Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Outpatient Mental Health Services
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PRODUCT TYPE: Medicare, Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff make Level of Care (LOC) determinations for Outpatient (OP) Mental Health services and to describe the authorization process.

B. Policy

1. Clinical criteria for outpatient mental health services include:

- **1.1.** A Diagnostic and Statistical Manual of Mental Disorder (DSM) and International Classification of Diseases (ICD) covered diagnosis supported by mental health assessment information to make:
  - **1.1.1.** LOC determination based on:
    - **1.1.1.1.** Treatment history,
    - **1.1.1.2.** Degree of impairment,
    - **1.1.1.3.** Current symptoms,
    - **1.1.1.4.** Community supports,
    - **1.1.1.5.** Medical appropriateness to support DSM and ICD covered diagnosis.

2. Appropriate available treatment environment characterized by:

- **2.1.** The most normative,
- **2.2.** Least restrictive,
- **2.3.** Least intrusive,
- **2.4.** Culturally and linguistically appropriate,
- **2.5.** Evidenced based and/or evidence informed,
- **2.6.** Extent of family and community supports.

3. Oversight

3.1. TBH facilitates a community level planning and decision making body called Systems of Care (SOC) Practice Level Workgroup to:

3.1.1. Provide practice-level consultation,

3.1.2. Identify needed community services and supports, and

3.1.3. Provide a forum for problem solving to:

3.1.3.1. Families,

3.1.3.2. ISA providers,

3.1.3.3. Child serving agencies,

3.1.3.4. Child and Family Teams.

3.2. The SOC Practice Level Workgroup must have representation of the local system of care that includes:

3.2.1. Consumers,

3.2.2. Family members,

3.2.3. Child serving providers,

3.2.4. Child and family advocates,

3.2.5. Culturally specific community based organizations,

3.2.6. Other local stakeholders representative of the local system of care.

C. Procedure

1. Referrals:

1.1. Referred member must be enrolled in Trillium Community Health Plan.

1.2. Trillium members are able to access OP mental health assessment with an in-network participating provider without referral.

1.3. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

1.4. For Intensive Outpatient Services and Supports (IOSS) member must be under the age of eighteen (18) years old.

1.5. For Assertive Community Treatment (ACT) member must evidence a severe and persistent mental illness (SPMI).

2. Non-participating ACT provider services always require a prior authorization (PA) based on Authorization Required Qualifiers (ARQ) prior to the first date of service.

2.1. Provider must submit:

2.1.1. PA request,

2.1.2. Updated mental health assessment information and service plan information within previous sixty (60) days justifying:

2.1.2.1. A covered DSM and ICD diagnosis reflecting a severe and persistent mental illness which seriously impairs the member's functioning in community living, or

2.1.2.2. Other psychiatric illnesses dependent on the level of the long-term disability, or

2.1.2.3. Significant functional impairments as demonstrated by at least one of the following conditions:

2.1.2.3.1. Significant, recurrent, or persistent difficulty performing the range of practical daily living tasks required for basic adult functioning in the community or requiring significant support/assistance from others to do so, or

2.1.2.3.2. Significant difficulty maintaining consistent employment or carrying out a homemaker role at a self-sustaining level, or

2.1.2.3.3. Significant difficulty maintaining a safe living situation.

2.1.2.4. Members with one or more of the following problems indicating continuous high service needs including:

2.1.2.4.1. High use of acute care psychiatric hospitals or emergency departments,

2.1.2.4.2. Intractable severe major symptoms such as psychosis or suicidality,

2.1.2.4.3. Coexisting substance use disorder for longer than six (6) months,

2.1.2.4.4. High risk or recent history of criminal justice involvement,

2.1.2.4.5. Significant difficulty meeting basic survival needs,

2.1.2.4.6. Difficulty effectively utilizing traditional office-based OP services.

2.1.2.5. Other possible information to submit includes documentation of a LOC Utilization System (LOCUS) instrument score for adults.

3. Non-participating IOSS provider services always require a PA based on ARQ prior to the first date of service:

3.1. Provider must submit:

3.1.1. PA request,

3.1.2. Updated mental health assessment information within previous sixty (60) days justifying:

3.1.2.1. A covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

3.1.2.2. Mental, emotional or behavioral symptoms, evident for the last six (6) months or are likely to continue for more than one (1) year, **and/or**

3.1.2.3. Updated evidence of substantial functional limitation in two (2) or more of the following age-appropriate domain areas:

3.1.2.3.1. Activity of Daily Living (ADL)/Individual Functioning,

3.1.2.3.2. Relational/Family System,

3.1.2.3.3. Educational/Occupational,

3.1.2.3.4. Housing/Basic Needs,

3.1.2.3.5. Substance Use,

3.1.2.3.6. Social,

3.1.2.3.7. Legal,

3.1.2.3.8. Medical/Physical Health,

3.1.2.3.9. Recent Hospitalizations, Crisis Intervention, and/or Emergency Room use,

3.1.2.3.10. Safety,

3.1.2.3.11. Other,

3.1.2.3.12. Clinical justification for requested services.

3.1.3. Service Plan conducted and/or updated within the last year reflecting:

3.1.3.1. Assessment,

3.1.3.2. LOC to be provided,

3.1.3.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan,

3.1.3.4. Member/family participation in services,

3.1.3.5. Be completed and signed by qualified program staff,

3.1.3.6. Recommended service and supports through signature of a licensed QMHP.

4. For OP services not requiring a PA based on ARQ, provider is able to submit claims.

5. For non-par provider services always requiring a PA prior to or on the first date of service, provider must submit:

5.1. PA request,

5.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

5.3. Summary completed within previous sixty (60) days including:

5.3.1. Current symptom description with impact upon functioning,

5.3.2. Services or LOC to be provided, with

5.4. Clinical justification for requested services including summary of how service modalities would meet treatment goals for current episode of care outside of currently available in-network services.

6. For initial Intensive Outpatient (IOP) and Partial Hospitalization (PHP), prior to or on the first date of service, provider must submit:

6.1. PA request,

6.2. Updated behavioral health assessment information or addendum completed by a QMHP within the previous sixty (60) days including:

6.2.1. Evidence of a covered DSM and ICD diagnosis,

6.2.2. Behavioral presentation with current symptom description and impact upon functioning.

6.3. Service Plan conducted and/or updated within the previous sixty (60) days reflecting:

6.3.1. Assessment,

6.3.2. LOC to be provided,

6.3.3. And include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan:

6.3.3.1. Include the participation of the individual and family members, as applicable.

6.3.4. Be completed and signed by qualified program staff.

6.4. Clinical justification for services requested including:

6.4.1. How the member would benefit from requested LOC,

6.4.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

6.5. When medical risks or comorbidities are present, include pertinent medical documentation within previous thirty (30) days evidencing medical stability.

7. For concurrent IOP and PHP authorization requests, provider must submit concurrent authorization request with summary of:

7.1. Diagnostic, medical stability, or medication changes since last review,

7.2. Recent services/interventions within previous two-four (2-4) weeks including:

7.2.1. Member/family participation in services,

7.2.2. Frequency of services,

7.2.3. Response to treatment,

7.2.4. Barriers to treatment progress,

7.2.5. Areas of progress.

7.3. Clinical justification for services requested including:

7.3.1. Behavioral presentation with current symptom description and impact upon functioning,

7.3.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

7.4. Discharge/transition planning information specific to remaining treatment goals.

8. For OP services requiring a contingent PA based on utilization:

8.1. Provider is able to submit claims for CPT codes based on ARQ without a PA up to the ARQ limits per member per calendar year.

8.2. Provider can use Look-Up Tool to determine if authorization is required for procedure code.

8.3. Once claims have met a contingent authorization ARQ limit, provider must submit:

8.3.1. PA request,

8.3.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

8.3.3. Chart notes or session information from the most recent three (3) dates of service prior to PA submission,

8.3.4. Service Plan conducted and/or updated since most recent mental health assessment, reflecting:

8.3.4.1. Assessment,

8.3.4.2. LOC to be provided,

8.3.4.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan:

8.3.4.3.1. Include the participation of the individual and family members, as applicable. Be completed and signed by qualified program staff.

9. For OP concurrent (Recertification) for additional codes or units within current approved date range and/or an extended or new date range is based on additional clinical justification submitted. Clinical justification including:

9.1. Concurrent authorization request,

9.2. Updated behavioral health assessment information or addendum completed by a QMHP within the previous sixty (60) days including:

9.2.1. Evidence of a covered DSM and ICD diagnosis,

9.2.2. Behavioral presentation with current symptom description and impact upon functioning.

9.3. Service plan information completed within the previous sixty (60) days,

9.4. Clinical justification for requested services including:

9.4.1. How the member would benefit from requested services and,

9.4.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

10. TBH Licensed UM staff:

10.1. Determine clinical appropriateness and medical necessity of requested level of care for treatment, indicated by:

10.1.1. Review of clinical information submitted, including behavioral health assessment information and pertinent medical justification, within seven (7) business days for IOSS, youth IOP, or youth PHP,

10.1.2. Other LOC will be determined within the fourteen (14) day pre-service timelines, including adult IOP or PHP and youth OP service requests.

10.2. Determine services are reasonably expected to improve/stabilize psychiatric symptoms,

10.3. Prevent higher level of care,

10.4. Determine necessity of services to continue,

10.5. Offer TBH Care Coordination (CC) via notification of UM approval of an initial OP contingent authorization, and/or

10.6. Upon determination of a concurrent OP contingent authorization, refer to TBH CC for member and/or provider outreach, and/or

10.7. Refer to TBH CC staff when necessary to ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

11. Expected outcomes:

11.1. Improvement/stabilization of psychiatric symptoms,

11.2. Less restrictive LOC services are determined to be clinically appropriate,

11.3. Prevention of psychiatric hospitalization, out of home placement or homelessness.

12. When request is approved:

12.1. All initial (Certification) non-par OP and par OP contingent requests will be determined within the fourteen (14) day pre-service timeline. All initial (Certification) non-par OP and par OP contingent PA requests will not exceed twelve (12) months. Par OP contingent PA requests will not exceed 12 months nor a date range beyond the end of the current calendar year.

12.1.1. For codes subject to ARQ contingent limits, initial non-par and initial contingent requests will be authorized for up to:

12.1.1.1. 25 units for a combined grouping of 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, and T1006;

12.1.1.2. 120 units for a combined grouping of H0004, H0005, H0006, H0036, H0038, H2014, H2027, H2032, and T1016.

12.1.2. Concurrent (Recertification) for additional codes or units within current approved date range and/or an extended or new date range is based on additional clinical justification submitted. Concurrent (recertification) requests will be determined within the fourteen (14) day pre-service timeline. OP concurrent (Recertification) requests for participating providers will not exceed a date range beyond the end of the current calendar year.

12.2. Non-par initial requests for IOSS services for youth will be determined within seven (7) business days. Non-par concurrent requests for IOSS services for youth and initial and concurrent non-par requests for adult ACT services will be determined within fourteen (14) day pre-service timelines. Non-par initial and concurrent authorizations for youth IOSS services will not exceed 12 months. Concurrent (Recertification) for additional codes or units within current approved date range is based on additional clinical justification submitted. Requests for an extended date range beyond 12 months will be treated as a new, initial PA request.

12.3. For initial youth IOP and PHP, review will occur within seven (7) business days.

12.4. For concurrent youth IOP and PHP services, review will occur within fourteen (14) day pre-service timelines.

12.5. For initial and concurrent adult IOP and PHP services, review will occur within fourteen (14) day pre-service timelines.

12.6. Initial (Certification) and Concurrent (Recertification) PA for ACT, IOP, and PHP services will not exceed six (6) months and will be determined within the fourteen (14) day pre-service timeline.

13. When request is denied:

13.1. If the initial (Certification) or concurrent (Recertification) review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

13.2. When the decision is to deny request, practitioner may request an expedited appeal if he/she disagrees with the determination.

14. When request is returned to sender:

14.1. Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

14.1.1. Member identifying information,

14.1.2. Requesting and Servicing Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:

14.1.2.1. Medicaid Provider/DMAP number for non-par outpatient service requests,

14.1.2.2. Start date and end date for services,

14.1.2.3. ICD diagnostic code(s),

14.1.2.4. Billing code(s),

14.1.2.5. Number of units/visits/days for each billing code.

14.2. Upon review, no authorization is required per the ARQ for participating providers.

14.3. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

14.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

14.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster,

14.4.2. Mechanical or administrative delays or errors by the Contractor or State Office,

14.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

14.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number,

14.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered,

14.4.3.3. The provider submitted the request for authorization within sixty (60) days of the date the eligibility was discovered (excluding retro-eligibility).

14.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

14.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. Definitions

Word / Term	Definition
ACT	Assertive Community Treatment: an intensive and highly integrated behavioral health treatment modality for individuals diagnosed with severe and persistent mental illness.
Adult	A person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.
ARQ	Authorization Required Qualifier.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Child	A person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Contingent Prior Authorization	A blank ARQ alerting billing system an authorization could be required depends on whether member and category of service are covered by member's benefit plan.

Word / Term	Definition
Diagnostic and Statistical Manual of Mental Disorders (DSM)	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
ICD	The International Classification of Diseases.
Intensive Outpatient Services and Supports (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.
Level of Care (LOC)	The type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.
Level of Care Determination	The standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.
Level of Care Utilization System (LOCUS)	Level of care assessment tool being widely used by behavioral health to support accurate level of care recommendations and assess the current clinical needs of the individual to establish the intensity of services found along the continuum of care.
Licensed Utilization Management (UM) staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Medically Appropriate	Services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are: (a) Consistent with the symptoms of a health condition or treatment of a health condition; (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective; (c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and (d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.
Mental Health Assessment	The process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Oregon Health Plan (OHP)	In Oregon, the Medicaid Program is called OHP.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Qualified Mental Health Professional (QMHP)	An LMP or any other individual meeting the minimum qualifications as authorized by the Licensing Mental Health Authority or designee. Person demonstrating the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and

Word / Term	Definition
	criminal justice contacts, assessing family, cultural, social and work relationships, conducting a mental status examination, complete a DSM diagnosis; conducting best practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a Service Plan; and providing individual, family or group therapy within the scope of their training. (a) QMHPs shall meet the following minimum qualifications: (A) Bachelor's degree in nursing and licensed by the State or Oregon; (B) Bachelor's degree in occupational therapy and licensed by the State of Oregon; (C) Graduate degree in psychology; (D) Graduate degree in social work; (E) Graduate degree in recreational, art, or music therapy; or (F) Graduate degree in a behavioral science field; or (G) A qualified Mental Health Intern.
Service Plan	A comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	B.2.3.
	Covered Services
	B.24.a.3.
	B.2.4.k.(1-9)
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity
	E.23.
Code of Federal Regulations	422.101(b)(1)-(5)
	422.566
Current NCQA Health Plan Standards and Guidelines	UM 2: C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals

	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
Medicare Managed Care Manual	Chapter 13 (40.1)
Oregon Administrative Rules	309.019.0140
	309.019.0150
	309.019.0165
	309.019.0226
	309.019.0245
	309.022.0105
	309.039.0560
	410.120.1295
	410.141.3160
Oregon Regulatory Statutes	410.172.0630
	430.630
	430.644

F. Related Material

Name	Location
Use of Out-of-Network Providers and Steerage Policy	Trillium Database

G. Revision Log

Type	Date
Merged policy and procedure into one document.	12-18-17
Updated Definition List	1-10-18
Added CCO and OHA Contract Citations	2-5-18
Addition of Return to Sender Information	2-7-18
Updated Treatment Plan Requirement Language	12-10-18
Added Contingent and Concurrent Information	12-10-18
Updated Definitions	12/10/18
Updated OARS	12-10-18
Updated Return to Sender Language	12-10-18
Added Provider Look-Up Tool Reference to Procedure Section 8	8-14-19