Behavioral Health Utilization Management
Procedure Handbook

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health share
Health Share of Oregon

CareOregon

Behavioral Health Utilization Management
Procedure Handbook

A manual for CareOregon behavioral health providers serving Health Share of Oregon Members

Table of Contents

Introduction 1

Guidelines – values and principles 1

Glossary 2

Provider instructions 3

Member eligibility 3

Access 3

Submission of notifications of treatment and prior authorizations 5

Medical necessity 6

Medical appropriateness 6

OHP coverage and the Prioritized List 7

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 7

Prior authorizations 7

Requesting a prior authorization 8

Requesting secondary authorization 8

Provider TBD 8

Dual authorizations 9

Determinations 9

Denials 9

Services requiring prior authorization 11

Criteria for review 12

InterQual 12

Regional practice guidelines 12

Requests for ongoing treatment authorizations 16

Retroactive authorization determinations 16

Single case agreements (SCA) 16

Acute psychiatric inpatient requests 16

Eligibility is not determined until after admission 17

Authorization process 17

Administrative denials of admission process and timelines 17

Emergency services 18

Requests for continued inpatient stay authorizations 18

Discharge procedures 18

Medical unit transfers 18

General outpatient services 19

Connect submission and notifications of program enrollment 19

Substance use disorder (SUD) services 20

Referrals to long-term psychiatric care (LTPC) 20

Prior to referral 21

Making a long-term care referral 22

Introduction

The utilization management (UM) guidelines in this document explain the process CareOregon uses in the authorization of behavioral health services for Health Share of Oregon, LLC (Health Share) members. The purpose of this handbook is to guide providers in the submission of requests for authorization and program enrollment notifications of covered services and to inform providers of the criteria used by CareOregon in the review process.

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

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

Guidelines – values and principles

Values

CareOregon promotes resilience in and recovery of its members. We support a system of care that promotes and sustains a person's recovery from behavioral health conditions by identifying and building upon the strengths and competencies within the individual to assist them in achieving a meaningful life within their community. Individuals are to be served in the most normative, least restrictive, least intrusive, and most cost-effective level of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history, individual voice and choice, and extent of family and community supports.

Principles

1. Treatment planning incorporates the principles of resilience and recovery:
    - Employs strengths-based assessment
    - Individualized and person-centered
    - Promotes access and engagement
    - Encourages family participation
    - Supports continuity of care
    - Empowering
    - Respects the rights of the individual
    - Involves individual responsibility and hope in achieving and sustaining recovery
    - Uses natural supports as the norm rather than the exception
2. Policies governing service delivery are age and gender appropriate, culturally competent, evidence based and trauma informed. They attend to other factors known to impact an individual's resilience and recovery, and align with the individual's readiness for change. The goal is for the individual to have access to all services that are clinically indicated. Positive clinical outcomes are more likely when clinicians use evidence-based practices or best clinical practices based on a body of research and as established by professional organizations.

3. Treatment interventions should promote resilience and recovery as evidenced by:
    - Maximized quality of life for individuals and families.
    - Success in work and/or school.
    - Improved behavioral health status and functioning.
    - Successful social relationships.
    - Meaningful participation in the community.
4. When multiple providers are involved in the care of our members, it is our expectation that regular coordination and communication occurs between these providers to ensure coordination of care. This could include sharing of service plans, joint sessions, phone calls or team meetings.

Glossary

Authorization: A member-specific approval to a provider to deliver services, which is entered into CareOregon Connect and allows for billing.

Behavioral Health (BH): Mental health, mental illness, addictive health, and addiction and gambling disorders.

CareOregon Connect: CareOregon's provider portal where providers can access member eligibility, prior authorizations, program enrollment notifications and claims/payment information.

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."

Did not meet medical necessity criteria: When the clinical information provided did not meet either the admission criteria or continued stay criteria.

Managed Care Entity (MCE): An entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations. The MCE is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law, the PHP or CCO's contract with the Authority, and the OHP administrative rules governing MCEs.

Notice of adverse benefit determination (NOABD): 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.

Notification of continued services: Outpatient notifications for services rendered. Formerly referred to as a "re-authorization."

Notification of Treatment (NoT): A member-specific notification via entry in Connect or via fax for those services that do not require a prior authorization to deliver care. These notifications are required for payment, reporting and tracking purposes and are not clinically reviewed.

Prior authorization (PA): Payment authorization or approval for specified services prior to the provision of the service. A referral to a service is not considered a PA.

Provider submitted authorizaton or notification: The information that any contracted outpatient case rate provider or contracted outpatient fee-for-service provider enters into Connect to indicate that the provider will bill for services rendered to a member. The provider submitted authorization or notification may automatically approve in Connect, and a provider can submit claims under that submission.

Request for 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 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.

Single case agreement (SCA): A specialized agreement between CareOregon and a non-contracted provider for coverage of services for a single member.

Telehealth: Sometimes called telemedicine, telehealth allows for the provision of services without an in-person office visit. Telehealth is done primarily online via computer, tablet, or smartphone.

Provider instructions

Member eligibility

Authorizations and claims payments are subject to member eligibility. Eligibility can change after an authorization has been issued, impacting funded coverage. If eligibility changes prior to providing services, the authorization will no longer be valid. If OHP is the secondary payer, follow primary plan's guidelines for coverage. For Medicare members, CMS coverage rules apply, including benefit limits. Certain types of excluded services have been added below for convenience but should not be considered an exhaustive list.

Access

Health Share members have open and direct access to agencies and licensed independent practitioners on the provider panel. Members can access treatment by contacting contracted providers directly, being referred from an allied agency, or by calling CareOregon Member Customer Service for help identifying and accessing a behavioral health provider most likely to be appropriate to their needs.

Providers are required to offer members an intake assessment within two weeks from the date of request. Providers unable to meet this timeline are required to refer members to alternative providers who have capacity and/or refer the member to CareOregon Member Customer Service for assistance in identifying and accessing an alternative provider.

For referrals to Telehealth services, please review guidance on Telephone and video visit appointments on the CareOregon website. You can find this at the bottom of the *Provider Support Page* using the Quick Link titled **COVID-19 provider information.**

Screening and emergent/urgent response

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

Appointments must be therapeutic in nature and expand beyond administrative activities. Specialty behavioral health providers are to ensure members 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 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 use 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 start 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 substance use 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.

Behavioral Health Crisis Intervention Resources:

- Multnomah County Crisis Line
  503-988-4888 or 800-716-9496
  multco.us/behavioral-health/mental-health-crisis-intervention
- Washington County Crisis Line
  503-291-9111
  co.washington.or.us/HHS/MentalHealth/CrisisServices/index.cfm
- Clackamas County Crisis Line
  503-655-8585
  503-742-5335 (non-emergency)
  clackamas.us/behavioralhealth/urgentmentalhealth
- Cascadia Mental Health Urgent Walk-in Clinic
  Cascadia hours: 7 a.m. to 10:30 p.m.
  4212 SE Division St, Ste 100
  Portland OR, 97206
- Lines for Life/988
  800-273-8255
  linesforlife.org

Submission of notifications of treatment and prior authorizations

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

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

The preferred method of submission for all services is via Connect. For services that require prior authorization (PA), providers will submit requests and include clinical documentation to support medical necessity review. For services that do not require a PA, but still require an entry into Connect for payment, reporting and tracking purposes, providers will submit notifications of treatment in Connect. Notifications do not require clinical documentation or review and are entered in Connect for payment purposes. Under most conditions the notifications are auto approved. If there are any questions regarding the submission, CareOregon will reach out to clarify before processing. Self-entered authorizations should be entered/requested no later than 45 days from the start of services.

Providers that do not have access to Connect yet that need to submit a request for services can do so by using the appropriate form listed below and faxing to 503-416-4727.

- Find the mental health treatment request form at *link.careoregon.org/careoregon-mental-health-request*
- Find the substance use disorder treatment request form at *link.careoregon.org/careoregon-substance-use-disorder-request*

The form must be filled out in its entirety. Please do not save the form, as it is updated regularly.

Most determinations for standard prior authorization requests are made within 14 calendar days of the date of the request. A prior authorization can be requested as "expedited" if the standard review timeline would seriously jeopardize the member's life, health, or ability to function, and a decision will be made within 72 hours. Both standard and expedited requests can be extended an additional 14 calendar days for review if the member or provider requests it, or if CareOregon can demonstrate that additional time for the review is in the member's best interest.

Some specific levels of care operate under more specific turnaround times per OHP rules, and CareOregon abides by those requirements. Please see the table below under the section titled "Prior authorizations" for full details of turnaround times and authorization lengths.

If the request for services is approved, CareOregon will notify the requesting provider and give the date of the next medical necessity review, if applicable. If the request for a prior authorization is denied, CareOregon will send a Notice of Adverse Benefit Determination (NOABD) to the member and the requesting provider.

No prior authorization is required for urgent or emergent care.

Medical necessity and appropriateness

CareOregon defines medical necessity and medical appropriateness consistent with both the Oregon Administrative Rules and nationally recognized evidence-based standards (InterQual). All services provided to Health Share members must be medically appropriate and medically necessary.

Medical necessity

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

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

Medical appropriateness

Medically appropriate services are those services that are:

- Recommended by a licensed health provider practicing within the scope of their license.
- Safe, effective and appropriate for the member based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence.
- The most cost effective of the alternative levels or types of health services, items or medical supplies that are covered services that can be safely and effectively provided to a division client or member in the division or MCE's judgment.

- Rendered by a provider whose training, credentials or license is appropriate to treat the identified condition and deliver the service.

  and

- Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan.
- Not provided solely for:
  - The convenience of the member, the member's family or the provider of the services or supplies.
  - Recreational, research or data collection purposes.
  - The purpose of fulfilling a legal requirement placed on the member.

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

OHP coverage and the Prioritized List

For all services, the individual must have a diagnosis covered by the Oregon Health Plan that is the focus of treatment, and the presenting diagnosis and proposed treatment must qualify as a covered condition-treatment pair on the Prioritized List of Health Services. Diagnosis codes that fall below the funded line or are not on the Prioritized List are not funded. A prior authorization/referral will not override a non-funded diagnosis. Treatment codes that don't pair with the diagnosis or pair with the diagnosis and are below the line are also non-funded. The Prioritized List and additional information can be found at *link.careoregon.org/ohp-prioritized-list*

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

As of January 1, 2023, CareOregon covers the EPSDT services below the funding line on the Prioritized List of Health Services when medically necessary and medically appropriate. The EPSDT benefit provides comprehensive and preventive health care services for Medicaid members under the age of 21. Services will be reviewed regardless of line placement, pairing and quantity limits.

Prior authorizations should continue to be submitted per CareOregon's established authorization request process.

Please note that not all requests for members below the age of 21 will fit the definition of EPSDT services. Medical necessity and medical appropriateness are determined on a case-by-case basis.

Additional information may be found at:

- *link.careoregon.org/EPSDT-program*
- *link.careoregon.org/EPSDT-OHA-memo*
- *link.careoregon.org/EPSDT-provider-guide*
- *link.careoregon.org/EPSDT-fact-sheet*

Prior authorizations

Some covered services or items require authorization before the service may be provided. CareOregon does not require a prior authorization for general outpatient services. Services requiring prior authorization are listed below. Payment may be authorized for the type of service or level of care that meets the member's medical need and that has been adequately documented. Only services that are medically necessary, appropriate, and

for which the required documentation has been supplied will be considered. CareOregon may request additional clinical information to determine medical necessity and appropriateness.

Requesting a prior authorization

If the provider completes an assessment and believes that ongoing services are clinically indicated, the provider will submit an assessment and service plan indicating the member's current level of functioning, the frequency, duration and evidence base of the proposed services, and the anticipated benefit of those services. Other supporting clinical documentation is welcomed at the provider's discretion. CareOregon UM staff will review the documentation and consult with the provider as needed to confirm that the request is for treatment of a covered diagnosis, that medical necessity and appropriateness of the services is demonstrated, and to enter an authorization for services as approved.

Required elements of a request for initial and ongoing services are as follows:

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

Requesting secondary authorization

An authorization request is not required when CareOregon is the secondary health plan, unless any of the following apply.

-The primary health plan does not cover the requested service.

-The primary health plan has denied payment of part or all of the requested service.

If any of the above apply, an authorization request must be submitted to CareOregon.

Provider TBD

We understand that, at times, it may be most beneficial for a member's current provider to submit a request for a prior authorization as they have the most up to date, comprehensive information to include with the request. In these circumstances we allow for a submission of a request with 'TBD Behavioral Health Provider' as the delivering or rendering provider. The submission and approval of a prior authorization does not constitute a referral to a provider, and coordination with the delivering provider is required to initiate treatment.

As with other requests, submissions must include clinical documentation to support the medical necessity determination. If the authorization is approved, CareOregon UM staff will inform the referring provider of the approval and advise them to coordinate with the delivering provider. The referring provider will coordinate with a delivering provider and then contact the CareOregon UM Team at 503-416-3404 to update the authorization once a delivering provider has been identified.

The following service types may be submitted by the members current provider with 'Provider TBD' as the delivering provider.

- Subacute (Youth)
- Psychiatric Residential Treatment Services (PRTS, Youth)
- Psychiatric Day Treatment Services (PDTS, Youth)
- Psychological Testing

The following service types are requested by the delivering provider once they have determined the referral is appropriate.

- Eating Disorder Residential
- Eating Disorder Partial IOP
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)

ACT, Level D Youth and Level D Adult

Initial referrals for the service types below are managed by the Behavioral Health Navigation (BHN) Team. Initial referrals should all be submitted with "TBD Behavioral Health Provider". All notifications of continued treatment should be submitted by the current treating provider via Connect.

- Assertive Community Treatment (ACT)
- Level D Child
- Level D Adult ICM

Dual authorizations

We do not require prior authorizations for outpatient services. If more than one provider enrolls and submits outpatient claims for the same member during the same time period, it would not be considered a "dual authorization," but all services are still required to be medically necessary and documented per the Oregon Administrative Rules and Medicaid. We expect that the member's clinical documentation demonstrates the need for the additional service, the added benefit of the additional services, including the rationale and specialization of the **second** provider. This could last the duration of the treatment episode or support a transition or continuity of care.

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

Determinations

Most determinations for standard prior authorization requests are made within 14 calendar days of the date of the request, and CareOregon will not apply more stringent prior authorization standards to behavioral health services than standards that are applied to medical/surgical benefits. In the event a covered condition may result in imminent danger to the member's life, health or ability to function, prior authorization can be requested as expedited, and a decision will be made within 72 hours. Both standard and expedited requests can be extended an additional 14 calendar days for review if the member or provider requests it, or if CareOregon can demonstrate that additional time for the review is in the member's best interest. If the request for services is approved, CareOregon will notify the requesting provider and give the date of the next medical necessity review, if applicable. If the request for a prior authorization is denied, CareOregon will send a notice of action benefit denial (NOABD) to the member and the requesting provider. If the services denied had previously been authorized, the effective date of the denial will be 10 calendar days from the date of the determination to deny. No prior authorization is required for urgent or emergent care.

Denials

Authorization denials (any decision to authorize a service in an amount, duration or scope that is less than requested) are made by an individual with the appropriate clinical expertise.

For previously authorized services that are ongoing and continuous in nature that do not continue to meet coverage or medical appropriateness review criteria, or are being terminated, suspended or reduced for reasons listed in OAR 410-141-3885, a notice is mailed to the member and provider within 10 calendar days before the date of action goes into effect for either partial or complete denials in accordance with the procedures described in OAR 410-141-3885.

Denial letters document the service requested, the reason for the denial and the rule/criteria that was used to make the denial determination. The letter includes information on how to obtain a copy of the criteria used to make the denial determination and how to appeal the denial determination. If a known community resource is available for the service that is being denied, for whatever reason, the member is instructed to call CareOregon for information. The letter is sent to both the member and the requesting provider within one business day of the determination to deny the request. The effective date of the denial is the date of the letter. For OHP members who may want an alternate format or language, the denial letter instructs them to contact CareOregon's Customer Service.

A notification of the denial is also sent to the requesting provider. It includes the service requested (including codes), reason for the denial, how to request a provider reconsideration (re-review) and the availability of a CareOregon medical director to discuss the denial determination with the requesting provider.

Providers 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.

Continued >

Services requiring prior authorization

Service types /Level of care	Initial authorization length	Continued stay length	Utilization management turnaround time	Decision-making criteria
Applied behavioral analysis (ABA)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days	InterQual
Eating disorder-residential treatment	30 days	30 days	3 calendar days	InterQual
Eating disorder-partial hospitalization	30 days	30 days	14 calendar days	InterQual
Electroconvulsive therapy (ECT)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days	InterQual
Mental health intensive outpatient treatment (IOP)	7-14 days, dependent upon clinical circumstances	7-14 days, dependent upon clinical circumstances	14 calendar days	InterQual
Mental health partial hospitalization (PHP)	Dependent upon clinical circumstances; typically, 7-14 days	Dependent upon clinical circumstances; typically, 7-14 days	14 calendar days	InterQual
Psychiatric day treatment services (PDTS): *Youth*	90 days	30 days	3 business days	InterQual
Psychiatric residential treatment services (PRTS): *Youth*	30 days	30 days	3 calendar days	InterQual
Subacute treatment: *Youth*	7 days	Dates and units entered per provider request/clinical need	Next business day	InterQual
Psychological testing: *Youth and adult*	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days	Practice Guidelines
Transcranial magnetic stimulation (TMS): *Adult*	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days	InterQual

Criteria for review

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

InterQual

InterQual is a comprehensive, clinically based, member-focused set of medical review criteria designed to assess and support decisions about the medical necessity of behavioral health and medical services and levels of care. It is used as a screening tool to assist in determining if the proposed services are clinically indicated and provided at the appropriate level or whether further evaluation is required. For additional information about InterQual criteria, please call the Behavioral Health (BH) UM Team at 503-416-3404.

Regional practice guidelines

Most services that require a prior authorization use InterQual to determine medical necessity. The services below do not use InterQual and instead use CareOregon practice guidelines that are developed from scientific evidence or a consensus of health care professionals such as the HERC/Oregon Health Authority.. Please note that services for ABA use Interqual for decision making in addition to the practice guidelines.

Assertive community treatment (ACT)

Members shall meet the medically appropriate standard as designated in OAR Chapter 309-019-0245, ACT Admission Criteria. Members who are medically appropriate shall have the following characteristics:

Diagnostic guidelines

Participants who meet the SPMI Eligibility per OAR 309-019-0225(26) are the primary target population for ACT services per evidence-based model:

- Schizophrenia and other psychotic disorders
- Major depressive disorder
- Bipolar disorder
- Anxiety disorders limited to Obsessive-compulsive disorder (OCD) and Posttraumatic stress disorder (PTSD)
- Schizotypal personality disorder

Members with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, traumatic brain injury, personality disorder or an autism spectrum disorder are not the intended recipients of ACT, and may not be referred to ACT if they do not have a co-occurring, qualifying SPMI Eligibility disorder.

Members with other psychiatric illnesses are eligible depending on the level of the long-term disability.

If an individual is unable to maintain in community without 1:1 constant care; this is beyond the scope of what ACT could provide. ACT program may deny if the care requires 1:1 intervention on a continuum basis that is beyond the scope of ACT and make proper recommendations for higher level of care

Clinical criteria

Members with **significant functional impairments** as demonstrated by at least **one of the following** conditions:

- Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family or relatives
- Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities)
- Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing)

Members with **one or more** of the following problems, which are indicators of continuous high service needs (e.g., greater than eight hours per month):

- High use of acute care psychiatric hospitals or emergency departments for psychiatric reasons, including psychiatric emergency services as defined in OAR 309-023-0110 (e.g., two or more readmissions in a six-month period)
- Intractable (meaning persistent or very recurrent) severe, major symptoms including affective symptoms, psychosis and suicidal thoughts
- Coexisting substance use disorder of significant duration (e.g., greater than six months)
- High risk or recent history of criminal justice involvement (e.g., arrest, incarceration)
- Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness or imminent risk of becoming homeless
- Residing in an inpatient or supervised community residence in the community where ACT services are available, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available
- Difficulty effectively utilizing traditional office-based outpatient services

Specialty ACT programs

Forensics ACT (FACT) in addition to the general ACT criteria, members must also meet the requirements of these specialized teams.

- Moderate to high risk to re-offend as established by a standardized risk assessment (e.g., LS/CMI) and significant criminal justice involvement as evidenced by **one or more** of the following:
  - Recent history of multiple police contacts, arrests, bookings, and/or incarcerations
  - Recent history of custody holds, peace officer holds and/or civil commitment
  - Currently under supervision with Multnomah County Adult Probation and Parole

RISE

- Eligibility or enrollment in the Homeless Youth Continuum
- Age 18-24 years old

Referrals

All new referrals to ACT must be submitted via Connect or fax, using the OHA Universal ACT Referral Form and the ACT Referral Face Sheet found on the Metro BH Provider Page. Referrals must include supporting clinical documentation.

ACT referrals are not clinically reviewed, but will be routed to the Behavioral Health Navigation (BHN) Team for triage and coordination.

Requests for continued ACT services must be submitted by the current servicing provider via Connect. No referral form, ACT Face Sheet, or clinical documentation is needed for continued ACT services.

For more information on ACT Fidelity Model and services, please see the OCEACT website at *OCEACT.org*

Applied Behavior Analysis (ABA)

Members shall meet InterQual criteria in conjunction with state and federal guidelines, to determine if Applied Behavior Analysis (ABA) services are medically appropriate.

Diagnostic guidelines and tools

Authorization of ABA services requires a diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder by an MD, PhD, or PsyD, using one of the following standardized diagnostic measures:

- Autism Diagnostic Observation Schedule (ADOS)
- Childhood Autism Rating Scale, Second Edition (CARS - 2)
- An educational diagnosis conducted by an MD, PhD, or PsyD.

Authorization

ABA assessment authorization:

Providers must submit clinical documentation that includes the diagnostic guidelines and tools listed above. The ABA assessment authorization request should be submitted via Connect or fax.

ABA treatment authorization:

ABA treatment authorization requests should be submitted via Connect or fax. The servicing provider must submit clinical documentation along with a documented diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder. Clinical documentation should also include a treatment plan with the following information:

- Measurable goals with baseline included, and date of baseline.
- Medical concerns that may impact treatment.
- Familial/custody information.
- Language spoken by family and if interpretation services were/are needed.
- Barriers to Treatment (staffing, family cancellations, illnesses, lack of communication/unresponsive to communication, etc.)
- Diagnosing clinician, including their credentials, and date of diagnosis for all diagnoses listed in the report. If the family is unaware, please indicate this.
- All school/Early Intervention information and any other services the member is receiving, including provider names, hours/frequency of services, etc. (ex. Early Intervention for 3 hours 3x/week, Speech Therapy with provider name included).
- At least two measurable caregiver goals with baseline.
- Date member began ABA services with servicing provider, along with previous ABA service providers and dates if known.
- Dates of service requested. If this requires CareOregon to backdate, a reason must be included.
- If the hours accepted by member are different from the clinically recommended hours, a reason must be included (ex. Clinical recommendation is 15 hours/week but due to school hours, member can only accept 8 hours/week).
- Include all assessment tool data utilized for the report being submitted.

*Any authorization requests for members who are the age of 18 or older, will require secondary review with a CareOregon Medical Director. Requests should be submitted with units for the entire 6 month

authorization. These should be broken down by number of units of each CPT code and the number of units total. See example:

Code 123456 x units/6 months
Code 234561 x units/6 months
Code 345612 x units/6 months
Code 456123 x units/6 months
Total x units/6 months

Psychological testing

Service description

The primary purpose of Psychological Testing is to obtain diagnostic clarification of a covered mental health diagnosis; specifically, to address a diagnostic and/or treatment question(s) that cannot be answered through usual means of clinical interview and collateral data review (including review of any previous psychological testing). Psychological Testing is delivered by a doctoral level psychologist or a psychiatrist who is adequately trained in the administration and interpretation of psychological instruments.

Psychological Testing is not intended to be a first line of evaluation in the vast majority of cases. Testing is appropriate when a qualified mental health provider has assessed the member and is not able to diagnose and treat them without Psychological Testing. It is recommended that the member be assessed and referred by a Licensed Medical Professional (e.g., psychiatrist or mental health nurse practitioner).

Clinical criteria

Requests for Psychological Testing should include supporting documentation that includes a current Assessment and Treatment Plan, and addresses the following:

- Specific clinical questions that testing would be expected to answer
- Reason that the clinical questions cannot be answered by a Qualified Mental Health Professional or Licensed Medical Professional (e.g., psychiatrist or mental health nurse practitioner)
- Documentation of what actions will be taken or how the treatment plan will be amended by the test results

Exclusion criteria for authorization under OHP

All services must be both medically appropriate and necessary. Testing is not covered when one or more of the following is true:

- Testing is for educational (IEP/Learning Disorders), vocational or legal purposes (including court ordered testing)
- Testing is to assist in determining eligibility for any kind of services (e.g., vocational rehab, disability, IEP, etc.)
- Testing is conducted as a screening tool or part of an initial evaluation
- Testing is requested by member for personal interest

Behavioral health vs. physical health:
Per Health Share policy, authorization requests should be submitted to a Health Share member's physical health plan when any of the following is true:

- If the request is for neuropsychological testing
- If the primary reason for testing is to rule in/out autism spectrum disorder
- If the primary reason for testing is to rule in/out ADHD

Authorization: Prior authorization must be obtained before the start of services and must not exceed the allowable amount based on identified hours to complete testing.

Concurrent review and prior approval are required if the psychologist will exceed the number of hours preauthorized. This will only be approved in exceptional need cases where circumstances justify the necessity of additional hours of testing.

TBD Behavioral Health Provider

If a request with the delivering provider listed as TBD Behavioral Health Provider is approved, a behavioral health specialist from the CareOregon UM Team will send the referent a list of contracted providers. The referring provider should contact the CareOregon UM Team at 503-416-3404 to update the authorization once a delivering provider has been identified.

Transcranial Magnetic Stimulation (TMS)

Transcranial Magnetic Stimulation (TMS) treatment is overseen by a qualified psychiatric physician (MD or DO psychiatrist). The evaluation and plan or order for TMS treatment is written by a qualified psychiatrist, or if completed by a qualified mid-level psychiatric provider (PMHNP or PA), it is reviewed and approved with co-signature by the overseeing psychiatrist (MD or DO). All involved psychiatrists and psychiatric providers must have training and experience in administering TMS therapy, and the treatment must be given under direct supervision of a psychiatrist or psychiatric provider; i.e., that provider must be in the area and immediately available, and the qualified physician (MD or DO) overseeing TMS treatment must be available for telephonic or video consultation.

Requests for ongoing treatment authorizations

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

Retroactive authorization determinations

CareOregon accepts retroactive authorization requests. When requests are submitted, an authorization decision is made based on the member's coverage, benefit rules and medical appropriateness criteria in effect at the time of the service. Since the service has already been provided, it may take CareOregon up to 45 days to make a decision.

Single case agreements (SCA)

CareOregon may authorize services to providers when deemed medically appropriate or for continuity of care purposes where the member has been receiving services from the provider and there is no available contracted provider to provide the same service to the member. Unless otherwise specified in an SCA, the provider will be reimbursed at 100% of the State Fee for Service rate or 100% CMS for Medicare Advantage members. SCAs will only be reviewed for approval if an approved prior authorization is in place if services require a prior authorization. Noncontracted fee schedules can be found at *https://www.careoregon.org/docs/default-source/providers/behavioral-health/noncontracted-mh-and-sud-fee-schedule.pdf?sfvrsn=136d69d2_12*

An SCA is not required to pay at non-contracted rates for payment. To request an SCA for a member-specific need, the provider should note that an SCA is sought on the authorization request form. If the service is authorized, our Behavioral Health Utilization Management Team will send an SCA request to CareOregon's Contracting Team to initiate the SCA process. For more information on billing out of network, please refer to the

Provider Guide to Billing Out-of-Network at *link.careoregon.org/careoregon-out-of-network-billing*

Acute psychiatric inpatient requests

Emergency and urgently needed services are covered 24 hours a day, seven days a week, regardless of whether services are rendered by a contracted provider or non-contracted provider. CareOregon will not require prior authorization for emergency room screening examinations that lead to the examining provider making a clinical determination that, under the prudent layperson standard, an actual emergency medical condition exists.

By its emergency services policy, CareOregon:

- Does not require prior authorization for urgent and emergent services.
- Does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Does not hold members liable to pay for subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.
- Does not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider of the member's screening and treatment within 10 days of presenting themselves for emergency services.
- Does not deny payment for treatment obtained under either of the following circumstances:
    - A member had an emergency medical or dental condition; this includes cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition or emergency dental condition.
    - A representative of CareOregon instructs the member to seek emergency services.

Eligibility is not determined until after admission

CareOregon gathers admission information from PointClickCare (formerly Collective/Premanage). If the member is still admitted when eligibility is determined, CareOregon will confirm eligibility and review clinical documentation for medical necessity of inpatient services. If approved, authorization will be retroactive to the day of admission. If the member has already discharged when eligibility is determined, UM staff will make an authorization determination within 30 calendar days of notification of the admission.

Authorization process

Authorizations are generated by CareOregon and a clinical review for medical necessity of the inpatient services is begun on the day of, or next business day after, the day of admission. If approved, authorization will be retroactive to the day of admission. For facilities with remote EPIC or other EHR access capability, remote access is used to review clinical records. When remote access is not available, clinical documentation indicating medical necessity of the admission shall be submitted via fax to CareOregon. CareOregon's Behavioral Health UM Team is available as follows:

Contact information	
Initial and concurrent authorizations	Phone: 503-416-3404	Fax: 503-416-4727 UM staff are available Monday through Friday, 8 a.m. to 5 p.m. Requests made after hours: CareOregon will review the admission record for medical necessity and contact hospital UR staff on the next business day after the admission.

Administrative denials of admission process and timelines

CareOregon requires notification of admission within one business day. A notice of denial of payment may be issued to the hospital if no authorization is obtained within that time frame, and the day(s) leading up to the admit notification from the hospital to CareOregon are not paid. Exception to this process: Out of area hospitals with an address that is outside a 50-mile radius from the Portland Metropolitan area.

Emergency services

Requests for continued inpatient stay authorizations

For facilities where remote EHR access is available, CareOregon UM staff will enter the record on the day of concurrent review and perform the review. Hospital Utilization Review (UR) will notify CareOregon if the member is discharging prior to the scheduled day. For facilities without remote EHR access, hospital UR will fax updated clinical information in legible written format to CareOregon UM.

Once clinical information has been received and reviewed, CareOregon UM staff will contact hospital UR staff via phone. If no additional information is needed, the CareOregon UM staff will determine the number of days for authorization of continued stay and the date of the next review. The number of days between clinical reviews will be individualized based on the situation.

CareOregon UM staff will take responsibility for communicating with hospital UR staff regarding authorization for continued stay and communicating with the hospital social worker for discharge planning as appropriate. The hospital UR staff is responsible for providing clinical on the day of review.

Discharge procedures

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

Hospitals that do not provide EHR access will notify CareOregon within 24 hours of discharge. Hospitals providing data via PointClickCare do not need to provide discharge notification.

Medical unit transfers

It is the responsibility of the hospital to notify CareOregon when a member transfers to a medical care unit and remains there past midnight. Authorization for the psychiatric inpatient episode of care will be ended as of midnight on the day of transfer.

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

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

Institution for mental diseases (IMDs)

CareOregon will abide by and authorize according to OAR rules for IMDs as noted in OAR Chapter 410-141-3860 and 410-172-0730.

An Institution of Mental Disease (IMD) means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. 42 CFR 435.1010.

General outpatient services

Connect submission and notifications of program enrollment

Behavioral health (BH) general outpatient services do not require a referral or an authorization, and members can self-refer to BH assessment and evaluation services. This is meant to reduce administrative burden and streamline access into services. Most of these services require a notification via Connect entry or via fax by the delivering provider for payment, reporting and tracking purposes. Please see “Submission of notifications of treatment and prior authorizations,” on page 5, for instructions on submission of notifications via Connect or fax.

Providers that fall into either of the categories below can submit claims without an authorization or notification in place for outpatient fee for service mental health services:

- Providers contracted ONLY for Mental Health Outpatient services
- Noncontracted providers

All others, including those that offer other service types or are contracted to provide Level A-D, must submit a notification in Connect that is valid and effective for the applicable dates of service, in order to receive claim payment.

If you are unsure whether you are required to submit a notification, you may refer to the Health Share Behavioral Health fee schedule, or reach out to provider customer service at 800-224-4840 (option 3).

Case rate level of care provider staff make level of care determinations for all services that are delivered within the Level A-D outpatient levels of care. Level of Care forms are completed for initial program enrollments and for continued stays in treatment. The forms should be completed and retained in the

member's medical record. When submitting the notification in Connect, you will use the Service Types noted below for the level of care assigned to the member.

Level Of Care Assigned	Connect Service Type
Level A Adult Level A Child	Level A
Level A SPMI	Level A Adult SPMI
Level B Adult Level B Child	Level B
Level B Adult SPMI	Level B Adult SPMI
Level C Adult Level C Child	Level C
Level C Adult SPMI	Level C Adult SPMI
Level D Adult ICM	Level D Adult ICM
Level D Adult TAY	Level D Adult TAY
Level D, ages 0-5 Level D, ages 6-17	Level D Child

Level D Youth and Level D Adult/ICM are considered general outpatient and do not require clinical review. They do require an entry in Connect for tracking, reporting and to facilitate coordination. Unlike other outpatient service types, they are coordinated by the CareOregon Behavioral Health Navigation (BHN) Team.

Level D requests:

- Must be submitted using the forms below, which can be found on the Metro Behavioral Health Provider Page at *link.careoregon.org/careoregon-bh-providers*
  - Adult Level D ICM Referral Form: *link.careoregon.org/careoregon-act-icm-referral-form*
  - Youth Level D Referral Form: *link.careoregon.org/careoregon-level-d-child-referral-form*
- Preferred route of submission is via Connect.
- Must include supporting clinical documentation to support triage and referral to programs.
- After the clinical review and determination is made, all approved referrals will be routed to the BHN Team for triage and coordination.
- Youth, age fourteen and older, may request mental health services without parent/guardian consent, in accordance with applicable ORS 109.675.

Substance use disorder (SUD) services

Substance use disorder (SUD) treatment services are a covered benefit for Health Share members. Requests and notifications for SUD services follow the same processes as all other service types as written above. All SUD services start with an American Society of Addiction Medicine (ASAM) six-dimension assessment, performed by an appropriately credentialed SUD clinician/provider, which will result in a level of care recommendation. Upon decision to enroll a Health Share member in a level of care corresponding to that which was assessed, SUD providers shall

submit a program enrollment notification via the CareOregon Connect portal. CareOregon will process the request within 2 business days, and updates to the status of the authorization can be viewed by the requesting provider in Connect. Providers who do not have Connect access can request status updates by contacting Provider Services at 503-416-4100. A fax template may also be requested for submission in the event of Connect unavailability.

Medication-assisted services

Members have the right to obtain medication-assisted treatment for substance use disorders, including opioid and opiate use disorders, without prior authorization of payment during the first thirty days of treatment. If the member is unable to receive timely access to care with a contracted provider, the affected member shall have the right to receive the same medication-assisted treatment from a non-participating provider outside of or within CareOregon's service area.

Referrals to long-term psychiatric care (LTPC)

When the need for long-term psychiatric care (State Hospital) is indicated, referrals are submitted by the responsible party from Clackamas, Multnomah or Washington County. The responsible party in Clackamas County and Washington County is the Choice Model Exceptional Needs Care Coordinator (ENCC). In Multnomah County, that function is delegated to the Commitment Services supervisor.

Once completed, the referral packet is signed and routed to CareOregon UM staff for review. CareOregon UM staff, in consultation with the CareOregon Medical Director, review and make an initial determination before routing the signed referral packet to the Oregon Health Authority (OHA) for final determination. For adults approved for LTPC, CareOregon continues to be responsible for payment for acute care until discharge. For children and youth, OHA is responsible for payment for acute care after seven days, taking responsibility on day eight.

Prior to referral

For admission to a State Hospital, an individual should have received:

- A comprehensive medical assessment to identify conditions that may be causing, contributing to or exacerbating the episode of behavioral illness and associated symptoms.
- Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the episode of behavioral illness and associated symptoms.
- Treatment in an acute setting within the parameters of the most recent version of the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders.

There must be evidence of additional treatment and services having been attempted, including:

- Use of evidence-based or promising psychosocial interventions that were delivered in relevant culturally competent, strength-based, person-centered and trauma-informed manners and that adequately treated the assessed and/or expressed needs of the individual.
- Treatments should include members of the member's family, support network and peer delivered services, unless the member does not consent.

- Documentation of ongoing review and discussion, by hospital staff, Care Coordinator, and CareOregon, of options for discharge to non-hospital levels of care.
- Documentation of services and supports attempted by the Care Coordinator to divert an individual from acute admission and establish treatment and recovery in a non-hospital setting.
- Determination for admission to LTPC per OAR 309-091-0015.

State Hospital level of care is determined appropriate when:

- The individual's condition or symptoms have not improved in an acute care setting despite having received a comprehensive psychiatric and medical assessment, and treatment with medications for at least 7 days at an adequate dose.
- The member needs either intensive psychiatric rehabilitation or other tertiary treatment in a state facility or extended care program, or extended and specialized medication adjustment in a secure or otherwise highly supervised environment.

There must be evidence of additional treatment and services having been attempted, including:

- Use of evidence-based or promising psychosocial interventions which were delivered in relevant culturally competent, strength-based, person-centered and trauma-informed manners and which adequately treated the assessed and/or expressed needs of the individual. Treatments should include members of the individual's family, support network and Peer Delivered Services, unless the individual doesn't consent.

Documentation of ongoing review and discussion, by hospital staff and responsible party, of options for discharge to non-hospital levels of care.

Making a long-term psychiatric care referral

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

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

Referral is received and reviewed by CareOregon UM staff. If approved, determination is sent to the responsible party that initiated the request, CareOregon's Regional Care Team and OHA via the "OSH Civil Referrals" email.

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

careoregon.org

HSO-24856201-1029

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