Behavioral Health Utilization Management

Procedure Handbook

A manual for CareOregon behavioral health providers
serving Jackson Care Connect CCO 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 Jackson Care Connect 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.

Jackson Care Connect (JCC) is one of the coordinated care organizations for Jackson County, Oregon. JCC is a wholly owned subsidiary of CareOregon (CareOregon, Inc. is the sole member of the LLC). As such, most of the functions performed by JCC are performed by CareOregon. Therefore, the Vision and Mission are shared.

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. Core Treatment Planning Values

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

- Strengths-based – Focused on the individual's strengths, abilities, and resources
- Individualized and person-centered – Tailored to each person's unique needs, goals, and preferences
- Accessible and engaging – Designed to encourage participation and remove barriers to care
- Inclusive of family involvement – Actively involves families and natural supports whenever possible
- Supportive of continuity – Promotes consistent and coordinated care across settings and providers
- Empowering – Fosters self-determination, autonomy, and a sense of control
- Respectful of rights – Upholds the dignity, rights, and cultural identity of each individual
- Hope-driven – Instills personal responsibility and optimism for recovery
- Rooted in natural supports – Integrates community-based and informal support systems as the norm, not the exception

2. Service Delivery Guidelines

All services should be governed by policies and practices that are:

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

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

3. Indicators of Resilience and Recovery

Treatment interventions should promote resilience and recovery, as demonstrated by:

- Maximized quality of life for individuals and families
- Success in work and/or school
- Improved behavioral health status and functioning
- Successful social relationships
- Meaningful participation in the community

4. Additional Clinical Expectations

- **Crisis Stabilization**
  Individuals experiencing a behavioral health crisis should receive a timely assessment and any medically necessary services to support stabilization and transition to a lower level of care.
- **Treatment for Underlying Conditions**
  Care must go beyond symptom management to address the underlying behavioral health condition, based on the individual's assessment or care plan.
- **Integrated Treatment**
  When individuals have co-occurring behavioral or medical conditions, treatment should be delivered in a coordinated and integrated manner.
- **Least Restrictive Care**
  Services should be delivered at the least intensive and least restrictive level of care that is both safe and effective while meeting the individual's clinical needs.

Glossary

- **Authorization**
  A member-specific approval granted to a provider to deliver services. The authorization is entered into CareOregon Connect and enables billing for the approved services.
- **Behavioral Health (BH)**
  An umbrella term that includes mental health, mental illness, substance use disorders, addiction, and gambling disorders.
- **CareOregon Connect**
  The secure provider portal used by CareOregon providers to access member eligibility, prior authorizations, program enrollment updates, and claims/payment information.
- **Contracted Providers**
  Providers who have entered into a contract with CareOregon to deliver mental health and/or substance use disorder services to Jackson Care Connect members. Also referred to as "in-network providers."
- **Did Not Meet Medical Necessity Criteria**
  A determination made when submitted clinical information does not satisfy the required criteria for admission or continued stay.
- **Managed Care Entity (MCE)**
  An organization that contracts to deliver services within a managed care system. MCEs include managed care organizations (MCOs), prepaid health plans, primary care case managers, and Coordinated Care Organizations (CCOs). MCEs are responsible for coordinating, delivering, and reimbursing covered services in accordance with state and federal regulations and Oregon Health Plan (OHP) administrative rules.

- Notice of Adverse Benefit Determination (NOABD)
  A formal written notice issued to a member (or their representative) and provider, communicating a decision to reduce, suspend, deny, or terminate services that were requested or previously authorized.
- Notification of Continued Services
  A notification submitted for outpatient services that have already been rendered. Previously referred to as a "re-authorization."
- Notification of Treatment (NoT)
  A member-specific notification submitted through CareOregon Connect for services that do not require prior authorization. Although not clinically reviewed, these notifications are required for payment, reporting, and tracking purposes.
- Prior Authorization (PA)
  Advance approval or payment authorization for specific services before they are provided. A referral is not the same as a PA, and a PA does not function as a referral.
- Request for Additional Clinical Information
  A formal request from CareOregon Utilization Management staff for current, valid, and relevant clinical documentation related to a member's functioning. Providers must respond within three business days and include the member's clinical presentation, response to interventions, prognosis, and continued need for services to avoid denial.
- Single Case Agreement (SCA)
  A one-time agreement between CareOregon and a non-contracted provider to authorize services for a specific member.
- Telehealth
  The remote delivery of healthcare services using technology such as computers, tablets, or smartphones. Telehealth eliminates the need for in-person visits and may also be referred to as telemedicine.

Provider instructions

Member eligibility

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

Access

Jackson Care Connect members can directly access agencies and licensed independent practitioners within the provider network. Members may seek treatment by contacting contracted providers, receiving referrals from allied agencies, or reaching out to CareOregon Member Customer Service for assistance in finding and accessing a behavioral health provider that best meets their needs.

Providers must offer an intake assessment within two weeks of a member's request. If a provider cannot meet this timeframe, they are required to refer the member to another provider with available capacity or direct the member to CareOregon Member Customer Service for help in finding an alternative provider.

For Telehealth referrals, please refer to the guidelines for telephone and video visit appointments available on the CareOregon website.

Screening and emergent/urgent response

Urgent behavioral health treatment appointments should be scheduled within 24 hours. In urgent or emergent situations, appropriate services may include referral to local county crisis services or a hospital emergency department, as needed, to prevent injury or serious harm. If a provider is unable to schedule an appointment within 24 hours in an emergency situation, the provider must refer the member to the appropriate county crisis services or the nearest emergency department.

Routine behavioral health treatment appointments should be scheduled as follows:

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

Appointments must focus on therapeutic interventions rather than administrative tasks. Specialty behavioral health providers are responsible for ensuring members have timely access to covered specialty services. If providers are unable to meet these time frames, the member must be placed on a waitlist and offered interim services within 72 hours of being added to the waitlist. Interim services should closely align with the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135.

If care cannot be provided according to the time frames listed here, the provider must contact CareOregon Care Coordination services, which will help place the member in the appropriate care setting.

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

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

For individuals using intravenous drugs, an immediate assessment and intake are required. Admission must occur within 14 days of the request. If interim services are needed, admission must begin within 120 days from the date the individual is placed on a waitlist.

When placed on a waitlist, members must receive interim resources and information to reduce health risks and prevent disease transmission. This includes counseling, peer services, and educational materials on bloodborne pathogens and prevention. Pregnant individuals should be informed about the effects of substance use on the fetus and referred for prenatal care. Peer-delivered services should also support parenting and youth in transition.

For opioid use disorder and medication-assisted treatment, assessment and intake must take place within 72 hours.

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

Substance use disorders

When a provider receives a request for outpatient substance use services, they will offer an initial service appointment within seven calendar days. In urgent or emergent situations, the provider may refer the member to local county crisis services or a hospital emergency department, if necessary, to prevent injury or serious harm.

If the member chooses to seek services elsewhere due to wait times, the provider must provide referral information to other appropriate providers within CareOregon's network, including the provider's name, address or general location, and phone number. The provider will also inform the member on how to contact CareOregon Customer Service for additional support. For providers with a certificate of approval: As per OAR 309-019-0110 (2)(e), the provider's policies and procedures must prohibit the titration of medications prescribed for opioid dependence as a requirement for receiving or continuing treatment.

Behavioral health crisis intervention resources

Jackson County Mental Health, mental health crisis:
Phone: 541-774-8201

Lines for Life
Phone: 988

Mercy Flights, mobile crisis:
Monday - Friday, 8 a.m. to 5 p.m.
Phone: 541-774-8201

Submission of notifications of treatment and prior authorizations

Provider portal (Connect)
Providers can access member eligibility, prior authorizations, and claims/payment information through the CareOregon provider portal, known as Connect.

The portal streamlines key administrative tasks, allowing you to:

- Submit treatment authorization requests and treatment notifications
- Check detailed claim status and review remittance advices
- View authorizations and notifications at the line-item level
- Verify member eligibility, including PCP assignment, other insurance, and covered benefits
- Generate and print PCP rosters
- Search and validate ICD-10, CPT, HCPCS, revenue codes, and modifiers

Submitting requests
All requests should be submitted through the Connect portal. If you do not currently have portal access, please call CareOregon Provider Customer Service at 800-224-4840 (option 3) to request an exception form and receive assistance with obtaining access. While electronic submission is preferred, exceptions for fax submissions can be made upon request.

Authorization vs. notification

- Prior Authorization (PA): Required for certain services. Providers must include clinical documentation to support the medical necessity review.
- Treatment Notifications: Required for services that do not need prior authorization but must be recorded for payment, tracking, and reporting. These entries do not require clinical documentation or review and are usually auto-approved.

If there are any issues with your submission, CareOregon will contact you for clarification. Please note that self-entered authorizations must be submitted within 45 days from the start of services.

Determinations

CareOregon processes standard prior authorization requests within 14 calendar days from the request date and applies the same standards to both behavioral health services and medical/surgical benefits. If a covered condition poses an imminent risk to the member's life, health, or ability to function, an expedited prior authorization can be requested, with a decision made within 72 hours. Both standard and expedited requests can be extended by up to 14 calendar days, either upon request from the member or provider or if CareOregon deems additional time necessary for review in the member's best interest. Specific turnaround times may apply for certain levels of care according to OHP rules.

If a prior authorization request is approved, CareOregon will notify the requesting provider and provide the date for the next medical necessity review if applicable. If the request is denied, CareOregon will issue a Notice of Adverse Benefit Determination (NOABD) to both the member and the requesting provider. No prior authorization is required for urgent or emergent care.

Authorization denials, including partial or complete denials or reductions in service amounts, are made by an individual with the appropriate clinical expertise. For services that are ongoing but no longer meet coverage or medical appropriateness criteria, or are being terminated, suspended, or reduced, CareOregon will notify both the member and provider at least 10 calendar days before the action takes effect, in line with OAR 410-141-3885.

Denial letters will specify the requested service, reason for the denial, and the rule/criteria used in the decision, as well as instructions on how to obtain a copy of the criteria and how to appeal. If a known community resource is available for the denied service, the letter will provide information on how to contact CareOregon. Denial letters will be sent to both the member and requesting provider within two business days of the denial decision, with the effective date being the date of the letter.

OHP members needing alternate formats or languages for the denial letter will be directed to contact CareOregon's Customer Service. Additionally, the requesting provider will receive a notification of the denial, which will include the service requested (with codes) and the reason for the denial. Providers are responsible for informing members of their rights, including grievance, appeal, and contested case hearing procedures, as outlined in the Jackson Care Connect Member Handbook and CareOregon Provider Manual.

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 Jackson Care Connect members must be medically appropriate and medically necessary

Medical necessity

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

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

Medical appropriateness

Medically appropriate services are those services that are:

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

  and

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

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

OHP coverage and the Prioritized List

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Starting January 1, 2023, CareOregon covers the EPSDT services listed below the funding line on the Prioritized List of Health Services, provided they are medically necessary and appropriate. The EPSDT benefit ensures comprehensive and preventive healthcare for Medicaid members under 21. All services will be reviewed, regardless of their placement on the list, pairing, or quantity limits. Prior authorization requests should continue to follow CareOregon's established process. Please be aware that not all requests for members under 21 will meet the criteria for EPSDT services. Medical necessity and appropriateness will be assessed on a case-by-case basis.

Additional information may be found at:

- EPSDT OHA site: https://www.oregon.gov/oha/hsd/ohp/pages/epsdt.aspx
- EPSDT CareOregon site: https://www.careoregon.org/providers/support/provider-updates/2023/03/02/early-and-periodic-screening-diagnostic-and-treatment-(epsdt)-coverage-expanded-effective-1-1-23

Prior authorizations

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

Only services that are medically necessary, appropriate, and for which the required documentation has been supplied will be considered. CareOregon may request additional clinical information to determine medical necessity and appropriateness.

Requesting a prior authorization

If the provider completes an assessment and believes that 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, and that the services are medically necessary and medically appropriate. Required elements of a request for initial and ongoing services are as follows:

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

Requesting secondary authorization

An authorization request is not required when CareOregon is the secondary health plan, unless:

- The primary health plan does not cover the requested service.
- The primary health plan has denied payment of part or all of the requested service.

If any of the above applies, an authorization request must be submitted to CareOregon. If there is a primary carrier, such as Medicare or private insurance, or third-party resource, such as worker's compensation, and CareOregon is the secondary payor, submit that carrier's Explanation of Benefits (EOB) with the claim when the EOB is received.

Provider TBD

We understand that in some cases, it may be most beneficial for a member's current provider to submit a prior authorization request, as they have the most up-to-date and comprehensive information. In these instances, we allow the submission of requests with "TBD Behavioral Health Provider" listed as the delivering or rendering provider. However, it's important to note that the submission and approval of a prior authorization does not serve as a referral to a provider. Coordination with the delivering provider is necessary to initiate treatment.

Submissions must include clinical documentation to support the medical necessity determination. If the request is approved, CareOregon's UM staff will notify the referring provider of the approval and instruct them to coordinate with the delivering provider. Once the referring provider has coordinated with the delivering provider, they must contact the CareOregon UM Team at 503-416-3404 to update the authorization once a delivering provider has been identified.

A provider may submit a request using "Provider TBD" for the following levels of care:

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

The following service types must be requested directly by the delivering provider, once they have determined the service is appropriate:

- Eating Disorder Residential
- Eating Disorder Partial Hospital and Intensive Outpatient
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)

Dual authorizations

Prior authorizations are not required for outpatient services. If multiple providers enroll and submit outpatient claims for the same member during the same time period, this will not be considered a dual authorization. However, all services must still meet the medical necessity and documentation requirements as outlined by Oregon Administrative Rules and Medicaid. The member's clinical documentation should clearly show the need for additional services, the benefits these services provide, and the rationale for involving a second provider, including their specialization. This applies throughout the treatment episode or in support of transitions and continuity of care.

When multiple providers are involved in a member's care, regular collaboration and communication are expected to ensure coordinated care. This may involve sharing service plans, conducting joint sessions, making phone calls, and/or holding team meetings.

Services requiring prior authorization

Service types /Level of care	Initial authorization length	Continued stay length	Utilization management turnaround time	Decision-making criteria
Applied behavioral analysis (ABA)	Dates and units entered per provider request/clinical need	Dates and units entered per provider request/clinical need	14 calendar days	InterQual
Eating disorder- residential treatment	30 days	30 days	3 calendar days	InterQual
Eating disorder- partial hospitalization	30 days	30 days	14 calendar days	InterQual
Eating disorder – intensive outpatient	14 days	14 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	Prioritized List/Guideline Note 102

Criteria for review

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

InterQual

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

Regional practice guidelines

Most services that require a prior authorization use InterQual to determine medical necessity. The services below do not use InterQual and instead use CareOregon practice guidelines that are developed from scientific evidence or a consensus of healthcare professionals.

Applied Behavior Analysis (ABA)

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

Diagnostic guidelines and tools

Authorization of ABA services is typically related to a diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder by an MD, DO, PhD, or PsyD. Other diagnoses may be considered for ABA services based upon clinical need for members under the age of 21. Jackson Care Connect accepts diagnoses of Autism Spectrum Disorder and/or Stereotypic Movement Disorder per the following standardized diagnostic measures:

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

Authorization

ABA treatment authorization:

ABA treatment authorization requests should be submitted via Connect. The servicing provider must submit clinical documentation along with a documented diagnosis to be treated by the proposed ABA services. Typically, Autism Spectrum Disorder or Stereotypic Movement Disorder are most commonly serviced by ABA, although other diagnoses may be considered for those 21 years of age or younger.

Clinical documentation should also include a treatment plan with the following information:

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

Any authorization requests for members who are the age of 18 or older will require secondary review with a CareOregon Medical Director. Requests should be submitted with units for the entire six month authorization. These should be broken down by number of units of each CPT code and the number of units total. See example:

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

Psychological testing

Service description

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

Psychological Testing is not intended to be a first line of evaluation. Testing may be appropriate when a qualified mental health professional has assessed the member and is not able to accurately diagnose and treat them due to clinical complexity. It is recommended that the member be assessed and referred by a Licensed Medical Professional (e.g., psychiatrist or mental health nurse practitioner).

Clinical criteria

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

- Specific clinical questions that testing would be expected to answer
- Reason that the clinical questions cannot be answered by a Qualified Mental Health Professional or Licensed Medical Professional (e.g., psychiatrist or mental health nurse practitioner)
- Documentation of what actions will be taken or how the treatment plan will be amended by the test results
- Exclusion criteria for authorization under OHP
- All services must be both medically appropriate and necessary. Testing is not covered when one or more of the following is true:
- Testing is for educational (IEP/Learning Disorders), vocational or legal purposes (including court ordered testing)
- Testing is to assist in determining eligibility for any kind of services (e.g., vocational rehab, disability, IEP, etc.)
- Testing is conducted as a screening tool or part of an initial evaluation
- Testing is requested by member for personal interest

Behavioral health vs. physical health:
Per CareOregon policy, authorization requests should be submitted under Jackson Care Connect member's physical health benefit if any of the following is true:

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

Authorization:
Additional prior authorization is required if the psychologist will exceed the number of hours previously authorized. This will only be approved when exceptional circumstances justify the necessity of additional hours of testing.

Transcranial Magnetic Stimulation (TMS)

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

Requests for ongoing treatment authorizations

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

Retroactive authorization determinations

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

Single case agreements (SCA)

CareOregon may authorize services to non-contracted providers when medically necessary or to maintain continuity of care. This is particularly applicable if the member has been receiving ongoing services from that provider and there is no available contracted provider who can deliver the same service to the member. Unless otherwise stated in a Single Case Agreement (SCA), the provider will be reimbursed at 100% of the State Fee for Service rate or 100% of CMS rates for Medicare Advantage members. SCAs will only be reviewed for approval if a prior authorization has been granted, where applicable.

An SCA is not necessary to receive payment at non-contracted rates. To request an SCA for a member-specific need, the provider should indicate this on the authorization request form. If the service is approved, our Behavioral Health Utilization Management Team will forward the SCA request to CareOregon's Contracting Team to begin the SCA process. For more information on billing out of network, please refer to the Provider Guide to Billing Out-of-Network.

General outpatient services

Connect Submissions and Program Enrollment Notifications
General outpatient behavioral health (BH) services do not require a referral or prior authorization. Members may self-refer for BH assessments and evaluations, helping reduce administrative burden and improve timely access to care.

However, certain services do require a notification from the delivering provider. These notifications are essential for payment, reporting, and tracking, and must be submitted through CareOregon Connect as outlined in the section, "Submission of Notifications of Treatment and Prior Authorizations."

Need Help Determining Notification Requirements?
If you're unsure whether a notification is required for a specific service, refer to the Jackson Care Connect Behavioral Health Fee Schedule or contact Provider Customer Service at 800-224-4840 (option 3).

Substance use disorder (SUD) services

Substance use disorder (SUD) treatment services are a covered benefit for Jackson Care Connect members. The process for requests and notifications for SUD services follows the same procedures as all other service types, as outlined previously. All SUD services begin with an American Society of Addiction Medicine (ASAM) six-dimension assessment, conducted by a credentialed SUD clinician or provider, which results in a level of care recommendation.

Once a decision is made to enroll a Jackson Care Connect member in a level of care based on the assessment, SUD providers must submit a program enrollment notification through the CareOregon Connect portal. CareOregon will process the request within 2 business days, and the requesting provider can view updates to the authorization status in Connect. Providers without Connect access

can request status updates by contacting Provider Services at 503-416-4100, or they may request a fax template for submission if Connect is unavailable.

Medication-assisted services

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

Acute psychiatric inpatient requests

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

By its emergency services policy, CareOregon:

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

Eligibility is not determined until after admission

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

Authorization process

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

CareOregon's Behavioral Health UM Team is available as follows:

Contact information	
Initial and concurrent authorizations	Phone: 503-416-3404 | Fax: 503-416-4720 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

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

Emergency services

Requests for continued inpatient stay authorizations

For facilities where remote EHR access is available, CareOregon UM staff will enter the record on the day of concurrent review and perform the review. Hospital Utilization Review (UR) will notify CareOregon if the member is discharging prior to the scheduled day.

For facilities without remote EHR access, hospital UR will fax updated clinical information in legible written format to CareOregon UM.

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

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

Discharge procedures

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

Hospitals that do not provide EHR access will notify CareOregon within 24 hours of discharge. Hospitals providing data via EHR access do not need to provide discharge notification; CareOregon may request additional information in the case of pending or tentative discharges.

Medical unit transfers

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

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

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

Institution for mental diseases (IMDs)

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

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

Referrals to long-term psychiatric care (LTPC)

When long-term psychiatric care (such as placement at the Oregon State Hospital) is indicated, referrals are typically initiated by the inpatient social work team at the treating hospital. The completed referral packet is submitted to **Jackson Care Connect's (JCC) Regional Care Team** and the **Behavioral Health Utilization Management (UM) Team**. JCC reviews the packet, makes a preliminary determination, and forwards the documentation to **Jackson County Mental Health's ENCC team** for final approval and submission to the **Oregon Health Authority (OHA)**.

Payment Responsibility
Adults: CareOregon remains responsible for payment of acute care services until discharge.
Children and youth: OHA assumes financial responsibility for acute care beginning on **day 8** of hospitalization.

Pre-Referral Requirements
Before referring a member for State Hospital admission, the following must be completed:

- A **comprehensive medical assessment** to identify any physical health conditions that may be contributing to or exacerbating behavioral health symptoms.
- **Medical treatment and stabilization** of any identified conditions by a qualified provider.
- **Acute psychiatric treatment** consistent with the latest version of the *American Psychiatric Association Practice Guidelines*.

Additionally, there must be documentation of:

- Attempts at **evidence-based or promising psychosocial interventions**, delivered in a **culturally competent**, **strengths-based**, **person-centered**, and **trauma-informed** manner.
- Inclusion of the member's **family, support network**, and **peer-delivered services**, unless the member declines participation.
- **Ongoing collaboration** between hospital staff, Care Coordinators, and CareOregon to explore alternatives to hospitalization and develop a discharge plan.
- Efforts by the Care Coordinator to **divert from hospitalization** through community-based services.
- A determination that the member meets **LTPC criteria per OAR 309-091-0015**, including:
- Lack of improvement in an acute setting as evidenced by the individual's mental health condition has not improved despite receiving at least seven days of appropriate psychiatric

treatment, including medication at adequate dosages, in an acute care setting
- A clinical need for **intensive psychiatric rehabilitation**, **tertiary treatment**, or **specialized medication adjustment** in a secure or highly supervised environment as evidenced by the individual continuing to require intensive psychiatric care that cannot be safely or effectively provided in a less restrictive environment.

LTPC Referral Submission

To initiate an LTPC referral, the responsible party must submit the following documentation:

- **Request for OSH and PAITS Services form**
- **Community Questionnaire**, including a proposed OSH discharge plan
- **Member demographic information**
- **Civil commitment documents**, such as the Commitment Judgment/Order, pre-commitment investigation, guardianship orders, or healthcare representative forms
- **History and physical** and **psychosocial assessment**, if available
- **Progress notes**, **medication administration records**, lab results, and any relevant diagnostic testing
- **Involuntary Administration of Significant Procedures documentation**, if applicable

Review Process

Once received, the referral is reviewed by **CareOregon Utilization Management** staff. If approved, the determination is shared with the responsible party, **Jackson County Mental Health**, and **JCC's Regional Care Team**.

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

careoregon.org
JCC-25954200-0610

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