



Behavioral Health Outpatient Treatment

State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:	LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid
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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 determination 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 and substance use 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.

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

Note:

- For mental health intensive levels of care see PacificSource Mental Health Treatment policy
- For substance use disorder intensive levels of care see PacificSource Substance Use Disorder Treatment policy

Clinical Guidelines

Outpatient Behavioral Health services utilize the following clinical guidelines:

- Treatment must be provided by eligible behavioral health practitioners/facilities as defined by the contract and benefit structure
- Coverage for outpatient behavioral health services is limited to those services which are a covered plan benefit

- Visit length conforms to the CPT coding as per the Current Procedural Terminology, published by the American Medical Association.
- The patient is diagnosed with one or more mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5). And the diagnosis is included in the health plan's definition of covered behavioral health conditions.
- Symptoms and functional impairments are documented and must support the DSM 5 diagnosis and ICD-10 diagnostic code.
- Substance abuse evaluation is part of the initial diagnostic evaluation. A referral is made for appropriate intervention to address substance use, if clinically indicated. Treatment of Substance Use Disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.
- Treatment which is court ordered or required by a third party must also meet medical necessity criteria and will not be covered solely on the basis of court order or third party requirement.
- The patient demonstrates the capacity and willingness to participate actively in treatment.
- The patient's record contains a treatment plan with goals that have formulated in collaboration with the patient. The treatment goals are individualized, specific, measurable, achievable, realistic, and time based.
- Providers consistently use a trauma-informed approach. Patients are assessed for Adverse Childhood Experiences (ACE), and providers use trauma-informed frameworks for assessment, treatment planning, and treatment delivery in a culturally and linguistically appropriate manner. This is reflected in the patient's Individual Service and Support Plan (treatment plan).
- The intensity and frequency of treatment is variable and depends on the patient's diagnosis and presenting symptoms and is appropriate to the diagnosis and the individualized treatment plan.
- Whenever possible, the treatment plan will include objective measures, such as diagnostic screening tools, used to assess a patient's baseline function and subsequent progress during the course of treatment (e.g., depression or anxiety scales).
- Treatment focuses on reducing active symptoms and functional impairments and is not primarily a substitute for the patient's natural, social, or community supports.
- Active family/significant other involvement is important unless contraindicated or declined by the patient 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 of distress and improving daily functioning as rapidly as possible, to a level at which the patient can maintain adequate functioning and tolerate residual symptoms.
- The treatment plan identifies alternative strategies if the patient is not progressing toward achievement of the treatment goals in a timely manner. Examples of alternative interventions include a psychiatric evaluation (if not yet obtained), a second opinion, or consideration of adjunctive or different treatment modalities.
- Timely psychopharmacologic evaluation and treatment will be considered for conditions that are known to be responsive to medication. Patient choice and resistance to medication (or other modalities known to be effective for the patient's condition) are addressed in treatment, and documented in the patient's treatment record.

- Coordination of care between the behavioral health practitioner and the patient's primary care practitioner (PCP) and psychotropic medication provider, is documented in the patient's treatment record. Patient 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 patient to a more intensive level of care for safety and short-term stabilization. PacificSource uses MCG criteria to determine medical necessity for levels of mental health care.
- Treatment will be discontinued when no longer clinically indicated. Patients may no longer meet clinical guidelines for outpatient treatment when:
 - Treatment goals are met or patient'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 patient's needs would be more appropriately addressed at a different level of care.

PacificSource Community Solutions (Medicaid):

- Members may obtain medication-assisted treatment for substance use disorders (SUD), including opioid and opiate use disorders, for up to thirty (30) days without first obtaining prior authorization for payment in accordance with CCO contract Ex. B, Part 2, Sec. 3, Para. b, Sub. Para. (5).
- Members have access to evidence-based dyadic treatment and treatment that allows children to remain living with their primary parent or guardian.
- Members ages birth through five with indications of adverse childhood events and high complexity have access to outpatient and intensive outpatient services in accordance with OAR Chapter 309, Division 22.
- Periodic social-emotional screening for all children birth through five years is conducted in the primary care setting and ensure any concerns revealed by the screening are addressed in a timely manner.

Peer Delivered Services:

PSCS 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.

Provider Network for Outpatient Services:

PacificSource has established timeliness access standards of care related to primary care, emergent/urgent care, and behavioral health care. For a detailed report, refer to PacificSource policy: Accessibility of Service for Primary Care Services, Emergent Urgent Care services and Behavioral Health Care services. 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. For a detailed network availability standards for Medicaid, refer to policy: Network Availability Standards-Medicaid.

References

American Psychiatric Association. (2013) Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition, DC: Author

ICD-10-CM Expert for Physicians: The Complete Official Code Set. Optum 360, LLC. (2019)

MCG 24th Edition Behavioral Health Guidelines

American Psychiatric Association Practice Guidelines (www.aacap.org)

PacificSource Medicaid Policy- Network Availability Standards

PacificSource Enterprise Policy- Accessibility of Services for Primary Care Services, Emergent Urgent Care services and Behavioral Health Care Services

This procedure has been developed with consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature

Appendix

Policy Number: [Policy Number]

Effective: 10/1/2020

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Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): OAR chapter 309, Division 19, 42 CFR 412.27(c), (3), 42 CFR 482.61(c), Medicare Managed Care Manual, Chapter 4