Multnomah Mental Health Provider Manual Outpatient Mental Health Services

Updated April 29, 2015

Contents

Overview

Welcome to the Multnomah Mental Health network of providers. This manual is referenced in provider contracts and includes guidelines on doing business with Multnomah Mental Health.

Together the provider contract, contract exhibits, contract attachments and this manual outline the requirements and procedures applicable to the participating providers in the Multnomah Mental Health network.

The Provider Manual is located at the County website: http://web.multco.us/mhas/mental-health.

In case of a discrepancy between the Provider Manual and the terms of a provider contract, the Contract shall prevail. County will notify Contractor by email of changes to the Provider Manual. Forms referenced in this manual or in the provider contracts are available for download or printing and specific links are located within the manual. Providers should access and download the most up-to-date information from the website at the time needed.

Contact Information

Adult Mental Health Initiative (AMHI)	General inquiries please email **multcoamhi@multc.us**
Adult Protective Services	Potential Abuse Allegations and requests for consultation: Phone : 503-988-8170. Email: aps-screening@multco.us
Appeals upon receipt of Notice of Action or claim denial	Appeals and Complaints Coordinator Fax: 503-988-4015
Authorizations (services requiring pre-authorization and Treatment Authorization Request Form)	Current Treatment Authorization Request (TAR) forms are located at: https://multco.us/mhas/mental-health-provider-documents-resources Completed TARs should be securely emailed to urteam@multco.us or faxed to 503-988-3137
Changing your Provider Profile (e.g. Name, Address)	To change or update your Provider Profile (e.g. name, address) the preferred method is to submit by fax at the following address: 503-988-5870
Claims	For general claims inquiries email billingsupport@multco.us
Complaints and Grievances	Contact Appeals and Complaints Coordinator 503-988-9971
Confidentiality / HIPAA	Privacy and Security incidents involving Member Information must be immediately reported to

Contract Inquiries	MMH Contract Specialist carol.a.snyder@multco.us
Fraud and Abuse Reports	Compliance Coordinator kristine.britton@multco.us
Integrated Service Array Intake Coordinator	Phone: 503-988-4161 Fax: 503-988-3328
Multnomah Mental Health Member Services	Any Multnomah Mental Health Member wishing to speak with plan representatives reach member services at 503-988-5887, twenty-four hours per day and seven days per week.
PhTech Provider Relations	Contact provider relations at 1-800-478-2818 to be connected to the appropriate claims or other representative at PhTech. CIM Users can use the CIM Provider Services link off the main CIM menu located at:
PhTech Provider Instruction Manuals	Instruction manuals for using PhTech's web based authorization and claims system is located at: https://phtech.zendesk.com/home
Utilization Review	General inquiries email **urteam@multco.us**

I. About Multnomah County Mental Health and Addiction Services

Values and Principles

Multnomah County Mental Health and Addiction Services Division (MHASD) is committed to providing evidence-based services that endorse a recovery philosophy and are integrated within a system of care. Our core values include consumer choice, prevention and early intervention, and responsibly managing a full system of care for vulnerable citizens of Multnomah County.

We value community input to MHASD strategic plans and services that are being provided. There are multiple examples of putting this value into action:

- System Supports the Individual: The Mental Health system is organized to support and encourage each individual receiving service to achieve his or her full potential.
- Accessible: Individuals and families are able to access services easily, including a competent diagnosis, an appropriate and affordable menu of care, and prompt response to crises.
- Individualized: An individual's needs, goals, and preferences dictate the services provided.

- Seamless services from multiple programs and agencies are coordinated or integrated to better serve individuals and ensure that individuals can navigate through the system.
- Child and Family Focused: For children, services are child-centered and family focused; services support and strengthen the family system and will be guided by the best interests of the child or adolescent.
- Recovery Oriented: Services are recovery-oriented with a focus on developing natural systems of support and self-determination.
- Age, Linguistic and Culturally Competent: Staff of all programs are sensitive and responsive to the elements of individual's identities, including age, ethnicity, race, language, religion, gender, sexual orientation, disability, and culture.

Consumer and Family Involvement

Consumer and family involvement in all aspects of the provision of mental health services is an essential core value of mental health services in Multnomah County. A recovery-oriented system of care requires that consumers and families be involved not only in treatment planning but also in the development of policy, program planning, service delivery, and evaluation of services. Consumers and family members are invited to join the Adult Mental Health and Substance Abuse Advisory Council (insert AMHSAAC link from new website) or the Children's Mental Health System Advisory Council (insert CMHSAC link from new website). These councils meet monthly to ensure that consumers and their families can provide input about the mental health and addiction services available in their county.

Multnomah County is committed to the values of consumer and family involvement and consumer empowerment in development of a recovery-oriented, community based system of mental health services. Consumer and family involvement technical assistance and education are available to all contracted provider organizations through Provider Meetings, and phone consultation with the Quality Management Coordinator.

Health Care Transformation

Oregon's Coordinated Care Organization model design grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Mental health, substance abuse, oral health, and long term care services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's population.

Oregon's vision is to create a health system in which:

- The health of all Oregonians is improved;
- Physical health, behavioral health and oral health are integrated and coordinated;

- Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;
- The system prioritizes prevention, wellness, and the community-based management of chronic conditions, keeping individuals healthy rather than only caring for them when they are sick;
- Individuals, providers, community leaders, and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable;
- Quality and consistency of care is improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;
- Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve overall population health;
- The health care workforce is strengthened and prepared for team-based, community oriented
- Coordinated care; and Electronic health information is available when and where it is needed to improve health and health care through a secure, private health information exchange.

Multnomah County MHASD is committed to successfully help change the system to meet these goals. We must simultaneously commit to address the Triple Aim™ (to increase population health, enhance patient experience/ quality, and control costs) for people living with serious mental illness in our community. The historical separation of the behavioral health system from physical health presents multiple barriers to service integration. Physical healthcare is a core component of basic services to persons with serious mental illness, and integration of primary care and behavioral health services is indisputably vital for achieving these goals.

II. Multnomah Mental Health

Multnomah Mental Health joined the Tri-County Medicaid Collaborative (now Health Share of Oregon) in pursuit of health transformation. On April 30, 2012, a group of public and private organizations and health plans applied to the Oregon Health Authority to become a unified, regional system of care for the metro area's 212,000 Medicaid eligible residents of Clackamas, Multnomah and Washington counties. In addition to Multnomah County, sponsors include Washington and Clackamas Counties, Oregon, Providence, Legacy Health, Kaiser Permanente, Metro-area Community Health Centers, the Oregon Medical Association, Oregon Nurses Association, Oregon Health & Science University, Tuality Healthcare and Adventist Health. Before joining Health Share of Oregon, Multnomah Mental Health and Addiction Services Division operated the managed mental health plan known as Verity.

Contracting with Multnomah Mental Health

Participating Network Providers

All in-network providers are required to respond to a Multnomah County Request for Programmatic Qualifications (RFPQ). Successful submission and acceptance of an RFPQ does not guarantee a contract for services will be issued. Information regarding contracting opportunities is available on Multnomah County's web page: https://multco.us/purchasing/bids-proposal-opportunities

Network providers are also required to have a Certificate of Approval to Provide Mental Health Services within Multnomah County. The certification process has recently changed. Existing providers will be recertified by Multnomah County Quality Management MHASD. New providers should contact the Quality Assurance and Certification Manager from the State of Oregon Addiction and Mental Health Division.

Non-Participating Providers

Multnomah Mental Health issues limited contracts with providers outside of the regular network (Non-Participating Providers) under the following conditions:

The maximum contract amount is $10,000 during the any one fiscal year (July 1, 20XX through June 30, 20XX). The contract maximum applies to individual single providers and multi-provider clinics and agencies.

Non-participating providers are accepted based on the service needs of the existing network. Special skills or experience not found in the network are two possible factors for Non-Participating provider acceptance. The need for increased capacity beyond the network's ability to deliver appropriate and timely services is third possibility.

Credentialing and Contracting Requirements for Non-Participating Providers.

The credentialing of out-of-network providers is on a case by case basis and is determined by the need of the County. Credentialing procedures and timelines will vary. Refer to the local County for these details. Upon management confirmation that the practitioner can offer a needed specialty, The County staff will request the practitioner to complete a full credentialing packet. This packet includes:

a. Oregon Practitioner Credentialing Application

b. Oregon DHS Criminal History Request form

Credentialing decisions shall be based on the needs of the requesting County member and/or the needs of the contracted network as a whole. The credentialing process and decision shall not be based solely on an applicant's race, ethnicity, identity, gender, age, sexual orientation or the type of service or patient in which the practitioner specializes. The County prohibits discrimination of any kind against out

of network individual practitioners and organizational Providers during the credentialing process, either by the County staff or delegated organizational entities.

Required Documentation and Verification

1. Upon receipt of a completed credentialing packet, The County staff shall verify the following:

    a. Content of Oregon Practitioner Credentialing Application

    b. Professional Liability Insurance - $1m/$3million minimum requirement

2. The County Conducted Background Checks

    a. Criminal records check though the Background Check Unit (BCU) of the Department of Human Services

    b. Office of the Inspector General (OIG) federal exclusion list

    c. System for Award Management (SAM) federal exclusion list

3. The County Conducted Credential Verification

    a. National Practitioner Databank,

    b. Primary source verification of degree(s) (e.g.. National Student Clearinghouse)

    c. Primary source verification of University/College Accreditation

    d. Primary source verification of license(s)/board certification(s)

    e. Primary source verification of DEA license, as applicable;

Contracted Individual Practitioner Notifications and Appeal Rights

1. Practitioner Rights

Contracted individual practitioners have the right to:

    a. Receive a copy of a policy and procedure to be informed of their rights and limitations during the credentialing process.

    b. Receive the status of their credentialing application. Practitioners should contact the County credentialing staff by telephone or in writing for this information. The County may choose what specific information is shared from the credentialing file.

c. Review information submitted/received to support their credentialing application. Practitioners should contact the County credentialing staff by telephone or in writing for this information. The County may choose what specific information is shared from the credentialing file.

d. Correct erroneous information; corrections/supplemental information must be provided to the County credentialing staff within fourteen (14) calendar days of notification to the practitioner.

e. Be informed when credentialing information received from other sources varies substantially from that provided by the practitioner. Corrections/supplemental information must be provided to the County credentialing staff within fourteen (14) calendar days of notification to the practitioner.

2. Notification of Credentialing Decisions

The practitioner is notified in writing of the following within seven (7) calendar days of the date of the decision:

a. A summary of the credentialing / re-credentialing/review process;

b. The date of the credentialing decision;

c. The credentialing decision/action;

d. A summary of the practitioner's rights to appeal.

III. Provider General Compliance Requirements

Quality Management Reviews and Oversight

Certificate of Approval Review and Oversight by MHASD / Tri-County Regional Review Team

As a function of the Multnomah County, Mental Health and Addiction Services Division (MHASD) representing the Community Mental Health Program (CMHP), the Quality Management Program provides oversight and makes recommendations to the State Addictions and Mental Health Division (AMH) regarding the renewal of Certificates of Approval held by Community Mental Health Agencies (Agency). Certification governs a variety of types of outpatient mental health services provided to a variety of different Medicaid populations as outlined within OAR 309-012-0130 through 309-012-0220. The oversight processes utilizes a standardized Tri-County regional review process and may include Tri-County regional team members.

Encounter Validation and Compliance Reviews

As part of the contract compliance review process and regular fraud waste and abuse monitoring, Health Share Mental Health RAE's complete regular encounter audit reviews with sub-contracted provider organizations and with individual practitioners as deemed necessary or appropriate to verify that covered services:

- Are provided within the scope of license or credential of the service practitioner and within the scope of the provider's contracted services
- Are billed in accordance with Medicaid standards in relationship to clinical documentation
- Are accompanied by required corresponding clinical documentation (e.g. assessment, service plan, etc.) according to Medicaid Rule and Oregon Administrative Rules

Provider Requirements

After receiving notification of MHASD or Tri-County Regional Review team's intent to conduct a Certificate of Approval and/or Compliance review:

I. Submit all required desk audit materials requested by the reviewers.
II. Coordinate site visit with reviewers and provide access to requested records, personnel files and arrange for any requested staff to participate in interviews.
III. Follow up on any required actions identified in review report(s).

Clackamas, Multnomah and Washington County's refund strategy is being implemented immediately for payments that have been paid in error or incorrectly resulting in a refund request.
Currently, Ph Tech, as the Third Party Administrator for all 3 counties sends refund requests and does so up to three times if a refund is not received. Effective immediately, after the third request Ph Tech will implement the "Punch Credit". This means that any future payments to your organization will be reduced by the refund amount until paid in full.
We strongly encourage providers to process refund request as early as possible to ensure funds are correctly assigned to agency programs and funding sources. A punch credit will only be initiated when a provider does not respond to refund requests.

Critical Incident Reporting

A 'critical incident' is an unexpected occurrence occurring on the premises of a program, involving program staff, and/or an service plan activity which results in: death or serious physical or psychological

injury, or the risk thereof; or clear and present risk to public safety; major illness; accident; act of physical aggression; medication error; suspected abuse or neglect; or any other unusual incident that presents a risk to health and safety.

Critical incidents should be reported, if determined by the sub-contracted provider, to be a direct result of mental health/service plan prescribed treatment or mental health issue.

Abuse Reporting and Protective Services

It is the responsibility of all subcontracted mental health providers to report all instances of suspected neglect or abuse of a child or an adult with mental illness.

Reporting Suspected Abuse of a Child

All MHASD subcontracted providers must establish and follow their own agency-specific policies and procedures for reporting any suspected abuse of children, as defined within ORS 419B.005 to 419B.50, compliant with OAR 407-045-0260 (13) and OAR 407-045-290 (2). In addition with ensuring compliance with the rules and statutes listed above, agency policies and procedures must include the immediate reporting of any suspected abuse of a child to the State of Oregon DHS Child Welfare Child Abuse Hotline at (503) 731-3100.

Reporting Suspected Abuse of an Adult with Mental Illness

All MHASD subcontracted providers must establish and follow their own agency-specific policies and procedures for reporting any suspected abuse of adults with a mental illness (who are currently enrolled in mental health services), as defined within OAR 943-045-0260 (3) and OAR 943-045-0260 (1), compliant with OAR 943-045-0260 (14) and OAR 407-045-0290 (2). In addition with ensuring compliance with the rules and statutes listed above, agency policies and procedures must include the reporting of any suspected abuse of an adult with a mental illness as soon as possible to Multnomah County Mental Health and Addictions Services, Lead Adult Protective Services Investigator at (503) 988-8170.

Reporting the Death of a Client Receiving Services

Upon becoming aware of the death of an adult client in mental health services, MHASD contracted providers shall report the death to Multnomah County Mental Health and Addictions Services Division, Lead Adult Protective Services Investigator at (503) 988-8170. The State of Oregon Addictions and Mental Health Division requires Multnomah County MHASD Adult Protective Service Investigators to investigate any death of a client receiving mental health services.

Confidentiality

MHASD contracted providers acknowledge that they are a “covered entity” for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA). Provider shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with HIPAA.

Providers will adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws. Security incidents involving Member Information must be immediately reported to the Privacy Officer.

Situations in which Health Share Multnomah Mental Health staff and staff of provider agencies are legally required to share information include:

- Reporting to Child Protective Services or law enforcement agency when there is a reason to suspect the abuse or neglect of a child.
- Reporting to law enforcement officers and the intended victim when there is a clear and serious threat of homicide or intent to do serious bodily harm to another person.
- Reporting abuse of an elderly person or a person with a mental illness or developmental disability to the appropriate agency.
- Reporting imminent risk of suicidal behavior to the appropriate caretaker.
- Responding to a doctor or the hospital in the event of a medical emergency.
- Responding to a court order requiring the release of a client's records

Privacy Practices

All MHASD sub-contractors are required to have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC ¦ 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the Coordinated Care Services received by the Members. Such policies and procedures must ensure that records are secured, safeguarded and stored in accordance with applicable ORS 413-171; ORS 414.679; SB 1580, Section 16; OAR 410-120-1360; OAR 943-014-0300 through 943-014-0320; and OAR 943-120-0000 through 943-120-0200.

Clients must have access to the client's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member can share the information with others involved in the client's care and make better healthcare and lifestyle choices.

Provider 's may use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the covered entity for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements.

Providers shall retain Clinical Records for seven years after the Date of Services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, providers shall retain the Clinical Records until all issues arising out of the action are resolved.

A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/Forms/Served/me2090.pdf, or may be obtained from OHA.

Provider Requirements

Policies and procedures related to confidentiality including:

I. Privacy Practices
   - A. Distribution and acknowledgment of NOPP receipt
   - B. Uses and Disclosure of information
   - C. Maintenance of records
   - D. Client access to records
   - E. Retention of records
     1. Adult - 7 year period
     2. Child - up to age of 21 or seven years from date of last service whichever is longer

II. EPHI practices
   - A. Periodic security updates
   - B. Protection from malicious software

C. Login monitoring
D. Password management
E. Data backup plan
F. Disaster recovery plan
G. Facility access controls
H. Employee sanction for failure to comply

III. Must post Copy of Notice of Privacy Practices information in common area of the clinic where it can be easily viewed by clients
IV. Copy of NOPP must be available at site, for members, if requested
V. Copy of Notice of Privacy Practices must be given to a client no later than the date of treatment

Client Rights and Responsibilities

All clients who receive mental health services (including clients served under the jurisdiction of the Psychiatric Security Review Board and clients served under any county funded mental health services) shall be informed of client rights and responsibilities at the initiation of mental health services, in accordance with OAR 309-019-0115.

For Medicaid enrollees

The rights and responsibilities brochure and posters shall be a combined list of rights outlined within the OARs listed above, as well as, the rights outlined in OAR 410-141-0320. They shall be updated within 60 days of any revision to all applicable OARs. Client rights and responsibilities posters are available from Multnomah Mental Health upon request and posed on the MHASD website. (These rights posters are inclusive of rights and responsibilities for Medicaid enrollees)

Provider Requirements

I. Policy and Procedures related to Client Rights and responsibilities including:
   A. Process in which rights and responsibilities are communicated to the client
   B. Method to monitor client rights and responsibilities
   C. Assurance that employees, contractors and affiliates consistently follow all laws pertaining to client rights and responsibilities
II. Documentation of Rights must be inclusive of those listed in Health Share Member Handbook (for Medicaid recipients)
III. A copy of client rights and responsibilities must be given to clients prior to receiving services

IV. Must post Client Rights and Responsibilities information in common area of the clinic where it can be easily viewed by clients

Third Party Liability and Recovery

All sub- contracted providers shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services provided during the contract year. "Third Party Liability" means any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a Member.

Provider shall develop and implement written policies describing its procedures for Third Party Liability recovery consistent with Third Party Liability recovery requirements in 42 USC 1396a(a)(25), 42 CFR 433 Subpart D, OAR 461-195- 0301 to 461-195-0350, OAR 410-141-3080 and ORS 416-510 to 416-610.

Providers shall maintain records of any actions related to Third Party Liability recovery.

Provider Requirements

I. Process for recovery
   A. Establishing a threshold to determine when it is not cost effective to pursue recovery
   B. Assurance that there be no discrimination against clients based on third party recovery potential
   C. Assurance that Medicare/Medicaid payment be reimbursed to payer for any paid services if third party payment is recovered
   D. Assurance that Medicaid is payer of last resort; provider will employ staff who have

Staff Credentialing, Personnel Records, and Orientation Training

All sub-contracted providers are required to have written policies and procedures for collecting evidence of credentials, evaluating the credentials, conducting primary source verification, reporting credential information and re-credentialing employees Covered Services, consistent with PPACA Section 6402, 42 CFR 438.214, 42 CFR 455.400-455.470, OAR 410-141-3120.

Licensed Medical Practitioners

Must meet the following qualifications:

- Physician licensed to practice in the State of Oregon; or
- Nurse practitioner licensed to practice in the State of Oregon; or
- Physician's Assistant licensed to practice in the State of Oregon; and
- Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.
- For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

Clinical supervisors

Must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting.

In addition, they must meet the following competencies: leadership, wellness, oversight and evaluation of services, staff development, service planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies.

QMHP's

Must meet the following minimum qualifications:

- Bachelor's degree in nursing and licensed by the State or Oregon;
- Bachelor's degree in occupational therapy and licensed by the State of Oregon;
- Graduate degree in psychology;
- Graduate degree in social work;
- Graduate degree in recreational, art, or music therapy; or
- Graduate degree in a behavioral science field.
- A qualified Mental Health Intern, as defined in 309-019-0105 (61).

In addition, they must demonstrate the following competencies: the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a five-axis DSM diagnosis, write and supervise the implementation of a Service Plan and provide individual, family or group therapy within the scope of their training.

QMHAs

Must meet the following minimum qualifications:

- Bachelor's degree in a behavioral sciences field; or
- A combination of at least three years of relevant work, education, training or experience.

In addition, they must meet the following competencies: the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in a Service Plan.

Peer Support Specialists

Must meet the following minimum qualifications:

- A self-identified person currently or formerly receiving mental health services; or
- A self-identified person in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs;
- A self-identified person in recovery from problem gambling; or
- A family member of an individual who is a current or former recipient of addictions or mental health services

In addition, they must:

- Successfully complete all required training offered by a training program for peer support specialist; or
- Be certified by an entity whose qualifications for the certificate includes completion of an Authority approved training program for peer support specialists and a minimum of 20 hours of continuing education every three years.
- Individuals who have worked or volunteered in the capacity of a peer support specialist in the state of Oregon at least 2000 hours from January 1, 2004 to June 30, 2014 but have not completed a training program are eligible for certification if they successfully complete an approved incumbent worker training.

Mental Health Intern

Must meet the following qualifications:

- Be currently enrolled in a graduate program for a master's degree in psychology, social work or in a behavioral science field;

- Have a collaborative educational agreement with the CMHP, or other provider, and the graduate program;
- Work within the scope of his/her practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by provider; and
- Receive, at minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.

Personnel Record Content Requirements

All subcontracted providers are required to maintain up-to-date personnel records for :

- Employees in compliance with the requirements described within 309-019-0130 (1)
- Contractors, student interns or volunteers in compliance with the requirements described within 309-019-0130 (2)

Orientation Training Requirements

The program must document appropriate orientation training for each program staff, or person providing services, within 30 days of the hire date. At minimum, orientation training for all program staff must include, but not be limited to,

- A review of crisis prevention and response procedures;
- A review of emergency evacuation procedures;
- A review of program policies and procedures;
- A review of rights for individuals receiving services and supports;
- Mandatory abuse reporting procedures;
- HIPAA, and Fraud, Waste and Abuse; and
- For Enhanced Care Services, positive behavior support training.

Provider Requirements

I. Policies and procedures related to staff credentialing and re-credentialing
II. Providers must maintain evidence of the following completed at the time of hire:
    a. Verification of a criminal record check consistent with OAR 943-007
    b. Primary source verification confirming degree from accredited college and/or licensure
    c. Appropriate exclusion list check

    Ongoing personnel records for each program staff must contain all of the following documentation:
    a. Verification of a criminal record check consistent with OAR 943-007;

b. A current job description that includes applicable competencies;
c. Documentation of verification of applicable competencies
d. Copies of relevant licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications;
e. Periodic performance appraisals;
f. Staff orientation training documentation; and
g. Disciplinary documentation.

III. Providers utilizing contractors, interns or volunteers must maintain the following documentation, as applicable:
a. A contract or written agreement;
b. A signed confidentiality agreement;
c. Orientation documentation; and
d. Verification of a criminal records check consistent with OAR 943-007.

Fraud, Waste, and Abuse

All sub- contracted providers are required to have fraud and Abuse policies and procedures, and a mandatory compliance plan, in accordance with OAR 410-120-1510, 42 CFR 433.116, 42 CFR 438.214, 438.600 to 438.610, 438.808, 42 CFR 455.20, 455.104 through 455.106 and 42 CFR 1002.3, which enable the Provider to prevent and detect fraud and Abuse activities. Fraud and Abuse policies must be reviewed annually. The providers' policies must include compliance with all federal and State laws and encompass controls in areas such as Claims, prior authorization, service verification, utilization management and quality review, Member Grievance and Appeal resolution, Participating Provider credentialing and contracting, Participating Provider and staff education, and Corrective Action Plans to prevent potential fraud and Abuse activities.

Effective System for Routine Monitoring and Identification of Fraud, Waste and Abuse

The best way for providers to reduce risk of fraud and Abuse is to maintain a robust process for monitoring claims. MHASD can provide technical assistance regarding frequency and minimum content for internal agency billing accuracy audits.

Monthly Exclusion List Checking

Providers shall perform monthly exclusion list checks of all employees, contractors, volunteers, interns and any other persons providing, arranging, or paying for mental health services paid in whole or in part with Medicaid dollars, against the OIG List of Excluded Individuals/Entities (LEIE) and the SAM/EPLS database. Provider will maintain monthly verification of this check.

Reporting

Providers will promptly (within 5 days) refer all verified and/or suspected cases of fraud and abuse, including fraud by their employees and subcontractors to the Medicaid Fraud Control Unit (MFCU) and to County. Provider may also refer cases of suspected fraud and abuse to the MFCU or to the DHS Provider Audit Unit prior to verification.

- **Medicaid Fraud Control Unit of Oregon**
  Office of the Attorney General
  1515 SW 5th Avenue, Suite 410
  Portland, OR 97201
  (971) 673-1880
  (971) 673-1890 fax

- **Oregon DHS Provider Audit Unit**
  2850 Broadway St. NE
  Salem, OR 97303
  (503) 378-3500
  (503) 378-3437 (fax)

When making a report, Provider will include the following information:

- Provider Name, Oregon Medicaid Provider Number, Address and Phone
- Type of Provider
- Source and nature of complaint
- The approximate range of dollars involved
- The disposition of complaint when known
- Number of complaints for the time period

Providers are required to notify MFCU and the County within 24 hours of the initial discovery of fraud and abuse activities.

Examples of reportable incidents

May include, but are not limited to:

- Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur as evidence by complaint or focused encounter data audits showing encounters billed without appropriate documentation.
- Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service.
- Any verified case where the provider intentionally billed Health Share Multnomah MH more than the usual charge to non-Medicaid recipients or other insurance programs.

- Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating and/or collecting Medicaid payments otherwise not due.
- Providers who intentionally make false statements about the credentials of persons rendering care to OHP members.
- Providers who intentionally fail to render medically appropriate covered services that they are obligated to provide OHP recipients under their contracts with the Coordinated Care Organization Agreement and OHP regulations.
- Providers who knowingly charge OHP members for services that are covered or intentionally bill an OHP member the difference between the total fee-for-service charge and Multnomah MH's payment to the provider.
- Any case of theft, embezzlement or misappropriation of Title XIX program money.

Whistleblower Protection

Retaliation for good faith reporting of perceived or suspected violations of law, regulation, or state policy or procedure, or for participation in an investigation of an alleged violation is strictly prohibited. Any employee, supervisor, manager or executive who commits or condones any form of retaliation, retribution or harassment against a reporting employee can be held accountable in a review. Agency policies should take appropriate measures to safeguard employees against retaliation.

Provider Requirements

I. Policy and procedure, in accordance with all statutes listed above, regarding the detection of fraud and abuse outlining their agencies approach to the following:
   A. Reporting timelines
   B. Employee training of Fraud and Abuse
   C. Employee whistleblower protection
   D. Examples of reportable Fraud, Waste and Abuse

II. Provide evidence of staff training regarding fraud, waste, abuse and whistleblower protections (within 90 days of hire, and annually thereafter), if requested.

III. Must comply with all reporting requirements for false claims and/or false encounters.

Grievance System

Sub contracted providers are required to maintain a grievance system in accordance with the following OARs specific to business lines, as applicable:

- Outpatient: OAR 309-019-0105 (41) and 309-019-0215
- Intensive Treatment Services for Children and Adolescents: OAR 309-022-0105 (37) and 309-022-0190 and
- Residential A&D: 309-018-0210

The process and any forms to start the process must be easily accessible for all OHP members and for non-Medicaid participants and their representatives acting upon the clients' behalf.

Every provider must post a 'Grievance Process Notice' in a conspicuous place stating the telephone number of: The Division; The CMHP; Disability Rights Oregon; and the applicable managed care organization such as Health Share-Multnomah Mental Health.

Complaints:

A formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual's chosen representative, pertaining to the denial or delivery of services and supports. Examples include decisions to not provide additional services after an initial assessment, dissatisfaction with the quality of a particular service such as group therapy, discontinuation of a particular service such as skills training, offensive music in the provider's lobby, etc.

Providers are required to ensure that any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with:

- The provider
- The individual's payer (e.g. Health Share of Oregon Clackamas, Multnomah or Washington County, Family Care, or a county's indigent services program such as the Multnomah County Treatment Fund)
- The Addictions and Mental Health Division (AMH)
- The Community Mental Health Program (CMHP) where the provider is located (e.g. Multnomah, Clackamas or Washington County)
- Disability Rights Oregon

It is important to note that these rules currently outline details of a grievance system required only for individuals whose services are "not funded by Medicaid." The Health Share Behavioral Health Risk

Accepting Entities consulted with representatives from AMH and the Division of Medical Assistance Programs and confirmed that this definition will be updated as soon as possible to apply to all individuals receiving services, including those funded by Medicaid. Therefore, a provider's grievance system must include the following for all individuals receiving services:

- Notify each individual, or guardian, of the grievance procedures by reviewing a written copy of the policy upon entry;
- Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;
- Encourage and facilitate resolution of the grievance at the lowest possible level;
- Complete an investigation of any grievance within 30 calendar days;
- Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;
- Designate a program staff person to receive and process the grievance;
- Document any action taken on a substantiated grievance within a timely manner;
- Document receipt, investigation and action taken in response to the grievance;
- Have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:
    - AMH;
    - Applicable CMHPs
    - Disability Rights Oregon; and
    - Applicable coordinated care organization(s) (e.g. Health Share of Oregon or Family Care) or payers (e.g. Multnomah County Treatment Fund or Clackamas Indigent Services Program)
- Have an Expedited Grievance process for circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in 309-019-0215 or 309-019-0190 are completed.
- The individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process;
- A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action; and
- The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

Appeals

Providers are required to maintain an appeal system in accordance with OAR 309-019-0215 and 309-022-0190. All individuals and their legal guardians, as applicable, must have the right to appeal entry,

transfer and grievance decisions. Therefore, a provider's appeal system must include the following for all individuals receiving services:

- If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director for Outpatient mental health services or AMH Director for ITS or outpatient A&D services;
- If requested, provider program staff must be available to assist the individual;
- The CMHP Director or AMH Director, must provide a written response within ten working days of the receipt of the appeal; and
- If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Director of AMH.

Conflict of Interest and Safeguards

MHASD sub-contracted providers must have provisions in place to eliminate conflict of interest within their organization and include safeguards against such.

- Providers shall not offer to any member, DHS or OHA employee (or any relative or member of their household) any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020(6) and OAR 199-005-0001 to 199-005-0035.

- Providers shall appropriate policies and procedures to avoid actual or potential conflict of interest involving members, DHS or OHA employees.

Provider Requirements

I. Conflict of Interest/Safeguards Policy including:
   A. Prohibition of accepting gifts
   B. Avoiding actual or potential conflict of interest involving members, DHS or OHA employees, or anyone with financial interest with the contract.
   C. Assurance and process by which staff and Governing Board members disclose actual or potential conflict of interest, ownership or controlling interests in the business entities and/or suppliers who deliver services to MHASD clients

Drug Free Workplace

Sub- contracted providers are required to comply with the following provisions to maintain a drug-free workplace:

- Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the workplace or while providing services to clients.

- Provider's notice shall specify the actions that will be taken against its employees for violation of such prohibitions;
    - Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, a policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;
    - Provide each employee, that is to be engaged in the performance of services, a copy of the statement mentioned in Paragraph above;
    - Notify each employee in the statement required by Paragraph above, that, as a condition of employment to provide services, the employee will abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction

Provider Requirements

I. Drug Free Workplace Policy including:
    A. Certifying that the agency provides a drug free workplace
    B. Method in which provider notifies employees that the use of any drugs or alcohol will be prohibited
    C. Specify actions taken against employees if policy is violated
II. Must provide a copy of the policy to employees when hired

Seclusion and Restraint

MHASD sub-contracted providers must have policy and procedures regarding the use of seclusion and restraints within their agencies in accordance with CFR 438.100 (b) (2) (v).

Provider Required Reporting and Standards

Access reporting

The regional access report measures access to non-urgent, urgent and emergent outpatient mental health assessment and treatment services for Health Share and indigent clients. The report captures the number of requests for an assessment or a level A, B, or C covered mental health service, and the number of appointments that were offered over the preceding calendar month within the prescribed access timelines

- 14 days for non-urgent requests,
- 48 hours for urgent requests,
- 24 hours for emergent requests

MHASD Subcontracted provider agencies are required to provide a monthly report detailing access to outpatient mental health services that are not predicated upon participation in other services (residential, A & D treatment, etc). This report is due on the 15th of each month. The report can be made at www.surveymonkey.com/s/ComprehensiveMentalHealthAccessReport

This information is required for all three counties (Clackamas, Multnomah, Washington). If you do not serve clients in one of these counties, you will be required to enter 0. Please note that this report only captures clients whose mental health services are not predicated upon participation in other specialty services (such as Residential, A & D treatment, etc.).

Delivery System Network Report (DSN) -formerly known as Provider Specialty Report

MHASD subcontracted provider agencies shall complete the DNS Report in the regional required format electronically to: MHO.Reports@multco.us .

The DNS Report is due each calendar quarter by the 15th of the month in July, October, January, and April.

The required format is located at: http://web.multco.us/mhas/mental-health

Contracted Provider organizations shall list the names of all clinicians (QMHP, QMHA, and other healthcare professionals) providing covered services for OHP beneficiaries. For employed persons whose duties may be administrative, if such persons are responsible for oversight of clinical or case-management, the amount of time recorded for such persons shall be limited to the proportion of time spent conducting clinical oversight or case-management activities. Specific instructions are located on the report instruction tab in the DNS report located on the website location above.

Providers shall indicate the FTE of the individual and the average number of hours worked each week over the calendar quarter for employed health care professionals. The standard work week, for the purposes of this report, shall be 40 hours.

Incentive Metrics Performance and Standards

7 day Follow- up after Psychiatric Hospitalization

This performance measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

All subcontracted providers are required to schedule an appointment with any of their clients who have been hospitalized within 7 days of discharge. The following is a chart of acceptable diagnosis and procedure codes to use for the encounter, in which are counted in the measure:

Mental Health Diagnosis Codes		
ICD-9-CM Diagnosis: 295-299, 300.3, 300.4, 301,308,309, 311-314		
CPT	**HCPCS**	
90791, 90792, 90832-90838, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004,H0031, H0034-H0037, H0039, H0040, H2000, H2001,H2010-H2020, H2021, M0064, S0201, S9480, S9484, S9485, T1016	
CPT	**POS**	
90818-90819, 90821-90824, 90826-90829, 90845, 90846, 90847,90849, 90853, 90857, 90862, 90870, 90875, 90876	With	Place of service codes are excluded
99221-99223, 99231-99233, 99238, 99239, 99251-99255	With	Place of service codes are excluded

Child Welfare Assessments Metric

This CCO incentive measure use used to determine the percent of children in DHS custody receives appropriate assessment(s) within 60 days of Oregon Health Authority/Department of Human Services providing notification to the CCO that the child had entered DHS custody and been placed in foster care.

All sub-contracted providers who provide services to children are required to participate in this metric under the following guidelines:

- A child who is 4 years of age or older as of the date of DHS custody is expected to receive both a physical health assessment and a mental health assessment within 60 days;
- Acceptable Mental Health Assessment Codes:
- Psychological assessment and intervention codes: 90791 – 90792, 96101 – 96102, H0031, H1011

Outcomes Measurement Performance and Standards

Agencies are expected to utilize a Health Share Multnomah Mental Health approved outcomes instrument to aid in treatment planning. Agencies shall determine how the tool will be used most effectively, and how information will be reported to Multnomah Mental Health. It is the expectation that agencies use the identified outcomes tool with their Health Share Multnomah Mental Health member population.

A Collaborative Outcomes Resource Network (ACORN) is the current identified outcomes tool for all outpatient programs. All agencies have been trained and new clinicians can self register in the toolkit. Beginning in January 2015 MMH providers are able to self select another outcomes assessment tool approved by a subcommittee of the outpatient provider association.

The website for ACORN general information is: https://psychoutcomes.org/bin/view/COMMONS

Multnomah Mental Health holds WebEx meetings with Center for Clinical Informatics twice each month. All agencies are encouraged to attend to get questions answered and to help improve the tool. If you do not have a current representation on the ACORN group please contact the Multnomah Mental Health QM department to get added to the list for notifications and meeting information.

Statewide Performance Improvement Project

This statewide performance improvement project (PIP) addresses one of the seven quality improvement focus areas in the state Accountability Plan, related to “integrating primary care and behavioral health.” Within the focus area of care integration, the selected topic for this PIP addresses monitoring diabetes care for individuals diagnosed with diabetes and schizophrenia or bipolar disorder. This topic will promote integration of physical and mental health services, and improve continuity and quality of care for a high-risk population.

The study indicator will measure both of the recommended clinical tests that can be documented in state administrative data: HbA1c and LDL-C.

Study Denominator:

- OHP-enrolled adults with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder.

Study Numerator:

- Both: at least one or more HbA1c test and at least one or more LDL-C test during the measurement year.

Providers may be asked to participate in this Performance Improvement Project as the Plan –Do- Study-Act process is being completed and interventions are being developed and implemented.

III. Provider General Service Requirements

Client Process Monitoring System (CPMS) & Measures and Outcomes Tracking System (MOTS)

The Client Process Monitoring System (CPMS) is a State processing system that tracks community-based treatment services for persons with mental illness, persons with developmental disabilities, and persons with substance abuse problems. Information from this system is combined with other information from other systems to create one integrated database under a single unique client identifier. The integrated database contains Consumer specific data across programs statewide and provides a Continuity of Care picture for individual Consumers. This information allows the State Addictions and Mental Health Division (AMH) to manage publicly funded mental health services, respond to legislative inquiries, and demonstrate cost effectiveness under the federal requirement for the OHP Medicaid Demonstration Project and Children's Health Program.

General Provisions

- Provider shall submit CPMS data for anyone who receives any amount of Covered Services provided by public funds, (except for acute inpatient hospital services which shall be reported on OP/RCS). Public funds include Medicaid, Medicare, OHP Members, and state/county/federal grants. For each client enrolled on CPMS the provider must maintain a file that includes, but is not limited to, documentation of the primary diagnosis, a psychosocial work-up (which might include a family history, prior treatment information, etc.) and a treatment or training plan.
- Provider must have the clinician that assesses the client complete the CPMS form. Portions of the form require clinical judgment and certain information is gathered only during the client assessment.

- Provider shall submit CPMS data for any OHP Member who is civilly committed to the custody of DHS under ORS 426.130.
- AMH shall process all CPMS data through the Mental Health Information System (MHIS). AMH shall "pend" CPMS data that cannot be processed because of missing or erroneous date.
- AMH shall notify Provider monthly of all pended CPMS data.
- Provider shall correct pended CPMS data within 30 calendar days of notice.

Timelines

- Provider must complete enrollment forms within 7 working days of the first face-to-face treatment contact (usually the initial assessment.)
- Provider must complete termination forms no later than 30 calendar days after the last face-to-face treatment contact.
- Provider must complete corrected Monthly Management Report (MMR) by the first working day of the month following receipt. NOTE: If there are no mistakes on the MMR you do not need to mail back to CPMS.
- Provider shall work with AMH Data Base Analyst in developing, formatting, and testing the CPMS to ensure reporting of accurate data.

Data Transmission and Format

- Provider shall submit all CPMS data to AMH via electronic media in the specific CPMS format. Provider may obtain reporting protocols upon request through the AMH Data Base Analyst.
- Provider may request electronic access to the MHIS for Utilization monitoring purposes.

Providers are encouraged to visit the following link for up to date CPMS information:
http://www.oregon.gov/DHS/mentalhealth/tools-providers.shtml

MOTS

The Addictions and Mental Health (AMH) Division is developing a comprehensive behavioral health electronic data system to improve care, control cost and share information. This data system improvement project is called COMPASS. CPMS will be replaced by Measures and Outcomes Tracking System (MOTS), AMH's new data collection system. In January 2013 providers must submit required data elements to Oregon Addiction and Mental Health Division. Instructions and COMPASS updates are located at: http://www.oregon.gov/oha/amh/pages/compass/index.aspx

Health Share Multnomah Mental Health Authorization Structure

Health Share Multnomah Mental Health subcontracted providers can self authorize outpatient mental health services based on the members level of care. Attachment B outlines the authorization structure for providers. (See Attachment A)

Health Share Multnomah Mental Health and Multnomah Treatment Fund Service Authorization and Claims Management

The Clinical Integration Manager or 'CIM' Authorization and Claims Management Database is the electronic tool offered by Health Share Multnomah Mental Health's Third Party Administrator (Performance Health Technology or PH Tech) for the input of service authorizations. Detailed instructions on how to become a user and log on to CIM can be obtained by contacting provider relations at 1-800-478-2818.

Depending on the level of care being requested, Providers may either directly enter an authorization into CIM for Health Share Multnomah Mental Health eligible members or submit a clinical packet for County Care Coordination review before authorization input by County staff.

Providers will be required to submit an initial authorization either into CIM, or for County reviews, no more than 90 days after the first date of service.

Multnomah Treatment Fund

The CIM database is also used to track service authorization for Multnomah Treatment Fund (MTF) consumers. All MTF authorization requests are reviewed and entered by County Care Coordinators.

Providers need to enter in encounter data for tracking of enrollment.

Health Share Multnomah Mental Health Medical Necessity Criteria

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:

- Required for prevention, diagnosis or treatment of physical, substance use or mental disorders and which are appropriate and consistent with the diagnosis
- Consistent with treating the symptoms of an illness or treatment of a physical, substance use or mental disorder
- Appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective

- Furnished in a manner not primarily intended for the convenience of the individual, the individual's caregiver, or the provider
- Most cost effective of the alternative levels of covered services which can be safely and effectively furnished to the individual

A covered service is considered medically necessary if it will do, or is reasonably expected to do, one or more of the following:

- Arrive at a correct diagnosis
- Reduce, correct, or ameliorate the physical, substance, mental, developmental, or behavioral effects of a covered condition
- Assist the individual to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities, and/or maintain or increase the functional level of the individual
- Flexible wraparound services should be considered medically necessary when they are part of a treatment plan.

The determination of medical necessity must be made on an individual basis and must consider the functional capacity of the individual and available research findings, health care practice guidelines, and standards issued by professionally recognized organizations.

Assigning Levels of Care

Client's levels of care will be determined using the guidelines described in attachment B. (See attachment B)

Exceptional Needs and Higher Level Intensive Services

If you believe a Health Share Multnomah Mental Health member requires a higher level intensive service contact MMH Utilization Review to request authorization. This would include hospitalization, sub-acute, Intensive case management, and exceptional needs care coordination.

Multnomah County Utilization Review Specialists (URS) must preauthorize all services that are not delegated to agencies. Exceptional Needs services include but are not limited to: Eating Disorders Outpatient Treatment Program, Dialectical Behavior Therapy, (DBT) Assertive Community Treatment, (ACT), Psychological Testing, and Home Health Services. Non-participating providers determined to have a specialized set of skills not available through other providers in the community will be accessed as appropriate for member needs. Medically appropriate services will be provided by credentialed providers that are qualified to provide those services. MHASD sub contracted providers must complete a

Treatment Authorization Request (TAR) form (Attachment C) to request an intensive or special service. TAR may be sent to 503-988-3137. TAR may also be securely emailed to URTeam@multco.us.

If the member is a child and receiving Wraparound services through Multnomah Mental Health and has Health Share benefits, contact the Integrated Service Array (ISA) intake coordinator to request higher level of care.

Obtaining Out of Network Services

If Multnomah Mental Health (MMH) is unable to provide necessary Covered Services which are culturally and linguistically and Medically Appropriate to a particular member from the Multnomah Mental Health Provider Panel, MMH shall adequately and timely cover these services out of network for the Member, for as long as MMH is unable to provide them.

MMH utilization review (UR) staff complete medical necessity determinations. When the result of the medical necessity determination identifies a service that (MMH) is unable to provide with the existing network, UR in collaboration with the UR physician may identify specialists or specialty facilities that are local, in-state, or out-of state.

Second Opinions

In establishing an adequate network of providers, Multnomah Mental Health is required by federal rule to ensure that the network "Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee." [42 CFR 438.206(b)(3)]

Previously authorized members have a right to a "second opinion" by a qualified health care professional within the organization where their service authorization originates, OR from any other contracted mental health provider. If the member's current provider is unable to provide a second opinion, or the member wishes to obtain a second opinion from another provider, the member's current provider will arrange the second opinion.

If a Multnomah Mental Health member with an open service authorization requests a transfer of services to another County contracted mental health provider, that provider will cooperate with the member and assist in making transfer arrangements with the new provider and Multnomah Mental Health Member Services. The current provider is responsible for determining the best course of action.

Requests from a provider for assistance in authorizing a second opinion that are received by Multnomah Mental Health Member Services shall be documented in the member's contact record in the County's clinical database.

When a call is received by Multnomah Mental Health Member Services, the calling provider will be alerted that they are able to authorize this additional service by entering an "Assessment Plus Two"

authorization into the current authorization database; Clinical Integration Manager (CIM). The provider may then submit a claim for payment as usual for this additional service under this authorization.

If the calling provider is unable to accommodate a request made by their member for a second opinion, Multnomah Mental Health Member Services shall request that the provider ask the member or member's guardian to contact Multnomah Mental Health Member Services in order to assess specific needs of the member.

Continuity of Care/ Care Coordination Standards

All sub-contracted providers are required to provide members with services that promote continuity of care in coordination with other community providers to meet the needs of the member in a holistic fashion. MHASD encourages use of evidence-based and innovative strategies to ensure coordinated and integrated person-centered care for all members, including those with severe and persistent mental illness or other chronic conditions:

- Providers shall support the appropriate flow of relevant information; identify a lead Provider or care team to manage Member care and coordinate all Member services; and, in the absence of full health information technology capabilities, implement a standardized approach to effective transition planning and follow-up.

- Providers will develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, other community based mental health services, DHS Medicaid-funded LTC services and mental health crisis management services.

- Providers shall use individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health needs. Provider shall ensure that individual care plans developed for members reflect member, family or caregiver preferences and goals to ensure engagement and satisfaction.

- Providers shall ensure that all documentation contained in the member's Service Record that is requested by (new) receiving provider(s) shall be furnished, (compliant with HIPAA and the provider's confidentiality policies and procedures) as soon as possible following a written request from the receiving provider(s) for the documentation.

- Providers shall develop culturally and linguistically appropriate tools to use to assist in the education of members about roles and responsibilities in communication and care coordination.

- Providers will have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion.

- Each member has access to a consistent and stable relationship with a care team that is responsible for comprehensive care management and transitions.

- The supportive and therapeutic needs of the member are addressed in a holistic fashion, using patient centered care and individualized care plans to the extent feasible.

- Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

- Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources.

- Members have access to advocates such as qualified Peer Wellness Specialists, Personal Health Navigators, or qualified Community Health Workers who may be part of the member's care team.

Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices. Providers shall coordinate with residential addictions and mental health services providers for their Members receiving both Medicaid-funded and non-Medicaid- funded residential addictions and mental health services.

- Providers will coordinate with state institutions and other mental health hospital settings to facilitate Member transition into the most appropriate, independent, and integrated community-based settings.

- Each Member has access to a consistent and stable relationship with a care team that is responsible for comprehensive care management and transitions.

- The supportive and therapeutic needs of the Member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.

- Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

- Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources.

- Members have access to advocates such as qualified Peer Wellness Specialists, Personal Health Navigators, or qualified Community Health Workers who may be part of the Member's care team.

- Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

Use of Student Interns in Clinical Practice Standards

Chapter 309, division 19 or the Oregon Administrative Rules (OARs), the Outpatient Addictions and Mental Health Services rule, was revised effective February 3, 2014. This revised rule established a definition of "Mental Health Intern" and redefined "QMHP" to include such.

Providers who utilize Mental Health Interns must:

1. Establish a policy and procedure that describes the process for credentialing and oversight of mental health interns (OAR 309-019-0105 (61)(c)). The policy and procedure must address the following elements, at minimum:

    a. The provider's procedures for ensuring that mental health interns are currently enrolled in a graduate or doctoral program at an accredited university for a master's or doctoral degree in psychology, social work or in a behavioral science field and that there is a current, collaborative educational agreement with the provider and the graduate or doctoral program as described in OAR 309-019-0105 (61)(a-b).

    b. The provider's procedures for establishing the scope of practice allowable for mental health interns. Scope of practice policy and procedure content may include guidelines or standards

related to client populations or the acuity of the clients the mental health intern is allowed to serve, array of services the mental health intern is allowed or expected to provide, continuity of care issues related to the short duration of the internship, etc. (OAR 309-019-0105 (61)(c)).

.

c. The provider's procedure for confirming a mental health intern's required QMHP competencies before the mental health intern provides related independent QMHP services (OAR 309-019-0105 (61) (c); OAR 309-019-0125 (8)).

d. If relevant, the provider's procedure for confirming a mental health intern's required QMHA competencies before the mental health intern provides related independent QMHA services (OAR 309-019-0125 (7)).

e. The provider's procedures for ensuring that mental health interns do not conduct independent assessment services before the mental health intern has successfully completed a DSM course through their educational program.

f. The provider's procedures for ensuring that all assessments and service plans completed by a mental health intern will be approved and signed by the mental health intern's clinical supervisor/field instructor, or qualified designee, before the provision of non-assessment, non-crisis services.

g. The provider's procedures for ensuring that the mental health intern's clinical supervisor/field instructor meets the requirements of a clinical supervisor as outlined in OAR 309-019-0105 (17) and OAR 309-019-0125 (2-3) (e.g. confirmation of QMHP and Clinical Supervisor competencies and 2 years post-graduate clinical experience in a mental health treatment setting).

h. The provider's procedures for ensuring that all mental health interns receive one hour of weekly, face-to-face supervision with a qualified clinical supervisor of which at least 50% must be one-on-one.

i. The provider's procedures for communicating to clients when services will be provided by a mental health intern.

j. The provider's procedures for ensuring that a mental health intern's status as such only applies for services provided as allowable by this policy and as a representative of the provider referenced within the collaborative educational agreement described within 1, a.

2. Maintain written documentation of the process for confirming that the mental health intern demonstrates the competencies listed in OAR 309-019-0125 (8).

3. Document evidence that the clinician (field instructor) providing weekly supervision for the intern according to their collaborative education agreement (OAR 309-019-0105 (61)(b)) meets credentialing requirements of a clinical supervisor, including the competencies for such, according to the requirements specified within OAR 309-019-0125 (2-3).

4. Maintain written documentation of the clinical supervision required by OAR 309-019-0105 (61)(d). Supervision notes should include the name of the mental health intern; the name of the supervisor; time, date, and duration of the supervision; and a general notation as to topic.

5. Maintain a personnel record for each mental health intern complying with OAR 309-019-0130 (2) that includes
    a. A contract or written agreement
    b. A signed confidentiality agreement
    c. Orientation documentation; and
    d. Verification of a criminal records check consistent with OAR 407-007-0000 through 407-007-0370.

6. Document evidence that orientation training occurred within the first 30 days of the mental health intern's placement with the provider that meets all content requirements described within OAR 309-019-0130 (3).

Additional Considerations:

1. An individual who is employed and placed as an intern at their place of employment may function and bill as a mental health intern during all employed hours unless the mental health intern's educational agreement places a restriction upon those services.

2. OAR 309-019-0105 (61) (a) requires that an intern "be currently enrolled in a graduate program for a master's degree in psychology, social work or in a behavioral science field." Please note that behavioral science field is distinct from social science. Behavioral science consists of fields of study focused on an individual and which prepares the student to provide behavioral health services to an individual. Social science consists of fields of study focused on systems (e.g. sociology, ecology, anthropology).

Performance Health Technology (PhTech)

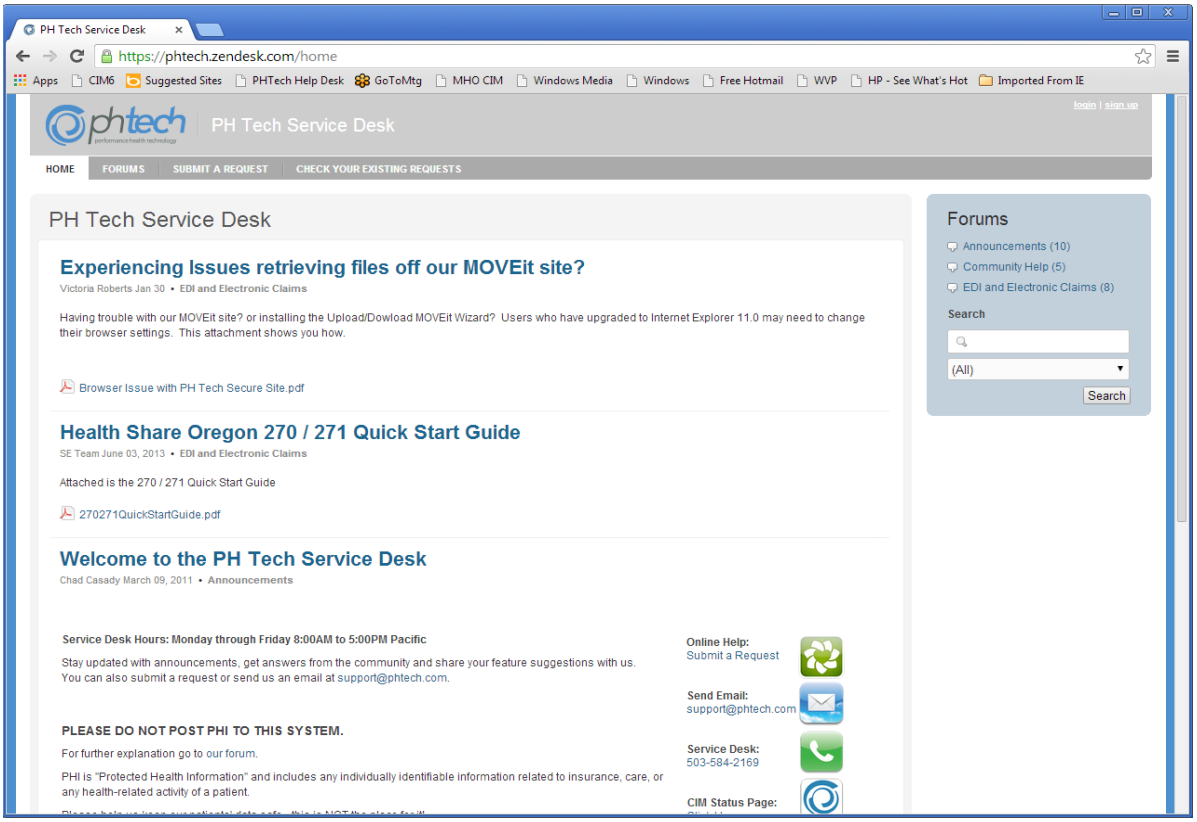
Multnomah Mental Health contracts with PhTech for third party claims administration. PhTech operates a web-based system for authorization entry by Multnomah Mental Health and network providers. All provider manuals are located on the PhTech ZenDesk link. The actual link and PhTech ZenDesk instructions are included below:

ZenDesk

The PH Tech Service Desk is also referred to as the HelpDesk or ZenDesk. It can be found at:

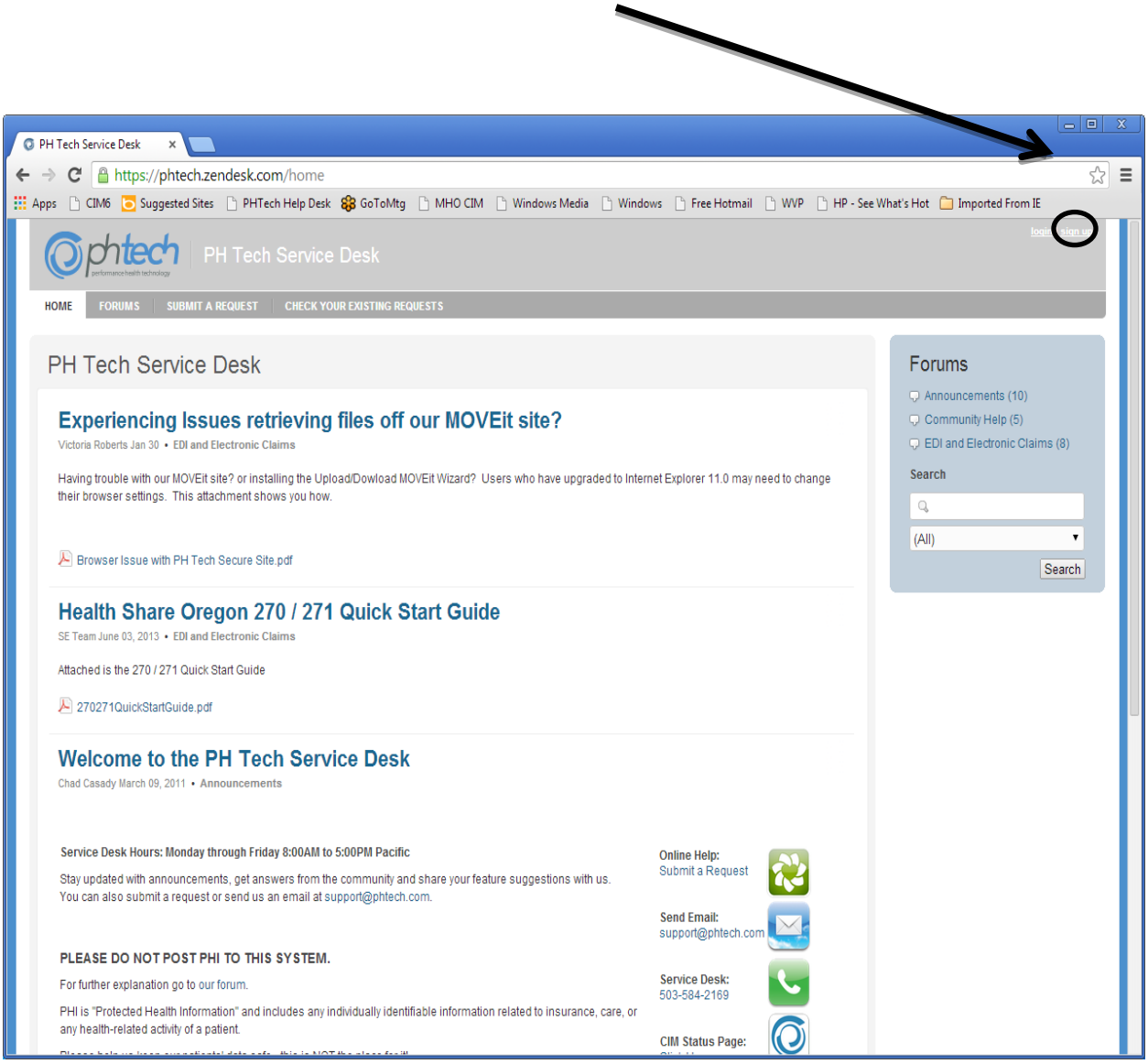
https://phtech.zendesk.com/

Zen Desk can be accessed by any browser, but seems to work better in **Chrome**.



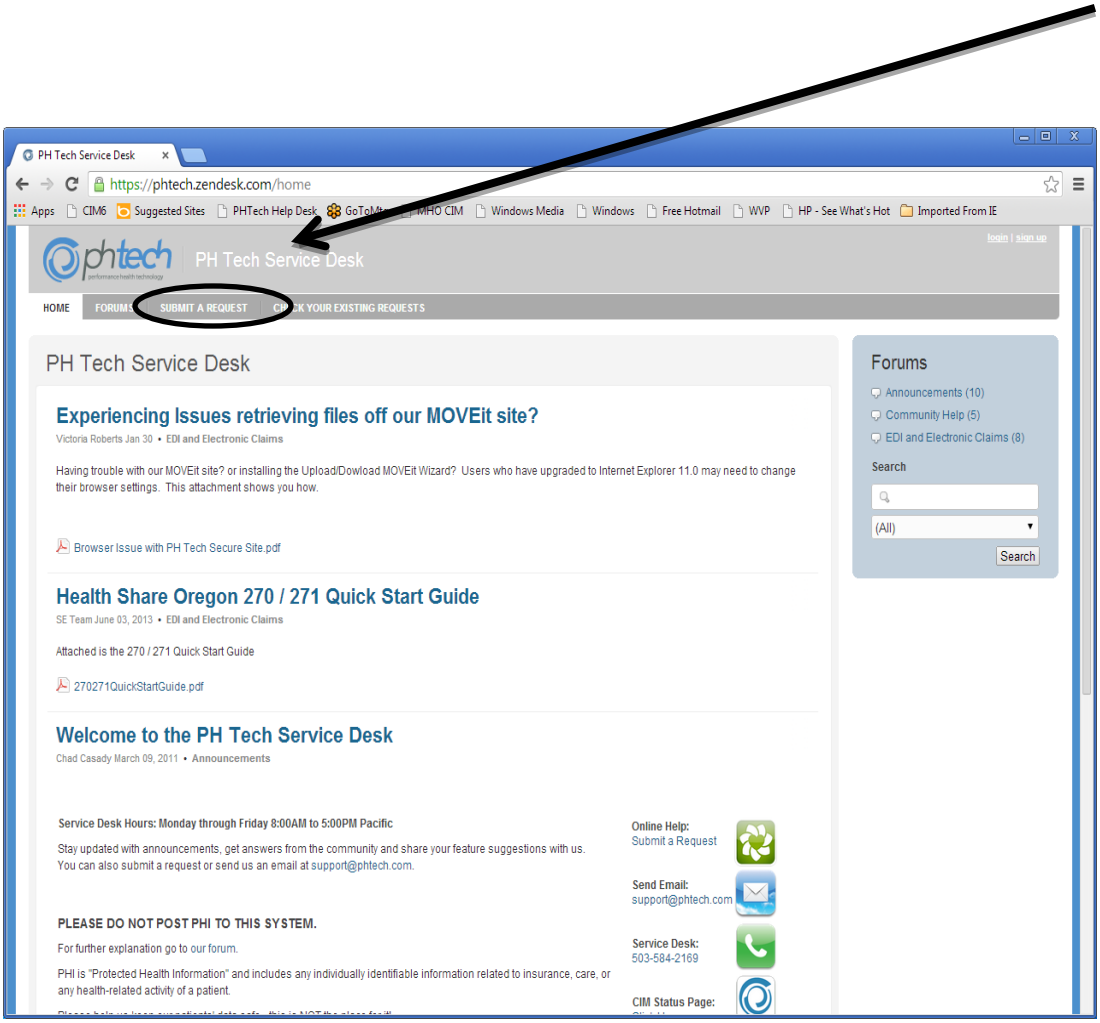
Multnomah County

1) **You will need to create an account. Go to "sign up".**



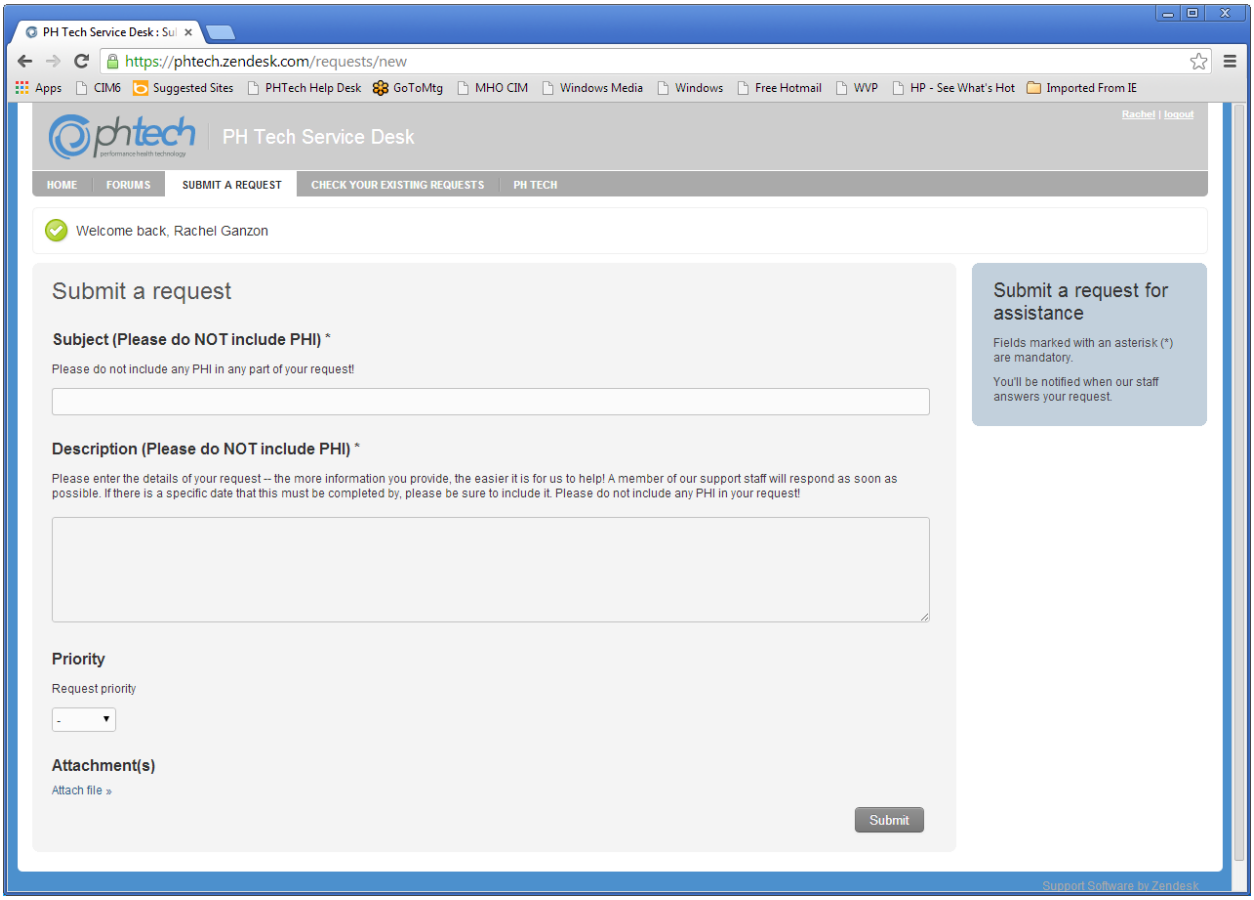
Multnomah County

2) When you want to submit a HelpDesk request, you will need to click on Submit a Request



Multnomah County

3) **Here is what the form looks like:**



4) **It is best to copy the Account Rep, so that she can help monitor the request. Because there is no field for a "cc: ", you will need to put this in the body of the Description. It is best to put this at the beginning.**

Example: Please copy Rachel Ganzon (Rachel.ganzon@phtech.com) on this ticket.

5) **The subject line should include your plan name in it, so that whoever works on this will be directed to the right database. (This is also easier for tracking.)**

Example 1: Clackamas report needed on Hospital stays

Example 2: Multnomah needs monthly extract

Example 3: WCHHS requests reports on CIM users

6) **Information needed in the request:**

- **Request Type** (Ad hoc, Recurring):
- **Request Category** (claim, referral, provider, member, etc)**:**
- **Due Date:**
- **Frequency** (One time, Daily, Weekly, Monthly):
- **Short Description:**
- **Plan (Health Share/Multnomah, MTF, Health Share/Clackamas, etc):**
- **Related tickets (if applicable):**

- **Criteria (if applicable):**
    - *Carrier(s):*
    - *Date Span (include date type e.g. DOS, check Date, eff_date, term_date, submittal_date):*
    - *Other:*

- **Example Record** (referral_id, claim#, member ID, report location, etc):
- **Deliverable:**
    - *Required Fields (claim#, member#, DOS):*
    - *Report Layout (e.g. by month, county):*

7) There is drop-down box for **Priority** of the request. Low/Normal/High/Urgent.

a. Consider **Urgent** as something that is "broken"—examples: your work that day cannot be done because of this need, data that you need that day is incorrect, or there is a compliance issue. If you request something with Urgent as the priority, it does usually mean that other tickets will be pushed aside in order to get your request done.
b. **High** priority means that there is a deadline within 5 days, without flexibility.
c. **Normal** priority would be something needed within the next 10 business days.
d. **Low** priority would be anything needed in 11 days or longer.
e. Please keep in mind that our teams only do their planning once a week. Example: Business Intelligence, which includes our Developers who do some of those automatic tasks—like blanket terming of authorizations, creating and delivery of your extracts, and our Decision Support Analysts—who create many of your monthly, quarterly, ad hoc

reports—this team does their planning on Tuesdays. Their iteration (when they work the requests) goes from Wednesday to the following Monday. You may wish to contact the Account Rep before submitting your ticket in order to determine your Priority.

8) If you have any data that needs to accompany the ticket, do NOT attach any document that has PHI. You can state in the ticket that you have additional data they will need, and they need to contact you so that you can send it to the assigned staff directly and encrypted. The ZenDesk site is NOT secure with regard to PHI.

After you submit a request, you will get an email from the PH Tech Service Desk (support@phtech.zendesk.com) with your ticket#. If you need the Account Rep's assistance to check the progress of the ticket, please reference the ticket# when you contact her.