Service Authorizations Guidelines & Procedures

Health Share of Oregon members are required to access covered behavioral health services through Health Share of Oregon's established contracted Pathways Provider network.

Requests for Exceptional Needs Service Authorizations may be made for situations where the members' treatment needs not met by Health Share's established contracted outpatient Provider network and require a higher level of care.

Exceptional Needs Services requiring pre-authorization include, but are not limited to:

- Eating Disorders Outpatient Treatment Program
- Dialectical Behavior Therapy (DBT)
- Assertive Community Treatment (ACT)
- Intensive Case Management (ICTS and ICM)
- Electro-convulsive Therapy (ECT)

Exceptional Needs Services require pre-authorization regardless of the provider type initiating the request. A Care Coordinator working at the member's Behavioral Health Plan will conduct utilization review on all exceptional needs requests. The Coordinator will confirm the credentialed status of the provider, or will initiate the credentialing process prior to authorizing services. Each request is evaluated on a case-by case basis to ensure:

- Eligibility status of the Member
- Individuals being considered for Exceptional Needs Services meet the criteria of medical appropriateness in accordance with Health Share Regional Practice Guidelines for the level of treatment being requested.
- All Providers approved to deliver the service are, or agree to be credentialed in accordance with the Health Share credentialing and re-credentialing processes.
- The Provider approved to deliver the service is willing to accept allowable rates.

All Authorization determinations are made within 14 calendar days of the date of the request.

If the request for authorization for Exceptional Needs Services or Continuity of Care is denied for a Health Share Member, the Coordinator will send a Notice of Action (NOA).

Exceptional Needs Services, and all services delivered by Specialty Mental Health Providers are authorized and paid using a Health Share's Regional fee-for-service rate structure.

Some Specialty Mental Health Providers may be granted Fee for Service Level of Care Mental Health Provider status and given privileges and access to enter their own authorizations and have Provider Submitted Authorizations which auto-approve. These permissions are given at the discretion of the Behavioral Health Plan coordinating Member Care, and are dependent on provider type, service type, and the provider's knowledge of Health Share's system of care.

Authorizations that are not self-entered by providers or set to auto-approve will be entered and/or approved by Behavioral Health Plan staff.

Exceptional Needs Service Authorization Procedures by County Behavioral Health Plan

Clackamas County

Initial Authorizations

Claims are paid consistent with published Health Share rates. In some cases, exceptions are made to service delivery requirements or rates for specific Providers and/or service types.

Routine outpatient services provided by Specialty Mental Health Providers will always initiate with an Assessment authorization to give the Provider the opportunity to complete an assessment and generate a picture of the Member's clinical presentation.

The Provider will then submit a treatment plan and assessment that are both valid and congruent with the Member's current level of functioning, and any other supporting documentation. The Behavioral Health Plan Care Coordinator will review the documentation and consult with the Provider as needed to confirm that the request is for treatment for a covered diagnosis; that the request meets medical necessity criteria; and to enter an authorization for services as approved.

Re-Authorizations

Non-Contracted Exceptional Needs Providers must submit an Authorization Renewal Request form (Appendix E1) and supporting clinical documentation to Clackamas County at least two weeks prior to the expiration date of the current authorization, to allow the County's care coordination staff to review and make a determination.

For Specialty Providers, self-entered authorization should be entered/requested no later than 45 days from the start of services. Those entered or requested 45 days past the requested start date will require justification from the Provider as to the reason for the belated request. In these cases, self-entered authorizations will automatically enter a pending status in CIM. If no valid justification is provided, the authorization will be made effective on the date that Clackamas County received the completed request and required materials from the Provider.

Exceeding an Authorization Limit

A Provider must submit an Authorization Renewal Request form and clinical justification for why the initial authorization was not sufficient to meet the needs of the Member if service provision exceeds the previously authorized amount prior to the end date of the authorization, and additional funds are being requested. This request may result in changes to the diagnosis or treatment plan, in which case the updated clinical documentation, such as an updated mental health assessment or treatment plan, must also be submitted. If, after reviewing the updated clinical information, the Clackamas Behavioral Health Plan Care Coordinator determines that additional treatment is indicated, additional dollars can be added.

All Authorization decisions will be made by Clackamas County staff within 14 calendar days of the date of the request.

Multnomah County

Adult Services

Exceptional Needs Services are pre-authorized during regular business hours, Monday-Friday.

Pre-authorization requests must be submitted to Multnomah Mental Health on a MMH Treatment Authorization Request form (TAR) or MMH Psychological Testing Authorization Request form (PTAR) located here: https://multco.us/mhas/mental-health-Provider-documents-resources.

Current clinical justification for medical necessity (mental health assessments or other evaluations) must be available for review by MMH. If there is no clinical information available, the Member will need to be assessed by an agency in the Health Share Pathways Provider Network. If the Member's symptoms are such that they are unable to successfully get this assessment completed, the Health Share Multnomah County Behavioral Health Plan Care Coordinator may work with the Member and referring Provider to determine barriers to accessing necessary services.

Multnomah County Utilization Review (UR) team members may authorize an assessment only when clinical justification for specialty services is unclear.

Child and Youth Services

Child and Adolescent Intensive or specialty services requiring pre-authorization include, but are not limited to:

- Psychiatric Residential Treatment
- Psychiatric Day Treatment
- Eating Disorder Treatment
- Home Based Services

Exceptional Needs Services are pre-authorized during regular business hours, Monday-Friday. Pre-authorization requests must be submitted to Multnomah County Youth Care Coordination Program on a Multnomah County Mental Health Care Coordination/Wraparound Request Form located here: https://multco.us/mhas/care-coordination-wraparound-referral-forms-resources. Care Coordination/Wraparound Requests must be submitted with a Mental Health assessment that includes an ICD-10 diagnosis made within the last 60 days.

Washington County

Pre-Authorization Inquiries from Members, Specialty Mental Health Providers and Fee For Service Level of Care Mental Health Providers

Contact Member services at 503-291-1155

Member Services staff are available on a 24 hour/7 days per week basis to receive requests for treatment services that will be triaged and forwarded to the Utilization Management Team.

Pre-Authorization Inquiries from Case Rate Level of Care Mental Health Providers

Case Rate Level of Care Mental Health Providers seeking specialty mental health services for an enrolled Member should contact the appropriate Care Coordinator to staff clinical and/or initiate the request for authorization:

- Outpatient System of Care Coordinator: (503) 846-4593
- Acute Care/Respite Care: (503) 846-3168

Members may be authorized to a participating agency and concurrently receive specialty/exceptional needs services when clinically indicated and as approved by a Washington County Care Coordinator.

Required Documentation

Upon request, Providers will submit clinical documentation to the Washington County Behavioral Health Plan Care Coordinator prior to the end of the 14 day determination period, to include:

- A mental health assessment completed within the last 60 days. If this has not been completed, the Care Coordinator may authorize the provider to complete an assessment to determine the need to see an exceptional needs provider.
- A treatment plan with measureable objectives and target dates.
- Clinical justification as to why treatment cannot or should not be obtained through a participating Provider.
- Additional information as needed to assist the determination to authorize.

Continued Care Requests

When Exceptional Needs Services are expected to exceed one year, the Provider will submit a request for authorization with the current mental health assessment and treatment plan no later than one month before the expiration of the current authorization. Continued care requests are reviewed by the Washington County consulting psychiatrist for approval of continued treatment. This approval will be reflected by a signature on the written authorization for continued services.
These processes will repeat as needed for the duration of treatment with the provider.