836-053-1403
Definitions of Coordinated Care and Case Management for Behavioral Health Care Services

As used in ORS 743A.168:

(1) The definitions set forth in section 5 of Section 4, Chapter 273, Oregon Laws 2017 apply to the use of those terms in these rules.

(2) “Caring contacts” mean brief communications with a patient that start during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary.

(3) “Case management” means the management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual’s patient-centered care plan.

(4) “Coordination of care” means the process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by:

(a) Organizing and participating in team meetings; and

(b) Ensuring continuity of care during each transition of care.

(5) “Crisis stabilization plan” means an individually tailored plan provided to a patient and the patient’s lay caregiver that:

(a) Is based on the patient’s behavioral health assessment and physical health assessment; and

(b) Describes the patient’s specific short-term rehabilitation objectives and proposed crisis interventions.

(6) “Lay caregiver” means:

(A) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient.

(B) For a patient who is at least 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.

(C) For a patient who is at least 14 years of age or older, and who has not designated a caregiver, an individual to whom a health care provider may disclose protected health information without a signed authorization under ORS 192.567.

(7) “Lethal means counseling” means counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.

(8) “Medically appropriate treatment” means the services and supports necessary to diagnose, stabilize, care for and treat a behavioral health condition.

(9) “Patient centered care” means care provided in a manner that:

(a) Is respectful of and responsive to a patient’s preferences, needs and values; and

(b) Ensures that all clinical decisions are guided by the patient’s values.

(10) “Peer delivered services” means an array of support services provided by agencies or community- based organizations to patients or family members of patients:

(a) Using peer support specialists; and

(b) That are designed to support the needs of patients and their families.

(11) “Peer support specialist” means a Peer Wellness Specialist or a Peer Support Specialist, including Family Support Specialist and Youth Support Specialist, as defined in ORS 414.025 and 414.665 and certified under OAR 410-180-0310 to 410-180-0312.

(12) “Qualified mental health professional” means an individual meeting the minimum qualification criteria adopted by the Oregon Health Authority by rule for a qualified mental health professional.

(13) “Safety plan” means a written plan developed by a patient in collaboration with the patient’s lay caregiver, if any, as facilitated by a health care provider that identifies strategies for the patient or lay caregiver to use when the patient’s risk for suicide is elevated or following a suicide attempt.

(14) “Transition of care” means the process of transferring a patient from one provider or care setting to another provider or care setting.

(15) Coordination of Care and Case Management processes shall ensure coordination and management of services when indicated by a behavioral health assessment conducted by a behavioral health clinician, including, but not limited to:

(a) A best practices risk assessment and, if indicated, a safety plan and lethal means counseling;

(b) A determination of the patient's clinical needs and recommendations, if within the scope of the provider's practice, for medically appropriate treatment including but not limited to one or more of the following:

(A) Adjusting or prescribing medication;

(B) Therapeutic services;

(C) Other medically appropriate treatment; or

(D) Peer delivered services.

(c) Caring contacts.

(d) Recommendations as required or permitted under ORS 192.567, 441.196 and 441.198 to the patient, lay caregiver and health care provider.

(e) Informing the patient, lay caregiver and health care provider of the practitioners who can provide the recommended services and how to access the practitioners and other community-based resources.

(f) Explaining to the patient and the lay caregiver crisis stabilization planning and patient centered care and establishing a goal of convening a care team.

(g) Identifying a person to provide coordination of care who:

(A) Is part of a patient centered behavioral health home, as defined in ORS 414.025, a patient centered primary care home, as defined in ORS 414.025, or a patient centered medical home recognized by the National Committee for Quality Assurance;

(B) Is appropriately licensed or certified;

(C) Will communicate directly with the patient and the lay caregiver; and

(D) When possible or requested, will meet personally with the patient and the lay caregiver.

(h) Creating with the patient and the lay caregiver a plan for the transition of care and sharing the plan with the patient's health care providers and care team.

Statutory/Other Authority: ORS 731.244 & OL 2017, Ch. 273 §5
Statutes/Other Implemented: OL 2017, Ch. 273 §5
History:
ID 3-2018, adopt filed 02/26/2018, effective 03/01/2018

836-053-1404
Definitions; Noncontracting Providers; Co-Morbidity Disorders

(1) As used in ORS 743A.168 and OAR Chapter 836:

(a) "Mental or nervous conditions" means any mental disorder covered by diagnostic categories listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV) or the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5).

(b) "Chemical dependency" means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems.

(c) "Chemical dependency" does not mean an addiction to, or dependency on:

(A) Tobacco;

(B) Tobacco products; or

(C) Foods.

(2) A non-contracting provider must cooperate with a group health insurer's requirements for review of treatment in ORS 743A.168(10) and (11) to the same extent as a contracting provider in order to be eligible for reimbursement.

(3) The exception of a disorder in the definition of "mental or nervous conditions" or "chemical dependency" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

Statutory/Other Authority: ORS 731.244 & 743A.168
Statutes/Other Implemented: ORS 743A.168
History:
ID 5-2016, f. & cert. ef. 4-26-16
ID 14-2015(Temp), f. & cert. ef. 12-17-15 thru 5-1-16
ID 3-2015, f. & cert. ef. 5-12-15
ID 19-2014(Temp), f. & cert. ef. 11-14-14 thru 5-12-15
ID 3-2013, f. 6-10-13, cert. ef. 6-17-13
ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-17-13
ID 13-2006, f. 7-14-06 cert. ef. 1-1-07
836-053-1405
General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency

(1) A group health insurance policy issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment of mental or nervous conditions and chemical dependency, including alcoholism, at the same level as, and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

(2) For the purposes of ORS 743A.168, the following standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions is provided at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions:

(a) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for medical and surgical services otherwise provided under the health insurance policy.

(b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services for mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services otherwise provided under the health insurance policy.

(c) If annual or lifetime limits apply for treatment of mental or nervous conditions and chemical dependency, including alcoholism the limits must comply with the “predominately equal” to and “substantially all” tests the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160.

(d) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles expenses for prescription drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for other medical services provided under the health insurance policy.

(e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, must be by the same process as drug selection for formulary status applied for drugs intended to treat other medical conditions, regardless of whether such drugs are intended to treat mental or nervous conditions, chemical dependency, including alcoholism, or other medical conditions.

(3) A group health insurance policy issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

(4) A group health insurer that issues or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

(5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical dependency, including alcoholism, may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses arising from other medical condition. Common methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.

(6) Nothing in this rule prevents a group health insurance policy from providing coverage for conditions or disorders excepted under the definition of "mental or nervous condition" in OAR 836-053-1404.

(7) The Director shall review OAR 836-053-1404 to 836-053-1408 and any other materials every two years to determine whether the requirements set forth in the rules are uniformly applied to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

Statutory/Other Authority: ORS 731.244 & 743A.168
Statutes/Other Implemented: ORS 743A.168
History:
ID 5-2016, f. & cert. ef. 4-26-16
ID 14-2015(Temp), f. & cert. ef. 12-17-15 thru 5-1-16
ID 3-2013, f. 6-10-13, cert. ef. 6-17-13
ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-17-13
ID 13-2006, f. 7-14-06 cert. ef. 1-1-07

836-053-1407
Prohibited Exclusions

(1) An insurer may not deny benefits for a medically necessary treatment or service for a mental or nervous condition based solely upon:

(a) The enrollee’s interruption of or failure to complete a prior course of treatment;

(b) The insurer's categorical exclusion of such treatment or service when applied to a class of mental or nervous conditions; or

(c) The fact that a court ordered the enrollee to receive or obtain the treatment or service for a mental or nervous condition, unless otherwise allowed by law.

(2) Nothing in this section:

(a) Requires coverage of a treatment or service that is or may be specifically excluded from coverage under state law.

(b) Prohibits an insurer from including a provision in a contract related to the insurer's general responsibility to pay for any service under the plan such as an exclusion for third party liability.

(c) Requires an insurer to pay for services provided to an enrollee by a school or halfway house or received as part of an educational or training program. However, an insurer may be required to provide coverage of treatment or services related to the enrollee's education that are provided by a provider and that are included in a medically necessary treatment plan.

Statutory/Other Authority: ORS 731.244 & 743A.168
Statutes/Other Implemented: ORS 743A.168
History:
ID 3-2015, f. & cert. ef. 5-12-15

836-053-1408
Required Disclosures

(1) Insurers must provide an enrollee or an enrollee's authorized representative reasonable access to and copies of all documents, records, and other information relevant to an enrollee's claim or request for coverage.

(2) Insurers must provide the criteria, processes, standards and other factors used to make medical necessity determinations of benefits for mental or nervous conditions. This information must be made available free of charge by the insurer to any current or potential enrollee, beneficiary, or contracting provider upon request, within a reasonable time and in a manner that provides reasonable access to the requestor.

(3) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

Statutory/Other Authority: ORS 731.244 & 743A.168
Statutes/Other Implemented: ORS 743A.168
History:
ID 3-2015, f. & cert. ef. 5-12-15