Health Share of Oregon

Regional Mental Health Services

CASE RATE PROVIDER MANUAL

January 2015

Together we are health share Health Share of Oregon

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Section 1:
Case Rate Frequently Asked Questions

Transition to Case Rates

Q: Why are we transitioning to case rates?
A: A key element of health care transformation is moving away from paying for volume to paying for value. The fee-for-service payment model creates an incentive to provide as many services as possible, while case rates will support a shift in focus to achieving outcomes. Case rates are meant to provide flexibility to the provider and client, to ensure that mutually established treatment outcomes are met. Ultimately, case rates will contribute to achieving the Triple Aim of better care, better health and lower costs.

Q: What do case rates represent?
A: Case rates are an AVERAGE payment for all of the clients served at a given level of care. By definition, some individuals will require MORE care and some will require LESS care in order to achieve the intended outcomes. Case rates are NOT a fixed budget for an individual client.

Q: What is the threshold for being included as a case rate provider?
A**:** All providers that provide $50,000 in services and/or serve at least 20 clients per year per county are required to transition to case rates. Providers that do not meet this threshold can opt in to case rate payments, as follows:

Child providers:
- Level A through C
- Level A through D
- Level D only

Adult providers:
- Level A through C outpatient
- Level A through D SPMI
- Level A through D outpatient and SPMI

Q: How/when will Health Share reassess which providers are included as case rate providers to ensure the correct providers are included based on current, total amounts of services provided and/or clients served?
A: *Under development*.

Case Rate Payments

Q: How will providers be paid for authorizations with a start date prior to January 1, 2015?
A: Authorizations with a start date prior to 1/1/15 will be paid on an invoice basis, similar to the process for the global budget payments:

Clackamas: payments based on open authorizations will be calculated each month, and providers will be alerted via email of the amount to submit via an invoice.

Multnomah: providers are not required to submit invoices. An invoice is generated internally by the county to issue payment. Questions regarding payment should be submitted to carol.snyder@multco.us.

Washington: payments based on open authorizations will be calculated each month, and providers will be alerted via email of the amount to submit via an invoice.

Q: When are the invoice-based payments scheduled to be issued?
A: Similar to the timing for global budget payments:

Clackamas: providers are asked to submit their invoices by the 10th of each month; checks will be issued as soon as possible after the 10th.

Multnomah: payments are targeted for the 15th of each month.

Washington: providers are asked to submit their invoices by the 10th of each month; checks will be issued as soon as possible after the 10th.

Q: How will providers be paid for authorizations with a start date of January 1, 2015 and after?
A: All case rates will be paid in full at the point of the first submission of a valid encounter to PH Tech for all Levels of Care. Both the authorization and at least one valid encounter must be present for a case rate to be paid. Case rate payments will be issued through regular, weekly accounting runs, much like the historical fee-for-service environment. Non-billable, encounter only codes are considered valid claims which will trigger a case rate payment.

Q: Will case rate payments for authorizations with a start date of January 1, 2015 be on the same voucher as fee-for-service payments?
A: Yes, one voucher will be issued by each Health Share mental health plan (County) that will include case rate and fee-for-service payments.

Client Status

Q: What happens when a client changes from one agency to another agency in the middle of their authorization?
A: Providers will be responsible for notifying the appropriate mental health plan (aka County) of the change in provider. The client's name and OHP number will be required, as well as contact information for who the plan should contact to determine the clinical reason for the change in provider. The authorization with the initial agency will be closed by the mental health plan when the authorization with the second agency is opened. The mental health plan will approve overlaps in authorization term dates to accommodate continuity of care needs such as continued medication management services at the original agency after services have begun at the new agency. Both agencies will receive a full case rate payment at the point of the first submission of a valid encounter for all levels of care. If the client returns to the initial provider, a new authorization and case rate will be trigged at the point of the first submission of a valid encounter under the new authorization.

Q: What happens when a client changes from one Health Share mental health plan to another plan in the middle of an authorization?

A: Both mental health plans will pay a full case rate payment at the point of the first submission of a valid encounter for all levels of care. In addition, both authorizations will remain open in CIM, ensuring that additional case rate payments are not made should the client's eligibility change again.

Q: What happens when a client changes to non-Health Share eligibility and then returns to Health Share eligibility?

A: The original authorization remains open until its natural end date. If the client transitions back to Health Share from an alternate plan before the original end date, the original authorization will be resumed and no additional case rate will be paid. If a change in level of care is needed, the agency will initiate the change in level of care request outlined below. If the client transitions back to Health Share after the original end date, a new authorization and case rate payment will be trigged at the point of the first submission of a valid encounter.

Q: What happens when a client leaves services with an agency and then returns after a lapse in treatment?

A: If the original authorization is still current at the time of the client's return, no additional case rate payment will be made and services will be encountered under the original authorization. If a change in level of care is needed, the agency will initiate the change in level of care request outlined below. If the original authorization has expired at the time of the clients return, a new authorization and case rate payment will be trigged at the point of the first submission of a valid encounter.

Q: What happens when a client changes levels within the same agency in the middle of their authorization?

A: Providers will be responsible for using the "extend authorization" functionality to request the change in level of care via CIM, maintaining the original end date of the original authorization. If the client moves to a level of care with a shorter or longer default authorization length, the provider will adjust end dates to ensure that authorization terms do not exceed regional level of care protocols. The mental health plan will approve the client's new authorization to the new level of care, and will initiate additional payment for changes to higher levels of care. The additional payment will be triggered at the point of the first submission of a valid encounter under the new authorization. The additional payments will ensure that a full case rate at the higher level of care has been made.

Q: What happens when a client's authorization and/or eligibility is entered retroactively?

A: Retro authorizations can be entered by providers within 45 days of the start date. Any authorizations entered greater than 45 days past the start date will pend for mental health plan approval. A full case rate will be paid for retro authorizations at the point of the first submission of a valid encounter.

Q: If a current client switches from FamilyCare to Health Share, and has already had an assessment, do we obtain an assessment authorization?

A: No, you do not need to repeat the assessment. Please obtain the correct level of care authorization (Level A-D) rather than an assessment authorization.

Billing

Q: How should day treatment providers bill for medication management in addition to the day treatment per diem code?

A: Effective October 1, 2014, day treatment providers have one authorization that incorporates per diem codes and medication management services.

Q: What if my agency provides services included in the global budget and "carve-out" services?
A: You will need to submit separate authorizations for each type of service provided; authorizations cannot be mixed.

Q: What is required on a FFS claim in order to trigger the FFS payment if I am also a case rate provider?
A: A GB modifier must be attached to ALL FFS claims when you are also a case rate provider for the same payor.

Q: Are authorization numbers required on case rate and fee-for-service claims?
A: It is recommended that authorization numbers be included on claims to ensure accurate processing; however, this is not a requirement for case rate or fee-for-service providers. The only reason a claim will be rejected related to authorization numbers is if an incorrect authorization number is included on a claim.

Q: Are authorization numbers required on general fund and Medicaid claims?
A: It is recommended that authorization numbers be included on general fund and Medicaid claims to ensure accurate processing; however, this is not a requirement for general fund or Medicaid claims. The only reason a claim will be rejected related to authorization numbers is if an incorrect authorization number is included on a claim.

Q: Does this authorization number on claims change apply to claims with dates of service after 1/1/15, or to any claims submitted after 1/1/15 regardless of date of service?
A: This change applies to claims/encounters submitted after 1/1/15, regardless of date of service; however, as outlined above, claims will not be rejected if they do not include the authorization number.

Third Party Liability

Q: How do case rates account for TPL where Medicaid secondary?
A: The case rates cover only the Medicaid portion of your payment.

Q: How do we adjust for timing on TPL submissions?
A: There is no change to the current process. Submit the claim to the primary payor first; then submit the EOB and secondary claim to PH Tech.

Q: What happens when we have received payments from a third party resource (TPR) (e.g. private insurance or Medicare)?
A: A full case rate will be paid at the point of the first submission of a valid encounter regardless of TPR payments. Risk corridor calculations will reflect TPR payments received.

Risk Corridor

Q: When will the risk corridor be implemented?
A: The risk corridor will be implemented July 1, 2015 and the first calculation will be approximately February 1, 2016.

Q: How often will the risk corridor be calculated?
A: The risk corridor will be calculated quarterly.

Q: How will risk corridor payments be handled?
A: Details are under development, but it is likely that providers will invoice the mental health plan for ceiling payments due to the provider, and the plan will invoice the provider for floor payments due to the plan.

Q: Will the risk corridor be calculated on Fee-for-Service equivalents or a total number of service hours provided to clients?
A: Fee-for-Service equivalents as identified on the regional fee schedule.

Q: How will non-billable encounters impact the risk corridor?
A: Non-billable encounters, 90899, will be included in risk corridor calculations.

Q: How will TPR payments affect the risk corridor?
A: TPR payments will be reflected in risk corridor calculations. Details are under development.

Q: How will open authorizations for clients disengaged from services affect the risk corridor?
A: *Under development*.

Q: How will possible decreases in total encounters submitted after October 1, 2015 due to DSM5/ICD10 implementation affect the risk corridor?
A: *Under development*.

Section 2:
Case Rate Phase-In Methodology

2014 Payment Methodology

During the second half of 2014, a transition process was used to smooth the move from the Global Budget to Case Rates with Case Rates going fully into effect in January 2015.

During the Phase-In Period, participating provider organizations were paid using a formula that combined Global Budget and Case Rate Payments as follows:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Global Budget %	75%	75%	75%	50%	50%	50%	0%
Case Rate %	25%	25%	25%	50%	50%	50%	100%

In July 2014, the Global Budget amount represented 75% of the weight of the total payment and what the agency would be paid if it was fully under Case Rates represented 25% of the weight. This weighting stayed in effect for three months. For October – December 2014, this weighting shifted to 50%/50%.

2015 Payment Methodology

As of January 2015, all authorizations with a start date prior to 01/01/15 will be paid on a monthly basis by the plans, similar to the process for global budget payments for the duration of the authorization (e.g. an authorization with a start date of 12/20/14 will be paid on an invoice basis through January, 2016):

> Clackamas: payments based on open authorizations will be calculated each month, and providers will be alerted via email of the amount to submit via an invoice.
>
> Multnomah: providers are not required to submit invoices. An invoice is generated internally by the county to issue payment. Questions regarding payment should be submitted to carol.snyder@multco.us.
>
> Washington: payments based on open authorizations will be calculated each month, and providers will be alerted via email of the amount to submit via an invoice.

As of January 2015, all authorizations with a start date 01/01/15 and after are paid in full via PH Tech at the point of the first submission of a valid encounter to PH Tech for all Levels of Care. Both the authorization and at least one valid encounter must be present for a case rate to be paid. Case rate payments will be issued through regular, weekly accounting runs, much like the historical fee-for-service environment.

Case Rate Payments Effective January 1, 2015

Level of Care	Case Rate	Auth Length
Assessment Plus Two Global	$224.00	30 days
Level A Child Global	$730.00	1 year
Level A Adult Global	$700.00	1 year
Level A Adult MRDD Meds Global	$700.00	1 year
Level B Child Global	$970.00	6 months
Level B Adult Global	$1,175.00	1 year
Level B Adult SPMI Global	$1,175.00	1 year
Level C Child Global	$1,880.00	6 months
Level C Adult Global	$3,400.00	1 year
Level C Adult SPMI Global	$3,400.00	1 year
Level D Child HBS Global	$1,710.00	1 month
Level D Adult TAY Global	$8,470.00	1 year
Level D Adult ICM Global	$8,470.00	1 year

Section 3:
Level of Care System Authorization Structure

Authorization Type	Authorization Period	Initial Authorization Auto-Approve?	Initial Authorization Treatment Registration Form?	Re-authorization Auto- Approve?	Re-authorization Treatment Registration Form?	Retrospective UM chart reviews
Assessment Plus Two tx sessions	30 days	Yes	N/A	N/A	N/A	N/A
Level A Child and Family	One Year	Yes	Yes*	Yes	Yes*	Yes – sample
Level A Adult	One Year	Yes	Yes*	Yes	Yes*	Yes - sample
Level A MRDD	One Year	Yes	Yes*	Yes	Yes*	Yes - sample
Level B Child and Family	6 Months	Yes	Yes*	Yes	Yes*	Yes - sample
Level B Adult	One Year	Yes	Yes*	Yes	Yes*	Yes – sample
Level B SPMI	One Year	Yes	Yes*	Yes	Yes*	Yes – sample
Level C Child and Family	6 Months	Yes	Yes*	Yes	Yes*	Yes – sample
Level C Adult	One Year	Yes	Yes*	Yes	Yes*	Yes – sample
Level C Adult SPMI	One Year	Yes	Yes*	Yes	Yes*	Yes – sample
Level D Child and Family	One Month	No	Yes*	No	Yes**	Yes – sample
Level D Adult ICM/TAY	One Year	No	Yes***	No	Yes*	Yes – sample

* Treatment Registration Form must be found in the clinical record of the client and will be reviewed during the sample retrospective chart review

** Level D Child and Family-Completed by RAE Wraparound Care Coordinators

*** Treatment Registration Form is a document that should be retained in the client's chart on site, and does not replace any existing pre-authorization forms and documents required by each Behavioral Health RAE. Providers should follow the same pre-authorization process for Intensive Case Management requests with the appropriate Behavioral Health RAE as before.

Section 4:
Adult Level of Care Utilization Management Guidelines Q&A

General Questions

Q: When does a Treatment Registration Form need to be in the chart along with the authorization in PH Tech?
A: Both the Treatment Registration Form in the client's chart and the authorization in PH Tech must be completed within 45 days of the authorization start date for all Level A-D authorizations. A submission of the authorization outside of the 45 business rule will go into a "pend received status" and may not be approved with the original start date request.

Q: Are all clients who have an MRDD diagnosis assigned to Level A MRDD?
A: Someone with a MRDD diagnosis who can benefit from other treatment services can be served in a different level of care. The Level A MRDD LOC is for individuals who really are only receiving medication services-both MRDD and non-MRDD clients alike.

Q: If someone is Med Only, but not MRDD, do we assigned them Level A Adult MRDD/ Meds Only or is this Level A OP?
A: You can assign meds only (non-MRDD) clients to this level of care if they are not going to require any other treatment services.

Q: Can the separation of adult OP and SPMI be reconsidered as it has (in the past) and will (in the future) influence program design that may or may not be advantageous to clients or result in a reduction in cost?
A: These levels will be maintained separately for at least the first year to evaluate the service needs of these two distinct populations.

Q: What are the definitions of "crisis episodes" and "extended crisis episodes" for both adult and child?
A: Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters). The constellation of emotional, functional and situational events that occur within each crisis create different time trajectories and the duration of the interventions may be brief or extended in order to stabilize acute psychiatric or behavioral symptoms; evaluate treatment needs; and develop plans to meet the needs of the persons served.
Individuals with recurrent crises or a large constellation of unmet needs generally require more intensive and extended services, frequent reappraisal of approaches, including engagement with the individual and his or her support network. More clinical time is necessary to fill external gaps in services and supports that caused an individual to come into crisis.

Q: Which levels of care include criteria for skills training?
A: Skills training is a criteria for all levels except Level A and Level B Adult Outpatient.

Q: How will we obtain clarification on SPMI diagnosis?
A: It is the functional level and needed intervention versus the specific diagnosis that qualifies an individual as SPMI.

Q: How would level of care be determined for individuals receiving services from multiple programs within the same agency or multiple agencies? (For example, someone with co-occurring disorders is receiving addictions treatment from one team, housing services specific to people with serious and persistent mental illness from another, and medical case management from Multnomah County—when services are totaled they are actually receiving services at a high level of care but individual teams may be requesting authorization for just the services they are offering.)
A: Assessment should be made for those services your agency provides and are needed for the individual.

Q: Where would an individual whose baseline level of functioning is low and who has impairments in multiple areas but does not have an SPMI diagnosis fit into level of care system outlined?
(I.e. Individual diagnosed with Borderline Personality Disorder, co-occurring substance use disorder, Borderline Intellectual Functioning, and a significant health problem).
A: It is the functional level and needed intervention versus the specific diagnosis that qualifies an individual as SPMI.

Q: How are authorizations treated for people who frequently drop in and out of care? Does each treatment episode result in a new 1 year authorization?
A: No – one authorization for the year for the individual unless they change agencies. See Section 9 for additional details on changing agencies.

Q: Can the LOCUS, ECSII and CASII continue to be used as decision support tools?
A: There is nothing prohibiting providers from using the CASII and LOCUS. Clinical leaders need to make a conscious decision to evaluate whether or not their clinicians are reliably delivering services at the LOCUS/CASII levels assigned before using. In addition, these tools should not be used independent of the UM Guidelines.

Q: Can the Transition Criteria related to treatment completion be re-worked as a more objective measure?
A: Transition and/or treatment completion criteria are up to the agency discretion. All providers should be practicing utilization review where they are evaluating continuation of care concurrently. In pre-authorized levels of care the plans will approve during the course of care.

Assessment Plus Two Authorization Type

Q: What codes can be used in the Assessment Plus Two session authorization type?
A: Attached is the list of the codes included in the authorization type. 90785, 90791, 90792, 90792 AF, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90882, 90887, 90899, 90899 CC, 90899 EO, 99201, 99201 AF, 99203, 99203 AF, 99204, 99204 AF, 99205, 99205 AF, 99212, 99212 AF, 99213, 99213 AF, 99214, 99214 AF, 99215, 99215 AF, 99407, H0002, H0004, H0031, H0034, H0036, H0038, H0038 HQ, H2010, H2011, H2011 HN, H2014, H2014 HQ, H2027, H2027 HQ, H2032, H2032 HQ, S9453, T1013, T1016, T1016 HN, T1023

Q: Does a case management encounter count toward the two sessions?
A: Our intent is that the "plus two sessions" are face to face psychotherapy. We recognize you may use other codes, like case management, to help broker an entitlement for the client or gain collateral information. We are not limiting the number of encounters for this authorization type but will be reviewing data to see what codes are being used with this authorization type.

Q: What kind of encounters qualify as "plus two"? If client presents for intake in crisis and receives two case management services, does that count as the "plus two"?
A: Our intent is that the "plus two sessions" are face to face psychotherapy. We recognize you may use other codes, like case management, to help broker an entitlement for the client or gain collateral information. We are not limiting the number of encounters for this authorization type but will be reviewing data to see what codes are being used with this authorization type.

Q: Should the assessment code be the first encounter and then two psychotherapy codes or use the screening code followed by the encounter code?
A: As long as the codes are allowable in the authorization type, it is up to each agency on how to best use these codes, in what order and in compliance with the OAR.

Q: Is the client in a pre-authorization/short term state or are we providing short term Assessment Plus Two without needing an authorization?
A: The Assessment Plus Two sessions is its own separate authorization and is considered short term treatment. The data shows that there is a percent of clients who do not come back after the first 1-2 sessions so this authorization type allows for short term treatment prior to longer level of care (LOC) assignment.

Q: Can the Level of Care be assigned prior to the end of the 30 day authorization expiring?
A: Again, it is our intent that clinicians do use the Assessment Plus Two session authorization type fully. You may be able to assign sooner because the authorization plus two sessions have been completed, that is fine. The 30 day authorization length allows for cancelations and no shows.

Level B SPMI

Q: Is this the appropriate level for clients with generally an extensive history of trauma or who have recently experienced a horrific traumatic event?
A: It is the functional level and needed intervention versus the specific diagnosis that qualifies an individual as SPMI.

Q: Is this the correct level for those with severe and clearly identified Borderline Personality Disorders?
A: It is the functional level and needed intervention versus the specific diagnosis that qualifies an individual as SPMI.

Q: Is this the correct level for those with significant Traumatic Brain Injury that does not allow a return to normal mood regulation?
A: The co-morbid MH diagnosis must be the focus of treatment.

Level C Adult SPMI

Q: What is the difference between level C and Level D?
A: Level D is always pre-authorized and requires approved programs except for clients served in culturally specific programs. The main difference between levels C and D is the service intensity and frequency required to meet the client's needs.

Level D ICM and TAY

Q: For adults referred for Level D ICM/TAY, have they already been assessed to need this level of care or do we need to do an Assessment Plus Two authorization?
A: Once the Level D referral has been approved, the receiving ICM/TAY provider does not need to do an Assessment Plus Two authorization. You will need to do an assessment per the OAR and the assessment codes are part of the Level D authorization.

Q: What allowances can be made for those clients that need the same type of services but don't have the matching diagnosis(es)?
A: It is the functional level and needed intervention versus the specific diagnosis that qualifies an individual as SPMI.

Q: Is Assertive Community Treatment (ACT) in level D?
A: ACT is a separate service with a separate authorization.

Q: Are agencies being asked to discharge clients at some point in time when a client is not engaged at the recommended level or there is a lack of progress?
A: This is a clinical decision made at the agency level.

Q: Can a person be assigned a Level D and not be in ICM or TAY?
A: No. The only exception would be for an individual in a culturally specific program.

Q: How does Level D differ from ACT?
A: Services differ from ACT in the following ways:

- ICM requires 24/7 telephonic support; ACT requires 24/7 face to face support
- ICM requires service frequency of one or more contacts per week; ACT requires service frequency of several contacts per week to as much as daily contact

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.

TIPS FOR USING THIS DOCUMENT
Adult Level of Care Guidelines

After you read this page, please take a few minutes and read through the entire document before you start working with it. Please note that each of the eight authorization types are on a separate page so that you can place them side by side to compare criteria.

You will see that there are a total of eight authorization types for adults:

1. Assessment Plus Two
2. Level A Adult MRDD or Adult Meds only
3. Level A Adult Outpatient
4. Level B Adult Outpatient
5. Level B Adult SPMI
6. Level C Adult Outpatient
7. Level C Adult SPMI
8. Level D Adult Intensive Case Management (ICM) or Transition Age Youth (TAY)

In two of the authorization types (Level D, and Level A Adult MRDD or Adults Meds only), we have clustered two different kinds of authorizations under each of those two authorization types. As you are reading those descriptions, please keep in mind that they are two separate kinds of authorizations—they are clustered under one authorization type solely to try and keep the number of authorization types to a minimum.

There are four types of information provided for each of the authorization types:

- Column 1: Service Description and Expectations
- Column 2: Admission Criteria
- Column 3: Continued Stay Criteria for Renewal of Same Level of Care
- Column 4: Transition Criteria

As you are reviewing the document for the first time, we encourage you to focus on the first two columns, as they contain the information that will be most relevant to your decision-making process. As to the last two columns:

- "Continued Stay Criteria" is fairly consistent across all of the authorization levels with the exception of one criteria that refers to cultural or language barriers that are impacting the client's ability to integrate skills. Continued stay criteria is used when you are considering whether the individual should remain at this current level of care.
- "Transition Criteria" refers to any sort of transition from the client's current level of care: higher, lower, or discharge, and the information in that column is the same for all of the authorization types.

At point of reauthorization, if you are considering either a higher or lower level of care, you will look at the Admission Criteria for the level of care you are considering.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
ASSESSMENT PLUS TWO			
Assessment and up to two sessions prior to assignment by clinician for an appropriate Level of Care. Initial assessment appointment does not require a covered diagnosis on the prioritized list. Subsequent two sessions prior to ongoing Level of Care assignment must be driven by a covered diagnosis on the prioritized list and an assessment and service plan in compliance with applicable OARs.			
LEVEL A: ADULT MRDD or ADULT MEDICATION ONLY			
Specialized assessment and medication management by a MD or PMHNP and minimal adjunct case management *Examples:* • *Individual with a developmental disability that will not benefit from talk therapy.* • *Individuals that have progressed to the point in care where they only require complex medication management (e.g. injectable medications)* • *For adults only medication, this can be clients in a general outpatient setting or who fit the criteria for Severe and Persistently Mentally Ill (SPMI)* **Authorization Length: 1 year**	• Covered diagnosis on the prioritized list **AND one of the following:** • Need for care coordination with DD services and ongoing medication management • Need for medication management for a medication regime that is more complicated than generally provided in primary care.	**Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this level of care.**	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

(Note: There is no "Level A SPMI")
LEVEL A ADULT OUTPATIENT

Services are designed to promote, restore, or maintain social/emotional functioning and are focused and time limited with services discontinued when client's functioning improves. Outpatient services include evaluation and assessment; individual and family therapy; group therapy; medication management. Outpatient services are office based. *Example:* • *Mild depression or anxiety that cannot be addressed only by primary care intervention.* **Authorization Length: 1 year**	Both of the following: • Covered diagnosis on the prioritized list • Episodic depression, anxiety or other mental health conditions with no recent hospitalizations and limited crisis episodes within the past year **AND at least one of the following:** • Mild functional impairment • A presentation that is elevated from baseline	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

LEVEL B ADULT OUTPATIENT

Services are designed to promote, restore, or maintain social/emotional functioning and are focused and time limited with services discontinued when client's functioning improves. Services may include evaluation and assessment; individual and family therapy; group therapy; medication management. Case management is not generally required by individual. Outpatient services are more commonly provided in the office and with more frequency than Level A. *Examples include:* • *Moderate risk of harm to self or others requiring more frequent sessions* • *Individual is stepping down from higher level of care and increased frequency addresses symptoms* **Authorization Length: 1 year**	• Covered diagnosis on the prioritized list **AND at least one of the following:** • Moderate risk of harm to self or others • Moderate functional impairment in at least one area such as such as housing, financial, social, occupational, health, and activities of daily living • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care Meets criteria for a different level of care due to change in symptoms or function at this level of care

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

LEVEL B ADULT SPMI

Services are designed to promote recovery and rehabilitation for adults with SPMI. These services instruct, assist, and support an individual to build or improve skills that have been impaired by these symptoms. Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. **Emphasis is placed on linkages with other services and coordination of care**. Services are primarily office based and may include evaluation and assessment; consultation; case management; individual and family therapy; group therapy; medication management; skills training; supported employment; family education and support; relapse prevention; occasional crisis support. Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; and Psychosis. Diagnoses can also include Mood and Anxiety Disorders that are severe and persistent in nature and have serious impact on activities of daily living.	**ALL** of the following: • Covered diagnosis on the prioritized list • No hospitalizations or major crisis episodes within the past year • No risk of harm to self or others or risk of harm to self or others that is consistent with baseline presentation. **AND at least two of the following:** • Symptoms related to the mental illness result in a moderate functional impairment and are fairly well controlled • Individual able to navigate system with minimal to moderate support OR has supports (such as family or AFH) in place to meet client's needs • Low to moderate psychosocial stress (housing and benefits are generally stable) • Individual is generally functioning at baseline • Individual has extended periods of abstinence when a co-occurring disorder exists and risk factors are minimal • Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Example: • *Individual functioning at baseline would benefit from additional life skill development and social support in order to maintain independence* **Authorization Length: One Year**	language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports		

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

LEVEL C ADULT OUTPATIENT

Services are designed to promote, restore, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued when client's functioning improves. Services may include more community-based services and can include evaluation and assessment; individual and family therapy; group therapy; medication management; consultation; case management; skills training; crisis support; relapse prevention, hospital diversion; integrated substance abuse treatment *Examples Include:* • *Mental health issues are compounded by risk of loss of housing due to extended periods of crisis* • *Individual may benefit from care coordination and case management* **Authorization Length: 1 year**	• Covered diagnosis on the prioritized list **AND at least two of the following must be met:** • Risk of harm to self or others or risk of harm to self or others that is escalated from baseline • Moderate functional impairment in at least two areas (such as housing, financial, social, occupational, health, activities of daily living.) • At least one hospitalization within the last 6 months • Multiple system involvement requiring coordination and case management • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Significant current substance abuse for which integrated treatment is necessary • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses • Extended or repeated crisis episode(s) requiring increased services • Individual has a marginalized identity which creates barriers to receiving appropriate services,	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

	and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports • Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination		

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

LEVEL C ADULT SPMI

Services are designed to promote recovery and rehabilitation for adults with severe and persistent symptoms of mental illness. These services instruct, assist, and support an individual to build or improve skills that have been impaired by these symptoms. Comprehensive assessment and treatment planning focus on outcomes and goals with specific interventions described to achieve them. **Emphasis is placed on linkages with other services and coordination of care**. Services may include: evaluation and assessment, outreach, consultation, case management, counseling, medication evaluation and management, daily structure and support, skills training, family education and support, integrated substance abuse treatment, supported employment, relapse prevention, hospital diversion, crisis intervention and supported housing. Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; Psychosis, Mood and Anxiety Disorders that are severe and persistent in nature and have serious impact on activities of daily living *Examples Include:* • *Individual requires increased coordination in order to meet basic*	Two of the following: • Covered diagnosis on the prioritized list • Significant assistance required to meet basic needs such as housing and food • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses **AND at least two of the following:** • At least one hospitalization within the past year • Symptoms related to the mental illness result in a moderate to significant functional impairment and are only partially controlled • Risk of harm to self or others or risk of harm to self or others that is escalated from baseline • Multiple system involvement requiring substantial coordination • Extended or repeated crisis episode(s) requiring increased services • Significant current substance abuse for which treatment is necessary • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

needs such as safety, housing and food. • *Individual's symptoms are partially controlled. Additional care coordination linking client to resources will prevent hospitalization.* **Authorization Length: 1 year**	• Individual has a marginalized identity which creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports • Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination		

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria

LEVEL D: ADULT Intensive Case Management (ICM) or Transition Age Youth (TAY)

Services are provided at an intensive level in the home and community with the goal of stabilizing behaviors and symptoms that led to admission. Programs include an array of coordinated and integrated multidisciplinary services designed to address presenting symptoms in a developmentally appropriate context. These services could include group, individual, family, psycho educational services, crisis management and adjunctive services such as medical monitoring. Services include multiple or extended treatment visits. Diagnoses generally covered under this authorization type: Schizophrenia; Schizoaffective Disorder; Psychosis, Mood and Anxiety Disorders are severe and persistent in nature and have serious impact on activities of daily living. 24/7 telephonic crisis support is provided by the ICM or TAY team Services differ from Assertive Community Treatment (ACT) in frequency and in 24/7 face-to-face crisis availability	***Criteria for ICM:*** ● Covered diagnosis on the prioritized list **AND at least two of the following:** ● 2 or more inpatient admissions in the past year ● Recent discharge from the State Hospital (within the past year) ● Civil Commitment or Discharge from the state hospital within the past year) ● Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided ● Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness ● Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses **OR at least three of the following:** • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist	Criteria for ICM and TAY: **Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service • Eviction or homelessness is likely if level of care is reduced	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met • Continuing stabilization can occur with discharge from treatment with medication management by PCP and/or appropriate community supports • Individual has achieved symptom or functional improvement in resolving issues resulting in admission to this level of care • Meets criteria for a different level of care due to change in symptoms or function at this level of care

Examples Include: • *ICM: Adult with severe life skill deficits, secondary to mental health symptoms, with a recent transition from State or Inpatient Hospitalization requires coordination of multidisciplinary services in the home.* • *TAY: Teen or young adult with persistent psychotic symptoms requires intensive, in home, care coordination in order to meet treatment, housing, and employment needs.* **Authorization length: 1 year**	• Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness ***Criteria for TAY:*** • Covered diagnosis on the prioritized list **AND at least one of the following:** • 2 or more inpatient admissions in the past year • Recent discharge from the Children's Secure Inpatient Adolescent Program or long term Psychiatric Residential Treatment Services • Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness**,**		

	OR at least three of the following: • Intractable, severe major symptoms • Significant cultural or linguistic barriers exist • Significant criminal justice involvement • Requires residential placement if intensive services are not available • Not engaged in services but deemed at high risk of harm related to their mental illness • Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness • Co-occurring addiction diagnosis • Risk of loss of current living situation, in an unsafe living situation, or currently homeless due to symptoms of mental illness • Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses		

Section 6:
Child Level of Care Utilization Management Guidelines Q&A

General Questions

Q: When does a Treatment Registration Form need to be in the client's record along with the authorization in PH Tech?
A: Both the Treatment Registration Form in the client's record and the authorization in PH Tech must be completed within 45 days of the authorization start date for all levels of care. A submission of the authorization outside of the 45 business rule will go into a "pend received status" and may not be approved with the original start date request.

Q: Can community based services to children and families be allowed at all levels as appropriate?
A: There is nothing that stops providers from delivering community based services at any level, but different agency clinical philosophies and practices may cause one agency to deliver much more community based services in lower levels of care and be detrimental to standardization. Obvious initial need for community based services is an admission criteria for Levels C&D.

Q: Can the LOCUS, ECSII and CASII continue to be used as decision support tools?
A: There is nothing prohibiting providers from using the CASII and LOCUS. Clinical leaders need to make a conscious decision to evaluate whether or not their clinicians are reliably delivering services at the LOCUS/CASII levels assigned before using. In addition, these tools should not be used independent of the UM Guidelines.

Q: Why is the CASII included just for Level D?
A: It is only included for Level D because it is mandated by the State for ISA level of care.

Q*:* Are skills training and/or peer/family support specialist services covered in levels A and B?
A: Skills training and peer/family support specialist services are included in level B. Plans consider Level A to be more maintenance or brief situational treatment.

Q: Would integrated SA/MH treatment be allowed at Levels A and B or only at Level C?
A: Integrated MH/SA treatment necessitates a higher number of services than has been accounted for in modeling for future case rates and should only be used in Level C or above.

Q*:* Is the list of services in column 1 of the LOC guidelines all inclusive?
A: The service list is not all inclusive. Providers should deliver what is clinically necessary. The initial assessment and brief treatment authorization (Assessment plus two session authorization) should provide enough time to make a reasonably accurate determination that consultation or other services will be needed in a higher level of care.

Q: How do transition age youth fit into this LOC model? When a youth is over the age of 18, are they evaluated against the adult or youth criteria?
A: Transition aged youth should be evaluated against the youth criteria based on consideration of the developmental status of the individual until 18 years of age. For youth over the age of 18, adult criteria should be used. There may be exceptions to this based on pre-approval by the plans.

Q: How is “achieving maximum benefit” defined in transition criteria for Level B, C, and D and does the clinician or plan UR staff make the determination? And, at what point in time will this determination be made?
A: The clinician makes the decision for self-authorized levels of care and plan UR staff makes the decision for pre-authorized levels of care. The timing of the determination is up to the agency discretion. All providers should be practicing utilization review where they are evaluating continuation of care concurrently. In pre-authorized levels of care the plans will make determinations during the course of care.

Q: Can Level C clients have a hybrid of office-based and community-based services (i.e. medical and therapy visits in office with skills training in natural environments)?
A: This decision is up to the discretion of the individual provider. LOC guidelines allow for services provided in community, home, or school.

Q: How would we go about requesting psychological evaluations? Will those be prioritized for Level C and D?
A: Psychological examinations will continue to be exceptional needs services and require separate authorizations.

Q*:* What is the list of approved outcome measures related to this standardization?
A: Various performance measures are being discussed and presented to health share. Finalized measures will be established in early 2015.

Q: Which LOC is appropriate for youth with co-occurring developmental disabilities and/or substance abuse needs?
A: All levels of care are based on mental health need.

Q: Define expectations of therapist regarding availability during a crisis (i.e. should they interrupt sessions with other clients or can the crisis wait until the session is done to return the call)?
A: This is a judgment call that therapists must make on a case by case basis and is not defined in LOC criteria.

Assessment Plus Two Authorization Types

Q: What codes can be used in the Assessment Plus Two session authorization types?
A: 90785, 90791, 90792, 90792 AF, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90882, 90887, 90899, 90899 CC, 90899 EO, 99201, 99201 AF, 99203, 99203 AF, 99204, 99204 AF, 99205, 99205 AF, 99212, 99212 AF, 99213, 99213 AF, 99214, 99214 AF, 99215, 99215 AF, 99407, H0002, H0004, H0031, H0034, H0036, H0038, H0038 HQ, H2010, H2011, H2011 HN, H2014, H2014 HQ, H2027, H2027 HQ, H2032, H2032 HQ, S9453, T1013, T1016, T1016 HN, T1023.

Q: Does a case management encounter count toward the two sessions?
A: Our intent is that the "plus two sessions" are face to face psychotherapy. We recognize you may use other codes, like case management, to help broker an entitlement for the client or gain collateral information. We are not limiting the number of encounters for this authorization type but will be reviewing data to see what codes are being used with this authorization type.

Q: What kind of encounters qualify as "plus two"? If client presents for intake in crisis and receives two case management services, do those services count as the "plus two"?

A: Our intent is that the "plus two sessions" are face to face psychotherapy. We recognize you may use other codes, like case management, to help broker an entitlement for the client or gain collateral information. We are not limiting the number of encounters for this authorization type but will be reviewing data to see what codes are being used with this authorization type.

Q: Should the assessment code be the first encounter and then two psychotherapy codes or should the screening code be the first encounter?
A: As long as the codes are allowable in the authorization type, it is up to each agency on how to best use these codes, in what order and in compliance with the OAR.

Q: Is the client in a pre-authorization/short term state or are we providing short term assessment plus two services without needing an authorization?
A: The Assessment plus two sessions is its own separate authorization and is considered short term treatment. The data shows that there is a percent of clients who do not come back after the first 1-2 sessions so this authorization type allows for short term treatment prior to longer level of care (LOC) assignment.

Q: Can the LOC be assigned prior to the expiration of the 30 day assessment authorization?
A: It is our intent that clinicians use the assessment plus two session authorization type fully. You may be able to assign sooner because the assessment and two sessions have been completed. The 30 day authorization length allows for cancelations and no shows.

Q: What does a provider do when they complete an Assessment Plus Two and determine a youth needs a level D authorization, but is not yet ISA eligible?
A: A provider should enter an authorization for the highest LOC a child is eligible for (Level C), and concurrently complete an ISA application or referral to the appropriate county.

Level D

Q: For children referred for Level D Home-Based Stabilization, have they already been assessed to need this level of care or do we need to do an assessment plus two authorizations?
A: Once the Level D referral has been approved, the receiving Home-Based Stabilization provider does not need to do an assessment plus two authorizations. You will need to do an assessment per the OARs and the assessment codes are part of the Level D authorization.

Q: Why is Level D titled Home-Based Stabilization when level C may also be providing some home based services?
A: Based on rule, the ICTS provider is the entity that provides case coordination and facilitates Child and Family Team Meetings. These services are provided by the county staff so we are moving away from the term ICTS services and are calling this level of care Home-Based Stabilization services instead.

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.

TIPS FOR USING THIS DOCUMENT
Child and Family Level of Care Guidelines

After you read this page, please take a few minutes and read through the entire document before you start working with it.

You will see that there are a total of five authorization types for child and family

1. Assessment Plus Two (page 3)
2. Level A Child and Family
3. Level B Child and Family
4. Level C Child and Family
5. Level D Child and Family (Home Based Stabilization)

There are four types of information provided for each of the authorization types:

- Column 1: Service Description and Expectations
- Column 2: Admission Criteria
- Column 3: Continued Stay Criteria for Renewal of Same Level of Care
- Column 4: Transition Criteria

As you are reviewing the document for the first time, we encourage you to focus on the first two columns, as they contain the information that will be most relevant to your decision-making process. As to the last two columns:

- "Continued Stay Criteria" is fairly consistent across all of the authorization levels with the exception of one criteria that refers to cultural or language barriers that are impacting the client's ability to integrate skills. Continued stay criteria is used when you are considering whether the individual should remain at this current level of care.
- "Transition Criteria" refers to any sort of transition from the client's current level of care: higher, lower, or discharge, and the information in that column is the same for all of the authorization types.

At point of reauthorization, if you are considering either a higher or lower level of care, you will look at the Admission Criteria for the level of care you are considering.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
ASSESSMENT PLUS TWO			
Assessment and up to two sessions prior to assignment by clinician for an appropriate Level of Care. Initial assessment appointment does not require a covered diagnosis on the prioritized list. Subsequent two sessions prior to ongoing Level of Care assignment must be driven by a covered diagnosis on the prioritized list and an assessment and service plan in compliance with applicable OARs.			
LEVEL A CHILD AND FAMILY			
Generally office based, these outpatient mental health services are designed to quickly promote, or restore, previous level of high function/stability, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued as an individual is able to function more effectively. Outpatient services include evaluation and assessment; individual and family therapy; group therapy; medication management; and case management. *Examples Include:* • *"Maintenance Phase" of treatment to maintain baseline(has achieved maximum benefit* • *Primarily psychiatric services for on-going medication management* • *Clients who are relatively high functioning and well-regulated overall* • *Treatment will be limited and target a specific behavior, interaction, or symptom* **Authorization Length**: **One year**	• Covered diagnosis on the prioritized list **AND** • The need for maintenance of a medication regimen (at least quarterly) that cannot be safely transitioned to a PCP, **OR** • A mild or episodic parent-child or family system interactional problem that is triggered by a recent transition or outside event and is potentially resolvable in a short period of time **OR** • Transitioning from a higher level of service (step down) in order to maintain treatment gains and has been stable at his level of functioning for 3-4 visits **AND** • Low acuity of presenting symptoms and minimal functional impairment **AND** • Home, school, community impact is minimal	**Continues to meet admission criteria AND is capable of additional symptom or functional improvement at this level of care.**	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
LEVEL B CHILD AND FAMILY			
Generally office based, these outpatient mental health services are designed to promote, restore, or maintain social/emotional functioning and are intended to be focused and time limited with services discontinued as an individual is able to function more effectively. Outpatient services may include some combination of 2-3 of the following services*;* evaluation and assessment; individual and family therapy; group therapy; medication management; *and infrequent case management, skills training, and peer/family support.* *Examples include* • *Low frequency sessions, but client/family requires consistency and regular practice over time in order to develop new skills. ,habits and routines to compensate for lagging skills* • *Parent-child interactional problem may be causing some on-going impairment, therefore parent training may be a primary focus of treatment* • *Client may have more barrier to natural/informal supports and requires case management* • *Family utilizes services well and benefits from treatment, but struggles to internalize or generalize skill development* • *Home based services may be appropriate when there are cultural or developmental considerations* **Authorization Length**: **Six months**	● Covered diagnosis on the prioritized list **AND** ● Mild to Moderate functional impairment in at least one area (for example, sleep, eating, self care, relationships, school behavior or achievement) **OR** ● Mild to Moderate impairment of parent/child relationship to meet the developmental and safety needs **OR** ● Transition from a higher level of service intensity (step-down) to maintain treatment gains	**Continues to meet admission criteria AND at least one of the following:** ● Capable of additional symptom or functional improvement at this level of care ● Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** ● Documented treatment goals and objectives have been substantially met, ● No longer meets criteria for this level of care or meets criteria for a higher level of care, ● Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, ● It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
LEVEL C CHILD AND FAMILY			
These services can be provided in any of the following: clinic, home, school and community. These services are designed to prevent the need for a higher level of care, or to sustain the gains made in a higher level of care, and which cannot be accomplished in either routine outpatient care or other community support services. Outpatient services may include some combination of evaluation and assessment; individual and family therapy; medications management, casement management, skills training, peer/family support, respite and some phone crisis support *Examples include:* • *Client needs higher frequency of sessions and a combination of multiple service types* • *In vivo coaching and mild to moderate phone crisis support required to interrupt dysfunctional patters of interaction and integrate new skills* • *Unstable placement due to caregiver stress* • *Complex symptoms for which targeted caregiver /parent education is required to improve child function* **Authorization Length: Six months**	**Criteria for Early Childhood and School-Age and Adolescents:** ● Covered diagnosis on the prioritized list **At least one of the following:** ● Significant risk of harm to self or others ● Moderate to severe impairment of parent/child relationship to meet the developmental and safety needs ● Moderate to severe functional or developmental impairment in at least one area, **AND For School-Age and Adolescents at least one of the following:** ● Risk of out of home placement or has had multiple transition in placement in the last 6 months due to symptoms of mental illness ● Risk of school or daycare placement loss due to mental illness or development needs. ● Multiple system involvement requiring coordination and case management ● Moderate to severe behavioral issues that	**Continues to meet admission criteria AND at least one of the following:** ● Capable of additional symptom or functional improvement at this level of care ● Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is no more clinically appropriate service	**At least ONE of the following must be met:** ● Documented treatment goals and objectives have been substantially met, ● No longer meets criteria for this level of care or meets criteria for a higher level of care, ● Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, ● It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
	cause chronic family disruption • Extended crisis episode requiring increased services; • Recent acute or subacute admission (within the last 6 months) • Significant current substance abuse for which integrated treatment is necessary • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Child and/or family's level of English language skill and/or acculturation is not sufficient to achieve symptom or functional improvement without case management		

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
LEVEL D CHILD AND FAMILY (HOME BASED STABILIZATION)			
Home based stabilization services are provided, at an intensive level, in the home, school and community with the goal of stabilizing behaviors and symptoms that led to admission. May include some combination of evaluation and assessment; individual and family therapy; medications management; case management; skills training; peer/family support, and respite at an increased frequency. Treatment is not directed primarily to resolve placement OR behavior, conduct or substance abuse problems Crisis intervention is available 24/7 both by phone and in person. *Examples:* • *Client is discharging from residential stay or has had multiple acute/sub-acute placements in the last 6 months.* Determined appropriate for the Integrated Services Array (ISA) through the level of intensity determination or Wraparound Care Coordinator through the Review Committee Process. Individuals will be assigned a care coordinator who will facilitate a child and family team. The team will identify strengths, needs, and strategies to meet treatment needs. **Authorization Length: One month**	**Both must be met:** • Covered diagnosis on the prioritized list • Current serious to severe functional impairment in multiple areas **And one of the following:** • Treatment intensity at a lower level of care insufficient to maintain functioning • Hospital or subacute admission in the last 30 days **And two of the following:** • Serious risk of harm to self or others due to symptoms of mental illness • Serious impairment of parent/child relationship to meet the developmental and safety needs • Significant risk of disruption from current living situation due to symptoms related to a mental health diagnosis. • Transition from a higher level of service intensity (step-down) to maintain treatment gains • Child and/or family's level of English language and/or acculturation is not	**Continues to meet admission criteria AND at least one of the following:** • Capable of additional symptom or functional improvement at this level of care • Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service	**At least ONE of the following must be met:** • Documented treatment goals and objectives have been substantially met, • No longer meets criteria for this level of care or meets criteria for a higher level of care, • Not making progress toward treatment and there is no reasonable expectation of progress at this level of care, • It is reasonably predictable that continuing stabilization can occur with discharge from treatment and transition to PCP for with medication management and/or appropriate community supports.

Service Description and Expectations	Admission Criteria	Continued Stay Criteria for Renewal of Same Level of Care	Transition Criteria
	sufficient to achieve symptom or functional improvement without case management		

Section 8:
Process for Changing Level of Care

As we collaborate in the clinical design utilizing the new Level of Care Guidelines to help assure a consistent and uniform experience for Health Share members receiving outpatient mental health services, we recognize that there may be occasions when the Level of Care needs to be adjusted.

Changes in Level of Care within the Same Agency

We recognize there may be occasions in which the Level of Care assigned was incorrect. We believe that there are two primary situations that this applies to:

1. Significant change in clinical presentation after the start of the Level of Care assignment
2. Assignment to the incorrect Level of Care but not related to a change in clinical presentation

For step-by-step instructions and screen shots for changing a Level of Care, refer to Section 9 of this manual. The steps for changing an authorization within the same agency are outlined below:

- Use the "extend" function in Referral Manager in CIM. ***DO NOT*** create a new authorization, as this will create a new "episode" of care.

- Include a note in CIM to the plan using the "comments" section of the extend authorization screen which includes the reason for the change in level of care (e.g. change in clinical presentation or administration error)

- The end date on the "old" authorization should be used as the end date on the new authorization unless the end date is outside of the date range for the new authorization level. This impacts the Child and Family authorizations as they have different end dates. For example:

    - Assignment to Level A Child and Family with an authorization from 2/1/14 - 2/1/15. On March 1st, the assignment is changed to Level B. Because Level B is a 6 month authorization, the new end date will be 8/1/14 (6 months from the original start date).
    - Assignment to Level B Child and Family with an authorization from 2/1/14 – 8/1/15. On May 1st the assignment is changed to Level A. Because Level A is a 12 month authorization, the new end date will be 2/1/15 (12 months from the original start date).

- Changes in Levels of Care can be to either higher or lower levels of care during the authorization time period

- The effective date for all requests will be the date of the requested change

PH Tech will run a monthly report of authorizations that have been changed during the course of the original treatment episode. This data will be used to assess the frequency of changes to Levels of Care by provider organization. Once we have baseline data, if there is an organization at which changes seem to occur above baseline, we will solicit a conversation about the reasons for the changes and provide technical assistance as necessary.

Changes in Level of Care Across Agencies

We recognize there may be occasions when a client changes provider agency before the end of their current authorization. The steps for changing an authorization across agencies are outlined below:

1. **Multnomah, Clackamas and Washington Counties**: The new provider enters an Assessment Plus Two authorization in CIM, **THEN**

2. Based on county:
    a. **Multnomah County**: The new provider's Assessment Plus Two authorization is auto-approved **OR**
    b. **Washington and Clackamas Counties**: The new provider is notified that the Assessment Plus Two authorization was not approved in CIM. The new provider is responsible for contacting the appropriate plan contact to determine next steps including who the plan should contact at their agency to determine the clinical reason for the change. The plan contact will work with both agencies and/or the member to determine the appropriate date of the transition from the original agency to the new agency. The plan contact will close the original authorization with the original provider and approve the new authorization with the new provider once treatment needs/plans have been confirmed with provider contacts. For example: A member has a Level B Outpatient authorization at Provider M from 1/1/14 to 1/1/15. On 6/13/14, the member transitions to Provider T and Provider T submits an Assessment Plus Two authorization that denies. The plan contact adjusts the end date for Provider M's Level B authorization to 6/12/14, and approves the Assessment Plus Two Authorization at Provider T. **THEN**

3. **Multnomah, Clackamas and Washington Counties**: The new provider enters the ongoing Level A-D treatment authorization through routine authorization procedures. The new provider's ongoing Level A-D authorization will pend for plan approval. If the new provider has not yet been in contact with the RAE plan contact, the new provider will contact the appropriate RAE plan contact to determine next steps as outlined in #3 above.

Client Disengages from Services before a Level of Care Authorization is Expired

We recognize there may be occasions when a person disengages from services before the end of their current authorization. The original treatment authorization will remain open in CIM for the duration of the original authorization timeframe, unless a new provider agency requests a new authorization. If a new provider agency requests a new authorization, then the process outlined above for "Changes in Level of Care within Two Different Agencies" will be followed.

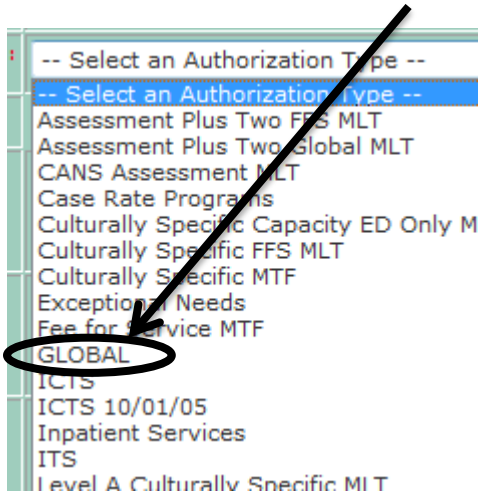
Section 9:
Case Rate Authorizations

In 2014, the behavioral health plans paid global budget payments directly to providers. In 2015, global budget authorizations with start dates in 2014 continue to be paid by each plan.

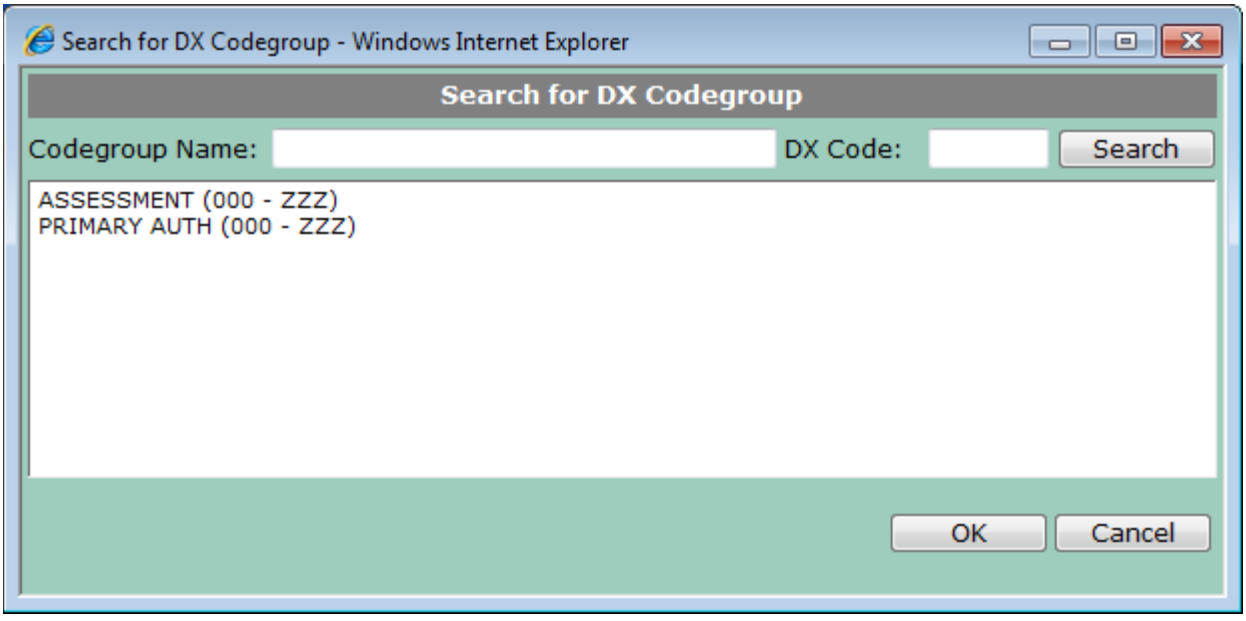
Case rate authorizations with effective dates starting 01/01/2015 will be paid through PH Tech's Clinical Integration Manager (CIM). In CIM, "global" refers to case rate authorizations and payments.

Submitting a case rate authorization in CIM

When submitting a new case rate authorization, choose **GLOBAL** for the "**Auth/Referral Type**".



You will then see options of "**Assessment**" or "**Primary Auth**" for the **Diagnosis Codegroup** to select:

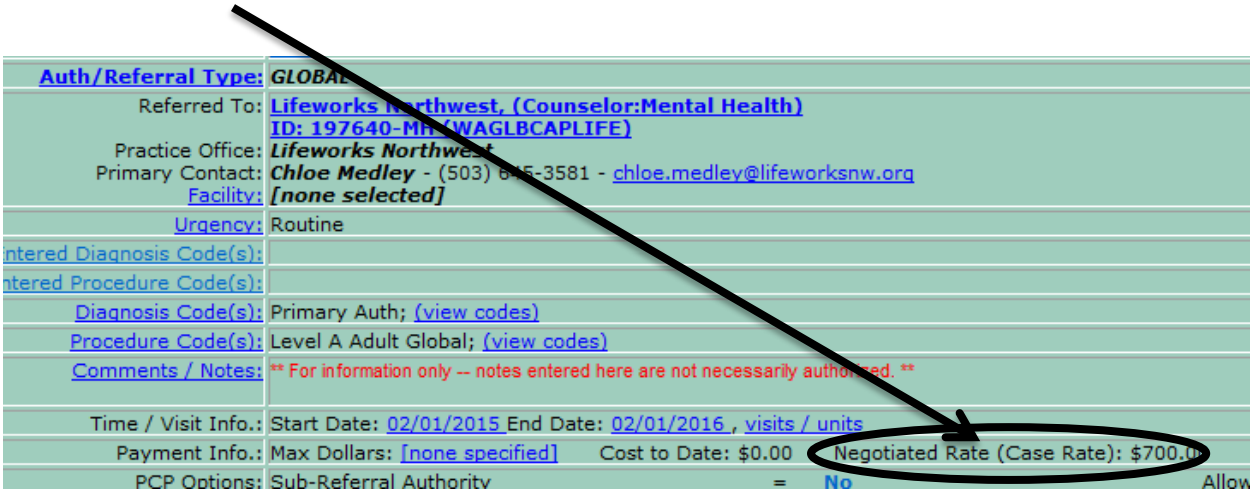


Choices for the Procedure Codegroup are as follows:

- Assessment Plus Two Global
- Level A Child Global
- Level A Adult Global
- Level A Adult MRDD Meds Global
- Level B Child Global
- Level B Adult Global
- Level B Adult SPMI Global
- Level C Child Global
- Level C Adult Global
- Level C Adult SPMI Global
- Level D Child HBS Global
- Level D Child ISA Global [Washington County choice only]
- Level D Child WRAP Global [Washington County choice only]
- Level D Adult ICM Global
- Level D Adult TAY Global
- Level D Adult Waitlist Global [Multnomah County choice only]

Negotiated Rate (Case Rate) amount

The Negotiated Rate (Case Rate) field was added for the case rate authorizations, to handle the payment that is being generated from CIM. You should not see this for other types of authorizations.



Changing Levels of Care for a Member

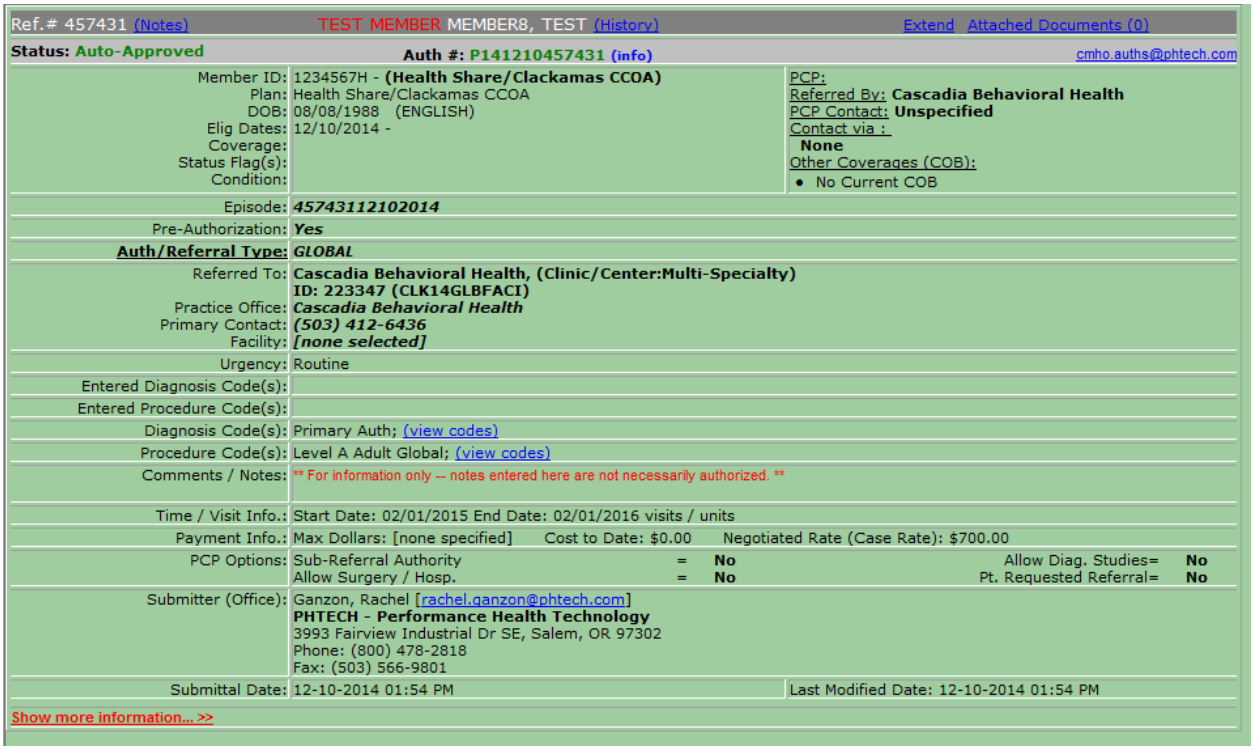
The counties will allow a change in Levels of Care within an episode of care, within the same agency. The way this change is made is through the provider using an "Extend" function, which is found when the authorization is displayed in the Referral Manager.

DO NOT create a new authorization, as this will create a new "episode" of care.

Using the "Extend" function will allow the provider to see the changes in Level of Care that the member has made. In addition, if the Level of Care goes up (example: from Level A Adult Global to Level B Adult Global), this function allows the difference in the case rate payments to be generated. Please note that the functionality of this additional payment can only happen ***within*** the same episode of treatment where the original authorization is found.

Use the following instructions to change a Level of Care for a member:

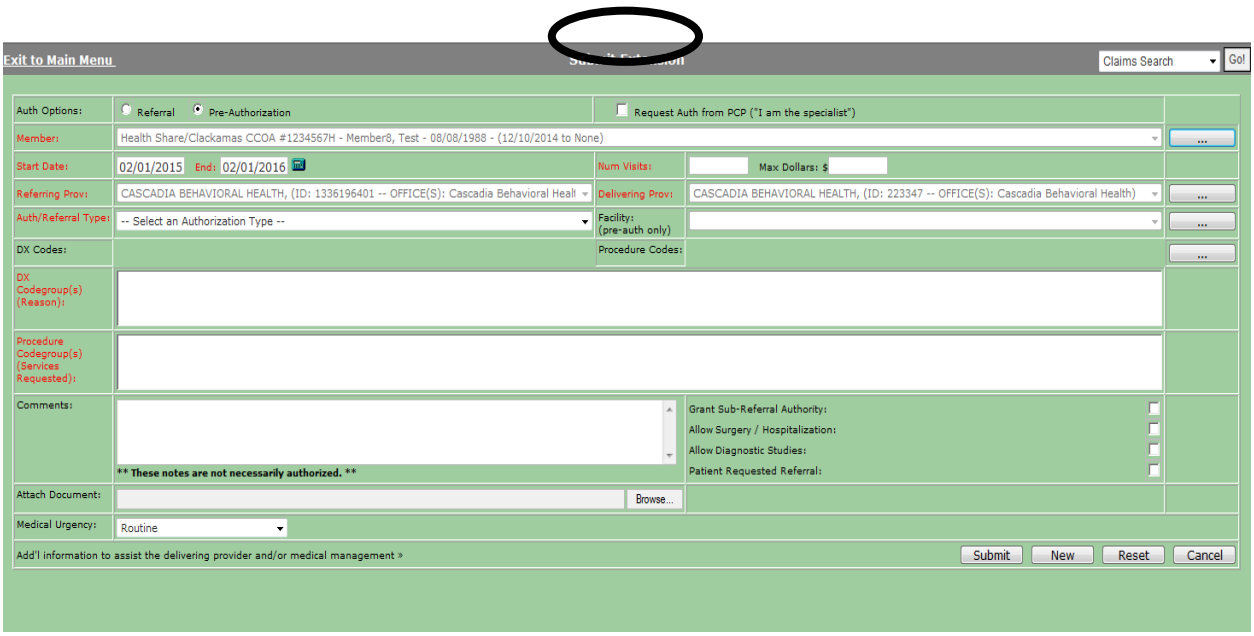
1) Go to Referral Manger in CIM, and pull up your authorization.



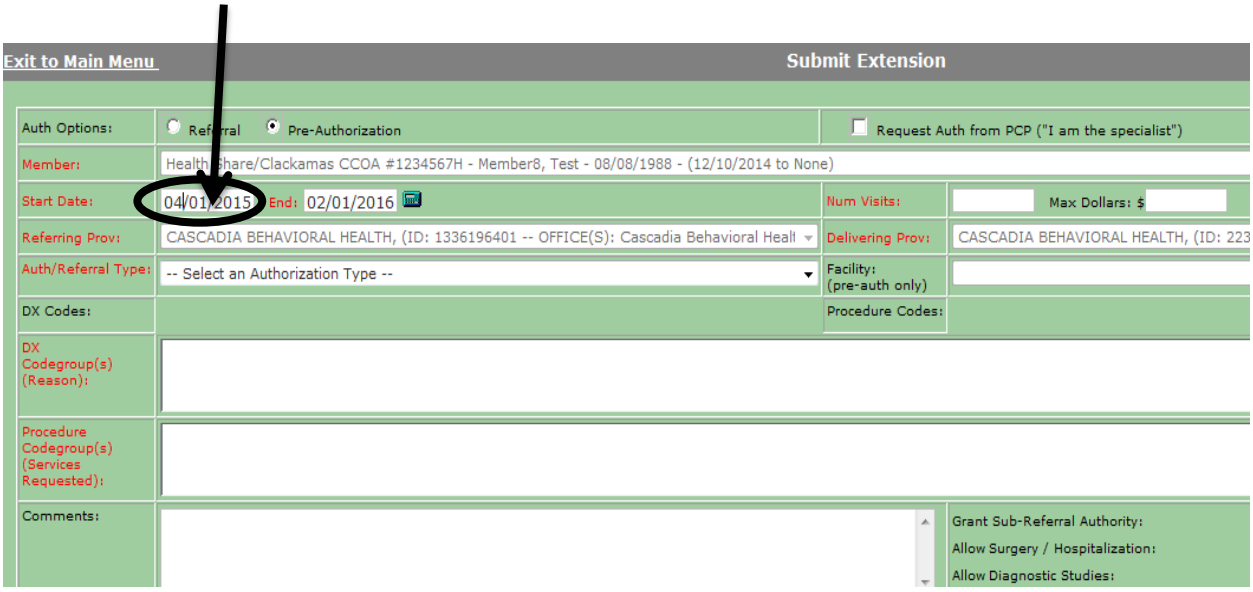
Ref.# 457431 (Notes)	TEST MEMBER MEMBER8, TEST (History)	Extend Attached Documents (0)
Status: Auto-Approved	**Auth #: P141210457431 (info)**	cmho.auths@phtech.com
Member ID:	1234567H - **(Health Share/Clackamas CCOA)**	PCP:
Plan:	Health Share/Clackamas CCOA	Referred By: **Cascadia Behavioral Health**
DOB:	08/08/1988 (ENGLISH)	PCP Contact: **Unspecified**
Elig Dates:	12/10/2014 -	Contact via :
Coverage:		**None**
Status Flag(s):		Other Coverages (COB):
Condition:		• No Current COB
Episode:	***45743112102014***	
Pre-Authorization:	***Yes***	
Auth/Referral Type:	***GLOBAL***	
Referred To:	**Cascadia Behavioral Health, (Clinic/Center:Multi-Specialty)**	
	ID: 223347 (CLK14GLBFACI)	
Practice Office:	***Cascadia Behavioral Health***	
Primary Contact:	***(503) 412-6436***	
Facility:	***[none selected]***	
Urgency:	Routine	
Entered Diagnosis Code(s):		
Entered Procedure Code(s):		
Diagnosis Code(s):	Primary Auth; (view codes)	
Procedure Code(s):	Level A Adult Global; (view codes)	
Comments / Notes:	** For information only -- notes entered here are not necessarily authorized. **	
Time / Visit Info.:	Start Date: 02/01/2015 End Date: 02/01/2016 visits / units	
Payment Info.:	Max Dollars: [none specified] Cost to Date: $0.00 Negotiated Rate (Case Rate): $700.00	
PCP Options:	Sub-Referral Authority = **No**	Allow Diag. Studies= **No**
	Allow Surgery / Hosp. = **No**	Pt. Requested Referral= **No**
Submitter (Office):	Ganzon, Rachel [rachel.ganzon@phtech.com] **PHTECH - Performance Health Technology** 3993 Fairview Industrial Dr SE, Salem, OR 97302 Phone: (800) 478-2818 Fax: (503) 566-9801	
Submittal Date:	12-10-2014 01:54 PM	Last Modified Date: 12-10-2014 01:54 PM
Show more information... >>		

2) Click on the Extend link.

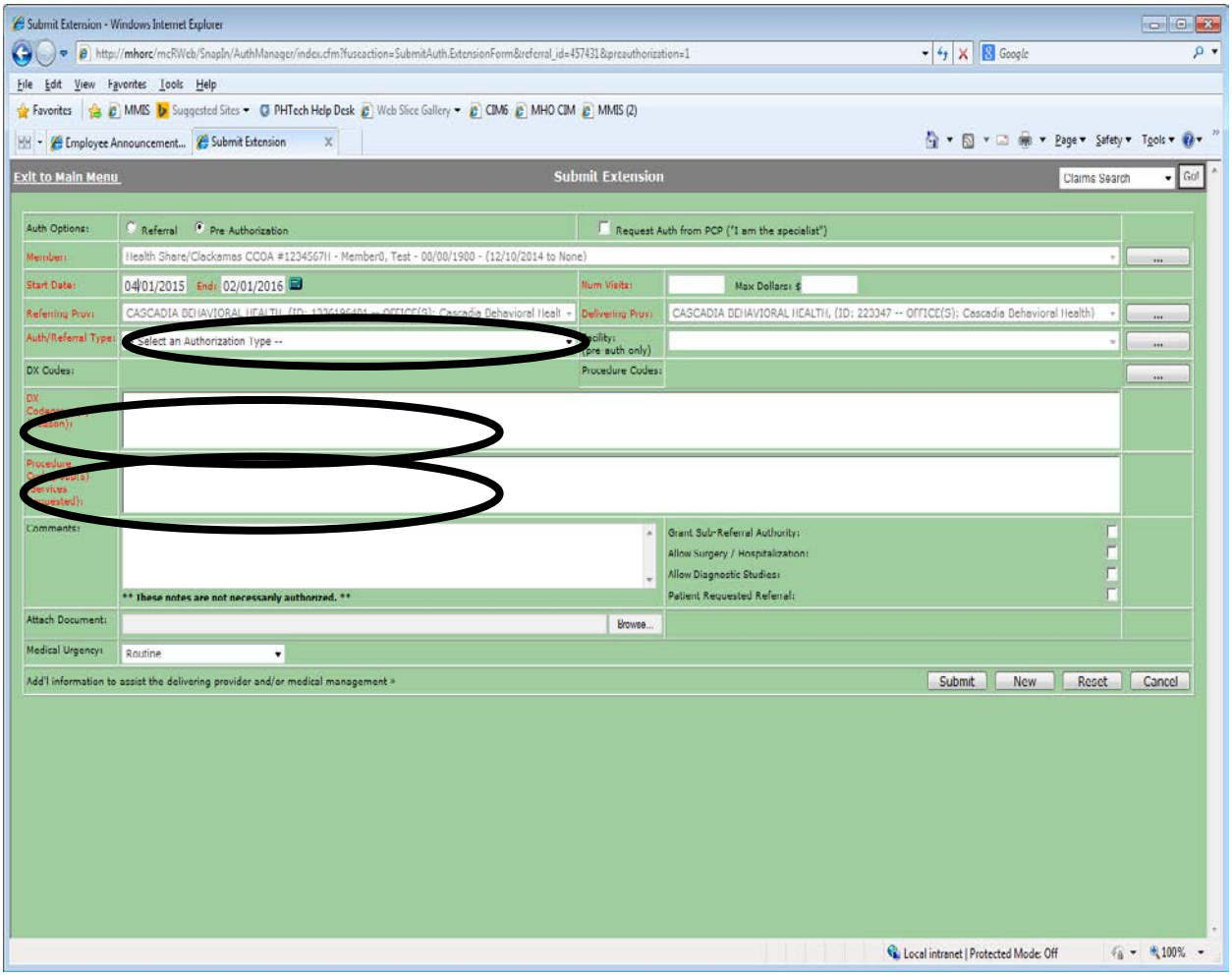
3) This will take you to the Submit Extension screen (which looks just like the Submit Authorization screen)



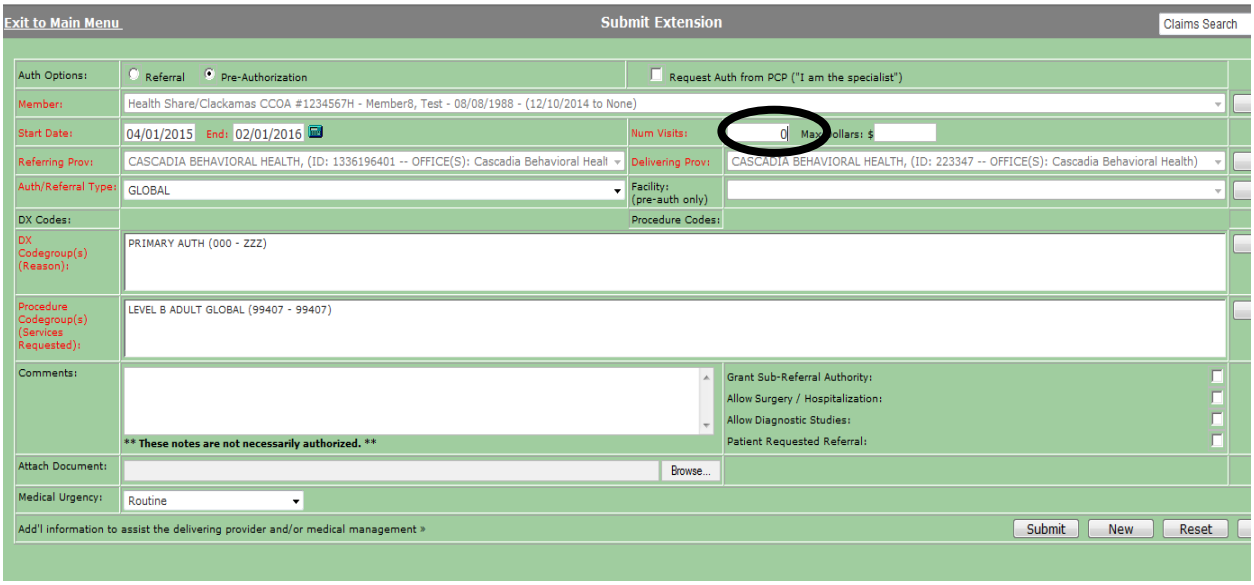
4) Update the Start Date to the date when the new Level of Care starts



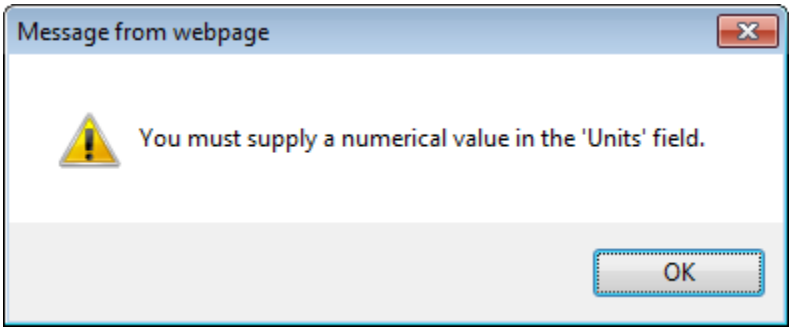
5) You will need to choose the Auth/Referral Type, DX Codegroup, and ***new*** Procedure Codegroup



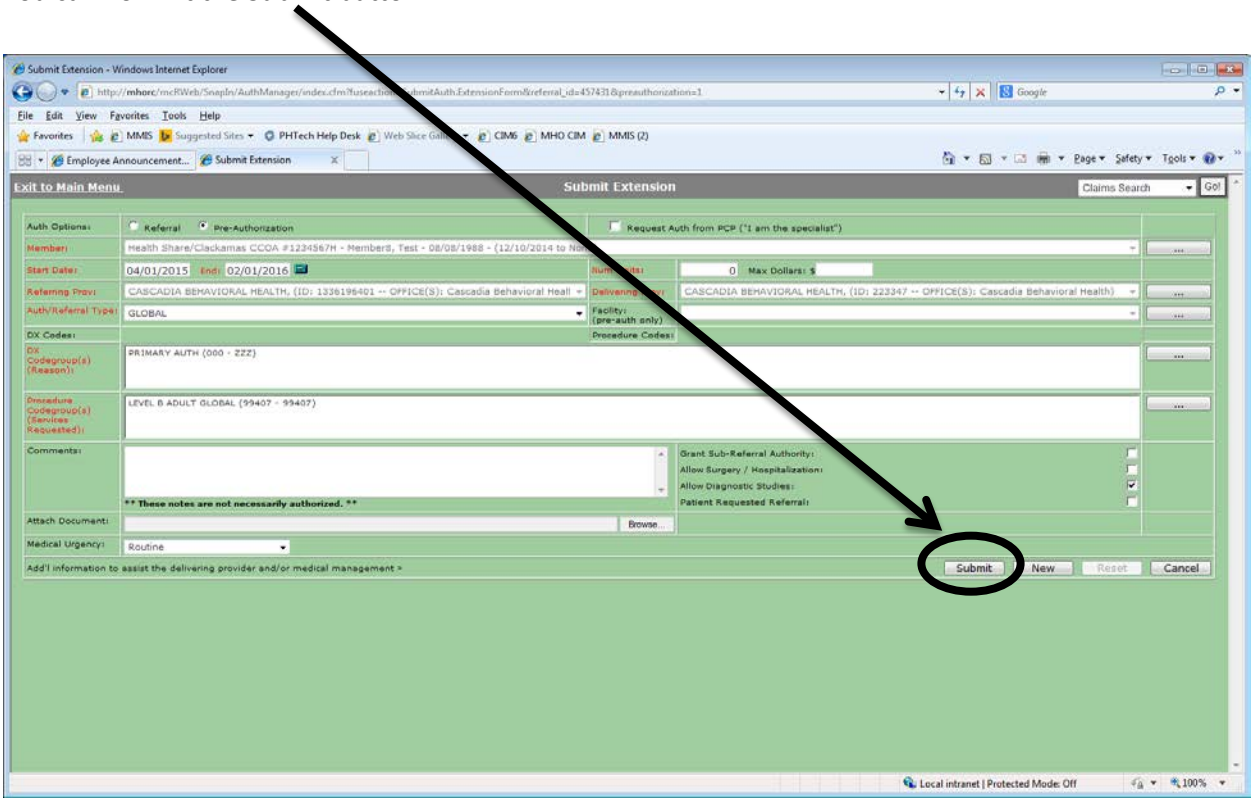
6) Enter “0” in the Num Visits: field



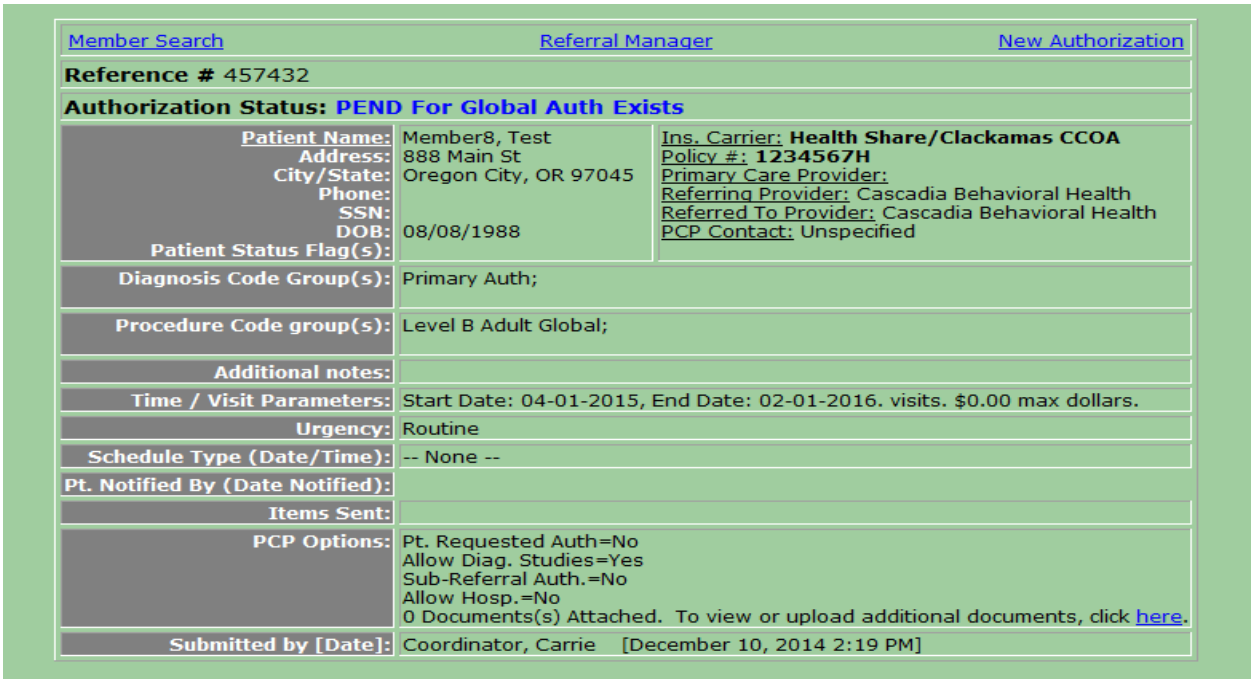
If you forget to put the 0 in the Num Visits: field, you will get a prompt to do this when you hit the Submit button.



7) You can now hit the Submit button



8) Because this change overlaps with the existing authorization, this will go into a "PEND for Global Auth Exists" status.



Member Search | Referral Manager | New Authorization

Reference # 457432

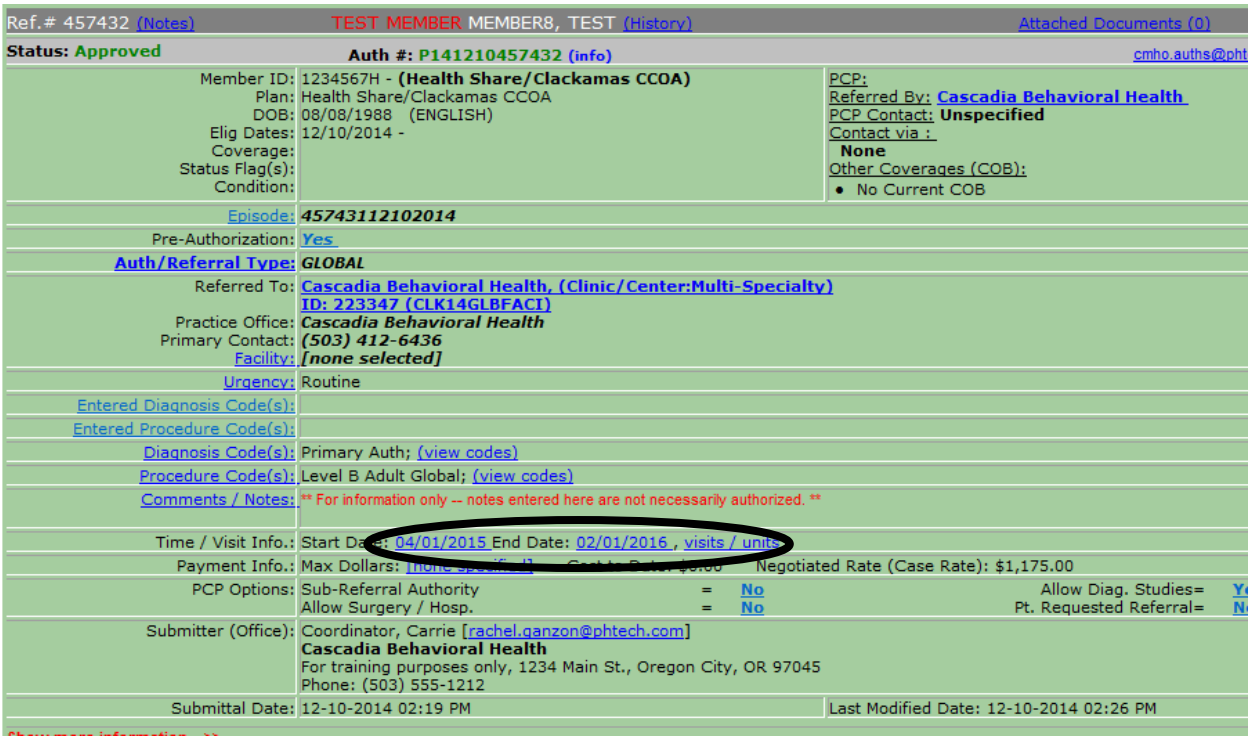
Authorization Status: **PEND For Global Auth Exists**

Patient Name:	Member8, Test	Ins. Carrier: **Health Share/Clackamas CCOA**
Address:	888 Main St	Policy #: **1234567H**
City/State:	Oregon City, OR 97045	Primary Care Provider:
Phone:		Referring Provider: Cascadia Behavioral Health
SSN:		Referred To Provider: Cascadia Behavioral Health
DOB:	08/08/1988	PCP Contact: Unspecified
Patient Status Flag(s):		

Diagnosis Code Group(s):	Primary Auth;
Procedure Code group(s):	Level B Adult Global;
Additional notes:	
Time / Visit Parameters:	Start Date: 04-01-2015, End Date: 02-01-2016. visits. $0.00 max dollars.
Urgency:	Routine
Schedule Type (Date/Time):	-- None --
Pt. Notified By (Date Notified):	
Items Sent:	
PCP Options:	Pt. Requested Auth=No Allow Diag. Studies=Yes Sub-Referral Auth.=No Allow Hosp.=No 0 Documents(s) Attached. To view or upload additional documents, click here.
Submitted by [Date]:	Coordinator, Carrie [December 10, 2014 2:19 PM]

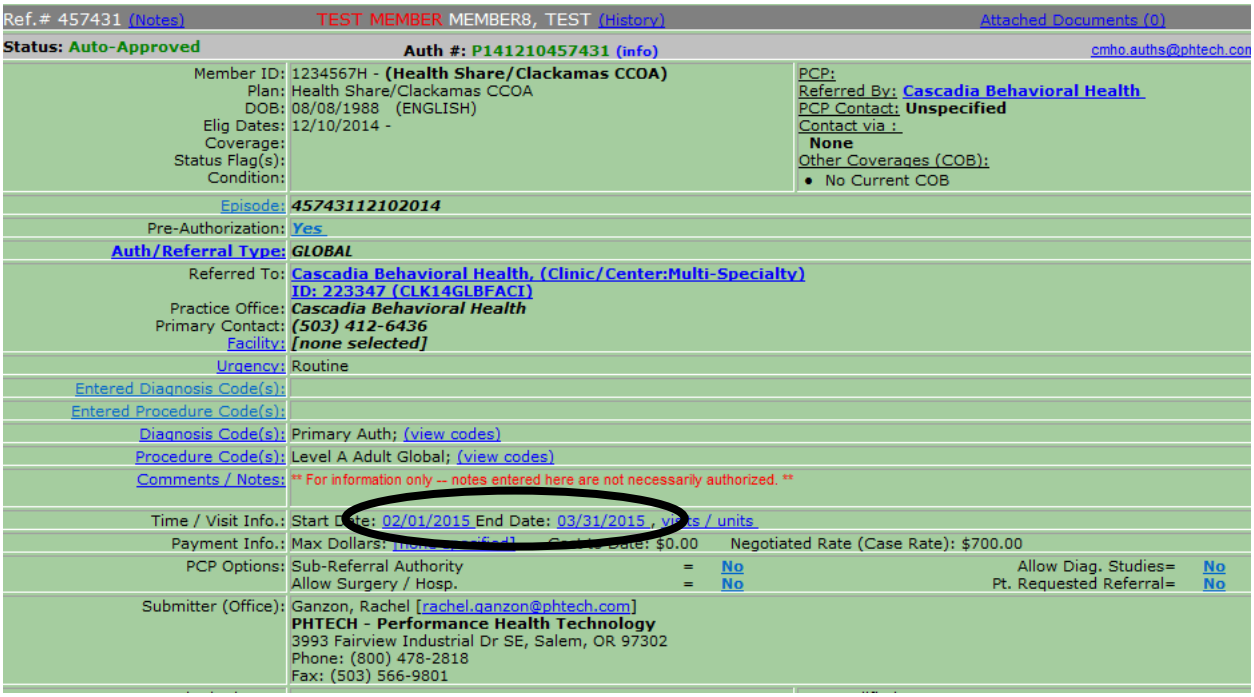
9) At this time, the county will need to review the change in the authorization and then approve it.

10) When the authorization is approved, you will see that the new Level of Care reflects the new dates for that part of the episode. You will also see a new Negotiated Rate (Case Rate).



Ref.# 457432 (Notes)	TEST MEMBER MEMBER8, TEST (History)	Attached Documents (0)
Status: Approved	**Auth #: P141210457432 (info)**	cmho.auths@pht
Member ID:	1234567H - **(Health Share/Clackamas CCOA)**	PCP:
Plan:	Health Share/Clackamas CCOA	Referred By: **Cascadia Behavioral Health**
DOB:	08/08/1988 (ENGLISH)	PCP Contact: **Unspecified**
Elig Dates:	12/10/2014 -	Contact via : **None**
Coverage:		Other Coverages (COB):
Status Flag(s):		• No Current COB
Condition:		
Episode:	***45743112102014***	
Pre-Authorization:	***Yes***	
Auth/Referral Type:	***GLOBAL***	
Referred To:	**Cascadia Behavioral Health, (Clinic/Center:Multi-Specialty)** **ID: 223347 (CLK14GLBFACI)**	
Practice Office:	***Cascadia Behavioral Health***	
Primary Contact:	***(503) 412-6436***	
Facility:	***[none selected]***	
Urgency:	Routine	
Entered Diagnosis Code(s):		
Entered Procedure Code(s):		
Diagnosis Code(s):	Primary Auth; (view codes)	
Procedure Code(s):	Level B Adult Global; (view codes)	
Comments / Notes:	** For information only -- notes entered here are not necessarily authorized. **	
Time / Visit Info.:	Start Date: 04/01/2015 End Date: 02/01/2016 , visits / units	
Payment Info.:	Max Dollars: [none specified] Cost to Date: $0.00	Negotiated Rate (Case Rate): $1,175.00
PCP Options:	Sub-Referral Authority = No	Allow Diag. Studies= Y
	Allow Surgery / Hosp. = No	Pt. Requested Referral= N
Submitter (Office):	Coordinator, Carrie [rachel.ganzon@phtech.com] **Cascadia Behavioral Health** For training purposes only, 1234 Main St., Oregon City, OR 97045 Phone: (503) 555-1212	
Submittal Date:	12-10-2014 02:19 PM	Last Modified Date: 12-10-2014 02:26 PM

You will notice that, once the new Level of Care is approved, the original authorization will adjust the end date of the original Level of Care.

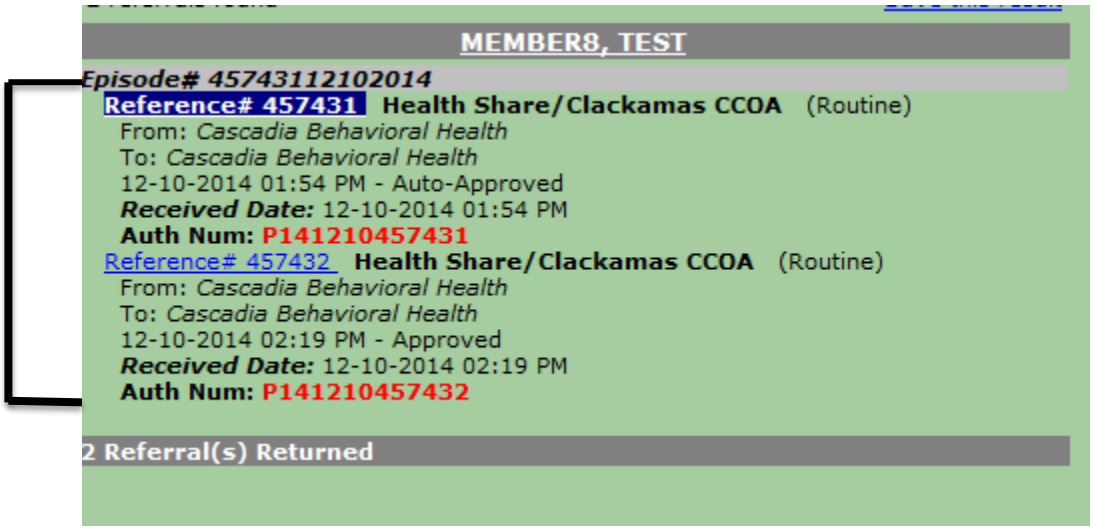


Ref.# 457431 (Notes)	TEST MEMBER MEMBER8, TEST (History)	Attached Documents (0)
Status: Auto-Approved	**Auth #:** P141210457431 (info)	cmho.auths@phtech.com
Member ID: Plan: DOB: Elig Dates: Coverage: Status Flag(s): Condition:	1234567H - **(Health Share/Clackamas CCOA)** Health Share/Clackamas CCOA 08/08/1988 (ENGLISH) 12/10/2014 -	PCP: Referred By: **Cascadia Behavioral Health** PCP Contact: **Unspecified** Contact via : **None** Other Coverages (COB): • No Current COB
Episode:	***45743112102014***	
Pre-Authorization:	*Yes*	
Auth/Referral Type:	***GLOBAL***	
Referred To: Practice Office: Primary Contact: Facility:	**Cascadia Behavioral Health, (Clinic/Center:Multi-Specialty)** **ID: 223347 (CLK14GLBFACI)** ***Cascadia Behavioral Health*** ***(503) 412-6436*** ***[none selected]***	
Urgency:	Routine	
Entered Diagnosis Code(s):		
Entered Procedure Code(s):		
Diagnosis Code(s):	Primary Auth; (view codes)	
Procedure Code(s):	Level A Adult Global; (view codes)	
Comments / Notes:	** For information only -- notes entered here are not necessarily authorized. **	
Time / Visit Info.:	Start Date: 02/01/2015 End Date: 03/31/2015 , visits / units	
Payment Info.:	Max Dollars: [illegible] Cost to Date: $0.00	Negotiated Rate (Case Rate): $700.00
PCP Options:	Sub-Referral Authority = No Allow Surgery / Hosp. = No	Allow Diag. Studies= No Pt. Requested Referral= No
Submitter (Office):	Ganzon, Rachel [rachel.ganzon@phtech.com] **PHTECH - Performance Health Technology** 3993 Fairview Industrial Dr SE, Salem, OR 97302 Phone: (800) 478-2818 Fax: (503) 566-9801	

11) The case rate payment you will ultimately receive will not exceed the case rate for the highest Level of Care for the member. Payment of the case rate is triggered when a valid encounter is submitted for the time period of the authorization.

*** Please note, the authorization number you send on your claim must match the appropriate date range/Level of Care authorization for the member.***

12) Please note that in order for the system to correctly pay the case rate and the difference of the case rates when the member moves up in Level of Care, the Levels of Care must all be ***within*** the same episode.



If you have problems with or questions about submitting case rate authorizations, please contact the Health Share/PH Tech Account Rep, Rachel Ganzon at 503-584-2107 (Rachel.ganzon@phtech.com).

Section 10:
Submitting Case Rate Encounters

Providers are required to submit encounters for all services provided as part of a case rate payment. Providers can check their Vouchers (accessed through Voucher Viewer in PH Tech's claims and authorization system, MHO CIM) to see that the services were accepted. These claims will be displayed with an Explanation of Benefit (EOB) code 24.

WHERE TO SEND YOUR CLAIMS

Claims/encounters should be directed to PH Tech in the following ways:

1) **Paper** claims will be submitted to PH Tech: Health Share/[county], PO Box 5490, Salem, OR 97304.
2) **Electronic** files will be submitted via the Secure File Transfer Protocol site that the provider has with PH Tech. EDI Support team can be reached at 503-584-2169, option 1, or edi.support@phtech.com.

In the past, some providers had more than one provider selection in MHO CIM to indicate when services were to "encounter only" or "capitate". The provider selection looked like the provider's agency name with some kind of suffix at the end such as "CAP". In addition, electronic submitters were required to input the "CAP" identifier in the 2310b loop of their 837P file. This will not be required for 2014/15 dates of service. You will also notice that the old provider selections are not available to choose when submitting an authorization with a 2014 start date.

Please note that in submitting claims, claims need to be split out by:

1) Rendering provider
2) Authorization number
3) County/insurance carrier

Case Rate Providers Submitting Fee-for-Service Claims

Providers who receive case rate payments may also still have authorizations for which they will bill and receive a Fee-for-Service (FFS) payment. To differentiate FFS claims use a "GB" modifier, placed in the first modifier position, for each fee for service line of service.

If you bill electronically, you will need to test with the PH Tech EDI Support team first. The testing will be specifically for the GB modifier being reported in that first modifier position. The EDI Support team can be reached by calling 503-584-2169, option 1, or by email at edi.support@phtech.com .

If you have questions, please contact PH Tech's Account Representative for Health Share, Rachel Ganzon, 503-584-2107, Rachel.ganzon@phtech.com .