



FREQUENTLY ASKED QUESTIONS ABOUT OUTPATIENT BEHAVIORAL HEALTH AND OREGON'S PARITY REGULATIONS

When did the new Oregon mental health parity regulations go into effect?

The parity regulations began January 1, 2007.

Who is affected by the parity regulations?

All group and portability health insurance contracts issued in Oregon are subject to mental health parity requirements.

Which groups are not included in the mental health parity regulations?

- The benefit for the Individual Elect plans has not changed. For these plans, inpatient mental health services are paid to a maximum lifetime benefit of \$1,000. Outpatient mental health treatment, as well as treatments and/or services provided for chemical dependency, remain excluded.
- The Oregon parity regulations do not apply to self-funded groups.
- Short Term Medical policies exclude mental health and chemical dependency treatment.

When should I submit a treatment plan?

- PacificSource does not require routine treatment plans for outpatient mental health or chemical dependency visits. However, we may conduct concurrent review of continuing outpatient services for those individuals with ongoing behavioral health concerns and/or chronic conditions, consistent with medical necessity reviews for all types of care. If additional documentation is required to understand the member's care needs, we will request that information from you.
- Claims received after this request for additional information is made will be pended for payment until we receive the documentation. If we do not receive the requested information within ten working days, you and the member will be notified that we are unable to process the claim due to lack of requested information.
- In our concurrent review of a member's care, we evaluate the medical necessity of ongoing care needs, and determine appropriate case management or disease management services that we might provide to your patient, our member. We are happy to assist you or the member with any questions or concerns.
- If you have questions, please contact our Health Services Department at (541) 225-2868 or (800) 624-6052, ext. 2868, or by e-mail at healthservices@pacificsource.com.

What criteria will be used to determine if additional visits are eligible for coverage?

Member eligibility, coverage limitations, and medical necessity.

What is the response turnaround time for treatment plan coverage determination?

Typically, two business days. Coverage determinations will be mailed to the provider and member.

What if I have additional questions?

You are welcome to contact our Customer Service Department at (888) 977-9299, or e-mail us at cs@pacificsource.com.