Behavioral Health Panel Toolkit

For newly contracted behavioral health practitioners

This packet provides convenient access to resources for newly contracted behavioral health practitioners. We appreciate your attention to the enclosed policies and requirements, and hope you find them helpful in caring for your PacificSource patients.

Contents

If you have questions, please contact your **Provider Relations Representative**, or email **ProviderRelationsRep@PacificSource.com**.

PacificSource

Behavioral Health Outpatient Treatment

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

Enterprise Policy

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 face-to-face or by real-time, synchronized two-way video and audio which originates in the practitioner's office setting, either as group, family, or individual psychotherapy or psychiatric evaluation and management appointments.

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

Criteria

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/facilities as defined by the contract and benefit structure
- Coverage is limited to those services and diagnoses which are a plan benefit
- 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.
- 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)
- Symptoms and functional impairments are documented in the assessment and must support the diagnosis;
- Substance abuse 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). Providers use trauma-informed frameworks for assessment, treatment planning, and treatment delivery in a culturally and linguistically appropriate manner. This is reflected in the member's Individual Service and Support 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 assist in adapting the intensity and frequency of behavioral health services to the behavioral health needs of the member
- 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 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
    - Are trauma informed
    - Include strategies to address environmental and physical factors, social determinants of health and equity, and neurodevelopmental needs that affect behavior.
- PCS does not require prior authorization for outpatient behavioral health services or behavioral health peer delivered services from within PCS' Provider Network also described in Ex. B, Part 2, Sec. 3, Para., Sub Para. (6) of the OHA Health Plan Services CCO 2.2 Contract.
- 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 access to a wide variety of outpatient intensive specialty programs which promote resiliency and rehabilitative functioning for individual and family outcomes. These programs include:
    - Assertive Community Treatment (ACT) - An evidence-based practice designed to provide comprehensive treatment and support services to individuals with serious and persistent mental illness
    - Intensive Care Coordination (ICC) - A specialized care management service designed to meet the needs, in complexity, scope, and intensity, of all members who qualify and choose to participate in the program

- Intensive outpatient services (IOP) - Structured, nonresidential evaluation, treatment, and continued care services for individuals who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services
- Intensive outpatient services and supports for children and adolescents (IOSS) - A specialized set of comprehensive in-home and community-based supports and mental health treatment services for children that are developed by the child and family team and delivered in the most integrated setting in the community
- Intensive In-Home Behavioral Health Treatment (IIBHT) - An intensive, community-based level of care for youth ages 0-20 years with complex mental health needs who are at risk for an out of home placement or who are stepping down from a higher level of care;
- Parent-Child Interaction Therapy (PCIT) - A therapeutic intervention intended for children ages 2 through 6 years experiencing significant social, emotional, or behavioral problem and their parents
- Fidelity Wraparound - A model of team-based intensive care coordination for children and their families based on National Wraparound Initiative values and principles

- Members eight (8) years and younger have access to evidence-based dyadic treatment and treatment that allows children to remain living with their primary parent or guardian.
- Level of care criteria for behavioral health outpatient services, intensive outpatient services and supports, and IIBHT includes children birth through five (5) years in accordance with OAR Chapter 309, Division 22. Members ages birth through five (5) with indications of adverse childhood events and high complexity have access to a minimum of intensive outpatient services.
- 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 encourages the utilization of Peer Delivered Services (PDS) and ensures that members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the member's diagnosis and needs are consistent with OAR 309-019-0105. See the PCS Peer Delivered Services Policy in related policy section for details 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.

Definitions

CALOCUS-CASSI - 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

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 there is secured HIPAA approved live streaming audio and video.

Documentation Requirements for Health Practitioners

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Background

Quality health care and accurate billing is based on rigorous and complete clinical documentation in the medical record. Complete and clear documentation is also critical to timely review for reimbursement of services. PacificSource requires sufficient documentation to meet policy requirements and regulatory compliance as well as ensure compliance with generally accepted best practice guidelines. This policy is intended to cover the basic documentation requirements. Additional requirements may be needed per treatment specific policies, procedures, criteria-based guidelines, and regulatory requirements used by and applicable to PacificSource.

All services shall be provided by staff within the scope of practice of the individual delivering service. Clinicians will follow scope of practice specific requirements determined by regulations, including those of the applicable licensing governing boards.

Criteria

Commercial, Medicaid and Medicare

I. Physical, Behavioral and Oral Health Documentation Requirements

A. General Procedures/Services Documentation Requirements

PacificSource requires **ALL** clinical documentation to meet the following requirements:

- Be complete, legible, and comply with signature and date requirements;
- Document date of service on every entry;

- Reflect the encounter was documented during the session or as soon as practical thereafter to maintain accurate documentation of services;
- Support the level of service provided, including PacificSource policy requirements;
- Use only standardized abbreviations or acronyms, when applicable;
- Be original entries and not be copied and pasted (i.e., duplicative or identical to other clinical notes) into the clinical record;
- Include and demonstrate medical necessity in each clinical note.

II. Initial Assessment or Exam Documentation Requirements

PacificSource requires physical and behavioral initial assessments or dental exams to include, but are not limited to the following components:

- Complete member identification; name or identification number on each page of the record;
- Reason for encounter, presenting problem(s)/problem list which includes significant illness(es), physical, behavioral, or dental condition(s), as applicable, and precipitating factors;
- Medical history, including but not limited to prior medical history (e.g., accidents, operations, illnesses, etc.), physical exam, and allergies and adverse reactions, as applicable. Current medications should also be listed along with the name of prescribing medical provider;
- Behavioral health history and current medications including name of prescribing medical provider, as appropriate;
- Psychosocial history (elements may include developmental and family history, etc.);
- Subjective and objective exams, including mental status exam, as appropriate;
- Evidence of coordination of care for physical, behavioral, and oral health needs, as appropriate;
- Review of risk factors (e.g., cigarettes, substance abuse, or risk-taking behaviors);
- Laboratory and other diagnostic studies;
- Working physical, behavioral, or dental diagnosis, as well as the appropriate procedural codes (e.g., CDT codes) or diagnosis codes (e.g., ICD-10);
- ASAM Dimensions 1 through 6 assessment, if member requires substance use disorder treatment;
- Treatment plan, clearly stating proposed treatments and level of care, and unresolved problems to be addressed in subsequent visits;
- Clinical justification for proposed level of care, instructions and proposed treatment recommendations;
- Name and credentials of provider completing assessment.

III. Follow-Up Encounters Documentation Requirements

PacificSource requires documentation of on-going member care. Follow-up assessments and procedures may require components from the initial assessment or exams, as listed above. In addition, follow-up encounters components must include, but are not limited to the following:

- Reason for encounter and relevant history;
- Type of service provided, setting, level of care, and participants present;
- Diagnosis, assessment, and clinical impressions;
- ASAM Dimensions 1 through 6, if the member requires substance use disorder treatment;
- Member's current clinical status, including member's progress, response, and changes in treatment in objective and measurable terms;
- Consultant reports, laboratory or other diagnostic tests completed since the previous assessment;
- Plan of care or treatment goals addressed;
- Appropriate risk factors;
- Rationale or clinical justification for provided services and continued treatment, if requested;
- Instructions for follow up, if applicable;
- For time-based services, include total face to-face time with patient;
- Name and credentials of provider facilitating the treatment.

Telehealth – Commercial

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

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Background

This policy describes PacificSource's billing, reimbursement and coverage guidelines for Telehealth services which occur when an eligible provider and member are not at the same site. This policy is meant to outline medical and behavioral health telehealth services. The guidelines and information provided are applicable to the state in which the member's plan originated, not where the member is residing at the time of service.

For information regarding participating provider eligibility, please see the PacificSource Provider Manual.

General Guidelines and Information

PacificSource recognizes federal and state mandates in regard to Telehealth, Telemedicine and Virtual Care. Any terms not otherwise defined in this policy are directed by the federal and state mandates. Provider contracts for telemedicine services must apply only to providers physically located within Oregon, Montana, Idaho or Washington, with few exceptions (i.e., Teladoc and interstate compacts). Providers and facilities outside our service area shall otherwise be referred to the external network (i.e., Aetna) for contracting.

Idaho

- Out-of-state providers providing services for Idaho patients with no patient contact for virtual care must have an active license from an applicable licensing board in Idaho, another state, or other U.S. jurisdiction, be in good standing, and follow all applicable laws, rules, and regulations. Additionally, mental or behavioral health providers who are out-of-state may not have an Idaho license but can choose to obtain a registration that is renewable biennially to provide telehealth services. An active Idaho license is not needed for pathology and teleradiology or for providers impacted by interstate compacts

Montana

- An active Montana license is needed for out-of-state providers providing services for Montana patients with no patient contact for telemedicine and telemonitoring. It is not needed for pathology and teleradiology
- Policy may not impose restrictions on site where the patient is located, on site where the physician is located, or distinguish between rural or urban locations
- Other factors affecting reimbursement may supplement, modify, or supersede this policy which include, but are not limited to the following:
    - Provider contracts
    - Benefit and coverage documentation
    - Other medical, behavioral health, or drug policies
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service

Oregon

- An active Oregon license is needed for out-of-state providers providing services for Oregon patients with no patient contact for telemedicine and telemonitoring. It is not needed for pathology and teleradiology
- The Oregon Medical Board requires a 'Telemedicine Active' license to practice medicine across state lines
- Oregon requires out-of-state physicians to acquire active telemonitoring status through the Oregon Medical Board before they can perform intraoperative tele-monitoring on patients during surgery

Washington

- Providers delivering telehealth and telemedicine services must be licensed to practice in the state of Washington or be licensed in a state with which Washington has a licensure compact for that provider type
- Established Relationship: the provider must have an established relationship with the patient, satisfied by:
    - Having seen the provider or another provider in the same practice or clinic in the last 3 years prior to the telehealth service
    - Having received a service either through audio-video telehealth within the last year prior to the telehealth service
    - Provider contracts must contain this requirement
- The provider must have access to the patient's medical record to provide the service, either through a physical chart or electronic health record

Out of Country

Telehealth services are not extended to out of country providers, as telehealth providers must:

- Meet the eligibility definition of originating providers
- Follow federal and state mandates/regulations

Criteria

Commercial

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

PacificSource considers telehealth services medically necessary when **ALL** of the following conditions to qualify for coverage are met:

- Synchronized video; except where otherwise mandated by state and/or federal law
- Services must be medically necessary, and member must be eligible for coverage
- Providers and originating site must be eligible for reimbursement
- Provider compliance with medical records requirements and provisions of HIPAA and HITECH is required for telehealth services

Idaho

- Synchronous or asynchronous telecommunications
- Technology must be capable of assisting a provider to deliver patient health care services, including but not limited to assessment of, diagnosis of, consultation with, treatment of, and remote monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration
- Does not include technology in isolation without access to and review of the patient's medical records, electronic mail messages that are not compliant with the health insurance portability and accountability act (HIPAA), or facsimile transmissions

Montana

- Audio only
- Video
- Other telecommunications technology or media that is:
    - Used by a health care provider to deliver services and is delivered over a secure connection that complies with state and federal privacy laws

Oregon

- Audio only (does not include use of facsimile, email or text message)
- Synchronous or asynchronous using audio only

- Video only
- Audio and video only
- Transmission from remote monitoring devices
- Telepharmacy – the pharmacist may use telepharmacy for supervision of the dispensation of prescription drugs to a patient

Washington

- Audio only (does not include use of facsimile or email but may include text messaging)
- Synchronized video
- Synchronous or asynchronous using audio only
- Video only
- Audio and video only
- Transmission from remote monitoring devices
- Telepharmacy – the pharmacist may use telepharmacy for supervision of the dispensation of prescription drugs to a patient

Coding Information

Reimbursement Information

- Telehealth visits will be subject to retrospective review as appropriate
- For services that a provider also bills for when done in the office (e.g., office visit E&M codes, psychotherapy visit codes), they will be processed under comparable benefits (such as office and home visits or mental health office visits), regardless of whether they were done in the office or over the phone/video. For services that a provider would only bill as telehealth (i.e., specific telephone-visit-only codes), those would fall under the telehealth/telemedicine benefit and apply the lower copay (shown as telemedicine visits on benefit summary), if applicable for the plan
    - **Washington:** Telehealth services are reimbursed at in-person rates unless there is a negotiated contract. Other factors affecting reimbursement may supplement, modify or supersede this policy which include, but are not limited to the following:
        - Provider contracts negotiated with practice groups of 11 or more providers
        - Benefit and coverage documentation
        - Other medical, behavioral health, or drug policies
- Fees for originating site are ineligible for reimbursement
- Facility fees are ineligible for reimbursement for any modality of telehealth
- Providers may not bill a service as telehealth if it is a notification to a member that typically is done by telephone and is not considered a medical service

Claim Information

- Place of Service (POS) code 02 or 10 on CMS HCFA 1500 form will calculate using the facility RVU for the applicable CPT code. Telehealth performed in the urgent care setting should be billed with POS location 02, not 20
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the -GT or -95 modifier
- Modifier -GT, -GQ, -93, or -95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations
- Documentation for telehealth services should be the same as if services were rendered face-to-face
- Document if the service was provided via technology with synchronous audio/video or audio alone
    - Document where the patient and provider are located
    - Document provider is speaking to the correct person (properly identified the person on the call)
    - Consent must also be documented for the visit to be performed via telehealth (can be done annually)
    - Document if the call started out with audio/video but was completed as audio only due to technical issues

Definitions

PacificSource recognizes federal and state mandates in regard to Telehealth and Telemedicine. Any terms not otherwise defined in this policy are directed by the federal and state mandates.

Distant Site – The physical location of the eligible health care provider

Eligible Providers - Provider types recognized by PacificSource who are eligible for services in the healthcare setting, are qualified health professionals, who are licensed, and are eligible for reimbursement of appropriate services via telehealth.

Originating Site - The physical location of the patient receiving telemedical health services. Eligible originating sites are limited to:

- Office of a qualified health care professional
- A hospital (inpatient or outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federal Qualified Health Center (FQHC)
- A hospital-based or critical access hospital based renal dialysis center. Independent renal dialysis facilities are not eligible originating sites
- Skilled Nursing Facility (SNF)
- Mobile Stroke Unit

- Patient home

Telehealth or Telemedicine - Consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals, and online audio and/or video conferencing.

Virtual Care – an umbrella term that encompasses terms associated with a wide variety of synchronous and asynchronous care delivery modalities enabled by technology, such as telemedicine, telehealth, m-health, e-consults, e-visits, video visits, remote patient monitoring, and similar technologies. Virtual care is technology-enabled health care services in which the patient and provider are not in the same location but are rendered at the physical location of the patient.

Telehealth – Medicare

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Medicare Policy

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Background

This policy describes PacificSource Community Health Plans billing, reimbursement and coverage guidelines for Telehealth services which occur when an eligible provider and member are not at the same site. This policy is meant to outline medical and behavioral health telehealth services. The guidelines and information provided are applicable to the state in which the member's plan originated, not where the member is residing at the time of service.

General Guidelines and Information

PacificSource recognizes federal and state mandates in regard to Telehealth, Telemedicine, and Virtual Care. Any terms not otherwise defined in this policy are directed by the federal and state mandates.

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation
- Other factors affecting reimbursement may supplement, modify, or supersede this policy which include, but are not limited to the following:
    - Legislative mandates
    - Provider contracts
    - Benefit and coverage documentation
    - Other medical, behavioral health, or drug policies
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service

Criteria

Medicare

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

PacificSource considers telehealth services medically necessary when **ALL** of the following conditions to qualify for coverage under the health plans are met:

- Synchronized video; except where otherwise mandated by state and/or federal law
- Services must be medically necessary, and member must be eligible for coverage
- Providers and originating site must be eligible for reimbursement
- Provider compliance with medical records requirements and provisions of HIPAA and HITECH is required for telehealth services

Coding Information

Reimbursement Information

- Telehealth visits will be subject to retrospective review as appropriate
- For services that a provider also bills for when done in the office (e.g., office visit E&M codes, psychotherapy visit codes), they will be processed under comparable benefits (such as office and home visits or mental health office visits), regardless of whether they were done in the office or over the phone/video. For services that a provider would only bill as telehealth (i.e., specific telephone-visit-only codes), those would fall under the telehealth/telemedicine benefit and apply the lower copay (shown as telemedicine visits on benefit summary), if applicable for the plan

Claim Information

- Place of Service (POS) code 02 or 10 on CMS HCFA 1500 form will calculate using the facility RVU for the applicable CPT code. Telehealth performed in the urgent care setting should be billed with POS location 02, not 20
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the -GT or -95 modifier
- Modifier -GT, -GQ, -93, or -95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations
- Documentation for telehealth services should be the same as if services were rendered face-to-face:
    - Document if the service was provided via technology with synchronous audio/video or audio alone
    - Document where the patient and provider are located
    - Document provider is speaking to the correct person (properly identified the person on the call)

- Consent must also be documented for the visit to be performed via telehealth (can be done annually)
- Document if the call started out with audio/video but was completed as audio only due to technical issues

Definitions

Distant Site – The physical location of the eligible health care provider.

Eligible Providers - Provider types recognized by PacificSource who are eligible for services in the healthcare setting, are qualified health professionals, who are licensed, and are eligible for reimbursement of appropriate services via telehealth.

- PacificSource follows the Center for Medicare and Medicaid Services (CMS) for coverage of telehealth and telemedicine services. Please refer to CMS.gov for coverage criteria.
- In addition to what is covered under CMS, PacificSource Medicare allows for Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Professional Counselors (LCPC), Licensed Mental Health Counselors (LMHC, Washington only), Federally Qualified Health centers (FQHC), and Rural Health Clinics (RHC) to be eligible providers for tele-video and telephonic services as appropriate with state law.

Originating Site - The physical location of the patient receiving telemedical health services. Eligible originating sites are limited to:

- Office of a qualified health care professional
- A hospital (inpatient or outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federal Qualified Health Center (FQHC)
- A hospital based or critical access hospital based renal dialysis center. Independent renal dialysis facilities are not eligible originating sites.
- Skilled Nursing Facility (SNF)
- Mobile Stroke Unit
- Patient Home

Telehealth or Telemedicine - Consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals, and online audio and/or video conferencing

Virtual Care – an umbrella term that encompasses terms associated with a wide variety of synchronous and asynchronous care delivery modalities enabled by technology, such as telemedicine, telehealth, m-health, e-consults, e-visits, video visits, remote patient monitoring, and similar technologies. Virtual care is technology-enabled health care services in which the patient and provider are not in the same location but are rendered at the physical location of the patient.

Telehealth – Oregon Medicaid

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

Medicaid Policy

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 Community Solutions (PCS) in Oregon. 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

This policy describes PacificSource Community Solutions (PCS) reimbursement for telehealth which occur when a qualified health care professional and member are not at the same location. This policy outlines medical, behavioral health, and oral health telehealth services.

Telehealth services specific to other states or Lines of Business (LOBs) are captured in the related policy section.

General Guidelines and Information

- This is a general reference regarding PacificSource Community Solutions (PCS) reimbursement for the services described and is not intended to address every reimbursement situation.
- PCS recognizes federal and state mandates in regard to Telehealth. Any terms not otherwise defined in this policy are directed by federal and state mandates.
- In general, providers rendering services via telehealth must be licensed in each state in which the member is located when receiving telehealth services.
- Providers use of telehealth technologies to render services should ensure the services are consistent with the provider's scope of practice to include education, training, experience, and ability to provide services via telehealth.
- Providers use of telehealth technologies must meet the same standards of care and professional ethical responsibilities as used in traditional in-person care.

- Services are subject to applicable Medicaid medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service.
- Telehealth providers will follow Drug Enforcement Administration (DEA) requirements for prescribing controlled substances.
- Telehealth-only providers are required to have a referral pathway for members who are unable to receive effective treatment via telehealth and/or for members who request in-person care.
- This policy may not be implemented exactly the same way as written due to system constraints and limitations; however, PCS will attempt to limit these discrepancies.

Criteria

Medicaid

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person. Providers must comply with all applicable federal and state statutes.

PacificSource Community Solutions (PCS) follows Ancillary Guideline A5 of the OHP Prioritized List of Health Services for coverage of Telehealth Services.

Eligible Providers

PCS recognizes those provider types that are eligible for services in the healthcare setting, qualified health professionals, and eligible for reimbursement of appropriate services via telehealth.

Eligible Services

Members can choose how services are received except where the Oregon Health Authority (OHA) issues guidance during a declared state of emergency or if a facility has implemented its facility disaster plan. The following health services are recognized as telehealth modalities by the OHA:

- Synchronous video
- Audio-only
- Asynchronous means of delivering data from remote monitoring devices.

Telehealth Service Requirements

- Must be medically and clinically appropriate for covered conditions within the Health Evidence Review Commission's (HERC) prioritized list and in compliance with relevant guideline notes.
- Oregon Health Plan (OHP) enrolled providers may be located in any location where member privacy and confidentiality can be ensured.
- There is no limitation on the location of the member.
- Provider must collaborate with the member to identify modalities (in-person and/or telehealth) for delivering services which best meets the needs of the member, considers the member's choice, and member's readiness for the selected modality of services.
- Provider must complete a capacity assessment of member's ability to access and effectively utilize telehealth technology, to include:

    - Identification and use of alternate formats based on the individual needs of the member
    - Optimal quality of care provided via use of telehealth platform or evidence of treatment alternatives provided
    - Access to private and safe location for member to participate in telehealth services
    - Adequate member access to internet services
    - Assessment of member digital literacy and documentation of efforts to overcome limitations in member's digital literacy
    - Culturally appropriateness of telehealth services
    - Consideration of member readiness to use telehealth services
    - Assessment of language barriers or hearing impairments
- Prior to the delivery of services via a telehealth modality, a member's written, oral, or recorded consent to receive services using a telehealth delivery method in the language the member understands must be obtained and documented by the health system, clinic, or provider in the member's health record.
    - Consent must include an assessment of member readiness to access and participate in telehealth delivered services, including conveying all other options for receiving the health care service to the member.
    - Consent must be updated at least annually thereafter.
    - For members who experience Limited English Proficient (LEP) or hearing impairment, providers must use qualified or certified health care interpreters when obtaining member consent.
- Providers shall develop and maintain care coordination policies and procedures that require the provider to refer members within ten (10) business days to a different local provider offering in-person services when in-person services are clinically indicated, when requested by the member, and/or the provider does not offer these services.
- Providers unable to offer in-person services inform the Coordinated Care Organization (CCO) upon referring a member to another provider in accordance with the requirements set forth in OAR 410-120-1990, to allow the CCO can provide care coordination services necessary to support the member in accessing care.
- Providers must ensure telehealth services delivered via telehealth technologies and modalities are as effective as in-person treatment care.
- Providers can only deliver services via telehealth that are within their respective certification or licensing board's scope of practice and comply with telehealth requirements.
- Member choice and accommodation for telehealth shall encompass the following standards and services:
    - Providers shall offer meaningful access to health care services for members and their families who experience Limited English Proficient (LEP) or hearing impairments by working with qualified or certified health care interpreters, to provide language access services as described in OAR 333-002-0040. Such services shall not be significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals.

    - Providers shall collaborate with members to identify and offer modalities for delivering health care services which best meet the needs of the member and consider member choice and readiness for the modality of service selected.
    - Providers shall offer telehealth services which are culturally and linguistically responsive as described in the relevant standards.
- Services shall be provided to any person 15 years or older without parent or legal guardian consent; birth control information and services shall be provided without consent of parent or legal guardian regardless of age; and services shall be provided to a minor 14 years or older without consent of parent or legal guardian for mental health and chemical dependency (excluding methadone).
- Provider must document efforts to help member find an in-person provider when the member chooses, when telehealth is not clinically appropriate, or when the member lacks meaningful access to telehealth services (i.e., when they lack the technology or when a safe and private location is unavailable).
- Provider must ensure telehealth services are culturally and linguistically appropriate as described by:
    - National Culturally and Linguistically Appropriate Services (CLAS) standards
    - Tribal based practice standards
    - Trauma-informed approach to care
- Providers are required to obtain and maintain technology used in telehealth communication that is compliant with privacy and security standards in the Health Insurance Portability and Accountability Act (HIPAA) and the Oregon Health Authority's (OHA) Privacy and Confidentiality Rules unless there is a safe harbor from HIPAA enforcement due to a declared emergency.
- Providers must have policies and procedures in place to prevent a breach in privacy or exposure of member health information or records (whether oral or recorded in any form or medium) to unauthorized persons and timely breach reporting as described in OAR 943-014-0440.
- Providers must maintain clinical and financial documentation related to telehealth services as required in OAR 410-120-1360, and any program specific rules in OAR chapters 309 and 410.

In-Person Referral Pathway

Providers shall ensure Oregon Health Plan (OHP) members are offered a choice of how services are received, including services offered via telehealth modalities and in-person services, except where the OHA issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.

- Providers must identify in-person referral pathways to support transitioning members to a qualified, in-person provider.
- Providers are expected to establish agreement(s) with in-person providers to enable collaboration between providers during member transitions to/from in-person or telehealth services.

Out of State Telehealth Providers

- Out of state telehealth providers are required to be licensed in the state where the member is located when telehealth services are being provided.
- Providers must verify the physical location of the member during every telehealth encounter.
- Providers are not permitted to provide telehealth services when the member has traveled to a state in which the provider is not licensed to practice.

Licensing Requirement for Telehealth Only Providers

Providers must be licensed to practice independently to be paneled for telehealth only services with PCS.

Emergency Coverage

Provider shall be responsible for responding to or making arrangements for emergent needs of members with respect to covered services twenty-four (24) hours per day, seven (7) days per week, including holidays. In the event that provider is unable to provide required covered services, provider shall arrange for a covering provider.

Coding Information

Reimbursement Information

- Telehealth visits will be subject to retrospective review as appropriate.
- For services that a provider also bills for when done in the office (e.g., office visit E&M code, psychotherapy visit codes), they will be processed under comparable benefits (such as office and home visits or mental health office visits), regardless of whether they were done in the office or via telehealth.
- Parity extends to health care interpreters' provider telehealth or in-person services.

Claim Information

- All claim types except Dental services, shall include modifier 95 when the telehealth delivered service utilizes a real-time interactive audio and video telecommunication system.
- When provision of the service is delivered using real-time interactive audio only telecommunication system, the encounter submissions all include modifier 93.
- All physical and behavioral telehealth and oral tele-dentistry services except School Based Health Services (SBHS) shall include Place of Service code 02 when the member is located in a place other than their home. When the member is located in their home, the claim shall include Place of Service code 10.
- Providers must maintain clinical and financial documentation related to telehealth services as required in OAR 410-120-1360, and any program specific rules in OAR chapters 309 and 410.
- Documentation for telehealth services should be the same as if services were rendered face-to-face:

- Document if the service was provided via technology with synchronous audio/video or audio alone.
- Document where the member is located and where the provider is located.
- Document provider is speaking to the correct person (properly identified the person on the call).
- Consent must also be documented for the visit to be performed via telehealth (can be done annually).
- Document if the call started out with audio/video but was completed as audio only due to technical issues.

Definitions

Telehealth - Includes telemedicine and the use of electronic information and telecommunications technologies to support remote clinical healthcare, member and professional health-related education, public health, and health administration.

Behavioral health self-audit checklist with OAR references

PacificSource Community Solutions

Provider name _____ Date _____

Position _____

Credentials _____

Checklist items

Are you retaining records for ten years after date of service? [OAR 410-141-3520 (10)]	☐ Yes ☐ No	Comments:
Are you trained in recovery principles, motivational interviewing, integration, and trauma-informed care? (CCO Contract, Exhibit M)	☐ Yes ☐ No	Comments:
Do you have documentation indicating that the member has been informed of their rights and responsibilities? [OAR 410-120-1855 (1)(h)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Does the documentation identify the provider and their credentials? [OAR 410-172-0630 (2)(a)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Are the services provided consistent with the diagnosis identified in the behavioral health assessment? [OAR 410-172-0630 (2)(b)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:

Continued >

When developing the member's Service Plan, are you assessing for Adverse Childhood Experiences (ACE), trauma, and resiliency in a culturally and linguistically appropriate manner, using a trauma-informed framework? (CCO Contract, Exhibit M)	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Are the goals on the Service Plan specific and measurable? [OAR 410-172-0630 (2)(c)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Were services provided in accordance with an individualized Service Plan? [OAR 410-172-0630 (2)(c)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Were the services provided medically appropriate? (See OAR 410-172-0630 for definition.) [OAR 410-120-1855 (1)(k)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Do service notes document the exact time of the encounter (i.e. no rounding up or down of the service time)? (False Claims Act)	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
Do service notes document the specific service provided? [OAR 410-172-0620 (2)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:

Continued >

Are all entries in the clinical record signed and dated by the provider? [OAR 410-172-0620 (2) and 410-172-0620 (4)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:
If applicable, are referrals documented? [OAR 410-120-1855 (1)(n)]	Chart 1 ☐ Yes ☐ No Chart 2 ☐ Yes ☐ No Chart 3 ☐ Yes ☐ No Chart 4 ☐ Yes ☐ No Chart 5 ☐ Yes ☐ No	Comments:

For questions, please contact the Behavioral Health Quality Improvement Specialist assigned to your region:

- Deschutes, Crook, Jefferson, Hood River, and Wasco Counties: BH.CQI@PacificSource.com
- Lane County: BH.CQI-LC@PacificSource.com
- Marion and Polk Counties: BH.CQI-MPC@PacificSource.com

Medicaid Documentation for Behavioral Health Practitioners

Behavioral Health Medical Records

Behavioral health practitioners are in the business of helping their patients. Patients are their priority. Meeting ongoing patient needs, such as furnishing and coordinating necessary services, is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between professionals. Records not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. The outcome can cause unintended complications.

Another reason for documenting medical services is to comply with Federal[1] and State laws.[2] These laws require practitioners to maintain the records necessary to "fully disclose the extent of the services," care, and supplies furnished to beneficiaries,[3] as well as support claims billed. In addition, proper documentation can help protect a behavioral health practitioner from challenges to furnished treatment, and civil, criminal, and administrative penalties and litigation.

General Behavioral Health Medical Record Documentation Requirements

Behavioral Health services must meet specific requirements for reimbursement. Documented services must:

- Meet that State's Medicaid program rules;
- To the extent required under State law, reflect medical necessity and justify the treatment and clinical rationale (remember, each State adopts its own medical necessity definition);[4]
- To the extent required under State law, reflect active treatment;
- Be complete, concise, and accurate, including the face-to-face time spent with the patient (for example, the time spent to complete a psychosocial assessment, a treatment plan, or a discharge plan);
- Be legible, signed, and dated;
- Be maintained[5] and available for review; and
- Be coded correctly for billing purposes.

There are some things to avoid as a behavioral health practitioner. Never bill "chance, momentary social encounters between a therapist and a patient" as valid therapeutic sessions;[6] never bill undocumented services; and never bill services coded at a higher level than those furnished. For example, if furnishing group therapy, be sure and bill group therapy codes rather than individual therapy codes, and document patient-specific information in each attendee's medical record.

Prevent Problems—Self-Audit

Behavioral health practitioners have specific responsibilities when they accept reimbursement from a government program. They "have a duty to ensure that the claims submitted to Federal health care programs are true and accurate,"[7] and that their medical record documentation supports and justifies billed services. All practitioners' documentation is open to scrutiny by many, including employers, Federal and State reviewers, and auditors.[8, 9] Practitioners can protect themselves and their practices by implementing an internal self-auditing strategy.

There are five basic self-audit rules behavioral health practitioners can use to get started:

1. Develop and implement a solid medical record documentation policy if there is not one in place, even if you are a practitioner in a solo practice. If there is one in place, make sure the policy covers meeting Federal and State Medicaid regulations. The policy should address what actually happens in everyday practice.
2. Develop or use one of the available standard medical audit tools. The tool should cover the documentation policy criteria and coding standards as part of the review.
3. Choose a staff member who understands documentation and coding principles to select a random sample of records for a specific time period. Decide how many records should be reviewed, and then pull every "nth" chart for that time period. If you are a practitioner in a solo practice, you may want to ask a like practitioner to review the charts.
4. Resist being the one to choose and audit your own charts. Most practitioners can read their own writing and understand the meaning of records they wrote even if the documentation is not actually in the record. Removing bias is important. For best results, make the audit as realistic as possible.
5. Use the self-audit results for improving practice compliance. There is no real value in conducting a self-audit unless discovered issues are resolved. Review and analyze the audit findings. Identify the common documentation, coding and billing problems, and solve the problems found. Then educate staff members and hold them accountable for making changes. After implementing any corrective action, audit the process again to ensure improved compliance and successful implementation.

Electronic health records (EHRs) require similar methods, but the unique nature of EHRs requires extra precautions.

1. Make sure auto-fill and keyword features are turned off. Watch for "cloned" notes—notes that appear identical for different visits; these may not reflect the uniqueness of the encounter or the patient's description of their chief complaint.
2. Make sure all notes have a date and time stamp, even when updating patient history and life events. Separate notes entered at different times by paragraph returns or other clear punctuation or spacing.
3. Make sure any edits to the patient's record are also initialed or identified with the person making the edit.

Fraud, Waste, and Abuse

Properly filed claims are the responsibility of all behavioral health practitioners. Practitioners can be culpable if they knowingly participate in fraudulent activities or know of illegal activity and do nothing.[10] Health care laws carry heavy penalties for offenders. Penalties can be administrative, civil, and criminal.[11, 12]

Report Fraud, Waste, and Abuse

If you are aware of or suspect fraud, waste, or abuse, report it to the authorities:

- State Medicaid agency and Medicaid Fraud Control Unit

  https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html

- U.S. Department of Health and Human Services, Office of Inspector General

  ATTN: Hotline
  P.O. Box 23489 Washington, D.C. 20026
  Phone: 1-800-447-8477 (1-800-HHS-TIPS)
  TTY: 1-800-377-4950
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov
  Website: https://forms.oig.hhs.gov/hotlineoperations

To see the electronic version of this fact sheet and the other products included in the "Documentation Matters" Toolkit, visit the Medicaid Program Integrity Education page at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Follow us on Twitter #MedicaidIntegrity

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Disclaimer

This fact sheet was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this material is voluntary. Inclusion of a link does not constitute CMS endorsement of the material. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

December 2015

Behavioral Health Critical Incident Reporting

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

Government Policy

Purpose: Critical Incident reporting shall be a tool used to increase safety, health, and performance. This policy establishes procedures for the review of unexpected occurrences that adversely affect members and/or program staff. The data collected will be used to recognize and monitor trends, assess risk factors, and identify training needs.

PacificSource shall have clear policies and procedures in place to monitor the health and safety of members and providers. Serious events which occur during the provision of behavioral health care by PacificSource providers will be systematically reported and reviewed. This policy establishes the criteria for Critical Incident reporting to PacificSource. This policy is not intended to replace internal reporting policies, or reports required by County, State, or Federal law.

Critical Incidents include, but are not limited to:

1) **Member suicide:** Includes suicide of any current member, or those having had any documented contact within the last 3 months with a PacificSource contracted provider.
2) **Attempted member suicide:** A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
3) **Member death:** Includes death of any current member, or those having had any documented contact within the past 3 months.
4) **Medication error:** Results in documented harm or an adverse effect which requires medical care.
5) **Poisoning/overdoses unintentional or intention unknown.**
6) **Substantiated allegation of physical or sexual assault to member by provider.**
7) **Alleged homicide or attempted homicide of or by a member:** Includes alleged homicide or attempted homicide of or by any current member, or those having any documented contact within the past 3 months with a PacificSource contracted provider.

Procedure: Clinical Quality Improvement

1) PacificSource's contracted providers shall establish processes to ensure compliance with this policy.

2) When an incident occurs which meets the definition of a Critical Incident, a Critical Incident Report shall be completed by the provider within five (5) business days of the incident, or knowledge of the incident, and submitted to PacificSource. Providers will be responsible for providing PacificSource additional chart documentation related to Critical Incidents.

   PacificSource staff will compile documentation specific to the incident and from member's chart to help inform Critical Incident review. PacificSource staff and Medical Director will review Critical Incidents for quality of care and process improvement opportunities. Review will also determine if additional corrective action is needed. Determinants that may lead to additional corrective actions include, but are not limited to, the following:

   - The member filed a grievance related to the Critical Incident;
   - There appears to be an increased risk for future harm to the member or provider staff without intervention;
   - There appears to be an increased risk for repeat of the Critical Incident;
   - Critical Incident Report highlights a pattern of low quality and/or inconsistent care that has been observed in other Critical Incident Reports.

   The Medical Director will direct appropriate cases to the Credentialing Committee for further review as necessary. All Critical Incidents will be reported quarterly to PacificSource's Behavioral Health Clinical Quality and Utilization Management Committee. Information presented will only include number of critical incidents and type. No protected health information will be shared.

Behavioral Health
Critical Incident Report

PacificSource Community Solutions

Member information

Name of member _____ Date of birth _____ Oregon Health Plan ID _____

Address _____ City _____ State _____ Zip _____

Gender identity:

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Gender nonconforming/genderqueer
- ☐ Gender fluid/not exclusively male or female
- ☐ Intersex/intergender
- ☐ Something else fits better (please specify):

_____

Race/ethnicity:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino/a/x
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other (please specify): _____

Language(s) spoken _____ Serious and persistent mental illness: ☐ Yes ☐ No

Provider information

Prepared by (provider name and agency) _____

Clinical director/supervisor _____ Date submitted to PacificSource Community Solutions _____

Incident information

Date of incident _____ Date reported to provider _____

Location of incident _____

Incident type:

- Member suicide
- Attempted member suicide
- Member death
- Medication error resulting in medical intervention
- Accidental overdose resulting in medical intervention
- Substantiated allegation of physical or sexual assault on member by provider
- Alleged homicide or attempted homicide of or by a member
- ☐ Other _____

Brief description of the incident.

Treatment history

Past psychiatric hospitalizations and/or residential placements (if applicable):

Facility	Dates of service	Reason

Length of treatment time at current agency _____ Date of last contact _____

Please describe last encounter with member.

Substance use disorder history

History: ☐ None ☐ Previous ☐ Current (at time of incident)

Treatment: ☐ None ☐ Previous ☐ Current (at time of incident)

Medications at the time of the incident

Please list all medications below. If more space is needed, please add a complete medication list.

Taking as prescribed? ☐ Yes ☐ No Recent changes in medications or use? ☐ Yes ☐ No

History of suicidality

Ideation/attempts: ☐ None ☐ Ideation only ☐ 1–2 attempts ☐ 3–4 attempts ☐ 5+ attempts

Time frame: ☐ Prior week ☐ Prior month ☐ 1–2 years ago ☐ 3–4 years ago ☐ 5+ years ago

If suicide risk was present prior to incident, what actions (such as safety planning or lethal means counseling) were taken?

Services provided prior to the incident

Service	Frequency scheduled	Percentage of appointments attended
Individual counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Family counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Group counseling		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Case management		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Medication management		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Peer-delivered services		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%
Other:		☐ Less than 25% ☐ 26-49% ☐ 50-74% ☐ Greater than 75%

Contributing factors

Please list any stressors (such as recent traumas and triggering events) that may have contributed to the incident.

Medical services received related to the incident

Describe the medical condition of the patient after the incident.

What actions were taken by the provider after the incident?

Clinical director/supervisor review

Clinical director or supervisor _____ Review date _____

Please provide any additional comments related to the incident.

Please submit the following clinical documentation with this report:

- Most recent assessment(s) (such as mental health, substance use disorder, psychiatric, etc.)
- Safety plan (if applicable)
- Service notes 30 days prior to the date of Critical Incident Report submission (including nonbillable encounters)
- Suicide risk assessments (if applicable)

All submissions should be sent via encrypted email to:

Deschutes, Crook, Jefferson, Hood River, and Wasco Counties: BH.CQI@PacificSource.com

Lane County: BH.CQI-LC@PacificSource.com

Marion and Polk Counties: BH.CQI-MPC@PacificSource.com

Behavioral health provider compliance survey (Medicaid only)

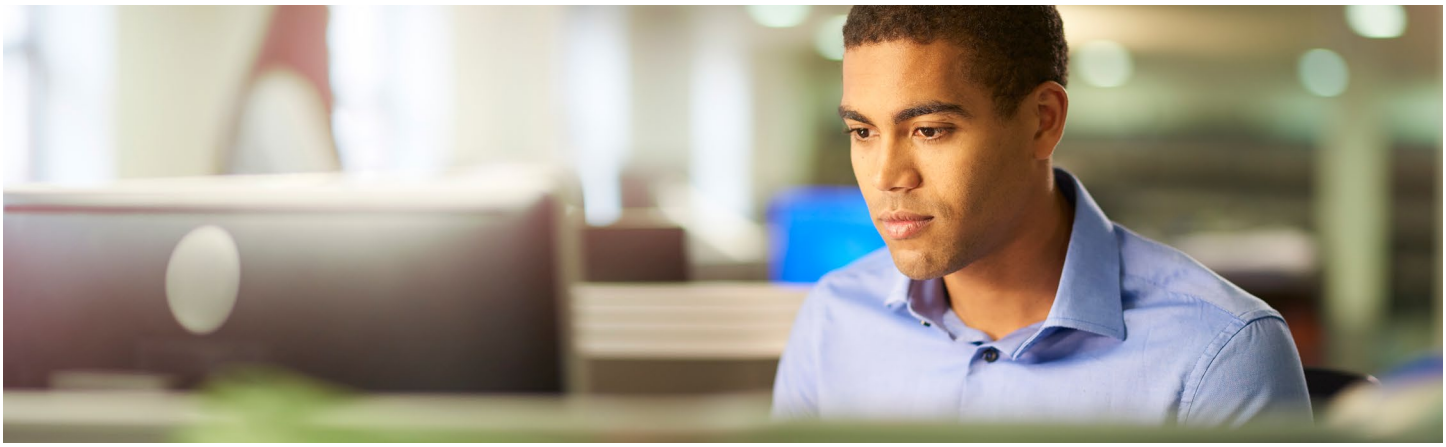
In accordance with OAR 410-141-3515, PacificSource Community Solutions is required to monitor behavioral health provider compliance with the following standards:

- **Routine behavioral health care for non-priority populations:** Assessment within seven days of the request, with a second appointment occurring as clinically appropriate.
- **Urgent behavioral health care for all populations:** Within 24 hours.
- **Specialty behavioral health care for priority populations:**
    - **Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode of psychosis, and the I/DD population:** Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must begin within 120 days from placement on a waitlist.
    - **IV drug users including heroin:** Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must begin within 120 days from placement on a waitlist.
    - **Opioid use disorder:** Assessment and entry within 72 hours.
    - **Medication assisted treatment:** As quickly as possible, not to exceed 72 hours for assessment and entry.

Provider compliance with these standards is collected through the monthly “Provider Availability & Access Standards” survey sent out to PacificSource behavioral health providers before the first Monday of the month. The survey also confirms contact information and provider appointment availability.

PacificSource also distributes a “Weekly Provider Availability Survey” for behavioral health providers to provide capacity updates each Friday. Survey responses are compiled in a spreadsheet and disseminated to all behavioral health providers each Tuesday. Providers may use this report to refer members to other providers as needed to accommodate capacity and/or area of focus needs.

Questions? Email: ProviderAccess@PacificSource.com.



Appeals and Grievances Guide

Provider appeals

As a contracted provider, you have the ability to request that the plan reconsider a coverage decision. **This is the only level of appeal available to providers.** Providers should submit a detailed request using the PacificSource appeal form on our website.

You can also submit an appeal online using our provider portal, InTouch for Providers (accessible through OneHealthPort). Please reach out to your Provider Relations Representative for more information on how to submit an appeal through the portal. If you currently do not have access to our portal, your Provider Relations Representative can help you get started.

Please include a detailed description of the issue in dispute, the reason for your request, as well as all evidence and documentation supporting your position.

Appeals must be received within the following time frames:

- Medicare and Medicaid plans: 60 calendar days
- Commercial plans: 180 calendar days

If you do not submit a complete and timely appeal, the plan will assume that you have accepted our coverage determination and do not wish to have us look at it again. Note that the plan may consider an exception to the filing timelines (within reasonable limits) if you can show good cause that prevented timely filing due to circumstances beyond your control.

Authorization appeals

Authorization appeals can be filed when we deny a request for prior authorization of services. This includes specialist referrals and inpatient stays. When filing an appeal for a denied authorization, please include supporting medical information indicating why the original decision should be overturned. Appeals based on a denial of coverage as experimental or investigational should also include peer-reviewed literature supporting your position. We respect individual opinions; however, indicating a disagreement with a coverage decision—without providing additional information to support further review—may result in an uphold of the original denial.

Questions?

PacificSource Appeals and Grievances
PO Box 5729
Bend, OR 97708-57729

Phone

541-330-4992
TTY: 711. We accept all relay calls.

Fax

541-322-6424

Email

NewAppeal@PacificSource.com

PacificSource.com

PacificSource

Every effort is made by appeal representatives to process your requests as quickly as possible. The plan will consider expediting a decision if a physician requests it, with clear indication that potentially waiting up to 30 calendar days to receive a coverage determination may place the patient's health in jeopardy. For example, the plan will not rush the review of an MRI coverage appeal just because the procedure is *scheduled* to occur prior to the 30-day timeframe. When the plan accepts a request to expedite a review, a response will be issued within 72 hours of receipt.

When authorizations have been denied because the plan reviewer requested additional documentation but did not receive it in a timely manner (such as with pharmacy requests) or has new information that was not included in the original request, you should not submit a provider appeal. In these cases, it is more appropriate to submit a *new* prior authorization request with the additional information. This is to your benefit, as it is a faster process.

Claims appeals

If your appeal involves claim issues, please include clear documentation that will help us investigate the claim in question.

In cases where a claim payment denial is considered member responsibility (such as when the member signed a valid waiver in advance, accepting financial responsibility for the services received), then the member may file an appeal on their own behalf, following the member appeals process. This does not prohibit you from also filing an appeal for payment. If you appeal a claim denial where the member has signed a valid waiver and the denial is upheld by the plan as member responsibility, then you may bill the member for the services. However, in cases where the provider office did **not** obtain a valid waiver from the member and the denial is upheld, then per Oregon Administrative Rules, the member may not be billed.

(Please note that OAR 410-120-1280 prohibits providers from billing Oregon Health Plan members for services or treatments that have been denied due to provider error, such as prior authorization not obtained or required documentation not submitted. Please see our guideline titled Billing of PacificSource Community Solutions Members.)

Claims denied for reasons such as invalid coding or invalid place of service should not be submitted for reconsideration via the appeals process. In these cases, please contact the claims department with your reconsideration request. This also applies to disputes related to duplicate claims, eligibility vs. date of service, sterilization consent forms, and timely filing denials.

The plan makes every effort to publish and make available our prior authorization requirements. However, typical claim appeals involve denials based on a lack of prior authorization. These are some examples of provider explanations that may result in upheld denials:

- Provider used an incorrect prior authorization grid, or states they were unaware of prior authorization requirements.
- Provider did not confirm member's coverage prior to providing services, and was unaware of or did not follow prior authorization requirements.
- Provider's records indicate accurate coverage information. However, staff did not contact the plan to obtain a prior authorization.
- Provider failed to provide UR information on inpatient services and did not obtain prior authorization for an admission or stay.
- The treating provider states that the referring provider did not obtain a prior authorization. It is the responsibility of both providers to confirm prior authorization.

We remind all providers that it is **to your benefit** to confirm a prior authorization is in place prior to rendering services.

PacificSource

Claims appeals are considered from the date the adverse benefit determination is made, and exceeding the timeframes below will result in the appeal being dismissed as untimely:

- Medicaid and Medicare: within 60 days
- Commercial: within 180 days

Grievances

PacificSource is responsible for providing a thorough process for timely resolution of all member complaints. The grievance process is outlined step by step in the member handbook. If a member is dissatisfied with the action of the health plan or any of its contractors, the member can file a grievance. PacificSource meets all guidelines established by the relevant regulatory agency, such as the Centers for Medicare and Medicaid Services (CMS) and DMAP.

All plan members receive information about their grievance rights in their member handbook. In reviewing the grievance, it may be necessary to obtain additional information from a physician or provider's office. If this is necessary, staff will contact the appropriate office with the request. Because there is an established time frame to resolve these issues, your prompt assistance is greatly appreciated.

Helpful links

Prioritized List of Behavioral Health Services (Medicaid)

Behavioral Health Fee Schedule (Medicaid)

Oregon Administrative Rules

Coding Manuals

- CPT Code Book
- HCPCS Code Book
- Optum Coding and Payment Guide for Behavioral Health Services (contains CPT and HCPCS)

DSM-5 Updates

- Updates to DSM-5-TR Criteria and Text

Prior Authorization

- Medical prior authorization info and search links (Commercial and Medicaid)
- Prior authorization search tool (Medicare)

PacificSource online resources

- Resources for Commercial and Medicaid
- Resources for Medicare
- Training opportunities

InTouch, our secure web portal for providers

- Log in through OneHealthPort
- Learn more about InTouch

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