# Behavioral Health Utilization Management

## Procedure Handbook

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CareOregon®

# Introduction

The utilization management (UM) guidelines in this document explain the process CareOregon uses in the authorization of behavioral health services for members of Health Share of Oregon, LLC (Health Share), Columbia Pacific Coordinated Care Organization (CPCCO), and Jackson Care Connect (JCC). 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

### Treatment planning

Treatment planning is grounded in the principles of resilience and recovery. Effective plans:

- Employ strengths-based assessment focused on the individual's abilities and resources
- Are individualized and person-centered, tailored to unique needs, goals, and preferences
- Promote access and engagement by removing barriers to care
- Encourage family participation and inclusion of natural supports as the norm
- Support continuity of care across settings and providers
- Empower individuals through self-determination and autonomy
- Respect the rights, dignity, and cultural identity of each person
- Instill hope and personal responsibility in achieving and sustaining recovery

## Service delivery guidelines

Policies governing service delivery must be:

- Age and gender appropriate
- Culturally competent
- Evidence-based and trauma-informed
- Responsive to factors that impact resilience and recovery
- Aligned with the individual's readiness for change

Positive clinical outcomes are more likely when clinicians use evidence-based practices or best clinical practices supported by research and professional standards. The goal is for individuals to have access to all clinically indicated services.

## Indicators of Resilience and Recovery

Treatment interventions should promote resilience and recovery, as demonstrated 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

## Additional Clinical Expectations

Crisis Stabilization: Individuals experiencing a behavioral health crisis should receive timely assessment and medically necessary services to support stabilization and transition to a lower level of care.

Treatment for Underlying Conditions: Care must go beyond symptom management to address underlying behavioral health conditions based on assessment or care plan.

Integrated Treatment: When individuals have co-occurring behavioral or medical conditions, treatment should be coordinated and integrated.

Least Restrictive Care: Services should be delivered at the least intensive and least restrictive level of care that is safe, effective, and meets clinical needs.

Care Coordination: When multiple providers are involved, regular communication and coordination are expected, including sharing service plans, joint sessions, phone calls, or team meetings.

# Glossary

Authorization: A member-specific approval granted to a provider to deliver services. Entered into CareOregon Connect and enables billing for approved services.

Behavioral health (BH): An umbrella term that includes mental health, mental illness, substance use disorders, addiction, and gambling disorders.

CareOregon Connect: The secure provider portal used by CareOregon providers to access member eligibility, prior authorizations, program enrollment updates, and claims/payment information.

Columbia Pacific Coordinated Care Organization (CPCCO): A specific CCO serving Columbia, Clatsop, and Tillamook counties.

Contracted provider: A provider who has entered into a contract with CareOregon to deliver behavioral health services. Also referred to as in-network provider.

Coordinated Care Organization (CCO): A community-based network of providers that coordinates physical, behavioral, and dental care for Oregon Health Plan members. CCOs focus on prevention, integration, and local accountability to improve health outcomes and manage costs.

Did not meet medical necessity criteria: A determination made when submitted clinical information does not satisfy required criteria for admission or continued stay.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): A Medicaid benefit for children and adolescents providing comprehensive preventive and treatment services.

Expedited request: A request for authorization that requires faster review due to urgent clinical need.

Health Share of Oregon (HSO): A Coordinated Care Organization serving the Portland metro area.

ICD-10, CPT, HCPCS codes: Standardized coding systems used for diagnoses and procedures in healthcare billing.

InterQual: A clinical decision support tool used to determine medical necessity for services.

Jackson Care Connect (JCC): A Coordinated Care Organization serving Jackson County.

Levels of service: Categories of care intensity, such as outpatient, intensive outpatient, or inpatient.

Long Term Services and Supports (LTSS): Services under the Oregon Health Plan for adults 65+ or individuals 18+ with disabilities. Must be based on medical necessity and functional need, not arbitrary limits. Prior authorization allowed but requires medical review.

Managed Care Entity (MCE): An organization that contracts to deliver services within a managed care system, including MCOs, prepaid health plans, and CCOs.

Medical necessity vs. medical appropriateness: Medical necessity refers to services required to diagnose or treat a condition; appropriateness refers to services that are suitable but not always essential.

Non-contracted provider: A provider who does not hold a contract with any CareOregon line of business to provide behavioral health services.

Notice of adverse benefit determination (NOABD): A formal written notice issued to a member and provider, communicating a decision to reduce, suspend, deny, or terminate requested or authorized services.

Notification of continued services: A notification submitted for outpatient services that have already been rendered; previously called 're-authorization.'

Notification of Treatment (NoT): A member-specific notification submitted through CareOregon Connect for services that do not require prior authorization. Required for payment and tracking.

Oregon Administrative Rules (OAR): State regulations governing healthcare compliance standards.

Oregon Health Plan (OHP): Oregon's Medicaid program that provides comprehensive health coverage to eligible residents, including low-income individuals and families, children, pregnant people, adults with disabilities, and seniors. OHP ensures access to physical, behavioral, and dental health services through Coordinated Care Organizations (CCOs) and other managed care entities.

Prior authorization (PA): Advance approval for specific services before they are provided. A referral is not the same as a PA.

Provider-submitted authorization or notification: Information entered into CareOregon Connect by a provider to indicate intent to bill for services rendered.

Request for additional clinical information: A formal request from CareOregon Utilization Management for updated clinical documentation to support continued services.

Single case agreement (SCA): A one-time agreement between CareOregon and a non-contracted provider to authorize services for a specific member.

Telehealth: The remote delivery of healthcare services using technology such as computers, tablets, or smartphones.

Young Adults with Special Health Care Needs (YSHCN): Children and youth (birth–21) with or at risk for chronic physical, developmental, behavioral, or emotional conditions who need services beyond typical care. In Oregon, enrollment must occur before age 21; coverage may continue until age 26.

# Provider Instructions

## Member eligibility

Authorizations and claims payments are subject to member eligibility. Eligibility can change after an authorization has been issued, which may impact funded coverage. If eligibility changes prior to providing services, the authorization will no longer be valid.

If Oregon Health Plan (OHP) is the secondary payer, follow the primary plan's guidelines for coverage. For Medicare members, CMS coverage rules apply, including benefit limits. Certain types of excluded services are listed below for convenience but should not be considered exhaustive.

# Access to behavioral health and substance use disorder services

Members of Health Share of Oregon, Columbia Pacific Coordinated Care Organization (CPCCO), and Jackson Care Connect (JCC) have open and direct access to agencies and licensed independent practitioners within the provider network. CareOregon is committed to ensuring timely and equitable access to behavioral health services for all members. This section outlines standards for member access, provider responsibilities, and timelines for routine, urgent, and priority care, consistent with OAR 410-141-3515 and OAR 309-019-0135.

## Member access pathways

Members can access behavioral health treatment through multiple channels:

- Direct contact: Members may contact contracted providers directly to request services.
- Referrals: Allied agencies may refer members to appropriate providers.
- CareOregon Customer Service: Members can call CareOregon for assistance in identifying and accessing a behavioral health provider most appropriate to their needs.

## Provider intake requirements

Providers must offer an intake assessment within two weeks of the member's request. If unable to meet this timeline, providers must:

- Refer the member to an alternative contracted provider with capacity, and/or
- Refer the member to CareOregon Customer Service for assistance in identifying an alternative provider.

## Telehealth services

For referrals to telehealth services, providers should review CareOregon's guidance on telephone and video visit appointments, available on the COVID-19 Provider information page of the CareOregon website.

## Screening and response standards

### *Routine care timelines*

Routine behavioral health treatment appointments must follow these timelines:

- Within 7 days: Complete an intake assessment.
- Within 14 days: Schedule a second appointment (or sooner if clinically indicated).
- Within 48 days: Provide three additional therapeutic appointments.

Appointments must focus on therapeutic interventions, not administrative tasks. Specialty behavioral health providers are responsible for ensuring timely access to covered services.

### *If providers cannot meet timeframes*

Providers must:

- Place the member on a waitlist, and
- Provide interim services within 72 hours of being added to the waitlist.

Interim services should approximate 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
- Assessments or other services described in OAR 309-019-0135

If care cannot be provided according to these timeframes, providers must contact CareOregon Care Coordination Services for assistance in placing the member in an appropriate care setting.

## Urgent and emergent care

Urgent behavioral health appointments must be scheduled within 24 hours of the request. In urgent or emergent situations, appropriate services may include referral to:

- Local county crisis services
- Hospital emergency department

If a provider cannot schedule an appointment within 24 hours, they must make a referral to the appropriate crisis service or emergency department.

## Priority populations

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

- 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 risk of first episode psychosis
- Children with serious emotional disturbance
- Individuals with intellectual or developmental disabilities (I/DD)

### *Additional requirements*

- Individuals using intravenous drugs: Immediate assessment and intake required; admission within 14 days of request or treatment within 120 days if interim services are necessary.
- Opioid use disorder and medication-assisted treatment: Assessment and intake required within 72 hours.

When placed on a waitlist, members must receive interim resources and information to reduce health risks and prevent disease transmission, including:

- Counseling
- Peer-delivered services
- Educational materials on bloodborne pathogens and prevention
- Prenatal care referrals for pregnant individuals
  Parenting and youth transition support

For more details, refer to OAR 410-141-3515.

## Substance use disorder access standards

- For outpatient substance use services, an initial service appointment must be offered within seven calendar days of the request.
- In urgent or emergent situations, providers may refer members to local county crisis services or a hospital emergency department to prevent injury or serious harm.
- If the member prefers to seek services elsewhere due to wait times, providers must:
  - Offer referral information to other appropriate providers within CareOregon's network, including provider name, address, and phone number.
  - Educate the member on how to contact CareOregon Customer Service for further assistance.

Providers with a certificate of approval must comply with OAR 309-019-0110(5)(e), which prohibits titration of medications prescribed for opioid dependence as a condition of receiving or continuing treatment.

## Behavioral health crisis intervention resources

### *Health Share of Oregon (HSO)*

- Multnomah County Crisis Line: 503-988-4888 or 800-716-9496
  Website: multco.us/services/behavioral-health-crisis-services
- Washington County Crisis Line: 503-291-9111
  Website: washingtoncountyor.gov/behavioral-health/crisis-services
- Clackamas County Crisis Line: 503-655-8585 | Non-emergency: 503-742-5335
  Website: clackamas.us/behavioralhealth
- Cascadia Mental Health Urgent Walk-in Clinic:
  Address: 4212 SE Division St, Ste 100, Portland, OR
  Hours: 7 a.m.–10:30 p.m.
- Lines for Life / 988 Suicide & Crisis Lifeline: 800-273-8255
  Website: linesforlife.org

### *Columbia Pacific CCO (CPCCO)*

- Tillamook County Mental Health Crisis Line: 503-842-8201 or 800-962-2851
- Domestic Violence – Tides of Change: 503-842-9486
- Clatsop County Crisis Line: 503-325-5724
- Rapid Access Clinic:
  Address: 115 W Bond St., Astoria, OR
  Hours: Mon–Fri, 9 a.m.–3 p.m.
  Phone: 503-325-5722
- Domestic Violence – The Harbor: 503-325-5735
- Columbia County Crisis Line: 503-782-4499
- Domestic Violence – SAFE:
  English: 503-397-6161
  Español: 844-953-0441
- Lines for Life: 988 or 800-923-4357
- YouthLine: Phone: 877-968-8491 | Text: teen2teen (839863)
- National Domestic Violence Hotline: 800-799-7233

### *Jackson Care Connect (JCC)*

- Jackson County Mental Health Crisis Line: 541-774-8201
- Mercy Flights Mobile Crisis:
  Hours: Mon–Fri, 8 a.m.–5 p.m.
  Phone: 541-774-8201
- Lines for Life / 988 Suicide & Crisis Lifeline: 988

## Submission of notifications of treatment and prior authorizations

Contracted providers can access member eligibility, prior authorizations, and claims/payment information through the CareOregon Provider Portal, known as Connect. The portal streamlines administrative tasks and allows providers to submit treatment authorization requests and notifications of treatment, check detailed claim status, review remittance advices, view authorizations at the line-item level, verify member eligibility (including PCP assignment, other insurance, and covered benefits), generate and print PCP rosters, and search and validate ICD-10, CPT, HCPCS, revenue codes, and modifiers.

All service requests should be submitted through the Connect portal. For services that require prior authorization, providers must submit the request along with supporting clinical documentation to demonstrate medical necessity. For services that do not require prior authorization but still require submission for payment, reporting, and tracking purposes, providers should enter a Notification of Treatment in Connect. These notifications do not require clinical documentation or review, are typically auto-approved, and must be submitted within 45 days of the service start date.

Providers who do not have access to Connect should contact CareOregon Provider Customer Service at 800-224-4840 (option 3) to request an exception form for fax submission when necessary and to receive assistance with portal access.

## Authorization timelines and review process

Most determinations for standard prior authorization requests are made within 7 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. Expedited requests are reviewed within 72 hours. Both standard and expedited requests may be extended an additional 14 calendar days if requested by the member or provider, or if CareOregon determines that additional time is in the member's best interest.

Certain levels of care operate under specific turnaround times per Oregon Health Plan (OHP) rules, and CareOregon adheres to those requirements. Please refer to the Prior Authorizations section for full details on turnaround times and authorization lengths.

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

No prior authorization is required for urgent or emergent care.

## Submitting requests for initial and ongoing authorizations

Providers should submit prior authorization requests and supporting clinical documentation through the Connect portal at least two weeks prior to the expiration date of the current authorization. Not all services require authorization; please refer to the Levels of Service grid for details.

For ongoing services, providers must submit an assessment and service plan indicating the member's current level of functioning, the frequency and duration of proposed services, clinical justification, and anticipated benefit. Additional supporting documentation may be included at the provider's discretion. CareOregon Utilization Management staff will review the documentation, consult with the provider as needed, and confirm that the request meets medical necessity criteria for a covered diagnosis.

Required elements for initial and ongoing requests include:

- Member identification information
- Name of the member's physician or lead clinical provider
- Date of admission to the program or service
- If Medicaid application occurs after admission, the date of application and authorization for Medicaid
- Plan of care
- Reason and plan for the requested services

These processes will repeat as needed for the duration of treatment until services are no longer clinically indicated, the member transitions to more appropriate care, or medical necessity is no longer evidenced.

## Second opinions

A second opinion by a qualified healthcare professional is available with or without prior authorization. CareOregon will arrange for second opinions when providers are unavailable or inadequate to meet a member's medical needs.

## Medical necessity & appropriateness

CareOregon defines medical necessity and medical appropriateness consistent with Oregon Administrative Rules (OAR 410-120-0000 through 410-120-1980 and OAR 309-019-0100 through 309-019-0220) and nationally recognized evidence-based standards (InterQual). All services provided to Oregon Health Plan members must be both medically appropriate and medically necessary.

### Medical necessity

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

- Prevention, diagnosis, or treatment of a 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, perform activities of daily living, or improve health status.
- The opportunity for a member receiving Long Term Services and Supports (LTSS) to access the benefits of non-institutionalized community living, achieve person-centered care goals, and live and work in the setting of their choice.

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

### Medical appropriateness

Medically appropriate services are those that meet all of the following criteria:

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

## OHP coverage and the Prioritized List

- Services must be covered by the Oregon Health Plan (OHP) that is the focus of treatment, and the presenting diagnosis and proposed treatment must qualify as a funded 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 or referral will not override a non-funded diagnosis.
- Treatment codes that do not pair with the diagnosis, or that pair with the diagnosis but fall below the funded line, are also non-funded.
- The Prioritized List and additional information can be found at:
    - CareOregon's resource page
    - Oregon Health Authority's official site
- EPSDT Exception: Requests for EPSDT members, including those eligible under YSHCN, will be reviewed for medically necessity and medical appropriateness, regardless of line placement.

## Special circumstances

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

Some members are eligible for benefits under EPSDT. EPSDT benefits are for OHP members who:

- Are under age 21 or
- Are under age 26 and have Young Adults with Special Health Care Needs (YSHCN) benefits.

These benefits include comprehensive preventive health care services from birth until they turn age 21 (or age 26, for members with YSHCN benefits).

CareOregon covers Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services that fall below the funding line on the Prioritized List of Health Services when they are medically necessary and medically appropriate.

The EPSDT benefit ensures that Medicaid members under age 21 receive comprehensive and preventive health care services. For behavioral health, this means CareOregon must cover services that are medically necessary to correct or improve mental health conditions, even if those services:

- Fall below the funded line on the Prioritized List of Health Services
- Do not meet standard pairing or quantity limits

Requests are reviewed on a case-by-case basis for medical necessity and appropriateness. Prior authorizations should continue to follow CareOregon's established process.

**Please note:** Not all requests for members under 21 qualify as EPSDT services. Determinations depend on whether the service addresses a condition and improves functioning or prevents worsening.

### Young Adults with Special Health Care Needs (YSHCN)

Young Adults with Special Health Care Needs (YSHCN) refers to individuals from birth through age 21 who:

- Have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and
- Require health and related services beyond what is typically required by children of the same age.

In Oregon's YSHCN program, youth must apply before turning 21 and, once enrolled, may remain covered until their 26th birthday. YSHCN programs focus on care coordination, medical necessity-based services, and EPSDT compliance under Medicaid to ensure services are provided in an amount, duration, and scope sufficient to meet the child's health and developmental needs.

### Long Term Services and Supports (LTSS)

Decisions regarding LTSS under the Oregon Health Plan (OHP) must be based on medical necessity and functional needs, not arbitrary limits. Denials cannot be issued solely because of the number of visits or service hours requested, nor can they be based only on diagnosis or type of illness.

While prior authorizations are permitted to ensure appropriateness, they must include a medical necessity review. Federal and state regulations require that LTSS be provided in an amount, duration, and scope sufficient to achieve their intended purpose. LTSS eligibility includes adults age 65 and older or individuals age 18 and older with a qualifying disability.

# Prior authorizations

## Services requiring prior authorization

Certain covered services or items require authorization before they may be provided. CareOregon does not require prior authorization for general outpatient services when delivered by a contracted provider. Additional details about authorization requirements for non-contracted providers can be found later in this document.

Payment may be authorized for the type of service or level of care that meets the member's medical needs and is adequately documented. Only services that are medically necessary, medically appropriate, and supported by required documentation will be considered. CareOregon may request additional clinical information to determine medical necessity and appropriateness.

| 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 | 7 calendar days | OHP GN 75 and CareOregon Practice Guidelines |
| Eating disorder-residential treatment | 30 days | 30 days | 3 calendar days | InterQual |
| Eating disorder-partial hospitalization | 30 days | 30 days | 7 calendar days | InterQual |
| Electroconvulsive therapy (ECT) | Dates and units entered per provider request/clinical need | Dates and units entered per provider request/clinical need | 7 calendar days | InterQual |
| Mental health intensive outpatient treatment (IOP) | 7-14 days, dependent upon clinical circumstances | 7-14 days, dependent upon clinical circumstances | 7 calendar days | InterQual |
| Mental health partial hospitalization (PHP) | Dependent upon clinical circumstances; typically, 7-14 days | Dependent upon clinical circumstances; typically, 7-14 days | 7 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 | 7 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 | 7 calendar days | OHP GN 102 |

## Requesting prior authorization

When a provider completes an assessment and determines that services are clinically indicated, the provider must submit an assessment and service plan. This plan should include the member's current level of functioning, the frequency and duration of proposed services, the evidence base supporting the services, and the anticipated benefit. Additional supporting clinical documentation may be submitted at the provider's discretion.

CareOregon Utilization Management 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 are demonstrated, and to enter an authorization for approved services.

Required elements for initial and ongoing requests include identification of the member, the name of the member's physician or lead clinical provider, the date of admission to the program or service, the plan of care, and the reason and plan for the requested services.

## Secondary authorization requests

An authorization request is required for payment of secondary costs (e.g. copayments, coinsurance) when CareOregon is the secondary health plan. Clinical review is not required for secondary costs, but an authorization must be in the system to allow payment of claims. If the primary health plan does not cover a service or has denied payment for part or all of a service, an authorization request can be submitted to CareOregon and will require clinical review for medical necessity and appropriateness. In all situations where CareOregon is secondary, the provider must submit the primary carrier's Explanation of Benefits (EOB) with the claim once received.

## Dual authorizations

A dual authorization may occur when a CareOregon member is receiving services simultaneously from more than one provider. Each authorization request will require clinical review for medical necessity and appropriateness, with the exception of contracted providers for services or levels of care that do not require clinical review. However, all services must still be medically necessary and appropriate, and documented according to Oregon Administrative Rules and Medicaid or Medicare requirements.

Clinical documentation must demonstrate the need for additional services, the added benefit of those services, and the rationale for involving a second provider, including any specialization required. This arrangement may last for the duration of the treatment episode or support a transition or continuity of care. When multiple providers are involved, CareOregon expects regular collaboration and communication to ensure coordinated care. This may include sharing service plans, joint sessions, phone calls, or team meetings.

## Health Share-specific policy: provider TBD

For Health Share members, CareOregon allows submission of prior authorization requests with "TBD Behavioral Health Provider" listed as the delivering or rendering provider when the member's current provider has the most comprehensive clinical information. Approval of a prior authorization does not constitute a referral; coordination with the delivering provider is required to initiate treatment.

Submissions must include clinical documentation supporting medical necessity. If approved, CareOregon UM staff will notify the referring provider and advise them to coordinate with a contracted delivering provider. Once identified, the referring provider must contact CareOregon UM at 503-416-3404 to update the authorization.

### Service types eligible for "Provider TBD" submission:

- Subacute (Youth)
- Psychiatric Residential Treatment Services (PRTS, Youth)
- Psychiatric Day Treatment Services (PDTS, Youth)
- Psychological Testing
- Applied Behavioral Analysis (ABA) Assessment

### Service types requested by delivering provider:

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

### Initial referrals managed by Behavioral Health Navigation (BHN) Team:

- Assertive Community Treatment (ACT)
- Level D Child
- Level D Adult Intensive Case Management (ICM)
- Intensive In-home Behavioral Health Treatment (IIBHT)

## Determinations and turnaround times

Under 42 CFR § 438.210(d)(1)(i)(B), CareOregon must respond to standard service authorization requests as quickly as the member's physical, oral, or behavioral health needs require—but no later than 7 calendar days after receiving the request.

Most determinations for standard prior authorization requests are made within 7 calendar days of the date of the request. Expedited requests for conditions that may result in imminent danger to the member's life, health, or ability to function, are decided within 72 hours.

An extension of up to 14 additional calendar days is allowed if:

- The member or provider asks for more time, or
- CareOregon's Utilization Management (UM) team needs additional information and can show the delay is in the member's best interest.

Both standard and expedited requests may be extended under these conditions.

CareOregon will not apply more stringent prior authorization standards to behavioral health services than those applied to medical/surgical benefits. Certain levels of care have specific turnaround times per Oregon Health Plan rules, and CareOregon complies with those requirements.

If approved, CareOregon will notify the requesting provider and indicate the date of the next medical necessity review, if applicable. If denied, CareOregon will send a Notice of Adverse Benefit Determination (NOABD) to the member and provider.

For previously authorized services that are ongoing and continuous, and are being terminated, suspended, or reduced, CareOregon will mail notice at least 10 calendar days before the effective date of action.

## Criteria for review

CareOregon determines medical necessity on an individual basis, primarily using InterQual criteria. Requests for services are reviewed by masters-level behavioral health clinicians and/or psychiatrists.

If a requested service is denied, reduced from a previous authorization, or authorized in amount, duration, or scope other than requested, the decision 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.
- Determine the appropriate level of care for proposed services.
- Serve as a screening tool to evaluate whether services are clinically indicated or require further review.

For additional information about InterQual criteria, contact the Behavioral Health Utilization Management (BH UM) Team at 503-416-3404.

## CareOregon practice guidelines

Most services requiring prior authorization use InterQual to determine medical necessity. However, certain services do not use InterQual and instead rely on CareOregon practice guidelines, which are:

- Developed from scientific evidence or
- Based on a consensus of healthcare professionals, including guidance from the Health Evidence Review Commission (HERC) and the Oregon Health Authority.

## OHP guideline notes

Some services requiring prior authorization under the Oregon Health Plan use the OHP Guideline Notes to determine medical necessity. These notes are part of the Prioritized List of Health Services and include:

- Clear criteria for medical necessity
- Prior authorization requirements
- Coverage limits, dosage guidance, and trial-of-therapy conditions

You can access the full set of Guideline Notes—including coverage criteria and prior authorization details—via the Oregon Health Authority's searchable tool here: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Searchable-List.aspx

## Applied Behavior Analysis (ABA)

### *Medical appropriateness*

CareOregon Practice Guidelines and the Oregon Health Plan Guideline Note 75, are used in conjunction with state and federal guidelines to determine if ABA services are medically appropriate and necessary.

### *Diagnostic guidelines and tools*

Authorization of ABA services requires a diagnosis of Autism Spectrum Disorder (ASD) or Stereotypic Movement Disorder by an MD, DO, 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, DO, PhD, or PsyD

Other diagnoses will require secondary review with a CareOregon Medical Director.

### *Special requirements for members age 13 or older*

Any authorization requests for members age 13 or older require secondary review with a CareOregon Medical Director.

### *ABA assessment authorization*

Providers must submit clinical documentation that includes the diagnostic guidelines and tools listed above. Requests should be submitted via Connect or fax.

### *Columbia Pacific and Jackson Care Connect specific guidelines – ABA assessment*

Due to a smaller region and provider network, ABA assessment authorization requests submitted for CPCCO and JCC members are approved without the requirement of clinical documentation. Authorizations should be submitted via Connect.

### *ABA treatment authorization*

Requests should be submitted via Connect or fax. The servicing provider must include clinical documentation along with a documented diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder.

The clinical documentation must also include a comprehensive treatment plan. This plan should:

- Outline measurable goals with baseline data and the date of baseline
- Graphs as they relate to goals
- Identify any medical concerns that may impact treatment
- Provide familial and custody information
- Note the language spoken by the family and whether interpretation services were or are needed
- Describe barriers to treatment such as staffing issues, family cancellations, illnesses, or lack of communication
- List the diagnosing clinician's credentials and the date of diagnosis for all listed diagnoses, and indicate if the family is unaware

In addition, the plan should include:

- All school and Early Intervention information and any other services the member is receiving, including provider names and hours or frequency of services (for example, Early Intervention for three hours three times per week, Speech Therapy with provider name included)
- At least two measurable caregiver goals with baseline data
- The date the member began ABA services with the current provider and any previous ABA service providers with dates if known
- Requested dates of service, including a reason if backdating is required
- An explanation if accepted hours differ from clinically recommended hours (for example, recommended 15 hours per week but member can only accept eight hours per week due to school schedule)
- All assessment tool data used for the report
- Discharge reports

### *Units*

Requests should include units for the entire six-month authorization, broken down by CPT code and total units:

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 diagnostic or treatment questions that cannot be answered through usual means such as clinical interviews and collateral data review (including prior testing).

Testing is delivered by a doctoral-level psychologist or a psychiatrist trained in the administration and interpretation of psychological instruments. It is not intended as a first-line evaluation. Testing is appropriate when a qualified mental health provider has assessed the member and cannot accurately diagnose or treat due to clinical complexity. 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 for authorization*

Requests for psychological testing must include supporting documentation with:

- A current assessment and treatment plan
- Specific clinical questions that testing is expected to answer
- The reason these questions cannot be answered by a qualified mental health or licensed medical professional
- Documentation of how test results will inform or amend the treatment plan

### *Exclusion criteria*

Testing is not covered when:

- Conducted for educational (IEP/learning disorders), vocational, or legal purposes (including court-ordered testing)
- Used to determine eligibility for services (e.g., vocational rehab, disability, IEP)
- Performed as a screening tool or part of an initial evaluation
- Requested for personal interest

### *Behavioral health vs. physical health*

Authorization requests should be submitted to the member's physical health plan when:

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

### *Authorization requirements*

Prior authorization is required before services begin and must not exceed the allowable hours identified for testing. Additional hours beyond the initial authorization require separate approval and will only be granted in exceptional circumstances where clinical need is clearly justified.

If the delivering provider is listed as "TBD Behavioral Health Provider," CareOregon UM will provide a list of contracted providers. The referring provider must update the authorization once a provider is identified by contacting CareOregon UM at 503-416-3404.

## Transcranial Magnetic Stimulation (TMS)

### *Service description*

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.

### *Medical appropriateness*

The Oregon Health Plan Guideline Note 102 is used in conjunction with state and federal guidelines to determine if TMS services are medically appropriate and necessary.

## Requests for ongoing treatment authorizations

Providers can request authorization for continued treatment via the same process that is outlined previously in this handbook for requesting prior authorization. Most requests for ongoing treatment should be submitted no more than 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.

## Denials

Authorization denials, including decisions to authorize a service in an amount, duration, or scope less than requested, are made by a clinician with appropriate expertise. Denial letters or a Notice of Adverse Benefit Determination (NOABD) include the service requested, the reason for denial, and the rule or criteria used. They also provide instructions for obtaining the criteria, appealing the decision, and contacting CareOregon for community resources if available.

Denial notifications are sent to both the member and the requesting provider within one business day of determination. For OHP members requiring alternate formats or languages, instructions are included in the denial letter. Providers must inform members of their rights at intake. Member rights, including grievance, appeal, and hearing procedures, are detailed in the CareOregon Member Handbook and the Provider Manual.

## Retroactive authorization requests

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, CareOregon has up to 45 days from the receipt of the retroactive authorization request, to make a determination. Claims that are submitted for an approved retroactive authorization are subject to CareOregon's timely filing policy.

## Single case agreements

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. As of 1/1/2026, unless otherwise specified in an SCA, the provider will be reimbursed at 90% of the State Fee for Service rate or 90% CMS for Medicare Advantage members. SCAs will only be reviewed for approval if an approved prior authorization is in place if services require prior authorization. Noncontracted fee schedules can be found here

### Single case agreement (SCA) requirement for non-contracted providers

For all approved authorization requests involving non-contracted providers, CareOregon will initiate a single case agreement (SCA). An SCA is required for a non-contracted provider to receive payment. Once a service is authorized, CareOregon's Behavioral Health Utilization Management

Team will forward the request to the Contracting Team to begin the SCA process. For more details on billing out-of-network, refer to the Provider Guide to Billing Out-of-Network

# Acute Psychiatric Inpatient

## Requests and authorization process

Authorizations are generated by CareOregon and a clinical review for medical necessity of the inpatient services is generally begun on the day of, or next business day after, 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<br>Fax: 503-416-4720 |

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.

## 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 (IMD)

CareOregon will authorize and reimburse services in accordance with OAR 410-172-0730 (Payment Limitations for Behavioral Health Services), aligned with the federal IMD definition (42 CFR 435.1010). An Institution for Mental Disease (IMD) refers to a hospital, nursing facility, or similar institution with more than 16 beds, primarily dedicated to providing diagnosis, treatment, or care for individuals with mental diseases, including medical attention and nursing care. Whether a facility is considered an IMD depends on its overall purpose and character. Importantly, institutions primarily serving individuals with intellectual disabilities are excluded from this definition, per 42 CFR 435.1010.

## Emergency services

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) 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. b) A representative of CareOregon instructs the member to seek emergency services.

## Post stabilization services

Post stabilization services are covered services provided to a stabilized member after an emergency medical condition in order to maintain the stabilized condition or to improve or resolve the member's condition. CareOregon will cover these services without requiring prior authorization when:

- CareOregon does not respond to a request for pre-approval within one hour, or
- CareOregon cannot be contacted, or
- CareOregon's representative and the treating physician cannot reach an agreement concerning the member's care and our Medical Director is not available for consultation.

The treating provider is responsible for determining when the member is stable for discharge or transfer.

CareOregon's financial responsibility for post stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A plan representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

## 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.

## 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, or other care coordination team. Due to regional variations, there may be slight differences in which party/organization manages the initial submission.

- Clatsop, Clackamas, Columbia, Tillamook, and Washington Counties – CHOICE model ENCC provides initial submission
- Multnomah County – Commitment Services supervisor
- Jackson County – Jackson Care Connect Regional Care Team

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.

# General Outpatient Services

## Mental health outpatient

Contracted CareOregon providers can submit a notification of treatment (NoT) via the Connect system for general mental health outpatient services. These services are not clinically reviewed and do not require submission of clinical documentation, but a NoT is required for payment of claims, reporting, and tracking purposes. Providers are expected to comply with state and federal documentation requirements.

## Level A-D outpatient submissions – Health Share specific

Case rate providers make the level of care determinations for all services that are delivered within the Level A-D outpatient services. Level of Care forms are completed for initial program enrollments and for continued stay in treatment. The forms should be completed and retained in the member's medical record, but do not require submission to CareOregon. When submitting the notification of treatment (NoT) in Connect, the provider 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**<br>**Level A Child** | **Level A** |
| **Level A SPMI** | **Level A Adult SPMI** |
| **Level B Adult**<br>**Level B Child** | **Level B** |
| **Level B Adult SPMI** | **Level B Adult SPMI** |
| **Level C Adult**<br>**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**<br>**Level D, ages 6-17** | **Level D Child** |

### Level D Youth and Level D Adult/ICM forms

These services are coordinated by the CareOregon Behavioral Health Navigation (BHN) Team. Level D requests must be submitted using the forms below, which can be found at careoregon.org/bhproviders

- Adult Level D ICM Referral Form
- Youth Level D Referral Form

- The preferred route of submission for initial requests is via Connect and all continued enrollments must be submitted via Connect
- Must include supporting clinical documentation to support triage and referral to programs.
- Youth, age fourteen and older, may request mental health services without parent/guardian consent, in accordance with applicable ORS 109.675.

# Substance Use Disorder Services

Substance use disorder (SUD) treatment services are a covered benefit for CareOregon 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 CareOregon 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.

# Out of Network Services

## Non-licensed board registered interns

- In 2024, CareOregon announced a policy change regarding claims from board-registered associates who:
    - Are unlicensed
    - Do not have a contract with CareOregon
    - Are not employed by a group with a Certificate of Approval from the State of Oregon
- Effective Date: August 1, 2025
- Action Required: Providers impacted by this change were required to transition CareOregon members out of their care prior to this date.

## Licensed non-contracted providers

- Effective October 1, 2025: CareOregon is no longer reimbursing non-contracted providers for outpatient mental health and substance use disorder (SUD) services.
- Referral Guidance: Members should be referred to a CareOregon contracted provider.

## Non-contracted services requiring prior authorization

**Effective October 1, 2025:** The following services will require prior authorization when requested by non-contracted providers seeking to initiate or continue care for CareOregon members:

- Partial Hospitalization Programs (PHP)
- Intensive Outpatient Programs (IOP) – MH and SUD
- Day Treatment Programs – MH and SUD
- Respite
- Subacute
- Residential Treatment – MH and SUD
- Applied Behavioral Analysis (ABA)
- Electroconvulsive Therapy (ECT)
- Psychological Testing

Note:

- All General OP services should only be referred to contracted providers.
- If a contracted provider is not available to meet a member's needs, provider and member should reach out to Care Oregon customer service for assistance in finding a contracted provider.
- All requests should be submitted through the Connect portal. Providers without access should contact CareOregon Customer Service for assistance.

## Turnaround times

- **SUD Services:** Two business days
- **MH Services:** See "Services requiring prior authorization" on page 12 for details.

# Medicare/Care Oregon Advantage

CareOregon Advantage is CareOregon's Medicare Part C Advantage plan. All CareOregon Advantage members are also OHP eligible under a CareOregon plan depending on their region of residence, also known as Dually Eligible or Dual Members. More information about CareOregon Advantage, including benefits, pharmacy information, and plan contacts, are available at careoregonadvantage.org. As all Advantage members are also OHP eligible, the behavioral health utilization management guidance contained in this manual pertains to both Medicare and OHP.

## Contact Customer Service

503-416-4100 or toll-free 800-224-4840
TTY: 711
Hours: 8 a.m. to 5 p.m.
Monday through Friday

**careoregon.org**

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