Chemical Dependency/Substance Abuse Rehabilitation

Policy Number: BIP141.N
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➲ Instructions for Use

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Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oregon

Oregon Revised Statute (ORS) Section 743A.168, Behavioral Health Treatment

https://oregon.public.law/statutes/ors_743A.168

(1) As used in this section:
(a) "Behavioral health assessment" means an evaluation by a provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment.
(b) "Behavioral health condition" has the meaning prescribed by rule by the Department of Consumer and Business Services.
(c) "Behavioral health crisis" means a disruption in an insured's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the insured's mental or physical health.
(d) "Facility" means a corporate or governmental entity or other provider of services for the treatment of behavioral health conditions.
(e) "Generally accepted standards of care" means:
(A) Standards of care and clinical practice guidelines that:
(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and
(ii) Are based on valid, evidence-based sources; and
(B) Products and services that:
(i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;
(ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and
(iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, treating physician or other health care provider.
(f) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.
(g) "Median maximum allowable reimbursement rate" means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.
(h) "Prior authorization" has the meaning given that term in ORS 743B.001 (Definitions).
(i) "Program" means a particular type or level of service that is organizationally distinct within a facility.
(j) "Provider" means:
(A) A behavioral health professional or medical professional licensed or certified in this state who has met the credentialing requirement of a group health insurer or an issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 (Definitions) and is otherwise eligible to receive reimbursement for coverage under the policy;

(B) A health care facility as defined in ORS 433.060 (Definitions for ORS 433.060 to 433.080);
(C) A residential facility as defined in ORS 430.010 (Definitions);
(D) A day or partial hospitalization program;
(E) An outpatient service as defined in ORS 430.010 (Definitions); or
(F) A provider organization certified by the Oregon Health Authority under subsection (8) of this section.

(k) "Relevant clinical specialties" includes but is not limited to:
(A) Psychiatry;
(B) Psychology;
(C) Clinical sociology;
(D) Addiction medicine and counseling; and
(E) Behavioral health treatment.
(L) "Standards of care and clinical practice guidelines" includes but is not limited to:
(A) Patient placement criteria;
(B) Recommendations of agencies of the federal government; and
(C) Drug labeling approved by the United States Food and Drug Administration.

(m) "Utilization review" has the meaning given that term in ORS 743B.001 (Definitions).

(n) "Valid, evidence-based sources" includes but is not limited to:
(A) Peer-reviewed scientific studies and medical literature;
(B) Recommendations of nonprofit health care provider professional associations; and
(C) Specialty societies.

(2) A group health insurance policy or an individual health benefit plan that is not a grandfathered health plan providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment 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. The following apply to coverage for behavioral health treatment:

(a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(b) The coverage of behavioral health treatment may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses of behavioral health treatment may be limited to treatment that is medically necessary as determined in accordance with this section and no more stringently under the policy than for other medical conditions.

(c) The coverage of behavioral health treatment must include:
(A) A behavioral health assessment;
(B) No less than the level of services determined to be medically necessary in a behavioral health assessment of the specific needs of a patient or in a patient's care plan:
(i) To effectively treat the patient's underlying behavioral health condition rather than the mere amelioration of current symptoms such as suicidal ideation or psychosis; and
(ii) For care following a behavioral health crisis, to transition the patient to a lower level of care;
(C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;
(D) Treatment at the least intensive and least restrictive level of care that is safe and most effective and meets the needs of the insured's condition;
(E) A lower level or less intensive care only if it is comparably as safe and effective as treatment at a higher level of service or intensity;
(F) Treatment to maintain functioning or prevent deterioration;
(G) Treatment for an appropriate duration based on the insured's particular needs;
(H) Treatment appropriate to the unique needs of children and adolescents;
(I) Treatment appropriate to the unique needs of older adults; and
(J) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

(d) The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care or placement.

(e) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan shall have a network of providers of behavioral health treatment sufficient to meet the standards described in ORS 743B.505 (Provider networks). If there is no in-network provider qualified to timely deliver, as defined by rule,

medically necessary behavioral treatment to an insured in a geographic area, the group health insurer or issuer of an individual health benefit plan shall provide coverage of out-of-network medically necessary behavioral health treatment without any additional out-of-pocket costs if provided by an available out-of-network provider that enters into an agreement with the insurer to be reimbursed at in-network rates.

(f) A provider is eligible for reimbursement under this section if:
  (A) The provider is approved or certified by the Oregon Health Authority;
  (B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;
  (C) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
  (D) The provider is providing a covered benefit under the policy.

(g) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.

(h) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.

(i) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan that reimburses out-of-network providers for medical or surgical services must reimburse out-of-network behavioral health treatment providers on the same terms and at a rate that is in parity with the rate paid to medical or surgical treatment providers.

(j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service or outpatient services if clinically indicated under any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician only if clinically indicated under any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge.

(k) Intentionally left blank —Ed.
  (A) Subject to the patient or client confidentiality provisions of ORS 40.235 (Rule 504-1. Physician-patient privilege) relating to physicians, ORS 40.240 (Rule 504-2. Nurse-patient privilege) relating to nurse practitioners, ORS 40.230 (Rule 504. Psychotherapist-patient privilege) relating to psychologists, ORS 40.250 (Rule 504-4. Regulated social worker-client privilege) and 675.580 (Confidentiality of communication by client) relating to licensed clinical social workers and ORS 40.262 (Rule 507. Counselor-client privilege) relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer or issuer of an individual health benefit plan may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.
  (B) Review shall be made according to criteria made available to providers in advance upon request.
  (C) Review shall be performed by or under the direction of a physician licensed under ORS 677.100 (Qualifications of applicant for license) to 677.228 (Automatic lapse of license for failure to pay registration fee or report change of location), a psychologist licensed by the Oregon Board of Psychology, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.
  (D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers and issuers of individual health benefit plans that are not grandfathered health plans shall provide a timely response to such

inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(L) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(3) This section does not prohibit a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section provided such methods comply with the requirements of this section.

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference, in accordance with this section.

(5) To ensure the proper use of any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge, a group health insurer or an issuer of an individual health benefit plan shall provide, at no cost:

(a) A formal education program, presented by nonprofit clinical specialty associations or other entities authorized by the department, to educate the insurer's or the issuer's staff and any individuals described in subsection (2)(k) of this section who conduct reviews.

(b) To stakeholders, including participating providers and insureds, the medical necessity, utilization or other clinical review criteria and any education or training materials or resources regarding medical necessity, utilization or other clinical review criteria, to the extent permitted by copyright laws.

(6) This section does not prevent a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743B.460 (Conditions for restricting payments to only in-network providers) or 750.005 (Definitions), subject to the following conditions:

(a) A group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan is not required to contract with all providers that are eligible for reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to subsection (2) of this section, pay benefits toward the covered charges of noncontracting providers of services for behavioral health treatment. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of behavioral health treatment, whether or not the behavioral health treatment is provided by contracting or noncontracting providers.

(7) Intentionally left blank —Ed.

(a) This section does not require coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days unless clinically indicated under any medical necessity, utilization or other clinical review conducted by the insurer for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) Support groups.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(8) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(j)(F) of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

(9) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (8) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(10) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (8) of this section. Any fees collected shall be paid

into the Oregon Health Authority Fund established in ORS 413.101 (Oregon Health Authority Fund) and shall be used only for carrying out the provisions of subsection (8) of this section.

(11) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress in accordance with this section. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (8) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(12) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section. The director shall adopt rules making it a violation of this section for a group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan to require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.

(13) This section does not:

(a) Prohibit an insured from receiving behavioral health treatment from an out-of-network provider or prevent an out-of-network behavioral health provider from billing the insured for any unreimbursed cost of treatment.

(b) Prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods.

(c) Require that any value-based payment method reimburse behavioral health services based on an equivalent fee-for-service rate. [Formerly 743.556; 2009 c.442 §47; 2009 c.549 §11; 2013 c.375 §1; 2013 c.581 §1; 2013 c.681 §62; 2016 c.11 §7; 2017 c.6 §29; 2017 c.17 §57; 2017 c.273 §5; 2017 c.409 §35; 2019 c.284 §6; 2019 c.285 §5; 2021 c.629 §5]

Oregon Secretary of State (OAR) Section 836-053-1404, Definitions; Noncontracting Providers; Co-Morbidity Disorders

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204610

Termed 12/31/2022

(1) As used in ORS 743A.168, this rule 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.

Effective 01/01/2023

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

(a) "Behavioral health condition" means any mental or substance use disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11).

(b) "Generally accepted standards of care" means;

(A) Standards of care and clinical practice guidelines that:

(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and

(ii) Are based on valid, evidence-based sources; and

(B) Products and services that:

(i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;

(ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and

(iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, treating physician or other health care provider.

(c) "Valid, evidence-based sources" includes but is not limited to:
(A) Peer-reviewed scientific studies and medical literature;
(B) Recommendations of nonprofit health care provider professional associations, and;
(C) Specialty societies.

(2) A non-contracting provider must cooperate with a health insurer's requirements for review of treatment in ORS 743A.168(2) and (3) 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 "behavioral health condition" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

OAR Section 836-053-1405

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204617

Termed 12/31/2022 (SB 1 - Effective January 1, 2007) 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.

Effective 01/01/2023, General Requirements for Coverage of Behavioral Health Conditions

(1) A group health insurance policy or an individual health benefit plan issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment of behavioral health conditions, including but not limited to prescription drugs, at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for medically necessary treatment for medical conditions.
   (a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for behavioral health treatment may not be greater than those under the policy for medical conditions.
   (b) The coverage of behavioral health treatment may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of medical conditions.
   (c) The parity requirements in subsections (1)(a) and (b) must comply with the “predominant” and “substantially all” tests in 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 45 CFR 147.160.
   (d) If annual or lifetime limits apply for treatment of behavioral health conditions the limits must comply with 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.
   (e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat behavioral health conditions must be by the same process as drug selection for formulary status applied for drugs intended to treat medical conditions, regardless of whether such drugs are intended to treat behavioral health conditions or medical conditions.
   (f) The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care or placement.
   (g) The coverage of behavioral health treatment must include clinically indicated outpatient coverage including follow-up in-home services or other outpatient services. The policy may limit coverage only if clinically indicated under any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge. Utilization and clinical review policies and procedures must meet the requirements of OAR 836-053-1405(9), (10), (11), and (12), as well as comply with the entire definition of “generally accepted standards of care” in OAR 836-053-1404.
(2) A group health insurer or an issuer of an individual health benefit plan issued of renewed in this state must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.
(3) A group health insurer or an issuer of an individual health benefit plan issued or renewed in this state must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.
(4) A group health insurance policy or an individual health benefit plan issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical and behavioral health conditions.
(5) A group health insurance policy or an individual health benefit plan 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 and behavioral health conditions.
(6) Subject to subsection (5) of ORS 743A.168 and OAR 836-053-1405(7) through (12) coverage for expenses arising from treatment for behavioral health conditions 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 a 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.
(7) Any medical necessity, utilization or other clinical review, not related to level of care placement decisions, must be based on:
   (a) The current generally accepted standards of care; or
   (b) Treatment criteria guidelines developed by the nonprofit professional association for the relevant clinical specialty.

(8) For medical necessity, utilization or other clinical review not related to level of care placement decisions, other criteria may be utilized as long as it is based on the current generally accepted standards of care including valid, evidence-based sources.
(9) Any medical necessity, utilization or other clinical review relating to level of care placement decisions must be based on:
  (a) The current generally accepted standards of care; and
  (b) The version available in 2021 of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.
(10) In instances where there are no guidelines or criteria from the nonprofit professional association for the relevant clinical specialty, other criteria may be utilized if the criteria are based on the generally accepted standards of care, and may include advancements in technology of types of care. Other criteria utilized must be made available to the department upon request.
(11) For purposes of medical necessity, utilization or other clinical review relating to level of care placement decisions the following guidelines or criteria will be considered compliant:
  (a) For a primary substance use disorder diagnosis in adolescents and adults, the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition (2013), by the American Society of Addiction Medicine (https://www.asam.org/asam-criteria).
  (b) For a primary mental health diagnosis in adults nineteen (19) years of age and older, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), Adult Version 20, by the American Association American Association for Community Psychiatry (https://sites.google.com/view/aacp123/resources/locus).
  (c) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/aacap/Member_Resources/Practice_Information/CALOCUS_CASII.aspx).
  (d) For a primary mental health diagnosis in children five (5) years of age and younger, Early Child Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/aacap/Member_Resources/Practice_Information/ECSII.aspx).
(12) All level of care placement decisions must be authorized at the level of care consistent with the insured's score or assessment using generally accepted standards of care and the relevant level of care placement criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next highest level of care based on the generally accepted standards of care. If there is disagreement about the appropriate level of care, the insurer shall provide to the provider of the service the full details of the insurer's scoring or assessment using the relevant level of care placement criteria and guidelines including information on the generally accepted standards of care or other criteria used to make the level of care decision.
(13) A group health insurer or an individual health benefit plan shall provide, at no cost:
  (a) A one-time formal education program for the insurer and insurer staff who conduct medical necessity, utilization and other clinical reviews on the proper use of such reviews. The training must be presented by nonprofit clinical specialty associations or other entities authorized by the department.
  (b) Medical necessity, utilization or other clinical review criteria used by the insurer, and any education or training materials regarding medical necessity, utilization or other clinical review criteria to stakeholders, including participating providers and enrollees.
  (c) Nothing in this section prohibits a group health insurer or an issuer of an individual health benefit plan from requiring providers to bill in accordance with generally accepted coding standards including the National Correct Coding Initiative.
(14) A group health insurer or an individual health benefit plan may not require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.
(15) This rule does not:
  (a) Prohibit an insured from receiving behavioral health treatment from an out-of-network provider or prevent an out-of-network behavioral health provider from billing the insured for any unreimbursed cost of treatment, to the extent permitted under state and federal law.
  (b) Prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods.
  (c) Require that any value-based payment method reimburse behavioral health services based on an equivalent fee-for-service rate.
(16) Nothing in this rule prevents a group health insurance policy or an individual health benefit plan from providing coverage for conditions or disorders excepted under the definition of "behavioral health condition" in OAR 836-053-1404.
(17) 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 and behavioral health conditions.

Texas

Texas Insurance Code (TIC) Chapter 1368

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1368.htm

Availability of Chemical Dependency Coverage Section 1368.001, Definitions

(1) "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.
(2) "Chemical dependency treatment center" means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:
  (A) Affiliated with a hospital under a contractual agreement with an established system for patient referral;
  (B) Accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;
  (C) Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
  (D) Licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.
(3) "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

Section 1368.002, Applicability of Chapter

This chapter applies only to a group health benefit plan that provides hospital and medical coverage or services on an expense incurred, service, or prepaid basis, including a group insurance policy or contract or self-funded or self-insured plan or arrangement that is offered in this state by:
(1) An insurer;
(2) A group hospital service corporation operating under Chapter 842;
(3) A health maintenance organization operating under Chapter 843; or
(4) An employer, trustee, or other self-funded or self-insured plan or arrangement.

Section 1368.003, Exception

This chapter does not apply to:
(1) An employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or members;
(2) An individual insurance policy;
(3) An individual evidence of coverage issued by a health maintenance organization;
(4) A health insurance policy that provides only:
  (A) Cash indemnity for hospital or other confinement benefits;
  (B) Supplemental or limited benefit coverage;
  (C) Coverage for specified diseases or accidents;
  (D) Disability income coverage; or
  (E) Any combination of those benefits or coverages;
(5) A blanket insurance policy;
(6) A short-term travel insurance policy;
(7) An accident-only insurance policy;
(8) A limited or specified disease insurance policy;
(9) An individual conversion insurance policy or contract;
(10) A policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or
(11) An evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date.

Section 1368.004, Coverage Required

(a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.
(b) Coverage required under this section may be provided:
  (1) Directly by the group health benefit plan issuer; or
  (2) By another entity, including a single service health maintenance organization, under contract with the group health benefit plan issuer.

Section 1368.005, Minimum Coverage Requirements

(a) Except as provided by Subsection (b), coverage required under this chapter:
  (1) May not be less favorable than coverage provided for physical illness generally under the plan; and

(2) Shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors that apply to coverage provided for physical illness generally under the plan.

(b) A group health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

(c) This section does not require payment of a usual, customary, and reasonable rate for treatment of a covered individual if a health maintenance organization or preferred provider organization establishes a negotiated rate for the locality in which the covered individual customarily receives care.

Section 1368.006, Limitation on Coverage

(a) In this section, "treatment series" means a planned, structured, and organized program to promote chemical-free status that:
  (1) May include different facilities or modalities; and
  (2) Is completed when the covered individual:
    (A) Is, on medical advice, discharged from:
      (i) Inpatient detoxification;
      (ii) Inpatient rehabilitation or treatment;
      (iii) Partial hospitalization or intensive outpatient treatment; or
      (iv) A series of those levels of treatments without a lapse in treatment; or
    (B) Fails to materially comply with the treatment program for a period of 30 days.

(b) Notwithstanding Section 1368.005, coverage required under this chapter is limited to a lifetime maximum of three separate treatment series for each covered individual.

Section 1368.007, Treatment Standards

(a) Coverage provided under this chapter for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.

(b) The department by rule shall adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers.

(c) Standards adopted under this section must provide for:
  (1) Reasonable control of costs necessary for inpatient and outpatient treatment of chemical Dependency, including guidelines for treatment periods; and
  (2) Appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section.

Washington

Revised Code of Washington (RCW) Section 48.43.760

https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.760

Opioid Use Disorder – Coverage Without Prior Authorization

For health plans issued or renewed on or after January 1, 2020, a health carrier shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists.

RCW Section 74.09.645

https://app.leg.wa.gov/RCW/default.aspx?cite=74.09.645
5700.SL.pdf (wa.gov) (Effective July 23, 2023)

Opioid Use Disorder – Coverage Without Prior Authorization

All Medicaid contracted managed care organizations shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

Refer to the Benefit Interpretation Policy titled Chemical Dependency/Substance Abuse Detoxification.

Not Covered

Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) for specific exclusions.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
09/01/2024	All	**Supporting Information** • Archived previous policy version BIP141.M
	Oregon	**Federal/State Mandated Regulations** • Revised language pertaining to *Oregon Revised Statute Section 743A.168*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.