2024 Mental Health Parity Evaluation
Frequency Asked Questions – Updated May 3, 2024

No.	Question	Answer
1	**Data Submission Template – 2-ClmSum -** The instructions direct us to the Guide to Mapping Oregon Medicaid Benefits and Services document from OHA for classifying claims and requests. In that document, it states that MH and SUD benefits are defined as "benefits for items or services for mental health/substance use disorder conditions listed in ICD-10 Chapter 5 (F)", which would be ICD-10 codes F01-F99. The Mapping Guide provides no further elaboration on distinguishing MH and SUD based on the ICD-10 codes. However, the subgroup of codes F01-F09 are described by ICD as "Mental disorders due to known physiological conditions". This includes disorders such as dementia and delirium which typically receive treatment more aligned with medical/surgical procedures than mental health/SUD procedures. The F10-F19 range (ICD description "Mental and behavioral disorders due to psychoactive substance use") appears to be aligned primarily to substance use disorders. For purposes of classifying service types as M/S or MH/SUD, is it reasonable to presume that if the primary ICD-10 code in the claim or request is in the range of F01-F99, the CCO should classify that claim or request as follows? • ICD-10 F01-F09: Classified as M/S. • ICD-10 F10-F19: Classified as MH/SUD, specifically SUD. • ICD-10 F20-F99: Classified as MH/SUD, specifically MH.	**Updated: 03/14/24:** CCOs and OHP should continue to use the ICD-10 Chapter 5 (F), or F01-F99, to identify MH/SUD claims when reporting aggregate claim counts. Per OHA guidance, CCOs and OHP FFS should classify claims as follows: • ICD-10 F01-F09: Classified as MH • ICD-10 F10-F19: Classified as SUD • ICD-10 F20-F99: Classified as MH

<table>
<tr><th>No.</th><th>Question</th><th>Answer</th></tr>
<tr><td>2</td><td>Data Submission Template – 3-ClmMLD - Please clarify how entries should be made when dealing with members who have had MH and/or SUD services. For example, say we have three members (MemIDs are A1, B2, C3). Member A1 has only had MH services in the reporting year, B2 has had only SUD services, and C3 has had both. Would this be the proper way to list these three members on the template?
<table>
<tr><th colspan="3">Oregon Medicaid ID - MemID</th></tr>
<tr><th>MH/SUD</th><th>MH</th><th>SUD</th></tr>
<tr><td>A1</td><td>A1</td><td>B2</td></tr>
<tr><td>B2</td><td>C3</td><td>C3</td></tr>
<tr><td>C3</td><td></td><td></td></tr>
</table>
</td><td>Yes, the example is correct.</td></tr>
<tr><td>3</td><td>Data Submission Template – 3-ClmMLD - If the example in Question #2 reflects how member IDs should be listed, it does seem that the presence of the first “MH/SUD” column is redundant, since each member who had MH/SUD claims in the reporting year will appear in one or both of the other two columns. Is there a purpose for the combined column?</td><td>Updated 03/14/24: The member level data in 3-ClmMLD will support the evaluation of the adequacy of MH/SUD networks. As such, please use the following directions when populating the unique list of members in each column:
The MH/SUD column should include a unique list of members based on 2-ClmSum when MH/SUD claims are classified according to the Oregon mapping document (i.e., F01-F99).
The MH column should include a unique list of members based on those members in MH/SUD column with ICD-10 codes in the following range: F01-F09 and F20-F99.
The SUD column should include a unique list of members based on those members in the MH/SUD column with ICD-10 codes in the following range: F10-F19.
Additional clarification will be incorporated into the instructions on 3-ClmMLD. The table below shows an example of how data may be distributed across the requested columns where Member A1 has a diagnosis of F20, Member B2 has a diagnosis of F11, Member C3 has multiple claims with diagnoses of F12 and F21, and Member D4 as a diagnosis of F02.</td></tr>
</table>

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<tr><td></td><td></td><td>
<table>
<tr><th colspan="3">Oregon Medicaid ID - MemID</th></tr>
<tr><th>MH/SUD</th><th>MH</th><th>SUD</th></tr>
<tr><td>A1 (F20)</td><td>A1</td><td>B2</td></tr>
<tr><td>B2 (F11)</td><td>C3</td><td>C3</td></tr>
<tr><td>C3 (F12, F21)</td><td>D4</td><td></td></tr>
<tr><td>D4 (F02)</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>4</td><td>Data Submission Template – 4-UMSum - When reporting on “Number of Denials Overturned by Appeal” and “Number of Appeals Overturned by Hearing”, how should we report a decision to partially overturn a denial? For example, a PA is submitted for 30 Occupational Therapy visits, and denied. On appeal, we decide to approve 10 visits but leave 20 denied. Should that be counted as an overturned appeal, or not?</td><td>Yes, please report decisions to partially overturn a denial as a denial overturned by appeal.</td></tr>
<tr><td>5</td><td>Data Submission Template – 2-UMSum - When reporting on “Number of Appeals Overturned by Hearing”, should we only count those cases where a Final Order directs the CCO to overturn the denial? What about a case where a hearing has been requested, but the CCO decides to reverse their denial prior to the actual hearing? Would that be counted as being overturned by hearing, since it had reached that stage of the process? Or would we count such an event as an overturn by appeal, since the CCO made the change prior to the case being heard by an ALJ?</td><td>Yes, please report decisions to overturn an appeal, even if the decision occurred prior to the hearing, as an appeal overturned by hearing.</td></tr>
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<table>
<tr><th>No.</th><th>Question</th><th>Answer</th></tr>
<tr><td>6</td><td>Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD - When reporting on whether a service request is OON or OOS (Tabs 5 and 6 only), does the following chart accurately represent the appropriate entry, based on the situation?

<table>
<tr><th>Location → ↓ Contract Status</th><th>Inside the State of OR</th><th>Outside the State of OR</th></tr>
<tr><td>In Network (Contracted)</td><td>NA</td><td>NA</td></tr>
<tr><td>Out of Network (Non-Contracted)</td><td>OON</td><td>OOS</td></tr>
</table>
</td><td>Yes, however, for CCOs, the evaluation is focused on whether the denial is related to services associated with an out-of-network (OON) provider. The use of the flag for OON and out-of-state (OOS) authorizations/denials was included to account for differences in the CCOs and OHP FFS provider networks.</td></tr>
<tr><td>7</td><td>Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD - We are not including denials of payment (i.e., claim denials, or Action Category F) in these reports, correct? If we recall, we have excluded these from previous years' Parity reports. We are asking because your instructions do include "retrospective review denials", which may cause some confusion for some CCOs because OHA sometimes refers to claim denials as "post-service denials", which is not the same thing as a retrospective review denial, but the two terms are similar enough that we thought it warranted clarification.</td><td>CCOs and OHP FFS should exclude claim denials resulting in a denial of payment NOABD. Retrospective review denials should be included in CCO and OHP FFS submissions.</td></tr>
<tr><td>8</td><td>Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD - When you state in the instructions "CCOs may populate the Primary Denial Reason field with OHA's Action Category and Subcategory codes", is there a specific format we should use for those codes? For example, if we denied a PA request because the service was not medically appropriate, would the Primary Denial Reason be entered as "A3", or "A.3", or "A-3", etc.?</td><td>While HSAG's preference is to receive the data as [Action Category].[Sub Category] (i.e., A.3), any format currently being used by the CCOs or OHP FFS in its system is accessible, as long as the formatting is consistent.</td></tr>
</table>

No.	Question	Answer
9	**Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD -** OHA recently added new Action Subcategories to the list of options for denials. Previously there were only 5 Subcategories, but starting with our 2023 grievance system quarterly reports, there are 13. Should we assume that if we are using the Action Category/Subcategory codes as our Primary Denial Reason, that we can only use the 5 that were in place during 2022, or could we use the newer Subcategory codes if they are appropriate? For clarity, here is the full list of Subcategories now in effect for CCOs; prior to this year, only the first 5 were in use.	CCOs and OHP FFS may use either the 2022 or 2023 categorization codes when reporting the primary denial reason through the Action and Sub Category codes. HSAG is not expecting the CCOs or OHP FFS to recode its data; please use whatever formatting and codes are associated with your 2022 UM data. To ensure proper mapping by HSAG, please to include a note in the comment section of the 0-OrgInfo tab describing the formatting you are using. Additional clarification has been added to the instructions in the template.
10	**Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD -** Similar to the question for Tab 4, when reporting on "Final Outcome of Appeal" or "Final Outcome of Hearing", how should a decision to partially overturn be counted? As Overturned or Upheld? For example, a member is hospitalized for 14 days. We deny coverage of the last 6 days through concurrent review. Later, on appeal, we decide to cover 3 more days, but leave 3 days uncovered.	See response to Question #4.
11	**Data Submission Template – 5-UM_IpMLD, 6-UM_OpMLD, 7-UM_RxMLD -** If a member has requested a hearing, but a CCO decides to overturn the denial prior to the case being heard, would that be counted as an overturn in "Final Outcome of Appeal" or "Final Outcome of Hearing"?	See response to Question #5.
12	**Data Submission Template – 9-ProvMLD -** Can you clarify the instruction of "If provider applications are denied due to a failure to complete the application process, the CCO should document that reason." Is HSAG looking for something more substantial than reporting "incomplete application" in the Reason for Decision column? This is the only type of denial/termination reason that was given more explicit instruction, so we want to make sure we are understanding the intent.	The clarification provided in the instructions is based on questions received in prior years. Use of "Incomplete Application" is acceptable.

No.	Question	Answer
13	**Tx Limitation Review Tool – Section 6 -** When you ask for CCOs to "List and briefly describe MN criteria and dissemination mechanism(s)" and then request documents in support, are you wanting us to list each individual criteria set document used in that category, or are you looking for more general descriptors (e.g. InterQual criteria, internal PA policies, FDA guidelines, etc.)?	Please provide sufficient documentation to ensure HSAG reviewers understand the criteria being used to make clinical decisions. For example, some national evidence-based clinical decision support tools (e.g., InterQual) include specific modules for different clinical areas (e.g., BH, acute care, etc.). In these cases, HSAG would expect the CCOs and OHP FFS to define the clinical guidelines/criteria used to make decisions; however, you do not need to submit specific criteria elements. With regard to internal policies/decisions processes, HSAG will need that information as they are not standardized nationally and need to understand them better.
14	In conjunction with Question #13, if you are asking CCOs to list each individual MN criteria document, are you also wanting a copy of every set of criteria listed, or just a representative sample? The full list of MN criteria in a category like Pharmacy could be quite long, potentially dozens of individual documents.	See response to Question #13.
15	For # of member months, should CCOs be counting a member as having a full month if they are only eligible for part of a given month?	The calculation of member months should be driven by the way member enrollment data is stored within the CCOs' or OHP FFS' data systems. If member eligibility and enrollment is captured to the day, then the number of member months should be based on the total actual days of enrollment, or vice versa.
16	Please provide a definition or guidance on which medications are considered MH/SUD drugs vs M/S drugs.	Please note that pharmacy claims are **excluded** from both claim summary and member level detail reporting. For utilization management decisions associated with pharmacy, the distinction between MH/SUD and M/S should be based on the members' clinical conditions and not the specific drug.
17	Should drugs in Class 7 or 11 be excluded from the report, even if prescribed for a condition that is not MH/SUD? (i.e., not with a primary Dx of F01-F99)?	Yes. For **CCOs only**, all pharmacy UM requests and decisions for Class 7 and 11 drugs, regardless of member diagnosis, should be **excluded** from summary accounts (i.e., 4-UMSum) and detail listings (i.e., 5-UM_IpMLD, 6-UM_OpMLD, and 7-UM_RxMLD). Please note this exclusion is not applicable to inpatient or outpatient UM decisions since CCOs are responsible for paying for the administration of Class 7 or 11 drugs when administered by a provider.

No.	Question	Answer
18	Should a denied authorization that has a denied inpatient stay and also denied [outpatient] services on the same auth be separated to have the inpatient line(s) on the inpatient UM tab and services on the outpatient UM tab?	If separate IP and OP services were requested and denied in a single authorization, the CCO should split the service requests and denials in the summary counts to account for one (1) IP and one (1) OP.
19	***New*** **Data Submission Template – 4-UMSum -** When you ask for CCOs to "List the Number of PA Requests for Services Below the Priority List Funding Line", does this apply to the EPSDT population since the funding line does not apply?	No, since OHP now covers all medically necessary and medically appropriate services for members under the age of 21, regardless of placement on the Prioritized List of Health Services, the request would not be considered a below the line denial.
20	***New*** **Data Submission Template – 8-ProvSum -** When the CCO establishes a contract with a provider, we might have a few practitioners underneath that we are counting in the average number, not the contract itself. Are we counting the number of contracts we have or the participating contracted practitioners the CCO has?	The intent of the *Monthly Average Number of Contracted Providers* data element is to capture individual providers contracted by the CCO directly, or through its subcontractor(s) on the CCO's behalf. These providers may, or may not, have a direct contract with the CCO. This number is used in calculating the percent of providers terminated.
21	***New*** **Data Submission Template – 9-ProvCredPLD, 10-ProvTermPLD -** It appears that in Tab 9 we are only reporting on providers who attempted to enroll with the CCO for the first time or went through recredentialing during the Reporting Period – including the reason for the decision if denied (Column H). Tab 10 appears to be for reporting on provider terminations during the Reporting Period outside of the enrollment/credentialing process. So if a provider that was denied enrollment during credentialing is reported in Tab 9, am I correct that we would not also have to report that same termination on Tab 10? So between the two tabs, we should end up reporting on all terminated providers, but there should be no duplication between them?	The 9-ProvCredPLD and 10-ProvTermPLD tabs are intended to include detailed, provider level data related to the summary counts reported on 8-ProvSum tab. • For CCOs, the total number of providers listed in 9-ProvCredPLD should equal the sum of counts reported in Column C (i.e., *Number of Initial Credentialing Applications Received*) and Column E (i.e., *Number of Recredentialing Applications Received*) while the total number of providers listed in the 10-ProvCredPLD tab should equal the sum of counts reported in Column G (i.e., *Total Number of Terminations*). • For OHP FFS, the total number of providers listed in 9-ProvCredPLD should equal the sum of counts reported in Columns C (i.e., *Number of Enrollment Applications Received*) and Column E (i.e., *Number of Revalidations Processed*) while the total number of providers listed in the 10-ProvCredPLD tab should equal the sum of counts reported in Column G (i.e., *Total Number of Terminations*).

No.	Question	Answer
		Only providers with an existing contract should be counted toward the termination counts; terminations could include providers undergoing **re**credentialing/**re**validations whose application was denied resulting in a termination of their contract with the CCO. Providers who were denied at initial credentialing/enrollment should not be counted towards termination counts.
22	***New*** **Treatment Limitation Attestation Tool and Data Submission Template -** We had a question regarding the Benefit Mapping Guide that is linked in the Data Submission Template. Under the *Outpatient* column in Table 1, it calls out Transportation-non emergent (i.e. NEMT). Is it HSAG's expectation that we supply the attestation tool, along with all applicable tabs in the Data Submission Template (sans claims information) with NEMT information? If so, can you give us a better understanding of how the NEMT's fit in the Outpatient Definition?	The intent of the *Treatment Limitation Attestation Tool* is to gather information on changes to the CCO's operations that may impact parity. If changes have been made to the administration of outpatient services, including non-emergency medical transportation (NEMT), the information should be included in the Treatment Limitation Attestation Tool, as appropriate, so it can be reviewed to ensure compliance with MH parity requirements. While NEMT claims are excluded from the claim-related tabs (i.e., 2-ClmSum and 3-ClmMLD), utilization data associated with NEMT services in 2023 should be included (i.e., prior authorization, denials, appeals, and state hearings) in the *Data Submission Template*. As per OHA's guidance document, *Mapping Oregon Medicaid Benefits and Services*, NEMT services are considered an outpatient benefit. According to the document if a service does not meet the criteria for inpatient, pharmacy, or emergency care services, the service is categorized an outpatient covered benefit.