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

- 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 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 placement criteria established by the American Society of Addiction Medicine (ASAM), 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 member demonstrates the capacity and willingness to participate actively in treatment
- The member's record contains a treatment plan with goals that have formulated in collaboration with the member. The treatment goals are individualized, specific, measurable, achievable, realistic, and time based
- 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., depression or anxiety scales)
- 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
- 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
- The treatment plan identifies alternative strategies if the member is not progressing toward achievement of the treatment goals in a timely manner. Examples include a psychiatric evaluation (if not yet obtained), a second opinion, or consideration of additional or different treatment modalities
- Timely psychopharmacologic evaluation and treatment will be considered for conditions that are known to be responsive to medication. Member choice and resistance to medication (or other

modalities known to be effective for the member's condition) are addressed in treatment, and 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 MCG criteria to determine medical necessity for levels of mental health care
- Treatment will be discontinued when no longer clinically indicated. Members may no longer meet clinical guidelines for outpatient treatment when:
    - Treatment goals 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
    - Be trauma informed
    - Include strategies to address environmental and physical factors, social determinants of health and equality, 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 are able to 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, equality, 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 chose 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 ensure 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.

Related Policies

Accessibility of Service for Primary Care Services, Emergent Urgent Care services, and Behavioral Health Care services

Assertive Community Treatment

Behavioral Health Provider Availability – Medicaid

Crisis Management and Services

Fidelity Wraparound Policy

Intensive Care Coordination (ICC) Services

Intensive In-Home Behavioral Health Treatment

Peer Delivered Services

Mental Health Treatment

Network Availability Standards - Medicaid

Network Availability Standards - Commercial

Substance Use Disorder Treatment

References

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

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

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

MCG 26th Edition Behavioral Health Guidelines

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

Appendix

Policy Number:

Effective: 10/1/2020 **Next review:** 8/1/2023

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): OAR chapter 309, Division 19, OAR 410-141-3515, Medicare Managed Care Manual, Chapter 4, section 30.0 Counseling Services.

Commercial OPs: 10/2022

Government OPs: 9/2022

Approved by OHA: 9/13/2022