Behavioral Health Utilization Management
Procedure Handbook

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health share
Health Share of Oregon

CareOregon

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Procedure Handbook

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

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Introduction

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

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 PH Tech's community integration manager (CIM) and allows for billing.

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

Authorization increase request: The request and clinical review process that providers engage in with CareOregon to determine whether funds will be added to an existing authorization amount (based on medical necessity). This may also be referred to as a "request for additional funds."

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

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

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."

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

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.

Program enrollment notification: A member-specific notification via entry in CIM or fax for those services that do not require a prior authorization to deliver care. These notifications are required for payment purposes and are not clinically reviewed.

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

Request 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 continuation/extension of services. Requested additional information should be received as soon as possible and within three business days to avoid an unnecessary denial due to lack of information.

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 a 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. When 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 is to make a referral to the appropriate county crisis services or nearest emergency department.

Routine behavioral health treatment appointments should be scheduled as follows:

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

Appointments must be therapeutic in nature and expand beyond administrative activities. Specialty Behavioral Health providers are to ensure patients have timely access to covered specialty behavioral health services. If providers cannot meet these time frames, the member must be placed on a wait list and provided interim services within 72 hours of being placed on a wait list. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance abuse disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. If care cannot be provided according to the time frames listed here, the provider must contact CareOregon Care Coordination services, which will help place the member in the appropriate care setting.

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

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

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

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

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

Substance Use Disorders

When a provider receives a request for outpatient services, an initial service appointment will be offered within seven calendar days. For urgent/emergent situations, other appropriate services may include referral of the member to local county crisis services or to a hospital emergency department as necessary to prevent injury or serious harm. If the member prefers to seek services elsewhere due to wait times, the provider must offer referral information to other appropriate providers within CareOregon's provider network, including name of the provider, address or general location and phone number. The provider will also educate the member on how to contact CareOregon Customer Service for further assistance. For providers who hold a certificate of approval: Per OAR 309-019-0110 (5) (e), the provider's policies and procedures shall prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment.

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 program enrollment notifications and prior authorizations

PH Tech is CareOregon's claims vendor, and CIM is the online claims portal system. The preferred method of submission for all services is via CIM. 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, providers will submit a notification in CIM. Notifications do not require clinical documentation or review and are entered in CIM 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 CIM can submit a mental health or SUD request form to CareOregon via fax to 503-416-3713.

- 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. Providers that do not have access to CIM but have served more than 10 Members over the past year can request CIM access by contacting PH Tech's Provider Relations Department at 503-584-2169, selecting option 2.

Most determinations for standard prior authorization requests are made within 14 calendar days of the date of the request. In the event a covered behavioral health condition may result in imminent danger to the member's life, health or ability to function, prior authorization can be requested as "expedited," indicating that the standard review timeline for review would seriously jeopardize the life or health of the member, 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. 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.

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 patient 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*

Prior authorizations

Some covered services or items require authorization before the service may be provided. CareOregon does not require a prior authorization for 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.

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 'Provider TBD' 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 other 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 a current provider with 'Provider TBD' as the delivering provider.

- Youth Subacute
- Youth PRTS
- Youth Day Treatment/Partial Hospitalization
- Eating Disorder Residential
- Eating Disorder Partial Hospitalization/IOP
- Psychological Testing
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)

Prioritized by the Behavioral Health Navigation (BHN) Team

- Assertive Community Treatment (ACT) - must be Provider TBD
- Level D Child Initial HBS Global - must be Provider TBD
- Level D Adult ICM Global - initial request must be Provider TBD

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. The review of these requests would include a review for medical necessity and appropriateness for **both** services. We will expect to see a demonstration of the added benefit of the additional services including the rationale and specialization of the **second** provider that matches the member's need(s).

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

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

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.

Services requiring prior authorization

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
Assertive community treatment (ACT)	1 year	1 year	14 calendar days	Practice Guidelines
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, patient focused set of medical review criteria designed to assess and support decisions about the medical necessity of admission to and continued stay at inpatient and ambulatory levels of care for the management of behavioral health disorders. 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. Please note that services for transcranial magnetic stimulation (TMS) now use InterQual criteria in place of the CareOregon guidelines.

Assertive community treatment (ACT)

Initial criteria

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

Diagnostic guidelines

Members should carry a diagnosis of a serious mental illness (SMI):

- Schizophrenia
- Schizoaffective disorder
- Bi-polar disorder
- Major depressive disorder

Members with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, traumatic brain injury 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 psychiatric disorder.

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

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)

- 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 using the ACT/ICM Referral Form found on the Metro BH Provider Page and can be submitted via CIM or fax. They must include supporting clinical documentation. After the clinical review and determination is made, all approved referrals will be routed to the Behavioral Health Navigation (BHN) Team for triage and coordination.

Continued stay/reauthorization

CareOregon's Utilization Management Team uses the ACT Transition to Less Intensive Services from the Oregon Center for Excellence for Assertive Community Treatment (OCEACT) and the ACT Discharge Criteria from the National Standards to guide medical decision making. The ACT Discharge Criteria can be reviewed at *link.careoregon.org/act-discharge-criteria*

If any of the following are selected, the authorization request will require review with CareOregon Medical Director:

- Declines or refuses services and requests discharge, despite the team's best attempts to engage the individual, including efforts to develop an acceptable treatment plan with the individual
- Inability to locate the individual for a prolonged period of time
- Long-term incarceration
- Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the ACT team that the individual will not be ready for discharge for a prolonged period of time
- Long-term stays in residential treatment services where it has been determined based on mutual agreement by residential treatment staff and the ACT team that the individual will not be ready for discharge for a prolonged period of time

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

Psychological testing

Service description

Psychological testing is defined as "a measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process" (American Psychological Association, 2020). Psychological testing requires the application of appropriate normative data for interpretation or classification and may be used to guide differential diagnosis in the treatment of psychiatric disorders.

Primary purpose of testing is to obtain diagnostic clarification of a covered mental health would fall under medical benefit 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).

Guidelines

Testing must consist of face-to-face psychological assessment of member and include the following:

- Clinical interview with member and collateral sources
- Integration of collateral information, including previous psychological and neuropsychological testing, as well as history and background information
- Tests administered must directly address referral question
- Must primarily include tests beyond self-report measures and most often should include psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., WAIS, Rorschach, MMPI)
- Documentation of what action will be taken or how treatment plan will be affected by 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: Psychological testing 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

Provider requirements: The delivering provider is a licensed doctoral level psychologist or a psychiatrist who is adequately trained in the administration and interpretation of psychological instruments.

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.

Referrals

It is recommended that the member be referred by a licensed medical professional. Referrals should be directly coordinated with the delivering provider.

If a referral is submitted with the delivering provider listed as Provider TBD and the referral 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.

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, including 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)

To support members' access to care, CareOregon reimburses out-of-network (non-contracted) providers at rates listed on the CareOregon Fee Schedule as long as services meet CareOregon's authorization requirements. An SCA is not required 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 the 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

Eligibility

If a member is inpatient when eligibility is determined, CareOregon will confirm eligibility and review clinical information (or 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. Medical necessity rules will apply to the stay appropriate to the date(s) services were provided.

Authorization process

CareOregon gathers admission information from Collective (formerly PreManage). 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. 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: 503-416-4720 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

Notification of admission within one business day is required by CareOregon. 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 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 disposition/discharge plan. Hospital UR staff will notify of actual discharge date on the same business day as the discharge.

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

Medical unit transfers

When a member transfers to a medical care unit and remains there past midnight, it is the responsibility of the hospital to notify CareOregon. It is considered that the member is receiving their primary treatment on a medical unit at that point and the authorization for psychiatric inpatient episode of care will be ended as of midnight.

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

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

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.

Referrals to long-term care (LTC)

When the need for long-term care 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 the determination before routing the signed referral packet to the Oregon Health Authority (OHA) for final determination. For adults approved for LTC, CareOregon continues to be responsible for payment for acute care until discharge. For children and youth, the 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 doesn't 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 LTC per OAR 309-091-0015

State Hospital level of care is determined appropriate when:

- The individual's condition or symptoms have not improved in an acute care setting despite having received a comprehensive psychiatric and medical assessment, and treatment with medications for at least 7 days at an adequate dose.
- 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.

Making a long-term 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 (Care Coordinator) and OHA

Outpatient services

Initiating services

Behavioral health (BH) 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. These services do require a notification via CIM entry or via fax by the delivering provider for payment purposes. Please see "Submission of notifications and authorizations" above for instructions on submission of notifications via CIM or fax. Youth, age fourteen and older, may request mental health services without parent/guardian consent, in accordance with applicable ORS 109.675.

One exception to this is for Level D Youth and Level D Adult/ICM. While these services are considered outpatient and do not require a prior authorization, they are coordinated with the CareOregon 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*
  - ACT/ICM Referral Form (Adult Level D): *link.careoregon.org/careoregon-act-icm-referral-form*
  - Level D Child Referral Form (Youth Level D): *link.careoregon.org/careoregon-level-d-child-referral-form*
- Can be submitted via CIM or fax.
- Must include supporting clinical documentation.
- After the clinical review and determination is made, all approved referrals will be routed to the BHN Team for triage and coordination.

Substance use disorder (SUD) services

Substance use disorder (SUD) treatment services are a covered benefit for Health Share members. 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 notification by entering a request in Community Integration Manager (CIM). 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 CIM. Providers who do not have CIM 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 CIM 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.

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

careoregon.org

health share
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