you are logged into OneHealthPort if CareOregon recognizes your TIN you will be able to access CareOregon Connect without logging out and back in.

If we are not already using OneHealthPort, how soon should we start setting up our logins?
Any contracted provider can get access immediately for CareOregon Connect under OneHealthPort. If you login prior to the system conversion, it 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.

Will 270 / 271 batch eligibility be available after 10/1/2023?
There is no change to how providers may use Health Share's CIM3 for eligibility checks, including the use of 270/271s. See https://www.healthshareoregon.org/providers/provider-portal and posted Provider Portal FAQs which include CIM links and PHTECH support information.

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

For our Health Share Members, can we continue to submit prior authorization in CIM?
No, you will need to submit prior authorizations / notification in CareOregon Connect instead of CIM for Health Share behavioral health Members.

If we only take Health Share Members for substance use disorder (SUD) services, are we included in this change?
Yes, all SUD and Mental Health notifications of treatment, authorizations, and claims are included in this change.

Will we need to get new authorizations for each Health Share Member, or will CareOregon honor their current authorization?
CareOregon will honor existing authorizations that span the 10/01/2023 date of service transition. Work is currently underway to determine the most efficient way to move existing

data from CIM to CareOregon Connect. Existing CIM Authorizations that span the 10/01/2023 date of service transition will be honored. Providers may continue to use the number displayed in the "Auth #" field in CIM. The current plan is to transition existing authorizations over without manual intervention and to keep the authorization number the same as it was in CIM for these authorizations that span the cutover period. CareOregon is continuing to work on testing but the plan at this time should not require manual entry of authorizations.

NEW: How do I know if I am an Outpatient FFS A-C Providers?
"FFS A-C" is a Level of Care system for a small number of Outpatient Mental Health providers. A provider's contract would outline if this level of care system applies to a specific provider.

Will FFS levels of care A, B and C notifications/authorizations still be required in CareOregon's portal?
Level of care notifications/authorizations will continue to be required and will continue to be auto approved.

Will routine outpatient mental health level of care notifications/authorizations still be required in CareOregon's portal?
Level of care notifications/authorizations will no longer be required for providers who ONLY contract for routine outpatient mental health services and DO NOT currently use the Level A-C FFS authorizations. An email notification was sent to impacted providers in early May to inform them that they will no longer need to submit notifications/authorizations after the system transition on 10/1/2023.

Will service types be changing?
Service types will be simplified in Connect. The number of service types is being reduced by about 30%. A mapping of current to 10/1/2023 forward service types can be found in the Appendix.

When a provider submits a notification of services at one location, will the auth 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 auth forms be available online for providers to fax in requests, or will they have to call for the form?
All authorizations and notifications will be entered in the online portal Connect. There will continue to be a fax option but anticipate that faxes will be the exception. The fax forms will be available on our webpage.

What is the best communication pathway if messaging is not an option in Connect after the transition? Is there an easy way to do that in Connect?
Providers should call Customer Service with questions about authorization or notification status and/or claim status. They will work directly with the Behavioral Health Utilization Management team if there are additional operational support needs.

With CO 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 ABA online after the transition?
Yes. Applied Behavioral Analysis (ABA) will be one of the service types that can be selected in Connect.

NEWLY UPDATED: In CIM, auth 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 Request number is the number that needs to be submitted on claims.

Section 4: Referrals and Care Coordination

Will we be able to see other open authorizations or diagnosis codes history in CareOregon 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 CareOregon 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 individual 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

How will the referral to care coordination process change?
There should 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

The Level D and ICM authorization structure is a challenge. Will this process 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 intended to be similar to the current workflow in CIM. The UM team will continue to work in collaboration with the BH Navigation Team in processing and triaging the notifications and referrals to the ICM providers.

Section 5: Clearing House & Claims Submission

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

Will we still be able to submit claims via direct 837 (without a clearinghouse)?
While providers cannot submit electronic 837s directly to CareOregon, we will follow up with more detailed instructions on how to direct your electronic claims to us via our clearinghouse, Change Healthcare.

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)? *Answer being researched - will be updated soon.*

Is an authorization number required on the claim?
Yes, the authorization number *must* be submitted on the claim for appropriate processing and payment. Connect will provide a "request number." This is the number that must be in the prior authorization box on the claim. In addition, claims must be billed with one authorization number per claim. Claims submitted without a prior authorization number will be denied.

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

Will paper claims still be allowed?
Yes, we will continue to accept paper claims as long as 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 forward 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 still processes 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). This process will continue for rejected paper claims.

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

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.

NEW: Will facility claims for SUD be transferred to Connect? If so, will these claims still have to be billed under a provider instead of a facility in the Connect system?
QNXT will be configured to allow facilities as rendering provider for specific procedure codes as allowed by OHA.

NEW: Will QNXT be configured to pay case rates, including for withdrawal management services? Currently, CPCCO and JCC Providers (already in Connect) send an invoice to

CareOregon's AP Department to receive case rate reimbursement for withdrawal management services.
Yes, case rates will be paid out of QNXT. We will be looking to implement this functionality in 2024 for JCC and CPCCO case rates.

Section 6: Claim Status, Adjudication, and Payment

NEW: **In Connect, are we going to be able to send an electronic message for reprocessing claims or correcting authorizations?**
Messaging / email functionality will not be available initially in Connect. All support needs can be directed to our Customer Service team at (503) 416-4100 option 3 for Provider, option 2 for Behavioral Health.

NEW: **We currently get many of our claim support needs met through the ZenDesk tickets and/or CIM Messaging functionality. How will I get my support needs met in Connect / QNXT?**
We are working on more robust support staffing and bringing this all in-house to Care Oregon. All support needs can be directed to our Customer Service team at (503) 416-4100 option 3 for Provider, option 2 for Behavioral Health.

Will all Health Share claims activity migrate to the same platform as Jackson Care Connect and Columbia Pacific CCO and CareOregon Advantage?
Yes, all claims processed by CareOregon for JCC, CPCCO, Health Share of Oregon, and CareOregon Advantage Members will be in Connect/QNXT for dates of service 10/01/2023 and beyond.

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

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 going through an additional change for all providers 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 ePayment Center by 06/03/2023. If a provider is not enrolled with CareOregon ACH now, they can register in the CareOregon ePayment Center. Enrolling in this process is a no fee option for ACH payment. 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 you choose to enter a relationship directly with Zelis, you may incur a cost.

What will the workflow be for monies owed to PHTECH 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 PHTECH through the runout period (which is TBD). PHTECH accepts paper checks for refunds.

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: I see we are no longer using the "Medication Management for CR Providers" authorization type as of 10/01/2023. 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 served equal to $1/12^{th}$ of your total 2022 fee for service payments received for all "Medication Management for CR Providers" authorizations. Payments will also include a quarterly reconciliation process to ensure providers are reimbursed for medication management service utilization above and beyond 2022 utilization. These payments will be in addition to the case rate payments you will receive via QNXT. More details to come.

NEW: Is there any way to update the CareOregon name on the Remits to identify coverage types (e.g., Medicare/Medicaid)?
The remittance advice 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 remittance advice 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".

Section 7: Connect (Provider Portal) Access

Is the Connect portal available through OneHealthPort?
Yes, access to the Connect provider portal 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/

When can I get access to Connect?
Providers that already serve CareOregon Members for physical health needs in metro and/or behavioral health needs in JCC and/or CPCCO can set up access now. Access for metro BH only providers will be available starting in September 2023 so that authorizations for dates of service 10/1/2023 and forward can be submitted.

Is Connect different than GSI (Aerial)?
GSI is a platform used for care management/care coordination and is different than CareOregon Connect provider portal that allows the entry of authorization.

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 into CareOregon Connect.

Section 8: Reporting

Where will we get claims and authorization reports after the transition?
Answer being researched - will be updated soon.

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 auth report, however it will have all the same auth data.

Will there be batch reporting with remark codes available in Connect to help identify when there is an issue with a claim?
A PDF of the remittance advice can be viewed and downloaded in CareOregon Connect. The remittance advice will have any applicable remark and reason codes listed for each claim.

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 CareOregon Connect in a PDF to view all claims in the same payment batch.

Section 9: Contracting

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 will be 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.

NEW: In Connect, is anything expected to change with credentialing for the other CCOs (for contracted provider, not COA)?

Nothing is expected to change for credentialing.

NEW: Where can Providers find guidelines on the CareOregon website around adding providers for DOS 10/1/2023 and beyond?
Answer being researched - will be updated soon.

Section 10: Training & Support

How are you going to support us during our EHR 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.

Is all this new information being provided already updated in the behavioral health Provider Manual?
Provider training materials and updates to the Behavioral Health Provider Manual will be completed as tools and workflows are tested and finalized.

NEW: Will CareOregon offer training to Providers on how to run reports and navigate the Connect system?
Yes, CareOregon is actively working on training resources for Providers and will send out information as soon as training is available. Initial previews of Connect functionality are being planned for upcoming Billing and Admin meetings. Stay tuned for more info!

Section 11: Service Type Crosswalk (Appendix)

CareOregon BHSI | Service Type Crosswalk (Part 1 of 2) PH TECH to Connect Effective 10/1/2023	
Prior to 10/1/2023	**10/1/2023 Forward**
ABA Assessment 7/1/16 ABA Treatment - 7/1/16 ABA IBU	ABA Applied Behavioral Analysis
ACT	ACT Assertive Community Treatment
Assessment Plus Two Crisis Stabilization Assessment	Assessment Plus Two
Crisis Services	Crisis Services CMHP
Foster Care Crisis Response and Coordination	Child Welfare Resource Support Network
Crisis Stabilization Treatment	Crisis Stabilization Treatment
Culturally Specific	Culturally Specific
Day Treatment 7/1/16	PDTS Psychiatric Day Treatment Services
DBT IOP	DBT IOP
EASA FFS EASA Case Rate	EASA Early Assessment and Support Alliance
Eating Disorder Partial-IOP	Eating Disorder Partial IOP
Eating Disorder Residential	Eating Disorder Residential
ECT Anesthesia Fees 7/1/16 ECT Treatment 7/1/16	ECT Electroconvulsive Therapy
Oregon Intercept 7/1/16 Community Based Intensive Treatment HBS	Intensive Treatment HBS
Partial Hospital-IOP 7/1/16	Partial Hospital IOP
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 A Adult Global SPMI	Level A Adult SPMI
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 B Adult Global SPMI	Level B Adult SPMI
Level C Child Global Level C Adult Global Level C 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 HBS Global	Level D Child
Medication Management for CR Providers	Services previously under this service group have been combined with Service Types: Global Level A-D and Assessment plus Two

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CareOregon BHSI | Service Type Crosswalk (Part 2 of 2) PH TECH to Connect Effective 10/1/2023	
Prior to 10/1/2023	**10/1/2023 Forward**
Psych Testing and Consultation 7/1/16 Psych Testing 7/1/16	Psychological Testing
PRTS/Sub-Acute Case Rate	PRTS Psychiatric Residential Treatment Services
Child Sub-Acute 7/1/16	Sub Acute
Transcranial Magnetic Stimulation (TMS)	TMS Transcranial Magnetic Stimulation
Withdrawal Management WM FFS	SUD Withdrawal Management
General Outpatient - Adult General Outpatient - Child	SUD General Outpatient
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
MAT OTP	SUD Medication Assisted Treatment OTP
IOP - Adult IOP - Youth	SUD IOP Intensive Outpatient
Assessment and Transition	SUD Assessment
Day Treatment SUD - Adult Day Treatment SUD - Child	SUD Day Treatment
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
Adult Respite Child Respite 7/1/16	Respite
Eating Disorder 7/1/16 Eating Disorder Less Intensive OP	Eating Disorder Treatment
Supported Employment	Supportive Employment