



PATHWAYS

Pathways Provider Manual

Pathways Regional Behavioral Health System

Health Share of Oregon

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Pathways Provider Manual Appendices

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Values & Principles

Values

Health Share of Oregon (Health Share) and Health Share's Behavioral Health Plan Partners promote resilience in and recovery of our Members. We support a system of care that promotes and sustains a person's recovery from a mental health condition or substance use disorder (SUD) by identifying and building upon their strengths and competencies in order to assist them in achieving a meaningful life within their community.

Members are to be served in the most normative, least restrictive, least intrusive, and most cost-effective level of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history, individual voice and choice, and extent of family and community supports.

Practice guidelines are intended to assure appropriate and consistent utilization of mental health and SUD services and to provide a frame of reference for clinicians in providing services to individuals enrolled in Health Share. The guidelines offer a best practice approach and are not intended to be definitive or exhaustive.

When multiple Providers are involved in the care of our Members, it is our expectation that regular coordination and communication occurs between these Providers to ensure coordination of care. This could include sharing of service plans, joint session, phone calls or team meetings.

Principles

1. Treatment planning incorporates the principles of resilience and recovery, and:
 - a. Employs strengths-based assessment
 - b. Is individualized and person-centered
 - c. Promotes access and engagement
 - d. Encourages family participation
 - e. Supports continuity of care
 - f. Empowers the Member
 - g. Respects the rights of the individual
 - h. Involves individual responsibility and hope in achieving and sustaining recovery
 - i. Uses natural supports as the norm rather than the exception

2. Policies governing service delivery are age and gender appropriate, culturally competent, evidence-based and trauma-informed, attend to other factors known to impact individuals' resilience and recovery, and align with the individual's readiness for change, with the goal of ensuring that individuals have access to services that are clinically indicated.
3. Positive clinical and recovery outcomes are more likely when clinicians use evidence based-practices or best clinical practices based on a body of research and as established by professional organizations.
4. Treatment interventions should promote resilience and recovery as evidenced by:
 - a. Maximized quality of life for individuals and families
 - b. Success in work and/or school
 - c. Improved mental health status and functioning
 - d. Successful social relationships
 - e. Meaningful participation in the community
 - f. Increase in housing stability
 - g. Increased abstinence from alcohol and/or drugs

Compliance with Pathways Provider Manual

Health Share shall make available to Providers this Provider Manual electronically or, by request, on paper. As part of their Participation Agreement with Health Share, Provider agrees to comply with the applicable policies and procedures set forth in this Provider Manual and that compliance is necessary to meet the obligations under Provider's Agreement with Health Share.

Glossary

General Terms

'Behavioral Health Plan Partner (aka BH Plan and BHPP)' means Clackamas County Behavioral Health; Washington County Mental Health; and/or Multnomah County Behavioral Health.

'CIM' is the database where eligibility, Authorizations, and Claims reside for Health Share's Behavioral Health Plan Partners.

'PH Tech' means Performance Health Technology. PH Tech is the Third Party Administrator for Health Share who processes claims.

'Clean/Valid Claim' is a claim which is submitted in the correct format with all required information. The Medicare Claims processing manuals for the [HCFA 1500](#) and [CMS 1450](#) should be consulted for additional information.

Provider Category Terms

'Contracted Providers' are authorized by all three BH Plan Partners to hold a contract with Health Share of Oregon to provide mental health and/or substance use disorder services to Health Share Members. Also referred to as "In-Network Providers."

'Outpatient-Fee for Service Mental Health Providers (aka OP FFS MH Providers)' receive reimbursement on a fee for service basis. The BH Plans must pre-authorize all services, and notify PH Tech. BH Plans refer Members to these Providers for specialty services that are not available with other Contracted Providers.

'Fee for Services Level of Care Mental Health Providers (aka FFS LOC MH Providers)' receive reimbursement on a fee for service basis; issue Provider Submitted Authorization and complete Level of Care assessments.

'Case Rate Level of Care Mental Health Providers (aka CR LOC MH Providers)' receive reimbursement on an episodic basis; issue Provider Submitted Authorization and complete Level of Care assignments.

'Non-Contracted Single Case Agreement Providers' hold a one-time, Member-specific single-case agreement which enables them to receive reimbursement for services delivered to an individual Member. The BH Plan with whom the Member is enrolled must authorize PH Tech to pay Claims submitted by a Non-Contracted Single Case Agreement Provider.

Authorization Terms

'Adverse Benefit Determination' is one or more of the following:

- (1) The Denial or limited Authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension or termination of a previously authorized service;
- (3) The Denial in whole or in part, of payment for a service;
- (4) Failure to provide services in a timely manner, as defined by OHA;
- (5) The failure of Contractor to act within the timeframes provided in 42 CFR 438.408(b); or
- (6) For a Member who resides in a Rural Service Area where Contractor is the only CCO, the Denial of a request to obtain Covered Services outside of Contractor's Provider Network under any of the following circumstances:
 - (a) The service or type of Provider (in terms of training, experience and specialization) is not available within the Provider Network;
 - (b) The Provider is not part of the Provider Network, but is the main source of a service to the Member – provided that (i) the Provider is given the same opportunity to become a Participating Provider as other similar Providers; and (ii) if the Provider does not choose to become a Participating Provider, or does not meet the qualifications, the Member is given a choice of Participating Providers and is transitioned to a Participating Provider within sixty (60) calendar days;
 - (c) The only Provider available does not provide the service because of moral or religious objections;
 - (d) The Member's Provider determines that the Member needs related services that would subject the Member to unnecessary risk if received separately and not all other related services are available with the Provider Network; or
 - (e) OHA determines that other circumstances warrant out-of-network treatment.

'Appeals'– A request for a review of a notice of action/adverse benefit determination.

'Authorization' means a Member-specific approval to a Provider to deliver services, which is entered into PH Tech's Community Integration Manager (CIM) and allows for billing.

'Authorization Amount' describes the dollar amount that Health Share's BH Plan partners approve for Provider Submitted Authorization and Authorizations entered into CIM.

'Authorization Increase Request' describes the request and clinical review process that Providers engage in with the BH Plans for determination of whether funds will be added to an existing Authorization Amount (based on medical necessity).

'Claim' describes the bill that the Provider submits to PH Tech in order to receive payment for services rendered

'Did not meet medical necessity criteria' refers to a scenario whereby the clinical information provided did not meet either the admission criteria or continued stay criteria in the [Health Share Pathways Regional Practice Guidelines](#).

'Encounter' refers to a single, individual service rendered.

'Exceptional Needs Service' is a service which requires that a Prior Authorization be obtained by all Providers.

'Initial Provider Submitted Authorization' means a Contracted Provider's first Authorization for services to a Health Share Member, when entered into PH Tech's CIM; or a BH Plan has authorized Levels of Care or specialty services that require Prior-Authorization.

'Notice of Adverse Benefit Determination' – A written notice to the Member or representative and Provider regarding a decision to reduce, suspend, deny, or terminate previously authorized or requested services.

'Re-authorization' refers to outpatient re-Authorizations for services rendered, also known as 'concurrent review' or 'continued stay'.

'Provider Submitted Authorization' means the information that any Contracted Outpatient Case Rate Provider or Contracted Outpatient Fee for Service Provider enters into CIM to indicate that the Provider will bill for services rendered to a Member. The Provider Submitted Authorization may automatically approve in CIM, and a Provider can submit Claims with respect to that Provider Submitted Authorization.

'Health Share Pathways Regional Practice Guidelines' refers to the Health Share of Oregon Regional Behavioral Health Guidelines for Clackamas, Multnomah and Washington Counties, which outline Regional medical necessity criteria.

'Request additional clinical information' means that, for the purposes of clinical review, BH Plan Utilization Review staff request clinical information that is current, valid, and congruent with the Member's level of functioning at the time of the request. When a request for additional clinical information is made, the Provider shall provide a brief description of the Member's current clinical presentation, response to interventions, prognosis, and description of need for continuation/extension of services.

Abuse Reporting

Providers will comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 124.050 et seq., ORS 419B.010 et seq., ORS 430.735 et seq., ORS 441.630 et seq., and all applicable rules associated with those statutes. Furthermore, Providers will comply with all protective services, investigation and reporting requirements described in OAR 407-045-0120 through 407-045-0240 and ORS 430.735 through 430.765.

As a Provider of behavioral health services, you are a Mandatory Reporter. You have the legal responsibility to report alleged abuse of the following individuals: children; adults aged 65 and over; adults with developmental disabilities; adults with mental illness; residents in licensed care facilities, nursing facilities, registered residential facilities, residential treatment home/facility, adult foster home; or is in a facility approved by the Health Systems Division for acute care services or crisis respite when the adult is in custody in the facility pursuant to ORS 426.072. What constitutes a mandatory report, and when and to whom to make the report, varies depending on which of these individuals is the subject of the report. If you are uncertain regarding the proper reporting authority, request assistance from the Adult Protective Services contact listed in the Plan Contact List of this Provider Manual.

At minimum, abuse reports for all individuals should include the following:

- The name, age and present location of the allegedly abused Member;
- The names and addresses of persons responsible for the Member's care;
- The nature and extent of the alleged abuse, including any evidence of previous abuse;
- Any information that led the person making the report to suspect that abuse has occurred, plus any other information that the person believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator; and
- The date of the incident.

Reporting Suspected Abuse of a Child

Provider shall immediately report any suspected abuse of a child to the State of Oregon DHS Child Welfare Child Abuse Hotline at (503) 731-3100, or Oregon's Statewide Abuse Reporting Hotline: 1-855-503-SAFE (7233). By law, mandatory reporters must report suspected abuse or neglect of a child regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. In other words, the mandatory reporting of abuse or neglect of children is a 24-hour obligation. For the purpose of this policy, the term "Child" means an unmarried person who is under 18 years of age.

Reporting the Death of Member Receiving Services

Upon becoming aware of the death of an adult Member, who at the time of death had been receiving behavioral health services, the Provider shall report the death to the County Adult Protective Services contact listed in the Plan Contact List above. The Oregon Health Authority requires the County to review any death of an adult Member receiving mental health services.

The Provider shall report the unexpected death of a Member younger than the age of 18 years who was receiving behavioral health services, including but not limited to when there was suspected abuse or neglect of that Member, to the multidisciplinary Child Fatality Review Team contact listed in the Plan Contact List above. Per ORS 418.747, the Oregon Health Authority requires local multidisciplinary teams to review all unexpected child fatalities.

Additional Requirements for Providers Operating under a Certificate of Approval

Providers operating under a State issued certificate of approval shall develop policies and procedures and comply with all investigation and reporting requirements described in OAR 407-045-0120 through 407-045-0240 and ORS 430.735 through 430.765.

Regional Practice Guidelines for Mental Health and Substance Use Disorders

Medicaid managed care organizations are required to adopt practice guidelines that are based on valid and reliable clinical evidence, consider the needs of our individuals, and are adopted in consultation with our participating Providers. Decisions for utilization management and coverage of services should be consistent with these guidelines.

Health Share, along with its Behavioral Health Plan Partners, has adopted a definition of medical necessity criteria and a set of practice guidelines as a resource for both Providers and our staff. It should be noted that these guidelines are administrative in nature; they are not clinical practice guidelines. Clinical practice guidelines reflect practice standards for the management and treatment of specific conditions. Administrative guidelines describe the criteria for Authorization for specific types of service.

The primary purpose of these guidelines is to assist Providers in selecting the appropriate level of care for Members and to inform Providers of the criteria used by the Behavioral Health Plan Partners in authorizing services.

Please refer to [Appendix A: Health Share Pathways Regional Practice Guidelines](#). For additional specific expectations regarding higher Levels of Care, please see [Appendix B: Inpatient Mental Health/Acute Care Guidelines](#); [Appendix C: Mental Health Day Treatment Clinic Services Guidelines](#); and [Appendix D: Psychiatric Residential Treatment Services Guidelines](#)

Services Requiring Prior-Authorization

Many services require the Behavioral Health Plan Partners to approve a Provider to deliver services to a Health Share Member before such services are rendered. These “pre-authorized” services include but are not limited to:

Mental Health

- Acute Care Hospitalization
- Adult Respite
- Applied Behavioral Analysis (ABA) Services - Youth
- Assertive Community Treatment
- Community Based Intensive Treatment (CBIT) - Youth
- Child Respite
- Crisis Stabilization - Youth
- Day Treatment
- Dialectical Behavioral Therapy (DBT)
- Eating Disorder Treatment
- Electro-Convulsive Therapy (ECT)
- Gender Dysphoria Assessments for Hormone Therapies and Gender Reassignment
- Outpatient Mental Health Treatment with an Outpatient Fee for Service Mental Health Provider
- Single Case Agreements with Non-Contracted Providers
- Home Based Services-Youth and Adult
- Inpatient Psychiatric Hospitalization
- Intensive Case Management
- Partial Hospitalization
- Psychiatric Day Treatment Services - Youth
- Psychiatric Residential Treatment Services - Youth
- Psychological Testing
- Respite Services - Youth
- Sub-Acute Services – Youth
- Transcranial Magnetic Stimulation

Substance Use Disorder (SUD)

- Single Case Agreements with Non-Contract Providers
- SUD Day Treatment
- SUD Residential Treatment
- Dual Diagnosis Residential
- Non-formulary Medication Assisted Treatment
- SUD Withdrawal Management Residential and Outpatient

To receive Authorization for Exceptional Needs Services from the Behavioral Health Plan in the county in which the Member resides for services that require Prior -Authorization, please refer to [Appendix E: Service Authorizations Guidelines & Procedures](#). To obtain Authorizations for SUD Day Treatment, Residential Dual Diagnosis, Residential Treatment, or Medically-Monitored Withdrawal Management Treatment Services, please refer to [Regional SUD Service Authorization Forms](#) located on the [Health Share website](#).

Access

Mental Health

When a Provider receives a request for community treatment services, the Provider determines the nature and urgency of the Member's treatment needs and offers an initial service appointment date that falls within the appropriate time frame. Timely access is defined as the following:

1. **Routine:** Appointment date that falls within 14 calendar days from the date of the request
 - i. Routine requests for service include circumstances where there is not an identifiable risk of harm, the need for inpatient treatment or out of home care is not imminent, and the individual requesting services can reasonably be expected to wait for the initial service without foreseeable risk.
2. **Urgent:** Appointment that falls within 48 hours from the time of the request for individuals with urgent treatment needs.
3. **Emergent:** Appointment that falls within 24 hours from the time of the request for individuals with emergent treatment needs.

For urgent/emergent situations, other appropriate services may include referral to the local county crisis service or to a hospital emergency department as necessary to prevent injury or serious harm. In an emergency situation, if a Provider is unable to schedule an appointment that occurs within 24 hours, the Provider is to make a referral to the appropriate county crisis services or nearest emergency department.

When a Provider is not able to offer timely access to services, the Provider will offer information that allows the Member seeking care to make an informed choice about waiting for a later appointment or seeking services elsewhere.

If the Member prefers to seek services elsewhere due to the wait, the Provider must offer referral information to appropriate Providers within the Health Share Contracted Provider Network and will include information about each of the Contracted Providers that provide the requested service, including the name of the Provider, the address or general location of the Provider, and phone number. The Provider will also educate the Member on how to contact the appropriate Behavioral Health Plan's Member services for further assistance.

In circumstances where the Member elects to wait for a later appointment with the same Provider, the next available appointment will be offered in addition to referral information for other Providers.

Provider will inform program staff who receive service requests and who coordinate access to services that Members seeking services have freedom of choice among participating Providers but may elect to remain on the wait list with the initial Provider. The Contracted Provider will also inform the program staff of the expectation to provide timely access to services and appropriate referral information when access cannot be offered within expected time frames.

Provider shall attempt to engage Members and provide access for a second appointment within fourteen (14) calendar days of the first visit and an additional two (2) visits after fourteen (14) calendar days to total four (4) clinical visits within the first forty-five (45) calendar days of care.

Substance Use Disorders

When a Provider receives a request for outpatient services, an initial service appointment will be offered within fourteen (14) calendar days.

For urgent/emergent situations, other appropriate services may include referral of the Member to local county crisis services or to a hospital emergency department as necessary to prevent injury or serious harm.

If the Member prefers to seek services elsewhere due to wait times, the Provider must offer referral information to other appropriate Providers within the Health Share Provider network, including name of the Provider, address or general location, and phone number. The Provider will also educate the Member on how to contact the appropriate Behavioral Health Plan Member services for further assistance.

Per OAR 309-019-0110 (5) (e), the Provider's Policies and Procedures shall:

Prohibit titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing to receive treatment;

Out of Office Planning for Independent Practitioners

Single case agreements are not issued to cover a second provider when the authorized provider will be out of the office/unavailable. It is the practitioner's responsibility to check with their licensing board on how to address this issue within their practice in line with their board requirements. Solo practitioners may partner with other Providers in their area who are also part of the Pathways Provider Network to cover services to members when necessary. It is the responsibility of the Provider to make coverage arrangements and contact the appropriate Behavioral Health Plan(s) to request prior authorizations for the covering provider. Health Share members may be directed to the Mental Health Crisis Clinics/Crisis services for support when their providers are not available.

Member Rights

Provider must notify Members of their rights at time of intake. Member rights, including grievance, appeal and contested case hearing procedures and timeframes, are included in [Appendix F: Health Share Member Handbook](#).

Members have the right to:

- be free from discrimination on the basis of health status, the need for health services, race, color, national origin, language spoken, religion, sex, sexual orientation, gender identification, marital status, age or disability; and the right to complain about discrimination.
- receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language and ability to understand.
- be actively involved in the development of Treatment Plans if Covered Services are to be provided and to have Family involved in such treatment planning.
- request and receive a copy of his or her own Health Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion.

Advance Directive and Declaration for Mental Health Treatment

Advance directives and declarations for mental health treatment information is available in the [Health Share Member Handbook](#) and in the Provider's contract. Contracted Providers shall offer assistance with advanced directives and declarations for mental health treatment information to Members upon request.

Member Assignment & Termination

Members may choose to receive care from any Contracted Provider that has the capacity to meet the individual's assessed behavioral health treatment needs. Once the Member has made a successful connection with the Provider, as evidenced by an Authorization for routine services, the individual will be considered "enrolled." For all enrolled Members, Provider will have the responsibility to assist Members to access services by providing outreach, office- and/or community-based appointments, engagement techniques and other methods likely to improve the chances that those in need will receive services.

Provider may not refuse to provide services to any Member meeting medical necessity criteria as specified in the [Health Share Pathways Regional Practice Guidelines](#). If there are reasonable clinical reasons why the Provider is unable to provide services that otherwise are a

good fit for the Member, arrangements for service to be received at an alternative agency is the mutual responsibility of the Member, the Provider and the Behavioral Health Plan.

Providers will continue to maintain responsibility for any Member with an open Authorization, including providing post-hospital follow up. The only circumstances that would terminate the Provider's responsibility for a Member with an open Authorization are one or more of the following circumstances:

- The Member has transferred services to another Provider, and the new Provider has confirmed that they have accepted the Member.
- The Provider and Member have agreed that the Member no longer needs formal behavioral health services, and has an established natural system of support that is likely to meet their ongoing needs. The Provider will be available to reopen the Member's treatment plan or provide aftercare services, as clinically appropriate.
- The Provider has documented consistent efforts to engage the Member over a period of time determined by clinical best practice which have not been successful, and the Member is not judged to be at risk for requiring a higher level of care.
- The Member moves out of the area and referral has been made to a receiving agency.
- The Member dies.
- The Member requests termination of services with the Provider.

Except for in these identified scenarios, case rate Providers are expected to continue to provide medically necessary services for the duration of the Authorization period and may not terminate the individual from treatment while the Member has benefits through Health Share. Providers must work with BH Plans directly for any exceptions to these requirements.

Transfers

Providers shall make all reasonable efforts to provide services to Members with an open Authorization and address any Member-reported concerns related to service delivery. This may include accommodating reasonable requests to transition to a new clinician (within the same Provider agency) or adjust treatment approach(es) to be more aligned with the treatment needs of the Member.

If a Member with an open service Authorization requests a transfer of services to another Contracted behavioral health Provider, the Provider will cooperate with the Member and assist in making transfer arrangements with the new Provider and the Behavioral Health Plan. The current Provider is responsible for determining the best course of action.

Care Integration and Coordination

Coordination with Physical Health

Health Share expects coordination of care and exchange of protected health information between the physical health care Provider and the behavioral health Provider to address physical and behavioral health needs, when indicated. As a best practice, behavioral health Providers are responsible for informing the Primary Health Provider (PCP) of the Member's entry into behavioral health treatment after an appropriate release of information has been signed (when required). The amount of information to be disclosed "must be limited to that information which is necessary to carry out the purpose of the disclosure" [42 C.F.R. §2.13(a)]. Thus, information shared between physical and behavioral health Providers will vary depending on the different purposes for which different recipients are being allowed access to the information, and each release of information must be individualized accordingly.

Providers are also responsible for informing the PCP of any significant change in the Member's mental status or medications.

Health Share's Behavioral Health Plan Partners support a model of care, such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare, or wraparound for children with behavioral health disorders, that emphasizes prevention and routine care. As a best practice, Providers determine if the Member has a PCP and assist Members to receive routine health exams with their PCP even when there is not an immediate health concern.

Members with No Identified PCP

The amount of assistance given to a Member by a Provider in obtaining a PCP or identifying their assigned PCP will be based on the functioning level of the Member and the Member's need for assistance. Either the Behavioral Health Plan Partner or the Provider will encourage Members receiving outpatient level of care services who disclose that they have no PCP to call their Physical Health Plan's Member Services to find out the process for obtaining a PCP. If the Member is a child or adolescent, their parent or guardian will be encouraged to obtain a PCP for their youth.

Clinicians providing behavioral health services and supports to Health Share Members with severe and persistent mental illness (both adult and child/adolescent) are expected to take an active role in seeking PCP services for their Members.

Members with no insurance coverage for physical health care will be provided with information about "safety net" clinic alternatives.

Members with Chronic Disease

Members or their guardians are asked to identify any current or chronic medical conditions as part of the assessment.

If such a medical disease or disorder is identified, the Provider will follow procedures outlined above to determine if the Member is receiving care for this condition from a PCP or a medical specialist.

If a Member identifies a significant physical disease or disorder for which the Member is not receiving treatment, the Provider will encourage and/or assist the Member to obtain necessary treatment as appropriate. When a Member with a significant medical disease or disorder is receiving behavioral health treatment, the Provider is encouraged to monitor the Member's compliance with their medical treatment plan.

Grievances

Members have the right to access grievance resources through various entities, including:

- The Provider with whom they have the grievance.
- The BH Plan with which the Provider is contracted. For example, a complaint against a Behavioral Health Provider goes to the appropriate County Plan for investigation and resolution. Please refer to Grievance Section of the Plan Contact List for specific BH Plan information.
- The Health Share Customer Service line at 503-416-8090, 1888-519-3845 or TTY/TDD 711. There also are Complaint Forms in a variety of languages on the Health Share website under the *For Members/Appeals and Grievances* page.
- The Oregon Health Authority. Members may complete and submit an [Oregon Health Plan Complaint Form \(OHP 3001\)](#) to OHP Client Services, P.O. Box 14015, Salem, OR 97309.
- The Oregon Health Authority Ombudsperson: 503-947-2346 or toll free: 877-642-0450

Crisis Response System

All Health Share Providers (regardless of organizational size or number of Members served) will be required, at minimum, to provide Members with the phone number to the crisis line associated with the County in which the Member resides, and coordinate care with the crisis line as needed. Please refer to the Plan Contacts section for each County's crisis line phone number.

Provider agencies will have a crisis response system for Members enrolled in their program. At a minimum, the Provider agency will have a clinician available by phone for consultation at all times, including after regular business hours. This individual shall be familiar with the Member or shall have the ability to access relevant information about the Member to assist in crisis response.

Enrolled Members who come to the attention of a crisis line shall be referred to their current Provider for crisis response during normal business hours. If a Member who is enrolled with one of the local Provider agencies comes to the attention of a crisis program, the team will contact the Provider directly and request assistance in responding to the situation.

Critical Incident Reporting

A ‘critical incident’ includes, but is not limited to, serious injury or death, act of physical aggression or self-harm that results in serious injury or death, suspected abuse or neglect, or any other serious incident that presents a risk to health and safety of a Health Share Member in the care of a contracted Provider.

Provider will, within 24 hours, notify the Behavioral Health Plan Quality Assurance team (or Choice team as indicated) of all critical and significant incidents that may become a matter of public record using the contact information provided below. Initial notification may be verbal or in writing, and should include Member demographics and a brief incident summary. The corresponding complete written report must be submitted within five (5) business days to the Behavioral Health Plan Partner. When submitting critical incident reporting for Clackamas and Washington County Members, providers may use their own reporting form to satisfy this obligation. When submitting critical incident reporting for Multnomah County Members, Providers must use [Appendix I: Multnomah County Quality Management Critical Incident Report](#), which is specific to Multnomah County.

Critical Incident Reporting Contact Information	
Clackamas County	Secure Email: BH-ProgramSupportRequests@co.clackamas.or.us Phone: 503-742-5335 Fax: 503-742-5304 2051 Kaen Road, Ste 154; Oregon City, OR 97045
Multnomah County	Secure Email: gmincidentreporting@multco.us Phone: 503-988-8600 Fax: 503-988-4015 209 SW 4 th Ave.; Portland, OR 97204
Washington County	Secure Email: hshmhprotectivesvcs@co.washington.or.us Phone: 503-846-4515 5240 NE Elam Young Pkwy Ste 150, MS 70. Hillsboro, OR 97124

Be advised that submitting a Critical Incident report **does not fulfill Abuse reporting obligations**. Depending on the nature of the incident, an abuse report may also be required per the Abuse Reporting requirements noted above and in the Provider Contract. This requirement applies to **all Pathways Providers contracted with Health Share of Oregon**.

Interpreter Services

Interpreter services are a covered benefit for Health Share Members at no cost to the Provider. Per your agreement with Health Share, Oregon Administrative Rules, and federal regulations, members have the right to receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language and ability to understand. Details for accessing interpretation services can be found on the [Health Share website](#).

Second Opinions

In establishing an adequate network of Providers, the Behavioral Health Plans are required by federal rule to ensure that the network *“Provides for a second opinion from a qualified (behavioral or physical) health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee”* [42 CFR 438.206(b)(3)].

Previously authorized Members have a right to a “second opinion” by a qualified health care professional within the organization where their service Authorization originates, OR from any other Contracted behavioral health Provider. If the Member’s current Provider is unable to provide a second opinion, or the Member wishes to obtain a second opinion from another Provider, the Member’s current Provider will arrange the second opinion. Requests for a second opinion from a behavioral health Provider outside of the Provider agency may be considered as an Exceptional Need request and will be handled in accordance with the Behavioral Health Plan’s Exceptional Needs Requests procedures outlined in the Provider Manual. Members may request a second opinion either orally or in writing to their current Provider or directly to the Behavioral Health Plan Partner.

Guidelines:

- Member has had at least one session with their assigned Provider at their current Provider agency;
- Member has been encouraged to talk about any concerns with their current Provider;
- The Member’s primary clinician will attempt to resolve the concern by exploring the basis of the concern with the Member. In situations where the concern is regarding the Provider, the primary clinician may act as an advocate for the Member and sit in with the Member to support them in discussing their concerns with their Provider;
- If the Member’s concerns are not resolved, the clinical team may support a request from the Member for a second opinion outside of the Provider agency;
- Member must agree to sign a release of information for the second opinion Provider and allow records to be released to that Provider prior to the scheduled appointment; and
- Authorization for a second opinion will be for a single assessment/evaluation with the expectation that the two professionals will communicate about recommendations for Member’s ongoing treatment with the primary Provider.

All requests for a second opinion outside of the assigned Provider agency should be submitted to the Behavioral Health Plan Care Coordinator for the County in which the Member resides (See contact information under Utilization Review in the BH Plan Contact List above). Requestors should be prepared to provide the following information:

- The Member's current presentation;
- The Member's behavioral health history;
- Member's concern about recommended course of treatment by current Provider and documentation that Member has addressed concerns with the Provider;
- Documentation of attempts to resolve the Member's concerns by referring the Member to another clinician within the agency; and
- Any additional information required by the relevant Behavioral Health Plan such as exceptional needs treatment Authorization request forms and/or supporting documentation

A qualified Behavioral Health Plan representative will review the request using the exceptional needs Authorization procedure and make a decision within fourteen (14) calendar days. The Behavioral Health Plan representative will assist in identifying an appropriate Provider for the second opinion and authorize the service. The referring Provider is expected to send a signed release of information to the secondary Provider along with Member's clinical records for review.

The Behavioral Health Plan will attempt to honor the Member's preferences about who will provide the second opinion where possible, but retains the right for a second opinion to be provided by a Contracted Provider whenever available.

The Behavioral Health Plan Partner or the Contracted Provider will inform the Member of the outcome of the second opinion request in writing. If the outcome is not what the Member requested, a Notice of Action may be issued to the Member in those instances where the outcome results in a Denial, suspension, reduction or termination of a covered service. The Member will be informed of their right to appeal the decision through the established grievance and appeal process.

Privacy and Confidentiality of Member Information and Records

Protecting the privacy and confidentiality of Member information and records is a paramount responsibility. To that end, Providers are required to have policies and procedures in place that ensure that Member records are secured, safeguarded and stored in accordance with the requirements of the Provider Participation Agreement as well as all applicable federal and state laws and regulations, including ORS 413.171, ORS 414.679, OAR 410-120-1360; OAR 943-014-0300 to 0320, and OAR 943-120-0000 to 0200 and OAR 410-141-0180. In addition to the above, any Provider, whether a facility or individual, which holds itself out as providing (and does provide) alcohol or drug abuse diagnosis, treatment or referral for treatment must comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse

Patient Records. That rule only allows information protected by Part 2 to be shared if the Provider obtains a written consent from the Member prior to treatment. Such consents must include a description of all entities to which the protected Member records will be disclosed, including to which entities those records may also be re-disclosed. In addition, the consent must state the purpose of the disclosure which is “payment and health care operations.” Given the nature of the Pathways Provider Network and its relationship with the County Behavioral Health plans in Multnomah, Clackamas and Washington counties, all Providers should ensure that consent forms developed pursuant to 42 CFR Part 2 specifically state that protected records may be disclosed for payment and health care operations to each the following entities:

- Clackamas County Behavioral Health Division
- Multnomah County Behavioral Health Division
- Washington County Behavioral Health Division
- Health Share of Oregon
- Performance Health Technology (PH Tech)

All of the above entities require access to protected records for the purposes of billing and payment as well as utilization management and care coordination. Health Share will conduct compliance audits to ensure that 42 CFR Part 2 consent forms adhere to the above requirements.

Flexible Services for Mental Health Providers

Per OAR 410-141-3000 (38), flexible services are cost-effective services offered to an individual member to supplement covered benefits. Flexible services lack any traditional billing or encounter codes (including physical, dental, or behavioral health), are not encounterable, and may not be reported for utilization purposes.

In accordance with OAR 410-141-3150, the following criteria must be met for the use of flexible services by Contracted Providers.

Requirements for Flexible Services

- Items and services requested must not be otherwise Medicaid reimbursable.
- No other funding source is available to cover the cost of the service or item (e.g. AMHI, ENCC).
- All flexible services and supports must be related to a treatment goal and documented in the Member’s treatment plan or medical record.
- Flexible services must be designed to improve health quality; increase the likelihood of desired health outcomes in a manner that can be objectively measured and produce verifiable results and achievements; and be based on evidence-based medicine, widely

accepted best clinical practice, and/or criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The treatment plan must clearly identify the current clinical justification (i.e. behavioral issue, psychosocial stressor, and/or functional impairment including intervention to address goal) for the use of flexible services and explain how the specific service or item will address/ameliorate the identified issue/stressor/impairment.

Providers should contact the Member's assigned Behavioral Health Plan to request authorization for flexible services, as described in the Flexible Services resource document available on the [Health Share website](#).

Flexible Services Grievance Requirements

Flex fund outcomes are subject to the grievance provisions of OAR 410-141-3225.

Members, their representatives, and Providers will receive a written outcome regarding flex fund requests. The written outcome shall inform the Member, their representative and Provider of the Member's right to file a grievance in response to the outcome. The Member may file the grievance orally or in writing with either the Behavioral Health Plan Partner, Health Share, or OHA. Members have no appeal or hearing rights in regard to a flexible services outcome.

Provider Fee Schedules

Health Share maintains Regional Pathways Provider Fee Schedules. Regular updates to Fee Schedules are posted on the Health Share website and Providers will be notified at least thirty (30) calendar days in advance (or as soon as possible) of revisions and updates to the Regional Pathways Provider Fee Schedules.

Billing, Service Authorization and Claims Management

Health Share standards related to authorization and claims processing and payment follow the requirements in [OAR 410-120-1280](#) and [OAR 410-141-3420](#).

Health Share of Oregon and the Behavioral Health Plan Partners work with a Third Party Administrator, Performance Health Technology (PH Tech), for Authorization and Claims management. The Community Integration Manager (CIM), is the online tool offered by PH Tech for

the submission and management of service Authorizations; it can also be used to manage adjudicated Claims. Detailed instructions for accessing CIM can be found on the Health Share of Oregon [‘For Providers’ Portal Registration/Portal FAQ](#) web page.

Authorization Requests

Services provided without an approved authorization may not be eligible for reimbursement.

Providers who are able to submit authorization requests directly through our Provider Portal, CIM, are expected to do so prior to service delivery.

However, Provider Submitted Authorizations must be submitted no later than forty-five (45) calendar days from the effective date of the authorization. Provider Submitted Authorizations entered into CIM more than 45 days from the authorization effective date will receive a “Pend Retro” status. Behavioral Health Plan Partners will review authorizations with the “Pend Retro” status and the start date will be changed to comply with this rule.

Requests to change the date(s) or authorization type of Provider Submitted Authorizations that will result in newly authorized days or services will only be considered if any resulting newly authorized days or services are within 45 days of the date of the request. For example, a request to adjust an authorization start date to 1/1/18 must be received by 2/15/18 (45 days from the date requested).

Providers who are required to submit authorization requests directly to the BH Plan, are expected to do so prior to service delivery. For services that require Prior Authorization, Providers should work with the appropriate County Behavioral Health Plan Partner to request Authorization. This process often requires the completion of a request form and the submission of clinical documentation. Please refer above to the section, “Services Requiring Prior -Authorization,” or contact the specific County Behavioral Health Plan Partner for additional information on requesting services that require prior Authorization.

Third Party Liability

As Medicaid is the payer of last resort, state and federal guidelines require:

- Reporting of all Third Party Liability (TPL) sources for clients who are covered by other health insurance; and
- Provider must bill all other insurance resources (including Medicare) before billing Medicaid ([OAR 410-120-1280](#)).

All Providers must make every reasonable effort to obtain and report TPL information for the clients they serve, and to bill TPL before billing Health Share of Oregon.

To ensure accurate processing and correct payment of secondary claims, Providers must include a copy of the explanation of benefits (EOB) from the primary payer when Health Share of Oregon is the secondary payer. Claims where Health Share of Oregon is the secondary payer must be received within **365 days of the date of service** and must include the primary payer's EOB.

Upon receipt of valid secondary claims, Health Share or Oregon will pay the patient responsibility documented on the primary payer's EOB up to the rate published in the Regional Mental Health Fee Schedule applicable for the date of service.

Confirming Member Eligibility

Per OAR 410-141-3420, providers are required to confirm new and current Member benefits and eligibility prior to providing all services. This includes member assignment specific to the Behavioral Health Plan Partner (Multnomah, Clackamas, or Washington). Failure to confirm Member eligibility may result in the Provider not being reimbursed, should the Member be ineligible for services. Additionally, as Medicaid is the payer of last resort, Providers must check Member benefits and eligibility to confirm if member has other coverage prior to billing Health Share of Oregon. If it is determined that the Member has other coverage, Provider must bill the primary payer prior to billing Health Share. Provider must also notify PH Tech at tprgroup@phtech.com, as well as the appropriate Behavioral Health Plan Partner, if a member has other insurance coverage (excluding Medicare coverage).

Member eligibility should be confirmed using the OHA Medicaid Portal, MMIS. Review [OHP Provider Web Portal-Eligibility](#), for more detailed information regarding logging into MMIS and checking member eligibility.

Claims Submission Process

Providers may submit Claims to PHTech within timely filing guidelines via by paper or Electronic Data Interchange (EDI). The preferred method of Claims submission is EDI.

Please limit Claims to services provided by **one Provider per Claim**. Please limit Claims to services covered by **one authorization per Claim**. If your agency provides services to Health Share Members for both mental health and SUD, please **limit each Claim to services for only mental health or only SUD services**.

When claims are submitted for services offered within a facility/office setting (not in the community) the actual address of the service location must be included on all claims submissions.

For additional information on claims submission please see the resource documents available on the [Health Share website](#).

Claims Adjudication

Claims are reviewed by PH Tech at the time of receipt to determine whether they meet the definition of a valid claim as stated in [OAR 410-120-0000 \(247\)](#) Claims received for payment of covered health services rendered to an eligible Member must:

- a. contain all relevant information for processing without requiring additional information from the Provider or from a third party;
- b. be received within the time limitations described in the section below titled “Claims Timely Filing Deadlines.”

At least 99% of valid claims are adjudicated within forty five (45) calendar days of receipt.

All Health Share claims are adjudicated in accordance with the Oregon Health Authority Health Evidence Review Commission Prioritized List of Health Services and the Centers for Medicare and Medicaid Services National Correct Coding Initiative (NCCI).

Additional information and the current Prioritized List can be found on the Oregon Health Authority website:

<https://www.oregon.gov/oha/hsd/ohp/pages/index.aspx>

Additional information and some of the National Correct Coding Initiative edits can be found on the following websites:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

<https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>

Claims Timely Filing Deadlines

OAR 410-141-3420 and Health Share requires both participating and non-participating Providers to submit valid claims for all mental health and substance use disorder (SUD) services within 120 calendar days of the date of service. A claim is considered **valid** if it contains all relevant information for processing, without requiring any additional information from the Provider or from a third party. If a valid claim is not received by PHTech within 120 days, it is not considered timely and will be denied for timely filing.

Exceptions to the 120 day timely filing rule include:

- Eligibility issues such as retroactive enrollments or dis-enrollments; or
- When Medicare or other third party resources are the primary payer.

Exceptions do not include failure of the Provider to verify the Member’s eligibility at the time of service.

When Health Share is the secondary payer, valid claims must be received within 365 calendar days from the date of service. The primary payer’s EOB must be submitted with all secondary claims.

If claims were denied for timely filing and the reason for exceeding the timely filing deadline is an extenuating circumstance, demonstrating a failure on the part of Health Share, the Behavioral Health Plan Partners, or Health Share's TPA the Provider must submit a timely filing waiver review request form. Extenuating circumstances may also include, or be caused by, a system-wide event or disruption impacting Health Share claims processing. In order for claims to be considered for a timely filing waiver, the Behavioral Health Timely Filing Waiver Request Form must be completed and submitted for review.

Timely filing waiver requests will be reviewed by a regional committee, which includes representation from Health Share and the three Behavioral Health Plan Partners. Timely Filing Waiver Requests will be considered for claims with dates of service within 365 days of the request date. Decisions to approve or deny requests to waive timely filing are final and are made at the sole discretion of Health Share and the Behavioral Health Plan Partners.

The submission of a Timely Filing Waiver Review request does not guarantee that timely filing will be waived. Health Share reserves the right to deny a Timely Filing Waiver Review Request for any reason.

Claims Reprocessing Deadlines

Providers shall submit to PH Tech a Claim to be reprocessed or corrected (see Corrected Claims below) within three hundred sixty five (365) calendar days from the original adjudication date.

Member Billing Regulations

Provider shall accept the agreed-upon contractual rate as payment in full for services rendered. In accordance with OAR 410-120-1280, Members shall not be billed for:

- ❖ Missed Appointments
- ❖ Services and Treatments which have been denied by the payer due to provider error (e.g. required documentation not submitted, prior authorization not obtained, etc)
- ❖ Any copayment, coinsurance, or deductible

Providers may only bill a Member in the following situation:

- ❖ The Member did not inform the Provider of OHP coverage, enrollment in Health Share, or third party insurance coverage at the time of, or after a service was provided; therefore, the provider could not bill the appropriate payer, obtain prior

authorization, and/or submit claims within timely filing limits. The Provider must verify eligibility and document attempts to obtain coverage information prior to billing the Member.

- ❖ The member became eligible for benefits retroactively but did not meet all other criteria required to receive the service.
- ❖ A third party payer made payments directly to the member for services provided.
- ❖ The member is receiving the limited Citizen Alien Waived Emergency benefit package (CAWEM). These members may be charged for services which are not part of the benefit. The provider must document that the member was informed in advance that the service would not be covered.
- ❖ The member has requested a continuation of benefits during a contested case hearing process, and the final decision was not in the favor of the member. The member shall be billed for any charges incurred for the denied service on or after the effective date on the Notice of Adverse Determination or Notice of Appeal Resolution. The provider must complete the [OHP 3165 form](#) prior to providing these services.

Members may elect to privately pay for services in exceptional circumstances:

- ❖ For covered services the provider may bill the member if the provider informs the member in advance of the following:
 - The provider documents in writing, signed by the member or the member's representative, indicating that the provider gave the member the information described below. That the client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and that the client agreed to privately pay for the service. The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to Health Share or third party payer that is subject to the agreement.
 - The agreement must include:
 - That the requested service is a covered service, and the appropriate payer would pay in full for the service; and
 - The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay, and that the member cannot be billed for an amount greater than the amount the payer would pay; and
 - The member knowingly and voluntarily agrees to pay for the covered service.
- ❖ For non-covered services, a provider may bill a member provided the following:
 - Prior to delivering the non-covered service, the [OHP 3165 form](#) is signed by the member; and
 - There is evidence of the [OHP 3165 form](#) in the member's file and available upon request.

Oregon Medicaid Enrollment for Claims Processing

All Providers, both organizational and individual, who will appear on a claim as a submitting, rendering, or attending Provider, must be enrolled in Oregon Medicaid and be issued an Oregon Medicaid enrollment number by the Department of Medical Assistance Programs (DMAP) in order to be reimbursed for services rendered. This number is commonly referred to as a “DMAP number.” Providers may e-mail providers@healthshareoregon.org for more information or to see if the Provider’s NPI is enrolled in Oregon Medicaid and has been assigned a DMAP number.

Corrected Claims

Providers shall submit corrected claims to PH Tech within three hundred sixty five (365) calendar days from the original adjudication date.

Provider should not submit e-mail requests to change required data elements to a Claim. PH Tech will not accept changes submitted either via direct email or via email link in CIM. Instead, Providers are required to submit a corrected Claim reflecting needed changes either by paper or electronically (EDI), as applicable. Below is a list of **example** data elements that cannot be changed based on email submitted either directly to PH Tech staff or via CIM link (this list is not exhaustive):

- Provider name/Tax ID/NPI
- Billing Provider name/Tax ID/NPI
- Plan/Provider/billing Provider/location address
- From and To Dates Of Service
- Diagnosis Code
- CPT Code
- Modifier
- Diagnosis Pointer
- Units
- National Drug Code (NDC)

Providers are encouraged to continue to use the email link within CIM for the following types of communication (this list is not exhaustive):

- Providers requesting adjustment to Authorization information
- Providers relaying information about patient/Member eligibility (retro changes)
- Claim status questions
- Provider questions concerning how decisions are made to process and pay Claims, including fee schedule, benefits, edits, etc.
- Provider request to VOID a Claim

Instructions on receiving and replying to messages within CIM can be found on the [Health Share website](#).

Provider Data Management

Roster Submissions

In order to ensure network accuracy and adequacy, and ensure accurate data for required state reporting, all Providers contracted as an organization **must submit** full practitioner rosters to Health Share which include all practitioners who provide services to Health Share members at contracted offices.

If changes to the Organizational Provider Roster have occurred since the date of the last roster submission, a new Organizational Provider Roster must be submitted to Health Share by the **first Friday of each quarter**.

Providers must use [Appendix H1: Organizational Roster Information](#) to submit practitioner information to Health Share in **Excel format**. Incomplete rosters, or rosters received in any other format will not be accepted and will be returned to the provider for correction.

If no changes have occurred to the Organizational Provider Roster since the date of the last roster submission, please submit a completed [Appendix H2: Organizational Roster Attestation](#), confirming that no changes have occurred, by the **first Friday of each quarter**.

A full organizational roster must be submitted by all Providers contracted at the organizational level by **the first Friday in April every year**, regardless of changes or the date of the last roster submission.

Setting Up a New Practitioner with an Organizational Provider

Currently contracted Organizational Providers who need to add a newly-hired and credentialed practitioner to CIM in order for claims to be processed correctly, must complete New Practitioner with Contracted Organizational Provider Form ([available online](#)) and send to provider.contracts@phitech.zendesk.com.

*****Prior to sending the above information, Organizational Providers are responsible for credentialing their Practitioners in order to meet the Medicaid regulations stated in the Provider Manual.*****

Information should be provided for each Practitioner who will submit Claims under the Organizational Provider.

In order for authorizations and claims to process correctly, all individual practitioners within a group must be loaded in to CIM. Failure to add new providers to CIM may result in claims payment issues.

New providers should also be added to the next version of the Organizational Provider Roster (see section above titled ‘Roster Submissions’).

Updating/Terminating a Current Practitioner with an Organizational Provider

A currently contracted Organizational Provider who needs to update (i.e. name change) or indicate the termination of an existing practitioner should send notification and details of the change or term to PH Tech at provider.contracts@phtech.zendesk.com. The Practitioner’s name, NPI, and affiliated organization must be included along with description of change or termination notice.

Additionally, the update/termination should be included on the next quarter’s [Appendix H1: Organizational Roster Information](#).

Updating and/or Adding Provider Addresses

Providers shall notify Health Share of Oregon of any change to a Provider’s office location(s) or administrative address. For changes to current office locations, or to add a new office location, Providers shall complete the Pathways Provider Address Addition Form or [Pathways Provider Address Relocation Form](#). If a Provider is closing an office and it is not being relocated, Providers shall complete the Pathways Provider Address Closure Form. For changes to any administrative addresses (i.e., billing, mailing, credentialing), please complete the [Pathways Provider Administrative Address Update Form](#). All forms are available on the [Health Share website](#). Completed form(s) and supporting documents should be sent to providers@healthshareoregon.org at least **30 calendar days** prior to your address change or addition.

Failure to notify Health Share of changes to service addresses may result in inaccurate data in the Provider Directory.

Changes to Provider Billing Data

Health Share must be notified at least **45 calendar days** prior to any changes to a Provider’s billing data, including Tax Identification Number (TIN), Organizational National Provider Identification (NPI) number, and/or Organizational Name.

To notify Health Share of a change to your billing data, please complete and submit the Pathways Provider Billing Data Change Form available on our website, along with your updated W9 (if necessary) to providers@healthshareoregon.org.

Failure to submit notice at least 45 days in advance of a change may result in claims or authorization processing errors.

Credentialing & Re-Credentialing Requirements

Health Share's credentialing department can be reached at providers@healthshareoregon.org.

Organizational Providers

Initial Credentialing

An Organizational Provider with an active Health Share contract has undergone an initial credentialing process and been approved by Health Share's committees to provide services.

Re-credentialing

Health Share re-credentials organizations every 2-3 years from the date of the Provider's contract effective date. At time of re-credentialing, Health Share will notify the Provider.

Ongoing Expectations

For participation in the Pathways Provider Network, providers shall maintain the following credentialing documentation in paper or digital form as applicable to the scope of their contracted services. Any changes to the status of credentialing documentation (example expiration without renewal, restrictions, or other changes must be immediately reported to Health Share):

- As applicable, active health care accreditation for all locations providing services under the contract with Health Share. Examples of accreditation includes, but is not limited to:
 - CARF Accreditation
 - Joint Commission Accreditation
- As applicable, active licensure for locations providing services under the contract with Health Share. Examples of licensure include, but not limited to:
 - Current Certificate of Approval from the Oregon Health Authority for all locations which provide outpatient mental health or substance use disorder services and have unlicensed practitioners providing services
 - Current DEA for locations which provide covered maintenance and withdrawal management services
 - Current OHA licensure(s) for locations which provide covered adult residential treatment services
 - Current DHS licensure(s) for any facility that will be providing covered child residential treatment services
 - Current Opioid Treatment Program Certification for locations that provide Medication Assisted Treatment to Health Share members

- Any other current health care related licensure granted to any facility which provides covered services to Health Share Members
- Active liability insurance showing:
 - General facility coverage with at least \$1M per occurrence/ \$3M aggregate coverage
 - Professional liability coverage with at least \$1M per occurrence/\$3M aggregate coverage
 - Worker’s Compensation coverage of at least \$500K per occurrence/\$500K aggregate coverage (only applicable if organization has employees)
- A policy on restraint and seclusion that ensures Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations specified in federal regulations on the use of restraints and seclusion.

Organization’s Responsibility to Oversee Licensed and Unlicensed Practitioners

Organizational Providers are responsible for processing and approving credentialing for their individual employed and contracted practitioners who are providing services to Health Share members. Resources regarding credentialing practitioners according to Medicaid standards are available by contacting providers@healthshareoregon.org.

1. Credentialing requirements for licensed practitioners

1. 42 CFR 438.214 Provider Selection
2. 42 CFR 455.412 Verification of Provider Licenses
3. 42 CFR 455.422 Appeal Rights
4. 42 CFR 455.436 Background Checks
5. 42 CFR 455.440 NPI
6. 42 CFR 455.436 Federal Database Checks
7. OAR 409-045-0035 OPCA Application
8. OAR 410-141-3120(4) Non-discrimination and Re-credentialing
9. Additional requirements as outlined in the Covered Services and Compensation Addendum(s)

2. Verification requirements for unlicensed practitioners

1. 42 CFR 455.436 Federal Database Checks
2. The Organization shall document and that the practitioner’s education, experience, competence, and supervision are adequate to permit them to perform their specific assigned duties. This shall be updated when there is a significant change in the practitioners’ duties.
3. Additional requirements as outlined in the Covered Services and Compensation Addendum(s)

Individual Providers

Initial Credentialing

An individual Provider with an active Health Share contract has undergone the initial credentialing process and been approved by Health Share to provider services.

Re-Credentialing

Health Share re-credentials individuals every 2-3 years from the date of the Provider's contract effective date. At time of re-credentialing, Health Share will notify the Provider.

Other Expectations

For participation in Pathways Network, providers shall maintain the following credentialing documentation in paper or digital form as applicable to the scope of their contracted services. Any changes to the status of credentialing documentation (example expiration without renewal, restrictions, or other changes must be immediately reported to Health Share):

- Active liability insurance with professional liability coverage with at least \$1M per occurrence/\$3M aggregate coverage
- Active licensure. Must have appropriate licensure for fulfilling scope of contracted services
- If applicable, current DEA. The DEA must be registered in the state providing services and have appropriate clearance for fulfilling scope of their contracted services.

Providers Contracted directly with one or more of the individual county Behavioral Health Plan Partners

Providers holding contracts directly with Clackamas, Multnomah and/or Washington Counties should call or email the appropriate county Quality Assurance representative identified in the Plan Contact list, for any credentialing related questions or requirements.

Fraud, Waste & Abuse

Effective System for Routine Monitoring and Identification of Fraud, Waste and Abuse

The best way for Providers to reduce risk of Fraud and Abuse is to maintain a robust process for monitoring Claims. The Behavioral Health Plan Partners can provide technical assistance regarding frequency and minimum content for internal agency billing accuracy audits.

Reporting

Providers will promptly (within five (5) business days) refer all verified and/or suspected cases of fraud and abuse, including fraud by their employees and subcontractors, to the Medicaid Fraud Control Unit (MFCU) and to the OHA Program Integrity Audit Unit and to the relevant Behavioral Health Plan Partners of Health Share.

Providers will cooperate with and permit the Behavioral Health Plan Partners, Health Share, the MFCU and/or PIAU to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities, as required to investigate an incident of fraud and abuse.

The Behavioral Health Plan Partners and Health Share reserve the right to impose sanctions, up to and including termination of contact, with any individual or organization found to have committed fraud or abuse.

Medicaid Fraud Control Unit
Oregon Department of Justice
100 SW Market St.
Portland, OR 97201
Phone: (971) 673-1880
Fax: (971) 673-1890

OHA Program Integrity Audit Unit
3406 Cherry Ave. NE
Salem, OR 97303-4924
503-378-8113
503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)

When making a report, Provider will include the following information:

- Provider Name, Oregon Medicaid Provider Number, Address and Phone
- Type of Provider
- Source and nature of complaint
- The approximate range of dollars involved
- The disposition of complaint when known
- Number of complaints for the time period

Examples of Reportable Incidents

Reportable incidents may include, but are not limited to:

- Providers who consistently demonstrate a pattern of intentionally reporting Encounters or services that did not occur as evidence by complaint or focused Encounter data audits showing Encounters billed without appropriate documentation.
- Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service.

- Any verified case where the Provider intentionally billed Health Share more than the usual charge to non-Medicaid recipients or other insurance programs.
- Any verified case where the Provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating and/or collecting Medicaid payments otherwise not due.
- Providers who intentionally make false statements about the credentials of persons rendering care to OHP Members.
- Providers who intentionally fail to render medically appropriate covered services that they are obligated to provide OHP recipients under their contracts with the Coordinated Care Organization Agreement and OHP regulations.
- Providers who knowingly charge OHP Members for services that are covered or intentionally bill an OHP Member the difference between the total fee-for-service charge and County's payment to the Provider.
- Any suspected case where the Provider intentionally submitted a claim for payment that already has been paid by OHA or by Health Share, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the claim form, and receipt of payment is known to the Provider.
- Any case of theft, embezzlement or misappropriation of Title XIX program money.

Additional Requirements for Organizational Providers ONLY

Policies and Procedures

Provider will have fraud and abuse policies and procedures in accordance with contract expectations. Provider will review its fraud and abuse policies annually.

Participation of Suspended or Terminated Providers

The following persons, or their affiliates as defined in the Federal Requisition Regulations, may not provide covered services to Health Share Members:

- Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Requisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implement such order.
- Persons or programs that are currently suspended or terminated from the Oregon Medical Assistance Program.

Persons or programs that are currently excluded from Medicaid participation and listed on the federal System of Award Management (SAM; formerly known as EPLS) (<https://www.sam.gov/>) and/or Office of Inspector General (OIG) Medicaid exclusion list (<http://exclusions.oig.hhs.gov>).

Providers shall not refer Health Share Members to persons or organizations whose participation in Medicaid or Medicare programs has been suspended or terminated. Providers will not knowingly:

- Allow a person whose participation in Medicaid or Medicare programs has been suspended or terminated to serve as a director, officer, partner; or
- Enter into an employment, consulting, or other agreement with a person whose participation in Medicaid or Medicare programs has been suspended or terminated for the provision of items and services that are significant and material to Health Share’s service agreement

Organizational Providers shall perform monthly exclusion list checks of all employees, contractors, volunteers, interns and any other persons providing, arranging, or paying for behavioral health services paid in whole or in part with Medicaid dollars, against the OIG List of Excluded Individuals/Entities (LEIE) and the SAM database. Provider will maintain monthly verification of this check.

Whistleblower Protection

Retaliation for good faith reporting of perceived or suspected violations of law, regulation, or state policy or procedure, or for participation in an investigation of an alleged violation is strictly prohibited. Any employee, supervisor, manager or executive who commits or condones any form of retaliation, retribution or harassment against a reporting employee can be held accountable in a review. Agency policies should take appropriate measures to safeguard employees against retaliation.

Additional Requirements for Providers with Certificates of Approval (COA) ONLY

Employee Code of Conduct

Provider must maintain a written employee code of conduct that addresses conflicts of interest; safeguards protected health information (PHI); and maintains compliance with all applicable laws and regulations, Fraud, Waste and Abuse policies, internal investigations, and employee education and accountability.

Mandatory Training

Provider must provide and document appropriate orientation training for each program staff, or person providing services, within thirty (30) calendar days of the hire date on fraud, waste and abuse in Federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510.

Additional Requirements for Providers Receiving \$5 Million or More Annually (total of all OHP contracts combined) ONLY

Policies and Procedures

Provider will establish written policies for all employees of the Provider (including management), and of any contractor, subcontractor, or agent of the Provider, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title

31, United States Code, administrative remedies for false Claims and statements established under chapter 38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false Claims and statements, and whistleblowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)).

Employee Handbook

Provider will include in any of its employee handbooks a specific discussion of the laws described in the policies and procedures section above, the rights of the employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

Overpayment Recoveries

Section 6402(a) of the Affordable Care Act (Social Security Act 1128 J (d)) requires agencies that have received an overpayment from Medicare or Medicaid to report and return the overpayment, including a written notice explaining the reason for the overpayment. Overpayments must be reported and returned by the later of sixty (60) calendar days from the date on which the Provider becomes aware of the possible overpayment, or the date of the applicable cost report.

Health Share defines the date of notice of overpayment as the following:

- The date on which any Medicaid agency official or other State official first notifies a Provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; or
- The date on which a Provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or
- The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a Provider without having first notified the Provider in writing.

Provider Agency Voluntary Self-Report of Overpayment

Voluntary reports of overpayment can be made either to the Third Party Administrator or directly to Affiliated Health Plan Partners.

Notification of Provider Agency

When the Third Party Administrator, an encounter data audit, or data mining identify preliminary overpayment findings, an overpayment communication is sent to the Provider agency with a letter requesting that the agency respond within fourteen (14) calendar days from the date of the letter or an agreed-upon individualized timeline. Provider agencies are given an opportunity to agree or disagree with

preliminary findings. If the Provider agency disagrees with one or more findings, it must provide supporting documentation to refute the finding.

The entity that identified the preliminary overpayment findings will notify the agency through a “final determination” letter which will specify repayment amounts, instructions, and a timeline not greater than thirty (30) calendar days for repayment.

Audit Rights of Health Share and Health Plan Partners

Providers will be subject to periodic Compliance/Quality Management audits to assure compliance with all Federal, State and local laws. Providers shall cooperate by providing access to records and facilities for the purpose of Compliance/Quality Management reviews by Health Share and the Behavioral Health Plan Partners. Required documentation shall be made available upon request. Requested documentation may include, but is not limited to the following: Fraud, Waste and Abuse, Credentialing, Member Rights, Grievances and Appeals, and Critical Incidents.

Required Submissions

Regional Pathways Provider Access Report

Health Share Pathways Providers who provide **outpatient behavioral health services** shall submit **Access Reporting** data by the 15th of each month. That data collected is intended to capture (on average) how many days out providers are currently scheduling the third next available non-urgent outpatient behavioral health assessment appointments.

Third next available appointment is defined as the length of time (in days) between the day a patient makes a request for an assessment appointment and the third available appointment. The third next available appointment is used rather than the next available appointment since it is a more sensitive reflection of true appointment availability.

Health Share Pathways Providers who provide **ABA services** shall submit **Access Reporting** data by the 15th of each month. That data collected is intended to capture (on average) how many days out providers are currently scheduling intake appointments and how long it is taking for services to begin.

For more information regarding how to submit the report, please see the Regional Pathways Access Report available on our [website](#) or contact providers@healthshareoregon.org.

Annual Provider Roster

A full organizational roster must be submitted by all Providers contracted at the organizational level by **the first Friday in April every year**, regardless of changes, or the date of the last roster submission.

Additional Reports as Requested

Health Share or our Behavioral Health Plan Partners may request additional reports from Providers which are not specifically named herein. Provider must submit these reports in a timely manner as they are requested.

Mental Health Outcomes

The following information on outcomes applies to all Health Share Providers contracted to offer Mental Health Outpatient services under the Case Rate or Fee for Service Level of Care model.

Feedback Informed Treatment: Description, Participation, and Standards

Feedback Informed Treatment (FIT) (also referred to as Outcomes Based Care, PCOMS, Routine Outcomes Monitoring, and Measurement Based Care) can be described as:

“A pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery” (Bertolino, B., & Miller, S. (eds.) (2011). The ICCE Feedback Informed Treatment and Training Manuals. Chicago, IL: ICCE Press)

Essentially, this can be distilled down as the process of:

1. Regularly and formally gathering client feedback about their level of distress (or wellness) and about the alliance between the client and the helper
2. Using that data to inform treatment
3. Engaging in deliberate practice to help foster professional development

Feedback Informed Treatment puts the client's voice at the center of services as an active participant and driver of the treatment process. Engaging in FIT processes allows clinicians and agencies to capture and tangibly demonstrate the good work they are doing with clients and notifies clinicians when clients are not benefiting so that treatment can be augmented as needed. In short, it is a client centered process that helps care providers ensure that as many people benefit from services as possible.

Providers are expected to use a Health Share approved outcomes instrument to aid in treatment planning and overall provision of services. All Providers contracted January 2018 or later who are contractually required to implement Feedback Informed Treatment may self-select either the Outcomes Rating Scale (ORS) and Session Rating Scale (SRS) or the ACORN for their outcomes tool. Providers contracted prior to January 2018 may continue to use their previously selected tool. If a Provider contracted prior to January 2018 would like to switch their FIT outcomes tool, they may select either the ORS/SRS or the ACORN. It is the expectation that Providers will participate in Feedback Informed Treatment initiatives, utilize the identified outcomes tool with their Health Share Member population, and that they are able to report on their outcomes to Health Share. Providers who are interested in FIT support, would like information about learning opportunities, or have other FIT-related questions should contact the Regional Behavioral Health Outcomes Coordinator.

Case Rate Level of Care Mental Health Providers

Performance Expectations

A key element of health care transformation is moving away from paying for volume to paying for value. The fee-for-service payment model may create an incentive to provide as many services as possible, while case rates support a shift in focus to achieving outcomes. Case rates are meant to provide flexibility to the Provider and Member, in order to ensure that mutually established treatment outcomes are met. Ultimately, case rates will contribute to achieving the Triple Aim of better care, better health and lower costs. Case rates are an AVERAGE payment for all of the Members served at a given level of care. By definition, some individuals will require MORE care and some will require LESS care in order to achieve the intended outcomes. Case rates are NOT a fixed budget for an individual Member.

Performance expectations include, but are not limited to the following:

- Provider shall maintain required access for routine, urgent and emergent appointments within timelines per the access requirements outlined in Regional Access Report.
- Provider shall ensure follow-up care for Members after discharge from a hospital for mental illness within seven (7) calendar days of hospital discharge.
- Provider shall complete an annual audit of its decision-making process to ensure consistent application of review criteria for Level of Care Authorization decisions, taking into account applicable clinical practice guidelines (see [Health Share Pathways Regional Practice Guidelines](#)), and consultations with requesting practitioners as appropriate.

- Provider shall ensure Members are receiving the frequency and intensity of service that is clinically indicated by the Member's Level of Care. Behavioral Health Plan Partners may periodically coordinate with Providers to ensure services are available to align with the frequency and intensity that Member requires.
- Provider shall improve outcomes by the use of approved outcomes tools.
- Provider shall provide 24-hour, seven day a week telephonic or face-to-face crisis support coverage as outlined at OAR 309-019-0150.

Risk Corridor Reconciliation Process

A regional risk corridor will be calculated to evaluate case rate payments in relation to the fee-for-service equivalent value of the encounterable services. There will be one regional risk corridor effective each Fiscal Year with an 80% floor and a 125% ceiling. The regional risk corridor will be calculated annually and the first calculation will occur approximately November 1, 2017. Fee-for-Service equivalents are identified on the regional fee schedule. Please note that if a Provider's usual and customary billed rate is lower than Health Share's fee-for-service equivalent, then the Provider's usual and customary billed rate will be used to calculate the risk corridor.

Alternative Payment Confidentiality Requirements

Pursuant to section 9.6 of the Health Share Provider Participation Agreement, all information on the case rate (alternative payment) system developed by Health Share and the Behavioral Health Plan Partners is considered 'Confidential Business Information'. This information includes all elements related to the case rate system including, but not limited to: case rate/risk corridor reports; authorization utilization report; case rate payment amounts; and the case rates technical assistance manual.

Fee for Service Level of Care Mental Health Providers

Level of care determinations are always made using the Regional Practice Guidelines, but in some instances are made by Behavioral Health Plan staff, and in other cases are made by staff at Case Rate Level of Care Provider agencies.

Behavioral Health Plan staff make Level of Care decisions for all services that require prior authorization. The Behavioral Health Plan staff evaluates the clinical documentation* received from the requesting Provider, and in consideration of the criteria listed in the Regional Practice Guideline make a Level of Care Determination.

**Clinical documentation submitted by a requesting Provider includes documents such as an assessment; treatment plan; and the most recent service notes.*

Case Rate Level of Care Provider staff make Level of Care determinations for all services that are delivered within the Level A-C outpatient levels of care. These Level of Care determinations are made by comparing the Regional Practice Guidelines criteria and the clinical information that has been gathered by the clinician completing the assessment. The results of the clinician's evaluation of level of care needs could result in one of the three outcomes.

The clinician at the Case Rate provider agency determines that the client's presentation:

- 1) Does not meet the threshold for treatment at any of the outpatient levels of care; or
- 2) Results in the clinician assigning one of the outpatient levels of care (A-C), which they can self-authorize; or
- 3) Results in the clinician submitting a request for a service that requires prior authorization.

Services such as Level D Outpatient treatment and Assertive Community Treatment, require prior authorization. The role of a Clinician at a Case Rate agency with regards to facilitating a determination for those Levels of Care includes contacting the appropriate County Behavioral Health Plan and providing all requested clinical documentation.

Outpatient Fee for Service Mental Health Providers

Outpatient Fee for Service Mental Health Providers (OP FFS MH Providers), are individual practitioners and small groups who have an identified area of expertise, experience, service location, language proficiency or other specialty which augments the Pathways Provider Network.

All services delivered by OP FFS MH Providers require an authorization from the Behavioral Health Plan Partner (BHPP) prior to delivery.

Authorizations to OP FFS MH Providers will be considered for Members who require the Provider's identified specialty in order to receive mental health treatment.