Hospitalization, Urgent Care and Behavioral Healthcare Services

Hospitalization ................. 81
Urgent Care ...................... 88
Behavioral Healthcare Services .... 88
Hospitalization

Emergency Hospitalization

Definition of a Medical Emergency

New York and Connecticut
A medical emergency is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of such severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health, could reasonably expect the afflicted Member to suffer serious consequences in the absence of immediate medical attention. Those consequences may include:

- Jeopardy to physical health or, in the case of a behavioral condition, jeopardy to the health and safety of the Member or others
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organs or parts
- Serious disfigurement

New Jersey
A medical emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that the absence of immediate attention could reasonably be expected to result in:

- Jeopardy to the health of the individual (or with respect to a pregnant Member, the health of the mother or the unborn child)
- Serious disfigurement
- Serious impairment to bodily functions
- Serious dysfunction of a bodily organ or part

Medical emergencies include, but are not limited to, the following conditions:

- Severe or acute chest pains
- Severe or multiple injuries
- Severe shortness of breath
- Extreme fever
- Loss of consciousness
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding or loss of blood
- Poisoning
- Convulsions

Suspected heart attack, suspected stroke, diabetic coma, appendicitis, burns, fracture or threatened loss of limb, abdominal catastrophes, suspected severe infections, severe metabolic derangements, or other conditions requiring immediate treatment

Emergency Admission Review

If your patient is admitted to a hospital as a result of an emergency (as defined above), Oxford will review the hospital admission for medical necessity and determine the appropriate length of stay based on Oxford’s approved criteria for concurrent review. Review begins when Oxford becomes aware of the admission. Oxford must be notified of all inpatient admissions (upon admission or on the day of admission) that are a result of an emergency.

If the Member is admitted to a contracted hospital, Oxford will use best efforts to transmit a decision about the admission to the hospital (to the facsimile number and contact person designated by the hospital) within 24 hours of making the decision. Oxford may also communicate its precertification decision to the hospital by telephone.

Emergency Room Visits

Emergency room visits during which a patient is treated and released without admission do not require notice to Oxford. Any and all follow-up needs related to such emergency services should
be coordinated through the Member’s primary care physician (PCP) and are subject to the standard referral process.

See section 4 on Referrals for more information.

**In-area Emergency Services**

You do not need authorization or notification from Oxford for in-area emergency room treatment and subsequent release. Such treatment is payable upon claims submission minus the emergency room copayment. However, all emergency inpatient and emergency room admissions do require notification upon admission or on the day of admission.

To notify Oxford of an inpatient admission, use Oxford’s electronic notification transaction on www.oxfordhealth.com, send a fax to Oxford at 1-800-303-9902 [24 hours a day, seven days a week], or call Oxford’s Medical Management Department at 1-800-666-1353.

**Out-of-area Emergency Services**

Out-of-area coverage for emergency room (ER) services is limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a Member from using ER services within Oxford’s service area.

**Coverage**

Oxford covers emergency room services for medical emergencies. The Member is responsible for paying the applicable copayment. Follow-up emergency room visits within Oxford’s service area are not covered. However, follow-up emergency care, if appropriate, may be covered when it takes place in the PCP’s office. Follow-up emergency care in a specialist’s office may be covered, and is subject to referral guidelines.

If commercial Members have questions or would like additional information, they should call Oxford’s Customer Service Department at 1-800-444-6222 [Mon. - Fri., 8 AM - 6 PM]. If Medicare Members have questions or would like additional information, they should call the Medicare Customer Service Department at 1-800-234-1228 [Mon. - Fri., 8 AM - 6 PM].

**Non-emergency Hospitalization**

Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires precertification. Participating physicians are required to request precertification by contacting Oxford, even if the Member was hospitalized by the PCP without a referral.

See section 4 on Precertification for more information.

**Maternity**

It is crucial that the Member, or the Member’s physician, notify Oxford of a pregnancy as early as possible to ensure the proper application of benefits. Non-emergency maternity admissions should be precertified. Newborn coverage varies from plan to plan and state to state.

See section 4 on Precertification for more information.

To determine coverage guidelines in your state, you or the Member should contact Oxford’s Customer Service Department at 1-800-444-6222.

**Hospital Services, Admissions and Procedures**

You must precertify all elective and non-elective inpatient hospital admissions, as well as admissions to skilled nursing facilities, sub-acute and rehabilitation facilities.

Please precertify online at www.oxfordhealth.com or call Oxford’s Medical Management Department at 1-800-666-1353.

Outpatient precertification is also required for surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility. Precertification is the responsibility of the hospital or ancillary facility and the physician.

See section 4 on Precertification for more information.
Inpatient Hospital Copayment
State regulations for commercial lines of business determine when a Member should be charged for subsequent inpatient hospital copayment(s) when readmitted into an inpatient setting. This assumes that the Member’s benefit structure has inpatient copayments. According to state laws, inpatient hospital copays must be based on a “per continuous confinement” basis.

Medicare Notice of Non-coverage and Medicare Appeal Rights (NODMAR) for Inpatient Hospitalization and Acute Rehabilitation
The Centers for Medicare & Medicaid Services (CMS) mandates that, prior to a Medicare Member’s discharge from an acute inpatient hospitalization or inpatient rehabilitation setting, the attending physician must concur with the discharge. The hospital must then deliver written notice of non-coverage to the Member. This applies only when the Member disputes the terms of the discharge. The Oxford Regional Senior Medical Director will be notified of any issues concerning a hospital’s failure to deliver a notice of non-coverage.

Notice of Medicare Non-coverage (NOMNC) for Skilled Nursing Facility (SNF) Care, Comprehensive Outpatient Rehabilitation Facility (CORF) and Home Health Care (HHC)
Effective January 1, 2004, CMS mandates that Oxford provide advance written notification of the termination of service prior to the termination for SNF, CORF and HHC services.

Oxford and its providers must ensure that this notice is provided to the Medicare Members no later than two (2) days [or two (2) visits] before the proposed end of the services.

Discharge Planning and Concurrent Review
Prior to the actual admission date, Oxford’s Medical Management Department works with the Member, physician and hospital to develop a prospective discharge plan. Upon admission, Medical Management will accept concurrent review information provided by the admitting physician and/or the hospital’s Utilization Review Department. Furthermore, if not already submitted, the hospital will provide Oxford with the discharge plan on the day of admission. If it develops that a patient requires an extended length of stay or additional consultations, please contact Oxford’s Medical Management Department at 1-800-666-1353 to update precertification. Please provide the names of any consultant involved in developing the discharge plan to the Oxford Case Manager. Any consultant not identified may not be eligible for reimbursement. Non-participating consultants may be used only in the event that a participating specialist is not available, and only after precertification is obtained from Medical Management. Oxford Health Plans’ concurrent review process uses approved criteria to determine the medical necessity of a Member’s continued hospitalization; it also allows for changes and updates to discharge plans.
Inpatient Concurrent Review — Day-of-service Decision Making Program

Oxford provides hospitals with day-of-service decision making for continued and ongoing care. To achieve this goal, we have refined some of our processes as part of a consistent application of the Milliman Care Guidelines™ and the Oak Group’s Managed Care Appropriateness Protocols™ (MCAP) for inpatient medical and surgical care, home care and recovery facility care. When issuing a precertification for an inpatient admission or concurrent review approval, the number of approved days or other types of services will be based on these guidelines. Oxford provides concurrent and prospective certification for all services via the end of day report (EDR). The EDR lists all Oxford Members currently known to be in that facility. We must, however, be made aware of each Member’s admission, and the facility involved must provide timely necessary clinical information to demonstrate medically appropriate covered care. Our intention is to eliminate most, if not all, retroactive denials. Below are more specifics about these processes.

Hospital Responsibilities

Concurrent Inpatient Stays (notification prior to discharge)

• The hospital will verify a patient’s status as an Oxford Member, since no payment will be made for services rendered to persons who are not Oxford Members

• The hospital is required to notify Oxford of any patient that changes level of care, including but not limited to NICU, ICU, etc.

• The Member must be enrolled and effective with Oxford on the date the service[s] are rendered; once the hospital verifies a Member’s eligibility with Oxford, that determination will be final and binding on Oxford; however, if the Centers for Medicare & Medicaid Services (CMS) or an employer or group retroactively disenrolls the Member up to ninety (90) days following the date of service, then Oxford may deny or reverse the claim; if there is a retroactive disenrollment for these reasons, the hospital may bill and collect payment for those services from the Member or another payor

• The hospital must provide a daily inpatient census log by 10 AM; the daily inpatient census log will reflect all admits and discharges through midnight the day prior; this will be considered the hospital’s official record of Oxford Members under its care

• The hospital must provide notification of all admissions of Oxford Members at the time of, or prior to, admission; the hospital must notify Oxford of all emergencies (upon admission or on the day of admission); the hospital must also notify Oxford of “rollovers” (i.e., any patient who is admitted immediately upon receiving a precertified outpatient service); you must also notify Oxford of any transfer admissions of Members

• The hospital must precertify any transfer admissions of Members prior to the transfer unless the transfer is due to a life threatening medical emergency
• The hospital must communicate necessary clinical information on a daily basis, or as requested by an Oxford Case Manager, at a specified hour that allows for timely generation of the Oxford EDR.

• If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will be given only if clinical information is received within 48 hours (72 hours for New Jersey hospitals).

• The hospital is responsible for verifying the accuracy of the admission and discharge dates for Oxford Members listed on the EDR.

• If Oxford conducts on-site utilization review, the hospital will provide Oxford’s on-site utilization management personnel reasonable workspace and access to the hospital, including access to Members, their medical records, the emergency room, hospital staff, and other information reasonably necessary to:
  • Conduct utilization review activities
  • Make coverage decisions on a concurrent basis
  • Consult in rounds and discharge planning in both inpatient and emergency room settings

• It is the responsibility of all providers to deliver letters of non-coverage to the Member before discharge; this includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

Please note: Appeals will be considered if the hospital can demonstrate that the necessary clinical information was provided within 48 hours but Oxford failed to respond in a timely manner.

Retrospective Review of Inpatient Stays (notification of admission after discharge)

Commercial Members — Upon request from Oxford, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will only be given if clinical information is received within 48 hours (72 hours for New Jersey Members).

Medicare Members — A retrospective review may only be initiated within the above guidelines and when the Member is not held financially liable. All information must be received within 10 business days of the initial request for retrospective review.

Oxford Responsibilities

• Oxford is responsible for maintaining a system for verifying Member eligibility/status.

• Oxford will use best efforts to transmit a decision regarding an emergency/urgent admission to the hospital (to the facsimile number and contact person designated by the hospital) within 24 hours of making the initial decision; Oxford may also communicate its decision by telephone.

• Oxford is responsible for requesting necessary clinical information; any failure by Oxford to seek such information will result in Oxford’s liability for that day’s service.

• Oxford agrees to provide concurrent and prospective certification for all services via a daily EDR when the facility provides timely necessary clinical information to demonstrate medically appropriate covered care; the EDR will communicate Oxford’s intention to pay for specific services or a specific plan of care for the Member.

• Oxford will assign a first day of review (FDOR) for all elective inpatient services and all days up to and including the FDOR will be certified; coverage decisions for the next day will be given on the FDOR.

• Oxford will notify the hospital and attending physician verbally or by written communication [that is consistent with NCQA requirements and applicable law] of all denied days; Oxford’s daily EDR will include a report on the decisions for the current day, as well as a preliminary decision for the next day when review is performed on that day; failure by Oxford to communicate a decision to deny precertification will result in Oxford’s liability for that day’s service; if Oxford denies inpatient days due to benefit or medical necessity reasons, the hospital may seek to appeal the adverse determination in accordance with applicable law and Oxford’s appeal procedures.
Section 5 — Hospitalization, Urgent Care and Behavioral Healthcare Services

- Oxford will perform clinical review of days that fall on the weekend (Saturday and Sunday), holidays for which either the facility or Oxford are closed, and days upon which there are unforeseen interruptions in business on the following business day; such reviews will be considered concurrent.

**Please note:** Oxford will not deny services retrospectively or reduce the level of payment for services that have been precertified or received concurrent review approval unless:

- The Member is retroactively disenrolled from Oxford as explained in the section titled “Hospital Responsibilities, Concurrent Inpatient Stays (notification prior to discharge)” (see page 84).
- The certification or concurrent review approval was based on materially erroneous information.
- The services are not provided in accordance with the proposed plan of care.
- Hospital delays in providing an approved service prolong the length of stay beyond that was approved by Oxford.

Neonatal Intensive Care Unit (NICU)

**Level of Care**

NICU bed levels are based on the intensity of services and identifiable interventions received by the neonate. The NICU bed levels of care are linked to a revenue code that is defined by the National Uniform Billing Committee. Oxford will assign NICU levels for those hospitals contracted with more than one level of NICU.

Clinical Process Definitions

**Acute Hospital Day**

An acute hospital day (AHD) is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high and care cannot reasonably be provided safely in another setting.

**Alternative Level of Care**

Oxford may in its discretion determine that an inpatient alternative level of care (ALC) applies in any of the following scenarios:

- An acute clinical situation has stabilized.
- The intensity of services required can be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the Member’s physician.

Inpatient ALC must meet the following criteria:**

- The skills of qualified technical or professional health personnel such as registered nurses, licensed practical [vocational] nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required; and
Hospitalization, Urgent Care and Behavioral Healthcare Services — Section 5

- Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result

* ALC only applies if the facility has a contracted rate.
** Failure to satisfy this criteria can result in denial of coverage.

New Technology

New technology refers to a new service, product, device, or drug that is new to the Oxford service area or region. This does not apply to a new service, product or device that is new to a hospital but not new to the region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

Potentially Avoidable Days

A potentially avoidable day [PAD] arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. A PAD must be followed by a medically necessary service.

There are several types of PADS:

- Approved Oxford potentially avoidable day (AOPAD): Oxford caused delay in service; the day will be payable
- Approved physician potentially avoidable day (APPAD): The physician caused delay in service; the day will be payable
- Approved mixed potentially avoidable day (AMPAD): A delay due to mixed causes not solely attributable to Oxford, the physician or the hospital; the day will be payable
- Denied hospital potentially avoidable day (DHPAD): The hospital caused the delay in service; DHPAD is a non-certification code, and the day is not payable

Oxford will not reverse any certified day unless the decision to certify was based on erroneous information supplied by the provider or a potentially avoidable day was identified.

Readmissions

When a Member is readmitted to the hospital for the same clinical condition or diagnosis within 31 days of discharge, the second hospital admission will not be reimbursed when any of the following conditions apply:

- The Member was admitted for surgery, but surgery was canceled due to an operating room scheduling problem
- A particular surgical team was not available during the first admission
- There was a delay in obtaining a specific piece of equipment
- A pregnant woman was readmitted within 24 hours and delivered
- The patient was admitted for elective treatment for a particular condition, but the treatment for that condition was not provided during the admission because another condition that could have been detected and corrected on an outpatient basis prior to the admission, made the treatment medically inappropriate

In any of the situations noted above, the hospital cannot bill the Member for any portion of the covered services not paid for by Oxford.

Utilization Management for Diagnosis Related Group (DRG) Hospitals

DRG is a statistical system of classifying an inpatient stay into groups of specific procedures or treatments. When a hospital contracts for a full DRG, Oxford will reimburse the facility a specific amount [determined by the contract] based on the billed DRG rather than paying a per diem or daily rate. A DRG is determined after the Member has been discharged from the hospital.

When admission information is received via Oxford's web site or the 24/7 program, Oxford will consider this to be notification only; first day approval will not be granted to hospitals with a DRG contract. When Oxford receives notification of an admission to a hospital with a DRG contract, Oxford's Case Manager will review the admission for appropriateness. If the Case Manager cannot make a determination based on the admitting
diagnosis, the Case Manager will request an initial review to determine whether the admission is medically necessary. If the admission is denied, the hospital will not have the reconsideration option; they must follow the standard appeal process. The hospital is required to provide admission notification and a daily inpatient census of all Oxford Members. In Oxford’s discretion, the Day of Service process may or may not be applied for DRG hospitals. Therefore, if Oxford chooses not to apply the DOS process, End of Day Reports are not generated. Decisions are communicated to DRG hospitals either telephonically and via letters or through an End of Week report, depending on the agreement established between Oxford and the hospital.

If a Member is readmitted into the same hospital/hospital system within 30 days of discharge, then the second readmission will not be reimbursed.

If a Member is transferred to a hospital within the same hospital system as the first hospital during one continuous admission, payment will be made only to the hospital the Member was transferred to as the final discharge DRG.

**Technical Definitions**

**Disposition Determination**

A disposition determination is a technical term describing a process of care determination that results in payment as agreed at specific contracted rates, and is designed to eliminate certain areas of contention among participating parties and allow processing of claims. Specific instances where a disposition determination may apply:

- Delay in hospital stay
- APPAD/AMPAD when so contracted
- ALC determinations when so contracted, unless there is a separate ALC rate
- Discharge delays that prolong the hospital stay under a case rate

**Late and No Notification**

Late notification is defined as notification to Oxford of a facility admission after the contracted 48-hour notification period and prior to discharge. No notification is defined as failure to notify Oxford of a Member’s admission to a facility after discharge, up to and including at the time of submitting the claim.

**Urgent Care**

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not a medical emergency and does not otherwise fall under the definition of emergency care as previously defined. Members are encouraged to call their PCP if they think they need urgent care. Members may also contact Oxford On-Call® for assistance with clinical issues. Oxford On-Call registered nurses may triage the Member and recommend an appropriate site of care based on information provided. Oxford Members may also seek urgent care at a contracted urgent care center facility, in which case precertification is not required. For commercial Members, use of non-participating facilities outside of Oxford’s service area requires notification to Oxford’s Customer Service. For Medicare Members, use of a non-participating facility outside of Oxford’s service area does not require precertification. Any and all follow-up needs related to such urgent care services should be coordinated through the Member’s PCP and are subject to the standard Referral Process outlined in section 4.

**Behavioral Healthcare Services**

**Overview**

Oxford’s Behavioral Health (BEH) Department specializes in the management of mental health and substance abuse treatments. The department consists of a Medical Director who is licensed in psychiatry, case managers (licensed RNs and licensed/certified social workers) and Behavioral Health Coordinators, who collectively handle certification, referrals and case management for Oxford Members.

Oxford’s BEH Department offers a toll-free, dedicated line (1-800-201-6991) that is available to Members, Employee Assistance Programs and providers,
Monday through Friday, from 8 AM to 6 PM. This line can be used to certify care and to obtain referrals for mental health or substance abuse treatments.

If your patient requires behavioral health services, please call Oxford’s Behavioral Health Department at 1-800-201-6991.

Oxford’s BEH Department recognizes the importance and the sensitivity surrounding mental health and substance abuse diagnosis and treatment. We encourage coordination of care between our participating behavioral health providers and primary care physicians as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information (ROI) Form that is designed to facilitate Member consent and to share information with the primary care physician in the presence of his or her behavioral health provider.

Please call the Behavioral Health Department at 1-800-201-6991, 24 hours a day/7 days a week, including holidays.

**Clinical Definitions and Guidelines**

Oxford’s BEH Department uses United Behavioral Health (UBH) Level of Care Criteria in determining medical necessity of inpatient psychiatric, partial hospitalization* substance abuse treatment and rehabilitation, and outpatient mental health treatment. In addition, Medicare coverage guidelines are also utilized for MedicareComplete® Members.

* Partial hospitalization is only available to Members with this benefit.

**Inpatient Mental Health**

Oxford defines a mental health condition as justifying inpatient (or acute) care when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention. Examples include:

- The patient has been unresponsive to an appropriate course of treatment at a lower level of care and is at significant risk
- The patient is considered a serious risk to self or others and requires 24-hour supervision
- The patient is unable to maintain a safe environment for self or others

**Outpatient Mental Health**

Oxford defines psychotherapeutic outpatient treatment as a range of approaches for the treatment of mental and emotional disorders that include methods from different theoretical orientations (i.e., psycho-dynamic, behavioral, cognitive, and interpersonal) and may be administered to an individual, family or group. Examples include:

- The primary diagnosis/focus of treatment is for a psychiatric condition and is not related to substance abuse or dependence
- The diagnosis or service is not a benefit exclusion (e.g., sexual disorders, marital counseling, etc.)
- The primary diagnosis is not identified as a V-code — any diagnosis beginning with a V indicates wellness and is not considered a psychiatric diagnosis
• Treatment is focused on restoring or maintaining function that has been compromised due to mental illness

• Treatment is goal-oriented and directed to achieve specific outcomes

**Please note:** Under NCQA guidelines and requirements, Oxford strongly supports coordination of care between behavioral health providers and primary care physicians (PCPs). With input from the BEH Quality Improvement Committee, we have developed a Release of Information (ROI) Form to facilitate the sharing of treatment information between BEH providers and PCPs. This form is designed to elicit Member consent to such sharing of information in the presence of his or her behavioral health provider.

See the **Release of Information (ROI) Form** at the end of this section.

**Inpatient Detoxification**

Oxford defines inpatient detoxification as the treatment of substance dependence to prevent a life-threatening withdrawal syndrome, provided on an inpatient basis. Conditions under which inpatient detoxification is medically indicated include:

• The patient is a risk to self and others

• The patient's medical status is altered by withdrawal syndrome that requires 24-hour monitoring

• A licensed physician (MD or DO) is available on-site 24 hours per day

• The DSM-V diagnosis indicates psychoactive substance dependence

• The facility is a licensed, accredited detoxification facility

**Outpatient Substance Abuse Rehabilitation**

Oxford defines outpatient substance abuse rehabilitation as the treatment of substance abuse or dependence at an accredited, licensed substance abuse facility. Conditions under which outpatient substance abuse rehabilitation is medically indicated include:

• The primary diagnosis and focus of substance abuse treatment is within the DSM-IV range of 303-305

• An evaluation by a licensed substance abuse provider has resulted in certification by Oxford's BEH Department

**Partial Hospitalization — Mental Health**

Oxford defines partial hospitalization* for mental health treatment as day treatment of a psychiatric disorder at a hospital or ancillary facility with the following criteria:

• Primary diagnosis is psychiatric

• The facility is licensed and accredited to provide such services

• The duration of each treatment is four (4) or more hours per day

* Partial hospitalization is only available to Members with this benefit.

**New Jersey Mental Health Parity (for commercial Members)**

The State of New Jersey has enacted Biologically Based Mental Health Parity legislation (P. L. 1999, c. 106) that states that biologically-based mental illness must be covered under the same terms and conditions as all other medical illnesses and diseases.

The law defines biologically-based mental illness as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

This law does not affect coverage for substance abuse or for mental illness that is not biologically based. These latter conditions include mental retardation, learning disorders, motor skills
disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, but which are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) referenced in this section.

The New Jersey law does not affect Medicare plans. In addition, it does not affect medical necessity, certification or referral requirements. New Jersey Members should check their Certificate of Coverage for certification and referral requirements.

Connecticut Mental Health Parity (for commercial Members)

Connecticut has also enacted Mental Health Parity legislation (Managed Care Act — Public Act No. 99-284). The law states that all Connecticut commercial group products will be required to provide benefits for the diagnosis and treatment of mental or nervous conditions under the same terms and conditions as all other illnesses and diseases.

For purposes of this legislative requirement, mental or nervous conditions means mental disorders, as defined in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). The definition does not include mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention that are not otherwise defined as mental disorders in the DSM referenced above.

Please note: Parity is also required for disorders related to the complications of alcohol and substance abuse, as defined in the DSM.

The Connecticut law does not affect self-funded plans or Medicare plans. In addition, it does not affect medical necessity, precertification or referral requirements.

Certification for Mental Health, Substance Abuse and Detoxification Treatment

Inpatient Care

All inpatient behavioral health treatment requires certification.

For initial certification of outpatient mental health services, please call Oxford’s Behavioral Health Department at 1-800-201-6991.
Outpatient Mental Healthcare

Initial sessions must be certified through Oxford’s BEH Department by the Member. This policy does not apply to Members of New Jersey small groups and Individual commercial plan Members, when a referral will be permitted.

Certification Process

Members will call Oxford to obtain initial certification. The Member will be provided referrals based on clinical and geographic needs. An open certification is generated allowing the Member to see any participating Oxford provider for routine outpatient psychotherapy services. The Member will receive a letter confirming the open certification, which is valid for one (1) year from the date of issue and must be presented at the initial appointment. Coverage will continue to be subject to the Member’s eligibility and the terms of his or her health benefits plan.

- If the letter is not presented at the first appointment, the provider may call Oxford at the toll-free number listed on the Member’s ID card to inquire about certification; if no certification is in place, the provider can initiate the open certification at the time of this telephone inquiry.
- The provider will give each new Oxford patient a Wellness Assessment (WA) to complete and will review the responses during the initial session; your patients can access this form before their first visit by downloading it from our web site at www.oxfordhealth.com.
- The provider then returns the completed Wellness Assessment to Oxford as instructed on the form or the address below.

The completed Wellness Assessment* Form should be returned to the BEH Department by fax at 1-800-760-4041, or mailed to:

OXFORD | IMPORTANT ADDRESS

Oxford Health Plans
Attn: BEH Department/WA
48 Monroe Turnpike
Trumbull, CT 06611

* WA forms should be current representations of treatment, not reproductions of original submissions.

Outpatient Substance Abuse Rehabilitation

All substance abuse treatment requires certification through the BEH Department. Providers are required to comply with Oxford’s concurrent review process.

Partial Hospitalization

Partial hospitalization is not a standard benefit for all Oxford Members and always requires certification through the BEH Department. If clinical criteria are met and the Member has the benefit, the Case Manager will facilitate certification and management at an Oxford contracted facility with a partial hospitalization program; the Case Manager will continue to follow the Member’s treatment while he or she is in the program. This will not be done unless the Member has a benefit that covers partial hospitalization.
Wellness Assessment - Adult

Hospitalization, Urgent Care and Behavioral Healthcare Services — Section 5
## Wellness Assessment - Youth

Completing this online questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child’s clinician. Shade circles like this ⭕️.

### Child's Information
- First Name: [Blank]
- Last Name: [Blank]
- Birthdate: [Blank]
- Gender: [Blank]
- Relationship to clinician: [Blank]
- Initial: [Blank]
- Initials: [Blank]

### For questions 1-12, please think about your experience in the past week.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>8.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>9.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>10.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>11.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>12.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### How much have your child’s problems worsened?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A Little</th>
<th>Somewhat</th>
<th>a Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>16.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>17.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>18.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>19.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>20.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>21.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Please answer the following questions only if this is your first time completing this questionnaire.

22. In general, would you say your child’s health is: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor
23. In the past 6 months, how many times did your child visit a medical device?  [ ] Never [ ] 1-2 [ ] 3-5 [ ] 6 or more
24. In past month, how many days were you unable to work because of your child’s problems?  [ ] Never [ ] 1-2 [ ] 3-5 [ ] 6 or more
25. In the past month, how many days were you unable to work because of your child’s problems?  [ ] Never [ ] 1-2 [ ] 3-5 [ ] 6 or more

[Signature]
[Date]
I, ____________________________, hereby authorize __________________________ to converse with and to disclose information regarding my treatment to __________________________ for the specific purposes of providing coordination and continuity of care. My Primary Care Physician shall not be entitled to any information beyond such treatment information without my written consent. I understand that this Primary Care consent form shall remain in effect throughout the course of treatment. I understand that I may revoke this authorization at any time by notifying my behavioral health provider in writing.

_____________________________ ____________________________
Signature (or parent or guardian) Date

_____________________________ ____________________________
Behavioral Health Provider Date
Section 5 — Hospitalization, Urgent Care and Behavioral Healthcare Services