

Behavioral Health Utilization Management Procedure Handbook



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**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 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. In addition, Care Oregon has adopted InterQual, when possible, as the definition of medical necessity criteria to accompany the UM policies and procedures in this handbook.

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 a mental health condition by identifying and building on 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, attend to other factors known to impact 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.

3. 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.
4. 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 mental health status and functioning
 - Successful social relationships
 - Meaningful participation in the community
5. When multiple providers are involved in the care of our members, it is our expectation that regular coordination and communication occur between these providers to ensure coordination of care. This could include sharing of service plans, joint sessions, phone calls or team meetings.

Medical Necessity Criteria

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 Oregon Health Plan Medicaid recipients must be medically appropriate and medically necessary. For all services, the individual must have a diagnosis covered by the Oregon Health Plan which 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.

- Medically appropriate services are those services which are:
 - Recommended by a licensed health provider practicing within the scope of their license
 - Safe, effective and appropriate for the member based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence
 - Not solely for the convenience or preference of a member, or a provider of the services
 - 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 the individual

All covered services must be medically appropriate for the member, but not all medically appropriate services are covered services.

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

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.

Services Requiring Prior Authorization

Level of Care	Initial Authorization Length	Continued Stay Length	Utilization Management Turn Around Time
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
Eating Disorder Programs Treatment: Residential and Partial Hospitalization	30 days	30 days	14 calendar days
Electroconvulsive Therapy (ECT)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Level D: Home Based Stabilization: Youth and Family Ages 6-17	90 days	90 days	14 calendar days
Mental Health Intensive Outpatient Treatment (IOP)	Dependent upon clinical circumstances; generally 14 days	Dependent upon clinical circumstances; generally 14 days	14 calendar days
Mental Health Outpatient: Level D Adult Intensive Case Management (ICM) or Transition Age Youth (TAY)	1 year	1 year	14 calendar days
Mental Health Outpatient: Level D Early Childhood Ages 0-5	90 days	90 days	14 calendar days
Mental Health Partial Hospitalization	Dependent upon clinical circumstances; generally 7- 14 days	Dependent upon clinical circumstances; generally 7- 14 days	14 calendar days
Neuropsychological Testing	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Psychiatric Day Treatment Services (PDTS)	90 days	30 days	7 business days
Psychiatric Residential Treatment Services (PRTS)	30 days	30 days	3 business days
Psychological Testing	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days
Subacute Treatment: Youth	7 days	Dates and units entered per provider request/clinical need	Next business day
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

In addition to the foundational definitions in the table above, the determination of medical necessity is also made by CareOregon on an individual basis using InterQual criteria. Requests for services are reviewed by Master's-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.

Prior Authorizations for Behavioral Health Treatment

All standard request prior authorization determinations 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, 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 rule, and CareOregon abides by those requirements. Please see the table below for full details of turnaround times and authorization length. 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. There is no prior authorization for urgent or emergent care.

Services Requiring Prior Authorization

Some providers may be granted privileges and access to enter their own authorizations in CareOregon's provider portal, Clinical Integration Manager (CIM), and some of these authorizations will be automatically approved. These permissions are given at the discretion of CareOregon, and are dependent on provider type, service type and the provider's knowledge of CareOregon's system of care. Authorizations that are not set to auto-approve will be entered and/or approved by CareOregon staff.

Requests for Initial Authorizations

CareOregon will authorize assessment services to give the provider the opportunity to complete an assessment and generate a picture of the member's clinical presentation, including instances in which ongoing treatment is not clinically indicated. If the provider believes that ongoing services are clinically indicated, the provider will submit an assessment and services plan indicating the member's current level of functioning, the frequency, duration and evidence basis 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 of the services is demonstrated and to enter an authorization for services as approved, including the documentation of the above.

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

- Identification of beneficiary (member information)
- Name of beneficiary'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 and authorization for Medicaid
- Plan of care
- Reason and plan for the services

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 for details). These processes will repeat as needed for the duration of treatment, including until the member no longer needs those 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.

A member may require services in excess of the dollar cap on their existing authorization at the time of the services. Additional funds can be requested for an open authorization; such requests for additional funds to a previously issued authorization are made through the same process as ongoing treatment authorizations. Providers shall include clinical rationale as to the reason for additional services. This request may result in changes to the diagnosis or treatment plan, in which case the updated clinical documentation, such as an updated mental health assessment or treatment plan, must also be submitted. If, after reviewing the updated clinical information, the CareOregon UM staff determines that additional treatment is medically necessary, additional dollars can be added to the previous authorization.

Submitting Requests for Assessment and Ongoing Treatment Authorizations

Providers with access to CIM may submit their requests via CIM, including supporting clinical documentation as attachments. Self-entered authorizations should be entered/requested no later than 45 days from the start of services.

Providers who do not have access to CIM can submit a Prior Authorization Request form and supporting clinical documentation to CareOregon via fax to 503-416-3713. The Prior Authorization Request form can be found on the CareOregon website.

Specialty Providers

Outpatient fee for service mental health providers (OP FFS MH providers) are individual practitioners and small groups who have an identified area of expertise, experience, service location, language proficiency or other specialty that augments the CareOregon network. Authorizations to OP FFS MH providers will be considered for members who require the provider's identified specialty in order to receive mental health treatment. If members contact CareOregon for a referral, CareOregon will refer the member to OP FFS MH providers when they require the provider's identified specialty. CareOregon will either provide the member with the OP FFS MH provider's contact information and/or assist the member directly in contacting the provider to start a referral.

If a member contacts an OP FFS MH provider directly for services, the provider should screen the member in order to:

- Ensure Health Share eligibility
- Ensure that their identified needs are in line with the provider's area of expertise
- Determine whether the level of care of the member's mental health needs can be met the by provider

If the member does not meet the criteria above, refer to CareOregon Customer Service for help with a referral.

Note: Standalone medication management services are limited in availability. Members who will require a provider for medication management and counseling services should be directed to CareOregon Customer Service for assistance in finding an agency that can provide comprehensive services.

Acute Psychiatric Inpatient Requests

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 to 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.

Eligibility is Not Determined Until After Admission

If the member is still admitted when eligibility is determined, CareOregon will confirm eligibility and review clinical information for medical necessity of inpatient services. If approved, authorization will be retroactive to the day of admission. If the client has already discharged when eligibility is determined, UM staff will make an authorization determination within 30 calendar days of notification of 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 outside a 50-mile radius from the Portland metro area.

MD-to-MD Communication on Admission and Continued Stay Criteria

Qualifications for an MD-to-MD Consult

All of the following must apply:

- The member is still not admitted to the acute care unit
- The member is not set to discharge the day of the MD-to-MD request
- If a complete request is received before the member discharges, then the MD-to-MD determination is completed
- The denial determination was based on medical necessity and is not an administrative denial
- New clinical information is provided in writing
- The new clinical information was received within one business day from the time of verbal denial notification

MD-to-MD process:

- CareOregon UM staff make UM decisions per routine UM protocol
- For denial of admission or continued stay criteria, the hospital UR is notified verbally, and a Notice of Denial of Payment is faxed to the hospital. If the attending MD at the hospital disagrees with the decision, the hospital can submit new information in writing to support admission or continued stay. This can include an updated progress note, email or some other means of written communication as deemed appropriate by the hospital. The hospital has one business day to submit new information once they receive verbal notification of the denial from CareOregon
- A CareOregon MD reviews information within two business days of receipt

- If a CareOregon MD overturns the denial, the CareOregon UM staff will notify the hospital, the CareOregon MD will provide a written response and the authorization will be updated to reflect the change in decision
- If a CareOregon MD overturns a denial, authorized days will include the day of the original denial through the date of CareOregon's decision to overturn

This process does not take the place of the appeal process but allows for an attending MD to present information about a complicated case while under her/his care.

Declined MD-to-MD Consults:

If the request does not meet the criteria above or the CareOregon UM staff determines the request does not demonstrate a good faith effort due to no new clinical information or lack of acuity demonstrated in the received clinical information, the request may be declined for processing. The CareOregon UM staff will notify the requester verbally that the MD-to-MD request has been declined and that the appeal process can be followed.

Requests for Continued Stay Authorizations

For facilities in which 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, CareOregon 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 UM staff regarding authorization for continued stay and communicating with the hospital social worker for discharge planning as appropriate. The hospital UM staff is responsible for providing clinical on the day of review.

Medical Unit Transfers

When a client 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 approved authorization for psychiatric inpatient episode of care will be ended as of midnight.

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

When a client 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.

Discharge Procedures

Hospitals will inform CareOregon UM of planned discharge date during concurrent review and will notify of actual discharge date on the same business day as the discharge.

At point of discharge, no later than the next business day, and in line with meeting the 7-day follow-up appointment requirement (or 3 days if in intensive care coordination), CareOregon will ensure that a secure email is sent to the outpatient provider with the following information:

- a. Client name, Medicaid ID and date of discharge
- b. Discharge medications and dosages, any pertinent available lab results and recommended level of care at discharge should be obtained by the current provider or the receiving provider and sent by the discharging hospital. A full discharge summary summarizing hospital course and treatment recommendations should be made available to the community mental health provider with 7 days of discharge from the hospital

Please note, even for a member with a denied payment or dual coverage, CareOregon is still responsible for the post-hospital follow-up appointment. As a result, the hospital will notify the UM staff of the member's discharge regardless of payment status.

Institution for Mental Diseases (IMDs)

CareOregon will abide by and authorize according to OAR rules for IMDs as noted in OAR Chapter 410-141-3000 (39) and 410-141-3160 (21).

Medical Necessity Criteria: Tables

CareOregon uses InterQual criteria to determine the presence of medical necessity based on the clinical documentation provided with each request. In some instances, local resources, community agreed-upon standards or regional consensus best practices inform medical necessity instead. Those instances are defined in the following table.

<p>Outpatient Mental Health Services: Level A-D Youth and Family</p>
<p>Assessment Plus Two</p>
<p>The assessment plus two authorization covers up to three sessions with no time limit. The purpose of this assessment phase is threefold: (1) gather adequate clinical information to recommend the appropriate level of care (LOC), (2) assess the client’s ability and willingness to engage in treatment and (3) determine the client’s functional capacity.</p> <p>Please note that initial engagement and assessment/screening service (e.g., 90899, T1023, 90791, 90792, H0002, H0031) <u>do not require a covered diagnosis</u> on the prioritized list. However, if other clinical services such as individual or family therapy are employed as part of the assessment plus two process, they do require a covered diagnosis on the prioritized list, as well as an assessment and service plan in compliance with applicable OARs and the fee schedule.</p>
<p>Level A-D Determination of Level of Care</p>
<p>There may be specific situations when the clinician has determined that a particular LOC is appropriate based on their assessment of the client’s clinical presentation and needs, but the client is either unable or unwilling to engage in treatment at that level. That inability to engage can be secondary to either a lack of interest in treatment and/or functional limitations in their ability to engage. In those situations, the clinician may request authorization at a lower LOC to reflect the client’s interest/readiness for change and/or functional ability to participate.</p> <p>If a clinician decides to request authorization at a lower LOC than is clinically indicated, the LOC registration form requires that the clinician explain how he/she will work with the client towards the goal of receiving all clinically indicated services.</p> <p>CareOregon reviews for medical necessity for Levels A-D using Interqual outpatient mental health criteria and then assigns a Level A-D for payment purposes according to these criteria.</p>

**Mental Health Outpatient: Level A
Youth and Family**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Generally office based, these outpatient mental health services are designed to quickly promote, or restore, previous level of high function/stability or maintain social/emotional functioning, and are intended to be focused and time-limited with services discontinued as an individual is able to function more effectively.</p> <p>Outpatient services include evaluation and assessment; individual and family therapy, group therapy, medication management and case management.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • An individual has already taken effective action and is in the maintenance phase of treatment to maintain baseline • A client who is pre-contemplative regarding engagement in a higher level of care • Primarily psychiatric services for ongoing medication management • Treatment will be limited and target a specific behavior, interaction, or symptom 	<p>Covered diagnosis on the prioritized list AND</p> <ul style="list-style-type: none"> • The need for maintenance of a medication regimen (at least quarterly) that cannot be safely transitioned to a PCP, OR • A mild or episodic parent, youth or family system interactional problem that is triggered by a recent transition or outside event and is potentially resolvable in a short period of time, OR • Transitioning from a higher level of service (step down) in order to maintain treatment gains and has been stable at this level of functioning for 3-4 visits, AND • Low acuity of presenting symptoms and minimal functional impairment, AND • Home, school, or community impact is minimal. 	<p>Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this level of care.</p>	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • No longer meets criteria for this level of care, or meets criteria for a higher level of care • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for medication management and/or appropriate community supports

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<ul style="list-style-type: none">• Natural supports are available consistently. Important life activities prohibit frequent participation in services• A client who is receiving services from other systems such as DD, APD, DHS, etc.			
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**Mental Health Outpatient: Level B
Youth and Family**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Generally office based, these outpatient mental health services are designed to promote, restore or maintain social/emotional functioning and are intended to be focused and time-limited with services discontinued as an individual is able to function more effectively.</p> <p>Outpatient services may include some combination of evaluation and assessment, individual and family therapy, group therapy, medication management and as needed case management, skills training and peer/family support.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • An individual who is taking effective action in treatment or who is prepared and determined to take effective action in treatment • A client who is pre-contemplative regarding engagement in a higher level of care • Low frequency sessions, but client/family requires consistency and regular practice over time in order to develop new skills, habits and routines to compensate for lagging skills 	<p>Covered diagnosis on the prioritized list, AND</p> <ul style="list-style-type: none"> • Mild-to-moderate functional impairment in at least one area (for example, sleep, eating, self-care, relationships, school behavior or achievement), OR • Mild-to-moderate impairment of parent/youth relationship to meet the development and safety needs, OR • Transition from a higher LOC intensity (step-down) to maintain treatment gains. 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills, and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • No longer meets criteria for this LOC, or meets criteria for a higher LOC • Not making progress toward treatment and there is no reasonable expectation of progress at this LOC • It is reasonably predictable that continuing stabilization can occur with discharge from treatment, transition to PCP for medication management and/or appropriate community supports

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<ul style="list-style-type: none">• Parent-child interactional problem may be causing some ongoing impairment. Therefore, parent training may be a primary focus of treatment• The client may have more barriers to natural/informal supports and requires case management• Family utilizes services well and benefits from treatment but struggles to internalize or generalize skill development• Home-based services may be appropriate when there are cultural or developmental considerations			
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**Mental Health Outpatient: Level C
Youth and Family**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>These services can be provided in any of the following: clinic, home, school and community. These services are designed to prevent the need for a higher LOC, or to sustain the gains made in a higher LOC, and which cannot be accomplished in either routine outpatient care or other community support services.</p> <p>Outpatient services may include some combination of evaluation and assessment, individual and family therapy, medication management, case management; skills training, peer/family support, respite and some phone crisis support.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • A client who is pre-contemplative regarding engagement in a higher LOC • Client needs higher frequency of sessions and a combination of multiple service types • In-vivo coaching and mild-to-moderate phone crisis support required to interrupt dysfunctional patterns of interaction and integrate new skills 	<p>Criteria for early childhood, school-age and adolescents:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list. <p>At least ONE of the following:</p> <ul style="list-style-type: none"> • Significant risk of harm to self or others • Moderate-to-severe impairment of parent/youth relationship to meet the developmental or safety needs • Moderate-to-severe functional or developmental impairment in at least one area <p>AND for school-age and adolescents, at least ONE of the following:</p> <ul style="list-style-type: none"> • Risk of out-of-home placement or has had multiple transitions in placement in the last six months due to symptoms of mental illness • Risk of school or daycare placement loss due to mental illness or developmental needs • Multiple system involvement requiring coordination and case management 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom • Management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objective have been substantially met • No longer meets criteria for this LOC or meets criteria for a higher LOC • Not making progress toward treatment and there is no reasonable expectation of progress at this LOC • It is reasonably predictable that continuing stabilization can occur with discharge from treatment, transition to PCP for medication management and/or appropriate community supports

<ul style="list-style-type: none"> • Unstable placement due to caregiver stress • Complex symptoms for which targeted caregiver/parent education is required to improve child function 	<ul style="list-style-type: none"> • Moderate-to-severe behavioral issues that cause chronic family disruption • Extended crisis episode requiring increased services • Recent acute or subacute admission within the last six months • Significant current substance abuse for which integrated treatment is necessary • Transition from a higher LOC intensity (step-down) to maintain treatment gains • Youth and/or family's level of English language skill and/or acculturation is not sufficient to achieve symptom or functional improvement without case management 		
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**Mental Health Outpatient: Level D
Early Childhood: Ages 0-5**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Early Childhood Home-Based Stabilization Services are provided at an intensive level in the home, school and community with the goal of stabilizing behaviors and symptoms of the child that led to the referral. May include some combination of evaluation and assessment, individual and family therapy (including evidence-based early childhood models), medication management, case management, skills training, peer/family support, respite at an increased frequency, school/daycare support and consultation and group parenting education and training. Treatment is not directed primarily to resolve placement or behavior.</p> <p>Services and interventions should be focused on both young child and caregiver.</p> <p>Crisis intervention is available 24/7 both by phone and in person. May be appropriate as an alternative to psychiatric day treatment, psychiatric residential treatment or inpatient treatment.</p> <p>Typically, children referred to this LOC are demonstrating attachment and/or trauma-related symptoms resulting in possible loss of early childhood placement.</p>	<p>All must be met:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list • Current serious-to-severe functional impairment in multiple areas • Treatment intensity at a lower LOC insufficient to maintain functioning <p>And four of the following:</p> <ul style="list-style-type: none"> • Serious risk of harm to self or others due to symptoms of mental illness (e.g., impulsivity resulting in elopement, aggression, sexualized behaviors, expressed intent to harm self or others, extreme irritability resulting in unsafe responses from others, etc.) • Serious impairment of caregiver capacity to meet the developmental and safety needs of their child (e.g., parent in substance abuse treatment, domestic violence, mental illness, etc.) • Significant risk of disruption from current living situation due to child's symptoms related to a mental health diagnosis 	<p>Must meet all the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Parent or caregiver is actively involved with treatment • Evidence of active discharge planning with the youth/family • Needs cannot be met at a lower LOC 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • No longer meets criteria for this LOC or meets criteria for a higher LOC • Not making progress toward treatment and there is no reasonable expectation of progress at this LOC • It is reasonably predictable that continuing stabilization can occur with discharge from treatment, transition to PCP with medication management, and/or appropriate community supports

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<p>For the initial 90-day authorization request, the provider will submit the following:</p> <ul style="list-style-type: none"> • Mental health assessment updated within the last 60 days, OR • Progress notes for the last 30 days, AND • Updated treatment plan. <p>For all subsequent 30-day authorization requests, the provider will either have</p> <ul style="list-style-type: none"> • A verbal conversation with CareOregon UM staff to justify continued stay, OR • Submit the last 30 days of progress notes. <p>In the event of a potential denial via the verbal authorization, backup clinical would be requested prior to the NOABD.</p> <p>The Health Plan will be responsible for the completion of the LOC treatment registration form.</p>	<ul style="list-style-type: none"> • Significant cultural and language barrier impacting ability to fully integrate symptom management skills and there are not more clinically appropriate services • Multiple recent placement changes for child resulting in increase in emotional/behavioral dysregulation • Current significant risk of losing daycare or early childhood education placement due to behaviors related to mental health symptoms or trauma (e.g., sexualized behavior, increased arousal, persistent negative emotional state, biting, extreme tantrums, aggression towards others, etc.) 		
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**Level D (Home-Based Stabilization)
Youth and Family: Ages 6-17**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Home-based stabilization services are provided at an intensive level in the home, school and community with the goal of stabilizing behaviors and symptoms that led to that referral. May include some combination of evaluation and assessment, individual and family therapy, medication management, case management, skills training, peer/family support and respite at an increased frequency. Treatment is not directed primarily to resolve placement OR behavior, conduct or substance abuse problems.</p> <p>Crisis intervention is available 24/7, both by phone and in-person.</p> <p>Children and youth are required to meet criteria for wraparound care coordination to be considered for this LOC.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • A client who is pre-contemplative regarding engagement in a higher LOC. • Client is discharging from residential stay or has had multiple acute/subacute placements in the last six months. 	<p>Both must be met:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list • Current serious-to-severe functional impairment in multiple areas <p>And one of the following:</p> <ul style="list-style-type: none"> • Treatment intensity at a lower LOC insufficient to maintain functioning • Hospital or subacute admission in the last 30 days <p>And two of the following:</p> <ul style="list-style-type: none"> • Serious risk of harm to self or others due to symptoms of mental illness • Serious impairment of parent/youth relationship to meet the developmental and safety needs • Significant risk of disruption from current living situation due to symptoms related to a mental health diagnosis • Transition from a higher LOC intensity (step-down) to maintain treatment gains • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there are not more clinically appropriate services 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there are not more clinically appropriate services 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • No longer meets criteria for this LOC or meets criteria for a higher LOC • Not making progress toward treatment and there is no reasonable expectation of progress at this LOC • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP with medication management and/or appropriate community supports

<p>For the initial 90-day authorization request, the provider will submit the following:</p> <ul style="list-style-type: none"> • Mental health assessment updated within the last 60 days, OR • Progress notes for the last 30 days AND an updated treatment plan. <p>For all subsequent 30-day authorization requests, the provider will either have</p> <ul style="list-style-type: none"> • A verbal conversation with CareOregon UM staff to justify continued stay, OR • Submit the last 30 days of progress notes. <p>In the event of a potential denial via the verbal authorization, backup clinical would be requested prior to the NOABD.</p> <p>The Health Plan will be responsible for the completion of the LOC Treatment Registration Form.</p>			
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Outpatient Mental Health Services - Level A-D Adult

Assessment Plus Two

The assessment plus two authorization covers up to three sessions with no time limit. The purpose of this assessment phase is threefold: (1) gather adequate clinical information to recommend the appropriate level of care (LOC), (2) assess the client's ability and willingness to engage in treatment and (3) determine the client's functional capacity.

Please note that initial engagement and assessment/screening services (e.g., 90899, T1023, 90791, 90792, H0002, H0031) do not require a covered diagnosis on the prioritized list. However, if other clinical services such as individual or family therapy are employed as part of the assessment plus two process, they do require a covered diagnosis on the prioritized list, as well as an assessment and service plan in compliance with applicable OARs and the fee schedule.

Level A-D Determination of Level of Care

There may be specific situations in which the clinician determines that a particular LOC is appropriate based on their assessment of the client's clinical presentation and needs, but the client is either unable or unwilling to engage in treatment at that level. That inability to engage can be secondary to either a lack of interest in treatment and/or functional limitations in their ability to engage. In those situations, the clinician may request authorization at a lower LOC to reflect the client's interest/readiness for change and/or functional ability to participate.

If a clinician decides to request authorization at a lower LOC than is clinically indicated (per the paragraph above), the LOC registration form requires that the clinician explain how he/she will work with the client towards the goal of receiving all clinically indicated services.

CareOregon reviews for medical necessity for Levels A-D using Interqual outpatient mental health criteria and then assigns a Level A-D for payment purposes according to these criteria.

**Mental Health Outpatient: Level A (MRDD/IDD or Medication Only)
Adult**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Specialized assessment and medication management by an MD or PMHNP and minimal adjunct case management.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Individual with a developmental disability who will not benefit from talk therapy • A client who is pre-contemplative regarding engagement in a higher level of care • Individuals who have progressed to the point in care where they only require complex medication management (e.g., injectable medications) • For adults only medication, this can be clients in a general outpatient setting or who fit the criteria for Severe and Persistently Mentally Ill (SPMI) 	<p>Covered diagnosis on the prioritized list, AND one of the following:</p> <ul style="list-style-type: none"> • Need for care coordination with DD services and ongoing medication management • Need for medication management for a medication regime that is more complicated than generally provided in primary care 	<p>Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this LOC.</p>	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or function at this LOC

Mental Health Outpatient: Level A Adult

(Note: There is no "Level A SPMI")

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are designed to promote, restore or maintain social/emotional functioning and are focused and time-limited with services discontinued when the client's functioning improves.</p> <p>Outpatient services are office-based and include evaluation and assessment, individual and family therapy, group therapy and medication management.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Mild depression or anxiety that cannot be addressed only by primary care intervention • A client who is pre-contemplative regarding engagement in a higher LOC 	<p>Both of the following:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list • Episodic depression, anxiety or other mental health conditions with no recent hospitalizations and limited crisis episodes within the past year <p>AND at least one of the following:</p> <ul style="list-style-type: none"> • Mild functional impairment • A presentation that is elevated from baseline 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or function at this LOC

Mental Health Outpatient: Level B Adult

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are designed to promote, restore or maintain social/emotional functioning and are focused and time-limited with services discontinued when the client's functioning improves.</p> <p>Services may include evaluation and assessment, individual and family therapy, group therapy and medication management. Case management is not generally required by individual.</p> <p>Outpatient services are more commonly provided in the office and with more frequency than Level A.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Moderate risk of harm to self or others requiring more frequent sessions • A client who is pre-contemplative regarding engagement in a higher LOC • Individual is stepping down from higher LOC and demonstrating symptom or functional improvement • Individual's clinical presentation is affecting at least one functional domain such as work or relationships and therefore would benefit from more frequent services 	<p>Covered diagnosis on the prioritized list, AND at least one of the following:</p> <ul style="list-style-type: none"> • Moderate risk of harm to self or others • Moderate functional impairment in at least one area such as housing, financial, social, occupational, health, and activities of daily living • Individual has a marginalized identity that creates barrier to receiving appropriate services, and/or individual's level of English language skills and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barrier impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or functioning at this LOC

Mental Health Outpatient: Level B SPMI Adult

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are designed to promote recovery and rehabilitation for adults with SPMI. These services instruct, assist and support an individual to build or improve skills that have been impaired by these symptoms.</p> <p>Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. Emphasis is placed on linkages with other services and coordination of care.</p> <p>Services are primarily office-based and may include evaluation and assessment, consultation, case management, individual and family therapy, group therapy, medication management, skills training, supported employment, family education and support, relapse prevention and occasional crisis support.</p> <p>Diagnoses generally covered under this authorization type:</p> <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Psychosis 	<p>ALL the following:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list • No hospitalizations or major crisis episodes within the past year • No risk of harm to self or others, or risk of harm to self or others that is consistent with baseline presentation <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • Symptoms related to the mental illness result in a moderate functional impairment and are well controlled • Individual able to navigate system with minimal-to-moderate support, or has supports (such as family or Adult Foster Home) in place to meet client's needs • Low-to-moderate psychosocial stress (housing and benefits are generally stable) • Individual is generally functioning at baseline • Individual has extended periods of abstinence when a co-occurring disorder exists, and risk factors are minimal 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objective have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues, resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or functioning at this LOC

<p>Diagnoses can also include mood and anxiety disorders that are severe and persistent in nature and have serious impact on activities of daily living.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Individuals functioning at baseline would benefit from additional life skill development and social support in order to maintain independence • A client who is pre-contemplative regarding engagement in higher LOC • Individual is stepping down from higher LOC and demonstrating symptom or functional improvement • Foster home example • Supported structured living example 	<ul style="list-style-type: none"> • Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skills and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports 		
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**Mental Health Outpatient: Level C
Adult**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are designed to promote, restore or maintain social/emotional functioning and are intended to be focused and time-limited with services discontinued when the client's functioning improves. This includes individuals who meet the criteria for transitional age youth.</p> <p>Services may include more community-based services and can include evaluation and assessment, individual and family therapy, group therapy, medication management, consultation, case management, skills training, crisis support, relapse prevention, hospital diversion and integrated substance abuse treatment.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Mental health issues are compounded by risk of loss of housing due to extended periods of crisis • Individual may benefit from care coordination and case management • A client who is pre-contemplative regarding engagement in a higher LOC 	<p>Covered diagnosis on the prioritized list, AND at least two of the following:</p> <ul style="list-style-type: none"> • Risk of harm to self or others, or risk of harm to self or others that is escalated from baseline • Moderate functional impairment in at least two areas (such as: housing, financial, social, occupational, health and activities of daily living) • At least one hospitalization in the last 6 months • Multiple system involvement requiring coordination and case management • Risk of loss of current living situation, in an unsafe living situation or currently experiencing homelessness due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses • Extended or repeated crisis episode(s) requiring increased services 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to changes in symptoms or functioning at this LOC

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	<ul style="list-style-type: none">• Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skills and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports• Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination		
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Mental Health Outpatient: Level C SPMI Adult

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are designed to promote recovery and rehabilitation for adults with SPMI. These services instruct, assist and support an individual to build or improve skills that have been impaired by these symptoms.</p> <p>Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. Emphasis is placed on linkages with other services and coordination of care.</p> <p>Services may include evaluation and assessment, outreach, consultation, case management, counseling, medication evaluation and management, daily structure and support, skills training, family education and support, integrated substance abuse treatment, supported employment, relapse prevention, hospital diversion, crisis intervention and supported housing.</p> <p>Diagnoses generally covered under this authorization type:</p> <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Psychosis 	<p>Two of the following:</p> <ul style="list-style-type: none"> • Covered diagnosis on the prioritized list • Significant assistance required to meet basic needs such as housing and food • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • At least one hospitalization within the past year • Symptoms related to the mental illness result in a moderate-to-severe functional impairment and are only partially controlled • Risk of harm to self or others, or risk of harm to self or others that is elevated from baseline • Multiple system involvement requiring substantial coordination • Extended or repeated crisis episode(s) requiring increased services • Significant current substance abuse for which treatment is necessary 	<p>Continues to meet admission criteria AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or functioning at this LOC

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<p>Diagnoses can also include mood and anxiety disorders that are severe and persistent in nature and have serious impact on activities of daily living.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • Individual requires increased coordination in order to meet basic needs such as safety, housing and food • Individual's symptoms are partially controlled • A client who is pre-contemplative regarding engagement in a higher LOC • Additional care coordination linking client to resources that will prevent hospitalization • Intensive case management (ICM) client or assertive community treatment (ACT) client who is not ready to engage in additional services 	<ul style="list-style-type: none"> • Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness • Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skills and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports • Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination 		
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**Mental Health Outpatient: Level D
Adult Intensive Case Management (ICM) or Transition Age Youth (TAY)**

Service Description	Initial Clinical Considerations	Concurrent Clinical Considerations	Transition/Discharge Considerations
<p>Services are provided at an intensive level in the home and community with the goal of stabilizing behaviors and symptoms that led to admission.</p> <p>Programs include an array of coordinated and integrated multidisciplinary services designed to address presenting symptoms in a developmentally appropriate context. These services could include group, individual, family, psycho-educational services, crisis management and adjunctive services such as medical monitoring. Services include multiple or extended treatment visits.</p> <p>Diagnoses generally covered under this authorization type:</p> <ul style="list-style-type: none"> • Schizophrenia • Schizoaffective disorder • Psychosis <p>Diagnoses can also include mood and anxiety disorders that are severe and persistent in nature and have serious impact on activities of daily living.</p>	<p>Criteria for ICM include covered diagnosis on the prioritized list, AND at least two of the following:</p> <ul style="list-style-type: none"> • 2 or more inpatient admissions in the past year • Discharge from the state hospital within the past year • Civil commitment or discharge from the state hospital within the past year • Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses <p>Or at least three of the following:</p> <ul style="list-style-type: none"> • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist 	<p>Criteria for ICM and TAY both include continuing to meet admission criteria, AND at least one of the following:</p> <ul style="list-style-type: none"> • Capable of additional symptom or functional improvement at this LOC • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service • Eviction or homelessness is likely if LOC is reduced 	<p>At least ONE of the following must be met:</p> <ul style="list-style-type: none"> • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCPC and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this LOC • Meets criteria for a different LOC due to change in symptoms or functioning at this LOC

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<p>24/7 telephonic crisis support is provided by the ICM or TAY team. Services differ from ACT in frequency and in 24/7 face-to-face crisis availability.</p> <p><i>Examples include:</i></p> <ul style="list-style-type: none"> • ICM: adult with severe life skill deficits, secondary to mental health symptoms, with a recent transition from state or inpatient hospitalization requires coordination of multidisciplinary services in the home. • TAY: Teen or young adult with persistent psychotic symptoms requires intensive, in-home, care coordination in order to meet treatment, housing and employment needs. 	<ul style="list-style-type: none"> • Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness <p>Criteria for TAY include covered diagnosis on the prioritized list, and at least one of the following:</p> <ul style="list-style-type: none"> • Two or more inpatient admissions in the past year • Recent discharge from the youth's Secure Inpatient adolescent program or long-term psychiatric residential treatment services • Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided 		
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	<ul style="list-style-type: none"> • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness <p>Or at least three of the following:</p> <ul style="list-style-type: none"> • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist • Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma, or multiple losses 		
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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, 2000). 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.

Psychological testing includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology (e.g., WAIS, Rorschach, MMPI).

Psychological 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, **AND**
- Must primarily include tests beyond self-report measures and most often should include psycho-diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology.

It is also recommended that the member be seen by a licensed medical professional who also recommends testing and the reason(s) why.

Provider requirements: The 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 reviewed in exceptional need cases in which circumstances justify the need for additional hours of testing.

Transcranial Magnetic Stimulation: Adult

Service Description

Transcranial Magnetic Stimulation (TMS) is an exceptional needs treatment intervention considered only after various trials of different therapies and medications, of various classes, have been exhausted.

TMS is generally used as a secondary treatment when the individual has not responded to medication and/or psychotherapy.

The TMS treatment is delivered by a device that is FDA-approved or FDA-cleared for the treatment of MDD in a safe and effective manner.

The decision to administer TMS must be based on an evaluation of the risks and benefits involving a combination of factors that include psychiatric diagnosis, type and severity of symptoms, prior treatment history and response and identification of possible alternative treatment options.

A request for an assessment must be made in writing by the prescriber (either a licensed psychiatrist or psychiatric nurse practitioner) to the assigned BHPP.

BHPP medical directors will determine whether criteria are met for an assessment to be covered by a TMS provider.

The order for treatment must be written by a physician who is board certified and who must have experience in administering TMS therapy and must certify that the treatment will be given under direct supervision of this physician.

Any of the following criteria are sufficient for exclusion from this LOC:

- The individual has medical conditions or impairments that would prevent beneficial utilization of the services
- The individual requires 24-hour medical/nursing monitoring or procedures provided in a hospital setting
- Younger than 18 years of age, or older than 70 years of age
- Members with a recent history of active substance abuse, obsessive compulsive disorder, or post-traumatic stress disorder
- Patients with a psychotic disorder, including schizoaffective disorder, bipolar disorder, or MDD with psychotic features
- Patients with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system
- The presence of metal or conductive device in the head or body that is contraindicated with TMS
- Members with MDD who have failed to receive clinical benefit from ECT or VNS
- Presence of severe cardiovascular disease
- Patients who are pregnant or nursing
- TMS is not indicated for maintenance treatment

Substance Use Disorder Practice Guidelines

Note: CareOregon uses ASAM level of care criteria for all SUD except medication-assisted treatment

Medication-Assisted Treatment			
Service Description	Criteria for Authorization	Concurrent Review Criteria	Transition/Discharge Criteria
<p>Medication-assisted treatment (MAT) encompasses a variety of pharmacological interventions used in the treatment of opioid use disorders or alcohol use disorders. MAT can be provided in a variety of settings, including opioid treatment programs (OTP) and office-based opioid treatment (OBOT). These guidelines apply to CareOregon members receiving services in specialty behavioral health settings.</p> <p>In the specialty behavioral health system, MAT is provided concurrently with non-pharmacological treatment modalities in all LOCs.</p> <p>Pharmacological agents include opioid agonist medications such as methadone and buprenorphine, and opioid antagonist medication such as naltrexone. These medications should be used for recovery from substance use disorders, not for the treatment of pain.</p>	<p>Generic name: buprenorphine/naloxone sublingual film</p> <p>Brand name: Suboxone film tab, Zubsolv</p> <p>Initial criteria:</p> <ol style="list-style-type: none"> Does the member have a DSM-5 diagnosis of opioid use disorder? <p>If yes, continue to #2. If no, do not approve.</p> <ol style="list-style-type: none"> For opioid use disorders, has the member failed an adequate trial of buprenorphine or buprenorphine/naloxone tablets including attempts at a mitigating strategy (crushing tablets, taking with food, taking small amounts at a time) AND there has been consideration of naltrexone tables and/or methadone? <p>If yes, continue to #4. If no, go to #3.</p>	<p>Generic name: buprenorphine/naloxone sublingual film</p> <p>Brand name: Suboxone film tab, Zubsolv</p> <ol style="list-style-type: none"> Has the member maintained abstinence from all substances with the use of buprenorphine/naloxone SL film based on negative blood or urine toxicology screens? <p>OR has the member maintained ongoing participation in a comprehensive substance use disorder program that includes psychosocial support?</p> <p>If yes, approve for six months. If no, continue to #2. <ol style="list-style-type: none"> Is there evidence of significantly reduced utilization of acute care services (ED visits, inpatient and/or detox services) and/or improved clinical outcomes? <p>If yes, approve for six months. If no, do not approve.</p> </p>	<p>It is appropriate to transfer or discharge the member from MAT with buprenorphine/naloxone SL film if he or she meets one of the following criteria:</p> <ul style="list-style-type: none"> The member has achieved the goals articulated in his or her individualized treatment plan and MAT with one of these medications is no longer needed The member is able to transition to a medication, such as methadone or buprenorphine, that does not require prior authorization The member has transitioned to MAT with their PCP and that provider will work with the member's health plan for prior authorization, if needed The member no longer meets concurrent review criteria

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<p>Please note that prior authorization within the Specialty Behavioral Health System is not required for methadone, buprenorphine, buprenorphine/naloxone or Naltrexone Extended Release Injection (Vivitrol). Prior authorization is required for buprenorphine/naloxone sublingual film.</p>	<p>3. Has the provider established a case for clear cost-avoidance with buprenorphine/naloxone SL film for the member from their opioid use disorder, AND a trial of buprenorphine/naltrexone tablets or buprenorphine has been determined not appropriate? OR has the provider established a rationale for why alternate medications are medically contraindicated and provided information on medications tried, adverse outcomes for each and the dose and duration for each medication?</p> <p>If yes, continue to #4. If no, do not approve.</p> <p>4. Is there documentation that the member is engaged in a substance use disorder treatment program with psychosocial support?</p> <p>If yes, continue to #5. If no, do not approve.</p> <p>5. Is there documentation that the member is not concurrently prescribed or taking buprenorphine/naloxone, buprenorphine, or other opiates from another provider?</p> <p>If yes, approve for six months. If no, do not approve.</p>		
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Contact Customer Service:

503-416-4100 or 800-224-4840

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Hours: 8 a.m. to 5 p.m.

Monday-Friday

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