Behavioral Health Outpatient Treatment

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

PacificSource covers outpatient behavioral health treatment for mental health disorders, substance use, and co-occurring disorders (more than one or a combination of mental health, substance use, and physical health disorders) for adults, children, and adolescents, subject to the contract benefit and policy limitations.

Outpatient Treatment is understood to be a range of treatment and recovery services either face-to-face or by real-time, synchronized two-way video and audio provided in the community, for members experiencing mental health conditions, substance use disorders, or problem gambling.

For additional information about PacificSource Community Solutions (PCS), see specific section below.

Criteria

Commercial, Medicare, and Medicaid

PacificSource **does not** require prior authorization or referrals for admission to outpatient behavioral health services.

Outpatient Behavioral Health services utilize the following clinical guidelines:

- Treatment must be provided by eligible practitioners as defined by the contract and benefit structure
- Only eligible practitioner types will be able to bill psychotherapy codes (908xx):
    - Licensed Medical Professional (LMP)
    - Licensed Professional Counselor (LPC)
    - Licensed Clinical Professional Counselor (LCPC)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Clinical Social Worker (LCSW)
    - Psychologist (PsyD, LCP, or LP)
    - Qualified Mental Health Professional (QMHP) - Medicaid COA providers only
    - Board Registered Associates (BRAs) - Billed under the rendering provider for Medicaid; Incident To for Commercial/Medicare (See Incident to Billing policy)

  Note: PacificSource (Commercial) and PacificSource Medicare will no longer allow BRAs to bill for services, **effective 10/1/2026**.
- Coverage is limited to those services and diagnoses which are a plan benefit. Services that are **NOT** a covered benefit include:
    - Adolescent Wilderness Treatment Programs
    - Aversion Therapy
    - Court-mandated Screenings or Programs, unless deemed to meet medical necessity requirements
    - Court-ordered Sex Offender Treatment Programs
    - Educational or Instructional, Correctional Services, or Sheltered Living Programs provided in school or halfway house
    - Hippotherapy/Equine/animal therapy
    - Hypnotherapy
    - Marriage or Couples Counseling
    - Psychoanalysis
    - Psychotherapy received as part of an educational or training program
    - Sensory Integration Training
    - Support Groups
    - Unlisted Psychiatric Service or Procedure
- Visit length conforms to the CPT coding as per the Current Procedural Terminology, published by the American Medical Association
- Treatment provided must be medically necessary (and medically appropriate for PCS).
    - PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for members under 21 or Young Adults with

Special Health Care Needs (YSHCN). Third Level Reviewers perform case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness, as defined in OAR 410-151-0001, prior to denying coverage of services

- An assessment is completed to determine a diagnosis that requires medically necessary outpatient behavioral health treatment
- The member has at least one diagnosis found in the ICD-10 classification system and Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)
- Symptoms and functional impairments are documented in the assessment and must support the diagnosis
- Substance use disorder evaluation is part of the initial assessment. A referral is made for appropriate intervention to address substance use, if clinically indicated. Treatment of substance use disorders is subject to the most current placement criteria established by the American Society of Addiction Medicine (ASAM)
- Treatment which is court ordered or required by a third party must also meet medical necessity criteria and will not be covered solely because of a court order or third-party requirement
- The member demonstrates the capacity and willingness to participate actively in treatment
- The member's record contains a treatment plan with objectives that have been formulated in collaboration with the member. The treatment objectives are individualized, specific, measurable, achievable, realistic, and time based, including a baseline evaluation for the purpose of evaluating treatment progress
- Providers consistently use a trauma-informed approach, and members are assessed for Adverse Childhood Experiences (ACE), trauma and resiliency in a culturally and linguistically appropriate manner, using trauma-informed framework. This is reflected in the member's Service Plan (treatment plan)
- The intensity and frequency of treatment is variable and depends on the member's diagnosis and presenting symptoms and is appropriate to the individualized treatment plan
- Whenever possible, the treatment plan will include objective measures, such as diagnostic screening tools, used to assess a member's baseline function and progress during treatment (e.g., PHQ-9 or GAD-7)
- The treatment plan identifies alternative strategies if the member is not progressing toward achievement of the treatment objectives in a timely manner. Examples include a psychiatric evaluation (if not yet obtained), a second opinion, or consideration of additional or different treatment modalities
- Providers use a comprehensive Behavioral Health Assessment Tool to guide the intensity and frequency of behavioral health services based on the member's needs, consistent with OAR 309-019-0135, when applicable
- Treatment focuses on reducing active symptoms and functional impairments and is not primarily a substitute for the member's natural, social, or community supports
- Providers will document each service provided in a service note that must include:
    - The specific services rendered
    - The treatment plan objective(s) addressed

    - The date, time of service, and actual amount of time services were rendered
    - The name and credentials of the person rendering services, including signature
    - Updates on individual's progress in treatment
- Active family/significant other involvement is important unless contraindicated or declined by the member and is intended to reduce specific symptoms or functional impairments. Family therapy is an integral part of child/adolescent behavioral health treatment
- Treatment duration is time-efficient and emphasizes reducing symptoms and improving functioning as rapidly as possible, to a level at which the member can maintain adequate functioning and tolerate residual symptoms
- Timely psychopharmacologic evaluation and treatment will be considered for conditions that are known to be responsive to medication. Medication benefits and risks will be discussed with the member before any psychotropic medications are prescribed. Ongoing monitoring of medication response and adherence will be documented in the member's treatment record
- Coordination of care between the behavioral health practitioner and the member's primary care practitioner (PCP) and psychotropic medication provider is documented in the member's treatment record. Member objection to authorize contact between the behavioral health practitioner and other relevant providers is documented and addressed
- Coordination of care and appropriate referrals are provided if there is a need to transition the member to a more intensive level of care for safety and short-term stabilization. PacificSource uses the following criteria to determine medical necessity for levels of mental health care:
    - Treatment for children ages 5 years and under uses Early Childhood Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry
    - Treatment for children ages 6 to 18 years uses Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry
    - Treatment for adults ages 19 and older uses Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), Adult Version 20, by the American Association for Community Psychiatry
- Treatment will be discontinued when no longer clinically indicated. Members may no longer meet clinical guidelines for outpatient treatment when:
    - Treatment objectives are met, or member's symptoms are sufficiently under control
    - The individual is non-participatory, uncooperative, or non-compliant with treatment
    - There is evidence that additional outpatient therapy will not create further symptom relief and/or significant change
    - The member's needs would be more appropriately addressed at a different level of care

Medicaid

- PacificSource Community Solutions (PCS) ensures access to behavioral health services, regardless of location, frequency, intensity, or duration of services, and as medically appropriate:
    - Include assessment, evaluation, treatment planning, supports, and delivery

    - Provide trauma informed care and treatment
    - Include strategies to address environmental and physical factors, social determinants of health and equity, and neurodevelopmental needs that affect behavior
- PCS protects members' right to obtain outpatient behavioral health services or behavioral health peer delivered services from within PCS' Provider Network without a prior authorization as specified in 410-141-3835, with the exceptions of the following treatments and services which require a prior authorization per CCO Contract Exhibit B Part 2(3)(b)(6):
    - Applied Behavior Analysis (ABA), see related PS related policy with the same title
    - Electroconvulsive therapy (ECT) or electroshock therapy:
        - ECT therapy is a procedure, which involves the intentional induction of generalized seizures by administering electrical impulses to the anesthetized member. Treatments are typically administered by a psychiatrist and an anesthesiologist or anesthetist
        - ECT therapy is generally administered in an inpatient setting but can be administrated on an outpatient basis in a facility with treatment and recovery rooms
        - PCS follows Guideline Note 69 of the Oregon Health Plan (OHP) Prioritized List of Health Services to determine coverage based on medical necessity
    - Neuropsychological evaluations, see related PS policy Neuropsychological and Psychological Testing
    - Transcranial Magnetic Stimulation (TMS), see related PS policy Transcranial Magnetic Stimulation
- PCS does not deny a member under age twenty-one (21) access to mental health assessment, treatment, or services on the basis the member also has an intellectual or developmental disability, consistent with Section 1 of the Enrolled Oregon Senate Bill 729 (2025)
- PCS does not require referrals from a primary care provider or otherwise to access behavioral health services. Members can self-refer to behavioral health services available from the provider network
- PCS ensures members have access to behavioral health screenings and referrals for services at multiple health system or health care entry points
- Members can receive behavioral health services from non-participating providers if those services are not available from participating providers or if a member is not able to access services within the timely access to care standards in OAR 410-141-3515:
    - PCS will coordinate behavioral health services with non-participating providers through utilization management and care management teams
    - PCS will reimburse for services that are determined to be medically necessary, including those provided outside of the state, when such services cannot be provided within the timely access to care standards in OAR 410-141-3515
- PCS utilization management and care management teams monitor needs related to social determinants of health, environmental and physical factors, equity, and neuro-developmental needs. Care management teams also screen members for adequacy of supports for the family

in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs, and home visiting). Members are referred internally to care management programs, or to community-based programs to address their needs. PCS also coordinates care with providers to ensure all necessary elements of a member's care are being addressed

- PCS ensures children, especially those in custody of Department of Health Services (DHS), who are prescribed psychotropic medications are prioritized for service coordination and behavioral health services. PCS CM may reach out to a provider who is prescribing psychotropic medications to children to ensure mediation therapy is appropriate or consult with PCS Behavioral Health Medical Director to review psychotropic medications in accordance with Ex. B, Part 2, Sec.7, Para. d., of the OHA Health Care Services CCO 2.0 Contract
- PCS ensures access to a wide variety of outpatient behavioral health services that include but are not limited to:
    - Specialty programs which promote resiliency and rehabilitative functioning for individual and family outcomes
    - Assertive Community Treatment (ACT), Enhanced care and outreach services, Wraparound, Behavioral Supports, Crisis Care, Respite Care, Intensive outpatient services and supports, Intensive In-Home Behavioral Health Treatment (IIBHT), and Parent-Child Interaction Therapy (PCIT)
- PCS provides treatment for members with Co-Occurring Disorders (COD) and shall ensure access to treatment for CODs for members assessed at Levels 1 or 2 of the ASAM Criteria with providers approved by OHA for COD services, contingent upon the availability of one or more appropriately approved COD providers in the PCS service area
- PCS shall ensure member access to outpatient problem gambling treatment services that are medically necessary covered services, contingent upon the availability of providers certified by OHA for such services in PCS service area. PCS shall assist its members in gaining access to problem gambling treatment services not covered by PCS' CCO contract, including, but not limited to, residential treatment and outpatient treatment that do not meet DSM diagnostic criteria for a gambling disorder. Such services are carve-out services and are paid for by OHA under its direct contracts with providers
- PCS ensures members have access to evidence-based dyadic treatment and treatment that allows children to remain living with their primary parent or guardian. Dyadic treatment is specifically designed for children eight (8) years and younger
- PCS ensures level of care criteria for behavioral health outpatient services, intensive outpatient services and supports, and IIBHT includes children birth through twenty (20) years old in accordance with OAR Chapter 309, Division 22. PCS requires providers to provide a minimum of intensive outpatient level of care for children birth through twenty (20) years with complex mental health needs and who are at risk for an out of home placement of who are stepping down from a higher level of care
- Periodic social-emotional screening for all children birth through five (5) years is conducted in the primary care setting and ensures any concerns revealed by the screening are addressed in a timely manner
- PCS does not require prior authorization for Medication Assisted Treatment (MAT) for substance use disorders, including opioid and opiate use disorders, at any point in treatment

- PCS members are informed of their benefit to access and are encouraged to utilize Peer Delivered Services (PDS), including Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, Youth Support Specialist, or other peer specialist, in accordance with OAR 309-019-0105 (See the PCS Peer Delivered Services policy for PDS information)

Provider Network for Outpatient Services

PacificSource has established timeliness access standards of care related to primary care, emergent/urgent care, and behavioral health care (See Accessibility of Service for Primary Care Services, Emergent Urgent Care services, and Behavioral Health Care services in the related policy section). PacificSource ensures that minimum necessary availability standards are reviewed at least quarterly, to ensure that there is a sufficient number of participating providers within our service areas. Provider Network is responsible to review and analyze our networks against established access standards. If there are deficiencies identified within the review, provider contracting will focus their efforts to address and eliminate the deficiency. See Network Availability Standards-Medicaid and Network Availability-Commercial listed in the related policy section for detailed network availability standards for Medicaid.

Claims Information

Commercial

- Psychiatric diagnostic evaluations (90791, 90792) are covered services, even if billed with a noncovered diagnosis. Billing of psychiatric diagnostic evaluations for a member is allowed once per year or when a member experiences a significant change in their clinical need
- Family psychotherapy with or without the patient (90846, 90847) is covered when billed with a covered mental health and/or a substance used disorder diagnosis, and the patient was the main discussion. Clinical editing may apply if other therapy codes are billed on same date of service
- Group psychotherapy (90853) is covered when billed with a covered diagnosis and is limited to one unit. Additional units are ONLY allowed if the provider's contract specifically indicates they can bill for more than one unit (there are very few providers with this provision in their contract)
    - It is not appropriate for providers to bill 90853 with a modifier 59, XE, 76, or 77. Claims with 90853 and modifiers will be routed to Claims Review

Definitions

CALOCUS-CASII - The Child and Adolescent Level of Care/Service Intensity Utilization System by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

ECSII - The Early Child Service Intensity Instrument by the American Academy of Child and Adolescent Psychiatry.

Licensed Medical Professional (LMP) - A professional licensed, registered, or certified under Federal or State regulations to provide health care services (e.g., psychiatrist, physician, physician assistant, nurse practitioner.

LOCUS - The Level of Care Utilization System for Psychiatric and Addiction Services by the American Association for Community Psychiatry.

Face-to-Face - A personal interaction where communication between at least two-person(s) can be had and facial expressions can be seen in person or through telehealth services where HIPAA approved live streaming audio and video is secured.

Mental Health Counselors - Licensed Master's level professionals who practice psychotherapy, this is limited to a Licensed Professional Counselor (LPC) or Licensed Clinical Professional Counselor (LCPC)

Related Policies

Applied Behavioral Analysis (ABA)

Assertive Community Treatment

Behavioral Health Provider Availability – Medicaid

Covered Services

Crisis Management and Services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Enterprise Accessibility of Services

Fidelity Wraparound

Incident to Billing

Intensive Care Coordination (ICC) Services

Intensive In-Home Behavioral Health Treatment

Peer Delivered Services

Medically Necessity Reviews

Mental Health Treatment

Network Availability Standards - Medicaid

Network Availability Standards - Commercial

Neuropsychological and Psychological Testing

Substance Use Disorder Treatment

Transcranial Magnetic Stimulation

References

American Academy of Child and Adolescent Psychiatry (AACAP). (n.d.). Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII).
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Mee-Lee, D., Shulman, G. D., Fishman, M., Gastfriend, D. R., & Miller, M. M. (2013). The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions (3rd ed.). American Society of Addiction Medicine

National Institute for Health and Care Excellence (NICE). (2022). Depression in adults: Treatment and management (NG222). https://www.nice.org.uk/guidance/ng222

Optum360 solutions. ICD-10-CM Expert for Physicians: The Complete Official Code Set, Optum360, LLC

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Behavioral Health Services – Chapter 309 https://secure.sos.state.or.us/oard/displayChapterRules.action

Oregon Administrative Rules (OARs). Oregon Health Authority. Health Systems: Medical Assistance Programs – Chapter 410. https://secure.sos.state.or.us/oard/displayChapterRules.action

Oregon Health Plan, Health Plan Services Contract. Coordinated Care Organization Contract with PacificSource Community Solutions, Inc.

Appendix

Policy Number:

Effective: 10/1/2020 **Next review:** 9/1/2027

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): 42 CFR § 422.116; Oregon Senate Bill 729 (2025), Oregon House Bill 3046; OAR Chapter 309, Division 19, OARs: 410-141-3515, 410-151-0001 and 410-141-3835, Medicare Managed Care Manual, Chapter 4, section 30.0 Counseling Services.

OPs Approval: 7/2026