Oregon Health Authority
Division of Medical Assistance Programs
Policy and Planning Section

Behavior Health Services Administrative Rulebook

Chapter 410, Division 120

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410-172-0600 – Acronyms and Definitions

(1) “ASAM PPC” means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care.

(2) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.

(3) “Behavioral Health Services” means medically appropriate services rendered or made available to a recipient for treatment of a behavioral health or substance use disorders diagnosis.

(4) “Community Mental Health Program (CMHP)” means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division as defined in OAR 309-019-0105.

(5) “Letter” means the document awarded to providers by AMH indicating the provider has complied with specific program requirements or administrative rule.

(6) “Level of Care” means the type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.

(7) “Level of Care Determination” means the standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.

(8) “Recovery Assistant” means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall:

(a) Be at least 18 years old;

(b) Meet the background check requirements described in OAR 410-180-0326;

(c) Conform to the standards of conduct as described in OAR 410-180-0340.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0610 – Provider Enrollment

(1) Providers shall be enrolled with the Division as a behavioral health provider. Paid providers of behavioral health services shall possess a current and valid license, letter, or certificate.

(2) Providers shall provide services within the scope of professional standards and practice defined by the providers licensing board or certifying organization.

(3) Providers shall meet all requirements in OAR 410-120-1260 (Medical Assistance Programs Provider Enrollment), OAR 943-120-0310 (Provider Requirements), and OAR 943-120-0320 (Provider Enrollment).

(4) Providers shall not be included on any US Office of Inspector General Exclusion lists.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0620 – Documentation Standards

(1) OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request.

(2) All records shall document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service.

(3) Clinical records shall document the recipient's diagnosis and the medical need for the service.

(4) The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service.

(5) Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts.

(6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150.

Stat. Auth.: ORS 413.042, 430.640, 430.705, and 430.715

Stats. Implemented: ORS 414.025, 414.065, and 430.640

410-172-0630 – Medically Appropriate

(1) In addition to the definition of medically appropriate in OAR 410-120-0000 for behavioral health services, “medically appropriate” means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition.

(2) The Division shall make payment for medically appropriate behavioral health services when the services or supports are:

(a) Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;

(b) Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;

(c) Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;

(d) Not provided solely for the convenience of the recipient, the recipient’s family, or the provider of the services or supplies;

(e) Not provided solely for recreational purposes;

(f) Not provided solely for research and data collection;

(g) Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0640 – Behavioral Health Services Fee Schedule

(1) The Division shall pay providers based on the Behavioral Health Services Fee Schedule (fee-for-service (FFS) payment rates for behavioral health services) posted on the Authority web site.

(2) Payment shall be made at each provider's usual and customary charge or the Division's published reimbursement upper payment limit, whichever is less, minus payments received or due from other payers. Payments to other specified providers shall be made according to other approved schedules.

(3) The Division's maximum allowable rate-setting process uses a methodology that is based on the existing Medicaid fee schedule with adjustments for legislative changes and payment levels.

(4) Limitations contained in the Behavioral Health Services Fee Schedule, such as the maximum rate and the amount, duration, and scope of services provided, are subject to change at the discretion of the Division. Updates and changes are posted on the Behavioral Health Services Fee Schedule website at www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(5) Payment shall be made for services listed in the Medicaid Behavioral Health Procedure Fee Schedule that are rendered to Medicaid-eligible individuals by a qualified provider during the period in which the provider is enrolled with the Division.

(6) For cost-reimbursed services, the provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported. Providers whose rates are paid based on a collective bargaining agreement are not exempt from this requirement.

(7) In accordance with 42 CFR § 405.506, a charge that exceeds the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or an applicable lowest charge level may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort, or expense that support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. The mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination that it is reasonable.

(8) Payment by the Division does not limit the Authority or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines that payment for the service was not provided in accordance with applicable

Oregon Administrative Rules or the service does not meet the criteria for quality or medical appropriateness of the care.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0650 – Prior Authorization

(1) Some services or items covered by the Division require authorization before the service may be provided. Services requiring prior authorization are published on the Medicaid Behavioral Health Services Fee Schedule.

(2) The Division shall authorize payment for the type of service or level of care that meets the recipient's medical need and that has been adequately documented.

(3) The Division shall only authorize services that are medically appropriate and for which the required documentation has been supplied. The Division may request additional information from the provider to determine medical appropriateness.

(4) Documentation submitted when requesting authorization shall support the medical justification for the service. The authorization request shall contain:

(a) A cover sheet detailing relevant provider and recipient Medicaid numbers;

(b) Requested dates of service;

(c) HCPCS or CPT Procedure code requested; and

(d) Amount of service or units requested;

(e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 309-019-0140; or

(f) Any additional supporting clinical information supporting medical justification for the services requested;

(g) For substance use disorder services, the Division uses the American Society of Addition Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. Providers shall use the ASAM;

(h) For Applied Behavioral Analysis services, the Division requires submission of:

(A) An evaluation as described in OAR 410-172-0770(1) from a physician or psychologist experienced in the diagnosis and treatment of autism;

(B) An order for treatment as described in OAR 410-172-0770(1)(e) from a physician or psychologist experienced in the diagnosis and treatment of autism;

(C) A functional analysis and a behavior treatment plan from a Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst certified by the Oregon Behavior Analysis Regulatory Board;

(D) A copy of a Division-authorized standard needs assessment supporting the level of service requested;

(i) Residential treatment services for children may require a letter of approval by a designated quality improvement organization (QIO) as defined in this rule;

(j) Some services require additional approval or authorization by a physician, the Authority, or designee. Services requiring additional approval are listed on the Behavioral Health Fee Schedule or described in this rule.

(5) The Division may not authorize services under the following circumstances:

(a) The request received by the Division was not complete;

(b) The provider did not hold the appropriate license, certificate, or credential at the time services were requested;

(c) The recipient was not eligible for Medicaid at the time services were requested;

(d) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the Division;

(e) The services requested are not in compliance with OAR 410-120-1260 through 410-120-1860;

(f) Authorization for payment may be given for a past date of service if:

(A) On the date of service, the recipient was made retroactively eligible or was retroactively dis-enrolled from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP);

(B) The services provided meet all other criteria and Division or Authority administrative rules and;

(C) The request for authorization is received within 30 days of the date of service.

(6) Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.

(7) Payment authorization is valid for the time-period specified on the authorization notice but may not exceed 12 months unless the recipient’s benefit package no longer covers the service, in which case the authorization shall terminate on the date coverage ends.

(8) Prior authorization of services shall be subject to periodic utilization review and retrospective review to ensure services meet the definition of medical appropriateness.

(9) Payments shall be made for the provision of active treatment services. If active treatment is not documented during any period in which the Division has prior authorized services, the Division may limit or cancel prior authorization or recoup such payments.

(10) If providers fail to comply with requests for documents for purposes of verifying medical appropriateness within the specified time-frames, the Authority may deem the records non-existent and cancel prior authorization.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

Service Specific Rules

410-172-0660 – Rehabilitative Mental Health Services

(1) Rehabilitative mental health services means medical or remedial services recommended by a licensed medical practitioner or other licensed practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or substance use disorder and are intended to restore functioning to the highest degree possible.

(2) Remedial rehabilitative behavioral health services shall be recommended by a licensed practitioner of the healing arts within the scope of their practice under state law.

(3) Rehabilitative behavioral health services that include medical services shall be provided under ongoing oversight of a licensed medical practitioner.

(4) Paid providers of rehabilitative behavioral health services shall meet one of the following qualifications or hold at least one of the following educational degrees and valid licensure:

(a) Physician or Physician Assistant licensed by the Oregon Medical Board;

(b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(c) Psychologist licensed by the Oregon Board of Psychology;

(d) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(e) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(f) Certificate issued by AMH as described in OAR 309-012-0130 through 309-012-0220.

(5) Non-paid providers shall be employed by a provider organization certified by AMH as described in OAR 309-012-0130 through 309-012-0220 and meet one of the following qualifications:

(a) Qualified mental health professional as defined in OAR 309-019-0105;

(b) Qualified mental health associate as defined in OAR 309-019-0105;

(c) Mental health intern as defined in OAR 309-019-0105; or

(d) Peer-Support Specialist as defined in OAR 410-180-0305.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0670 – Substance Use Disorder Treatment Services

(1) Substance Use Disorder (SUD) treatment services include, but are not limited to, screening; assessment; individual counseling; group counseling; individual family, group or couple counseling; care coordination; medication-assisted treatment; medication management; collection and handling of specimens for substance analysis; interpretation services; detoxification for substance use disorders; synthetic opioid treatment; and acupuncture.

(2) Paid providers of SUD treatment services shall meet one of the following requirements:

(a) Outpatient substance use disorder providers shall have a certificate issued by AMH as described in OAR chapter 415 division 012;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent individuals under ORS 443.400 or a detoxification center as defined in ORS 430.306 shall have a certificate issued by AMH as described in OAR chapter 415, division 012;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR chapter 415, division 020.

(d) Substance use detoxification programs shall meet the standards described in OAR 415, chapter 050.

(e) Physician or Physician Assistant licensed by the Oregon Medical Board;

(f) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(g) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(h) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(i) Psychologist licensed by the Oregon Board of Psychology;

(j) Acupuncturist licensed by the Oregon Medical Board;

(k) Non-paid providers shall be employed by a provider organization licensed or certified by AMH and meet one of the following qualifications for the scope of service provided:

(A) Qualified mental health professional as defined in OAR 309-019-0105;

(B) Qualified mental health associate as defined in OAR 309-019-0105;

(C) Mental health intern as defined in OAR 309-019-0105;

(D) Peer-support specialist as defined in OAR 410-180-0305;

(L) SUD counselor certified by a national or state accrediting body, including Certified Alcohol and Drug Counselor (CADC) certificate issued by the Addictions Counselor Certification Board of Oregon (ACCBO) including:

(A) CADC I - Requires education, supervised experience hours, and successful completion of a written examination: 150 hours of SUD education provided by an accredited or approved body; 1,000 hours of supervised experience; completion of the NCAC I professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(B) CADC II – Requires a minimum of a BA or BS degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 4,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(C) CADC III – Requires a minimum of a Master's degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 6,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors.

(3) Treatment staff holding certification in addiction counseling, qualification for the certification shall include at least: 750 hours of supervised experience in substance use counseling; 150 contact hours of education and training in substance use related subjects; and successful completion of a written objective examination or portfolio review by the certifying body.

(4) For treatment staff holding a health license described in this rule, the provider shall possess documentation of at least 60 (120 for supervisors) contact hours of academic or continuing professional education in SUD treatment.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0680 – Residential Treatment Services for Children

(1) Paid providers of children's psychiatric residential treatment services shall:

(a) Hold a Certificate of Approval Pursuant to OAR 309-012-0130 through 309-012-0220 from AMH; and

(b) Be accredited as a psychiatric residential treatment facility for children under age 18 by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the State of Oregon;

(c) Be licensed by the Office of Licensing and Regulatory Oversight (OLRO);

(2) Residential Treatment Services for Children shall provide a program consistent with standards set by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the state.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0690 – Admission Procedure for Residential Treatment Services for Children

(1) Admission procedures for children eligible for Medicaid shall be reviewed through an independent psychiatric review process established by the Division to certify the need for services.

(2) The referring source or the facility shall make available for the Certificate of Need (CONS) process the following information about the referred child:

(a) A written psychological or psychiatric evaluation completed within the previous 60 days;

(b) A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

(c) Results of any direct recipient observation and assessment subsequent to the referral;

(d) Other information from the referral source, other involved community agencies, and the family that are pertinent and appropriate to the admission procedure;

(e) Level of Need Determination Process outcome and Child and Adolescent Service intensity instrument (CASII) score;

(f) Identified care coordinator;

(g) Identified Intensive Community Based Treatment Services (ICTS) provider;

(h) Identified child and family team members;

(i) Service Coordination Plan or expected date of completion;

(j) Documentation regarding attempt or failure at lower level of care placement;

(k) Letter from Community Mental Health Program (CMHP) approving the referral to this level of care;

(L) Documentation that private insurance benefit will not fund stay.

(3) Certification for emergency admissions shall be made by the team responsible for a plan of care as described in CFR 441.156 within 14 days from the date of admission.

(4) The Division shall authorize payment for psychiatric residential treatment services for children upon the approval of a certificate of need by the Division or designee.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0700 – 1915(i) Home and Community-Based Services

(1) Habilitation services are designed to help an individual attain or maintain their maximal level of independence, including the individual's acceptance of a current residence and the prevention of unnecessary changes in residence. Services are provided in order to assist an individual to acquire, retain, or improve skills in one or more of the following areas: Assistance with activities of daily living, cooking, home maintenance, community inclusion and mobility, money management, shopping, community survival skills, communication, self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(2) Psychosocial rehabilitation services are medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.

(3) Paid providers of 1915(i) services shall meet one of the following qualifications:

(a) Physician or Physician Assistant licensed by the Oregon Medical Board;

(b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(c) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(d) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(e) Psychologist licensed by the Oregon Board of Psychology;

(f) Residential treatment home or facility licensed pursuant to OAR chapter 309, division 035;

(g) Adult Foster Home licensed pursuant to OAR chapter 309, division 040;

(h) Certificate issued by AMH pursuant to OAR chapter 309, division 012;

(4) Non-paid providers shall be employed or subcontracted with a provider licensed or certified by AMH and meet one of the following qualifications:

(a) Qualified Mental Health Professional as defined in OAR 309-019-0105;

(b) Qualified Mental Health Associate as defined in OAR 309-019-0105;

(c) Mental Health Intern as defined in OAR 309-019-0105;

(d) Peer-Support Specialist as defined in OAR 410-180-0305;

(e) Recovery Assistant.

(5) Providers of 1915(i) services may be required to meet Community Mental Health Program (CMHP) liability insurance requirements.

(6) Due to federal requirements for the Authority to ensure the impartiality of paid providers rendering services to 1915(i) eligible members, providers may be restricted from conducting eligibility reviews or developing the behavioral health assessment or service plan.

(7) To be eligible for services under the 1915(i) State Plan HCBS, the individual shall meet the following requirements:

(a) Been diagnosed with a chronic mental illness as defined in ORS 426.495;

(b) Been assessed as needing assistance to perform at least two personal care services as identified in these rules due to a chronic mental illness.

(8) Eligibility for 1915(i) services is determined by an external Quality Improvement Organization (QIO) as identified by the Division.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0710 – Residential Personal Care

(1) Personal care services provided to a resident of an AMH licensed residential treatment program include a range of assistance, as developmentally appropriate, and are provided to individuals with behavioral health conditions that enable them to accomplish tasks that they would normally do for themselves if they did not have a behavioral health condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task) or cueing (redirecting) so that the individual performs the task by him or herself.

(2) Personal care assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(3) Personal care services may be provided on a continuing basis or on episodic occasions.

(4) Paid providers of facility-based personal care services shall meet one of the following:

(a) Licensed residential facility pursuant to OAR chapter 309, divisions 035 and 040;

(b) Secure Residential Treatment Facility (SRTF);

(c) Residential Treatment Facility (RTF);

(d) Residential Treatment Home (RTH);

(e) Adult Foster Home (AFH).

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0720 – Prior Authorization and Re-Authorization for Residential Treatment

(1) The Authority does not consider a request for a fixed episode of care or standardized length of stay to be medically appropriate. Requested length of stay shall be based on an assessment of individual need and the medical appropriateness of the proposed time for treatment.

(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that will allow the individual to successfully reintegrate into an independent community-based living arrangement.

(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.

(4) Authority licensed residential treatment programs are reimbursed for the provision of rehabilitation, substance use disorder, habilitation, or personal care services as defined in these rules.

(5) The Division shall authorize admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

(6) Prior authorization requests for admission and continued stay may be reviewed to determine:

(a) The medical appropriateness of the admission for residential services provided;

(b) The appropriateness of the recommended length of stay;

(c) The appropriateness of the recommended plan of care;

(d) The appropriateness of the licensed setting selected for service delivery;

(e) A level of care determination was appropriately documented.

(7) If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission and procedures.

(8) If the reconsidered decision is to uphold the denial, prior authorization shall be denied.

(9) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410 120-1560 through1875.

(10) Upon denial of a prior authorization request for continued stay, the Division shall authorize payment for up to 60 days of continued stay for the purposes of supporting transition management and planning for the recipient.

(11) The Division shall determine re-authorization and authorization of continued stays based upon one of the following:

(a) The recipient continues to meet all basic elements of medical appropriateness and;

(b) One of the following criteria shall be met:

(A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;

(B) The recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;

(12) Requests for continued stay based on these criteria shall include documentation of ongoing re-assessment and necessary modification to the current treatment plan or residential plan of care.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0730 – Payment Limitations for Behavioral Health Services

(1) Services shall be subject to periodic utilization review to determine medical appropriateness.

(2) If a review reveals that a recipient received less than active treatment, payment shall not be allowed under these rules and prior authorization may be cancelled.

(3) The Division shall make no payment for services if the Division or designee has determined the service is not medically appropriate.

(4) Residential treatment services are provided to Medicaid Title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in “institutions of mental diseases” (IMD) who are over age 18 and under age 65. IMDs are defined in 42 CFR 435.1010.

(5) For residential facilities, the Division may not pay for planned or unplanned absences unless the provider can document clinical services were rendered during the temporary absence.

(6) For residential facilities, the Division shall pay for the day of admission but may not pay for the day of transfer or discharge.

(7) Medicaid may not reimburse costs associated with room and board for recipients residing in Authority licensed residential treatment programs.

(8) Consistent with 42 CFR 447.40, payment for a reserved bed is not covered under Medicaid.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0740 – Supported Employment

(1) To be eligible for Medicaid reimbursement, supported employment (SE) services shall be provided by a qualified SE provider.

(2) To become a qualified SE provider, an agency shall provide the evidence-based practice of individual placement support (IPS) and SE and submit a copy to AMH of a fidelity review conducted by an AMH approved fidelity reviewer that resulted in a score of 100 or better.

(3) Providers implementing IPS supported employment may become a provisionally-qualified SE provider by submitting a request to AMH with a letter of support that indicates receipt of technical assistance and training from an AMH approved IPS SE trainer. Medicaid reimbursement to a provisionally-qualified SE provider ends after 12 months. This option is intended only for providers initiating SE services.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0750 – Assertive Community Treatment (ACT)

(1) Assertive Community Treatment (ACT) services shall be provided by a qualified ACT provider to be eligible for Medicaid reimbursement.

(2) An agency shall provide the evidence-based practice of ACT to become a qualified ACT provider and submit to AMH a copy of a fidelity review conducted by an AMH approved ACT Fidelity Reviewer with a minimum score of 114.

(3) Agencies may become a provisionally-qualified ACT provider by submitting to AMH a request with a letter of support that indicates receipt of technical assistance and training from an AMH approved ACT Trainer. Provisional ability to receive Medicaid reimbursement shall end after 12 months. This option is intended only for providers initiating ACT services.

(4) If a Qualified ACT provider does not receive a minimum score of 114 on a fidelity review, the following shall occur:

(a) Technical assistance shall be made available for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90-day period, a follow-up review shall be conducted by an AMH approved reviewer.

(5) The provider shall forward a copy of the amended fidelity review report to AMH.

(6) If the 90-day review results in a score of less than 114, the agency's designation as a Qualified ACT provider may be suspended for up to one calendar year.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0760 – Applied Behavior Analysis

(1) ABA services shall be recommended by a licensed physician or licensed psychologist who has experience or training in the diagnosis of autism spectrum disorder and holds at least one of the following educational degrees and valid licensure:

(a) Physician licensed to practice in the State of Oregon;

(b) Psychologist licensed to practice in the State of Oregon;

(2) Paid providers of ABA services shall hold the following license or registration:

(a) Licensed Behavior Analyst as described in OAR 824-030-0010;

(b) Licensed health care professional who is registered with the Oregon Behavior Analyst Certification Board as described in OAR 824-030-0030.

(3) Non-paid providers of ABA services shall hold the following license or registration:

(a) Assistant Behavior Analyst licensed by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0020;

(b) Behavior Analysis Interventionists registered by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0040.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0770 – Individual Eligibility for Applied Behavioral Analysis Treatment

(1) Prior to receiving services, individuals receiving ABA shall have an evaluation by a physician or psychologist experienced in the diagnosis and treatment of autism using the current DSM criteria that includes:

(a) A Diagnosis of an Autism spectrum disorder;

(b) Documentation of and results from a standardized tool that has been used to substantiate the autism disorder or questionnaires that have been used to substantiate a diagnosis of self-injurious behavior;

(c) Documentation of behaviors that are considered to have an adverse impact on the individual's development or communication;

(d) Documentation of behavior that is injurious to themselves or others and that interferes with everyday functions or activities;

(e) Documentation that less intensive treatment or other therapy has been considered or found insufficient;

(f) Any other documentation that would substantiate the diagnosis of autism or self-injurious behavior such as:

(A) Notes from well-child visits or other medical professionals;

(B) Copy of existing or past Individual Education Plans (IEP);

(C) Results from any additional assessments such as IQ tests, speech and language tests, or tests of auditory function.

(g) A prescription for ABA treatment shall include:

(A) A diagnosis of autism or self-injurious behavior;

(B) A copy of the evaluation described above;

(C) An order for ABA treatment without specifying hours or intensity.

(2) Recipients ages one through twelve are eligible for intensive and less intensive interventions:

(a) Intensive interventions include therapies that address multiple behaviors at once, are more comprehensive in nature, and start at an earlier age;

(b) Less intensive interventions focus on a few targeted behaviors and generally are used with older children.

(3) Recipients age 13 and older are eligible for less intensive services only.

(4) Intensive and less intensive interventions are based on medical appropriateness as defined in these rules.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0780 – Behavioral Health Personal Care Attendant Program

(1) Behavioral health personal care attendant services are essential services that enable an individual to move into or remain in his or her own home. Behavioral health personal care attendant services are provided in accordance with an individual's authorized plan for services by a QMHA or QMHP as defined in OAR 309-019-0105:

(a) Behavioral health personal care attendant services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual's natural support system. Behavioral health personal care attendant services may not be implemented for the purpose of benefiting an individual's family members or the individual's household in general;

(b) Behavioral health personal care attendant services are limited to 20 hours per month per eligible individual;

(c) To meet an extraordinary personal care need, an individual, representative, or legal representative may request an exception to the 20-hour per month limitation. An exception shall be requested through the local community mental health program or agency contracted with the Authority serving the individual. The Division has up to 45 days upon receipt of an exception request to determine whether an individual's assessed personal care needs warrant exceeding the 20-hour per month limitation.

(2) Personal care services include:

(a) Basic personal hygiene, providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(b) Toileting, bowel, or bladder care, assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, and bowel care;

(c) Mobility, transfers, or repositioning, assisting an individual with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, and encouraging or assisting with range-of-motion exercises;

(d) Nutrition, preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(e) Medication or oxygen management, assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(f) Delegated nursing tasks, as defined in OAR 411-034-0010.

(3) When any of the services listed in section (2) of this rule are essential to the health, safety, and welfare of an individual and the individual is receiving personal care paid by the Division, the following support services may also be provided:

(a) Housekeeping tasks necessary to maintain the individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the individual's needs may be considered in housekeeping;

(b) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services (described in OAR chapter 410, division 136) and assistance with mobility and transfers or cognition in getting to and from appointments or to an office within a medical clinic or center;

(c) Observing the individual's health status and reporting any significant changes to physicians, health care professionals, or other appropriate persons;

(d) First aid and handling of emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another individual and responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(e) Cognitive assistance or emotional support provided to an individual by another person due to confusion, dementia, behavioral symptoms, or mental or emotional disorders. Cognitive assistance or emotional support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(4) Payment may not be made for any of the following excluded services:

(a) Shopping;

(b) Community transportation;

(c) Money management;

(d) Mileage reimbursement;

(e) Social companionship;

(f) Day care, adult day services (described in OAR chapter 411, division 066), respite, or baby-sitting services;

(g) Medicaid home delivered meals (described in OAR chapter 411, division 040);

(h) Care, grooming, or feeding of pets or other animals; or

(i) Yard work, gardening, or home repair.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0790 – Eligibility for Behavioral Health Personal Care Attendant Services

(1) To be eligible for Behavioral Health personal care attendant services, an individual shall:

(a) Demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition with personal care services and meet the eligibility criteria described in this rule;

(b) Be a current recipient of a Medicaid OHP full benefit package.

(2) An individual is not eligible to receive Behavioral Health personal care attendant services if:

(a) The individual is receiving personal care services from a licensed 24-hour residential services program (such as an adult foster home, residential treatment home, or residential treatment facility);

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;

(c) The individual's assessed service needs are being met under other Medicaid-funded home and community-based service options of the individual's choosing.

(3) Behavioral health personal care attendant services are not intended to replace routine care commonly needed by an infant or child typically provided by the infant's or child's parent.

(4) Behavioral health personal care attendant services may not be used to replace other non-Medicaid governmental services.

(5) The Authority may close the eligibility and authorization for Behavioral Health personal care attendant services if an individual fails to:

(a) Employ a provider that meets the requirements in this rule;

(b) Receive personal care from a qualified provider paid by the Authority for 30 continuous calendar days or longer.

(6) Behavioral health personal care attendant services may not duplicate other Medicaid services.

(7) Individuals eligible for Behavioral Health personal care attendant services as described shall apply through the local community mental health program or agency contracted with AMH.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715

410-172-0800 – Personal Care Attendant Employer-Employee Relationship

(1) The relationship between a provider and an eligible individual or the individual's representative is that of employee and employer.

(2) As an employer, the individual shall create and maintain a job description for a potential provider that is in coordination with the individual's plan for services.

(3) The only benefits available to homecare and personal support attendants are those negotiated in a collective bargaining agreement and as provided in statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare and personal support workers are not state or Division employees.

(4) To be eligible for Behavioral Health personal care attendant services, the individual or the individual's representative shall demonstrate the ability to:

(a) Locate, screen, and hire a provider meeting the requirements described in this rule;

(b) Supervise and train a provider;

(c) Schedule work, leave, and coverage;

(d) Track the hours worked and verify the authorized hours completed by a provider;

(e) Recognize, discuss, and attempt to correct any performance deficiencies with the provider and provide appropriate, progressive, disciplinary action as needed; and

(f) Discharge an unsatisfactory provider.

(5) The Authority shall pay for Behavioral Health personal care attendant services to the provider on an individual's behalf. Payment for services is not guaranteed until the Authority has verified that an individual's provider meets the qualifications set forth in this rule.

(6) In order to receive Behavioral Health personal care attendant services from a personal support worker or homecare worker, an individual shall be able to meet or designate a representative to meet the employer responsibilities in section (4) of this rule.

(7) Termination and the grounds for termination of employment are determined by an individual or the individual's representative. An individual may terminate an employment relationship with a provider at any time and for any reason. An individual shall establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.

(8) After appropriate intervention, an individual unable to meet the employer responsibilities in section (4) of this rule may be determined ineligible for Behavioral Health personal care attendant services.

(9) An individual determined ineligible for Behavioral Health personal care attendant services may request these services at the individual's next annual re-assessment. Improvements in health and cognitive functioning may be factors in demonstrating the individual's ability to meet the employer responsibilities described in section (4) of this rule. The waiting period may be shortened if an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the individual's next annual re-assessment.

(10) An individual may designate a representative to act on the individual's behalf to meet the employer responsibilities in section (4) of this rule. An individual's legal representative may be designated as the individual's representative:

(a) The Authority may deny an individual's designation of a representative if the representative has:

(A) A history of a substantiated abuse of an adult as described in OAR chapter 411, division 20, OAR chapter 407, division 45, or OAR chapter 943, division 45;

(B) A history of founded abuse of a child as described in ORS 419 B.005;

(C) Participated in billing excessive or fraudulent charges; or

(D) Failed to meet the employer responsibilities, including previous termination for failure to meet the employer responsibilities in section (4) of this rule.

(b) An individual may select another representative if the Authority suspends, terminates, or denies an individual's designation of a representative.

(11) An individual with a guardian shall have a representative for service planning purposes. A guardian may designate themselves the individual's representative.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0810 – Personal Care Attendant Qualifications

(1) A qualified provider is an individual who, in the Authority's judgment, demonstrates by background, skills, and abilities knowledge and ability to perform or to learn to perform the required work. A qualified provider shall:

(a) Maintain a drug-free work place;

(b) Complete the background check process described in OAR 943, division 007 with an outcome of approved or approved with restrictions;

(c) May not be an individual's legal representative;

(d) Be authorized to work in the United States in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules;

(e) Be 18 years of age or older.

(2) A qualified provider may be employed through a contracted in-home care agency or enrolled as a homecare worker or personal support worker under a provider number. The Authority shall establish the rates for services.

(3) Providers that provide Behavioral Health personal care attendant services shall:

(a) Be enrolled in the Consumer-Employed Provider Program and meet all of the standards in OAR chapter 411, division 31;

(b) Meet the provider enrollment and termination criteria described in OAR 411-031-0040 for personal support workers.

(4) The Authority shall conduct background rechecks at least every other year from the date a provider is enrolled. The Authority may conduct a recheck more frequently based on additional information discovered about a provider, such as possible criminal activity or other allegations.

(5) Prior background check approval for another Authority provider type is inadequate to meet background check requirements for homecare or personal support workers.

(6) Provider enrollment may be inactivated when a provider fails to comply with the background recheck process. Once a provider's enrollment is inactivated, the provider shall reapply and meet the requirements described in these rules to reactivate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0820 – Provider Termination

(1) The Authority may deny or terminate a personal care attendant's provider enrollment and provider number as described in OAR 411-031-0050. The termination, administrative review, and hearings rights for homecare workers are set forth in OAR 411-031-0050.

(2) The Authority may deny or terminate a personal support worker's provider enrollment and provider number when the personal support worker:

(a) Has been appointed the legal guardian of an individual;

(b) Has a background check that results in a closed case pursuant to OAR chapter 943, division 007;

(c) Lacks the skills, knowledge, or ability to perform or learn to perform the required work;

(d) Violates the protective service and abuse rules in OAR chapter 411, division 20, OAR chapter 407, division 45, and OAR chapter 943, division 45;

(e) Commits fiscal improprieties;

(f) Fails to provide the authorized services required by an eligible individual;

(g) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by an individual;

(h) Has been intoxicated by alcohol or drugs while providing authorized services to an individual or while in the individual's home;

(i) Has manufactured or distributed drugs while providing authorized services to an individual or while in the individual's home; or

(j) Has been excluded as a provider by the U.S. Department of Health and Human Services, Office of Inspector General from participation in Medicaid, Medicare, or any other federal health care programs.

(3) A personal support worker may contest the Authority's decision to terminate the personal support worker's provider enrollment and provider number:

(a) A designated employee from the Authority shall review the termination and notify the personal support worker of the decision;

(b) A personal support worker may file a request for a hearing with the Authority's local office if all levels of administrative review have been exhausted and the

provider continues to dispute the Authority's decision. The local office shall file the request for a hearing with the Office of Administrative Hearings as described in OAR chapter 137, division 3. The request for a hearing shall be filed within 30 calendar days of the date of the written notice from the Authority;

(c) When a contested case is referred to the Office of Administrative Hearings, the referral shall indicate whether the Authority is authorizing a proposed order, a proposed and final order, or a final order;

(d) No additional hearing rights have been granted to a personal support worker by this rule other than the right to a hearing on the Authority's decision to terminate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-8230 – Personal care attendant Service Assessment, Authorization, and Monitoring

(1) A behavioral health case manager shall meet in person with an individual to assess the individual's ability to perform the personal care tasks listed in this rule:

(a) An individual's natural supports may participate in the assessment if requested by the individual;

(b) A behavioral health case manager shall assess an individual's service needs, identify the resources meeting any, some, or all of the individual's needs and determine if the individual is eligible for behavioral health personal care attendant services or other services;

(c) A behavioral health case manager shall meet with an individual in person at least once every 365 days to review the individual's service needs.

(2) A behavioral health case manager shall prepare a service plan identifying the tasks for which an individual requires assistance and the number of monthly authorized service hours. The case manager shall document an individual's natural supports that currently meet some or all of the individual's assistance needs:

(a) The service plan shall describe the tasks to be performed by a qualified provider and shall authorize the maximum monthly hours that may be reimbursed for those services;

(b) A case manager shall consider the cost effectiveness of services that adequately meet the individual's service needs when developing service plans;

(c) Payment for behavioral health personal care attendant services shall be prior authorized by a behavioral health case manager and based on the service needs of an individual as documented in the individual's written service plan.

(3) When there is an indication that an individual's personal care needs have changed, a case manager shall conduct an in-person reassessment with the individual and any of the individual's natural supports if requested by the individual:

(a) Following annual reassessments and those conducted after a change in an individual's personal care needs, a case manager shall review service eligibility, the cost effectiveness of the individual's service plan, and whether the services provided are meeting the individual's identified service needs;

(b) The case manager may adjust the hours or services in the individual's service plan and shall authorize a new service plan, if appropriate, based on the individual's current service needs.

(4) A behavioral health case manager shall provide ongoing coordination of behavioral health personal care attendant services, including authorizing changes in providers and service hours, addressing risks, and monitoring and providing information and referral to an individual when indicated.

(5) The Authority may not authorize services within an eligible individual's home when:

(a) The individual's home has dangerous conditions that jeopardize the health or safety of the individual or the provider and necessary safeguards cannot be taken to improve the setting;

(b) The services cannot be provided safely or adequately by a provider;

(c) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and necessary safeguards cannot be provided to protect the individual's safety, health, and welfare.

(6) A behavioral health case manager shall present an individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when a provider or service setting selected by the individual or the individual's representative is not authorized.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0840 – Personal Care Attendant Payment Limitations

(1) The number of behavioral health personal care attendant service hours authorized for an individual per calendar month is based on projected amounts of time to perform specific personal care and supportive services to the eligible individual. The total of these hours are limited to 20 hours per individual per month. Individuals whose assessed service needs exceed the 20 hour limit may receive approval for additional hours.

(2) The Authority shall pay for behavioral health personal care attendant services when all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Authority is authorized.

(3) In accordance with OAR 410-120-1300, all provider claims for payment shall be submitted within 12 months of the date of service.

(4) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual's representative.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

410-172-0850 - Telemedicine for Behavioral Health

(1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient's benefit package:

(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Evidence Review Commission and the applicable HERC-approved code requirements, delivered consistent with the HERC Evidence-Based Guidelines;

(b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below.

(2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority.

(3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when:

(a) Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or

(b) Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission's Prioritized List of Health Services and Evidence Based Guidelines.

(4) Providers billing for covered telemedicine services shall:

(a) Comply with HIPAA and the Authority's Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;

(b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules set forth in OAR 943 division 14;

(c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;

(d) Comply with the relevant HERC evidence-based guidelines for telephone and e-mail consultation. Refer to the current prioritized list and evidence based guidelines at http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(5) For purposes of behavioral health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715

410-172-0860 – Billing for Dual Eligible Individuals

(1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other Third Party Liability (TPL).

(2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:

(a) For behavioral health services that are never covered by Medicare or another insurer;

(b) For behavioral health services that are not covered when rendered by the following provider types:

(A) Qualified Mental Health Professional (non-licensed) as defined in OAR 309-019-0105;

(B) Qualified Mental Health Associate as defined in OAR 309-019-0105;

(C) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(D) Certified Peer Support Specialist as defined in OAR 410-180-0305;

(E) Recovery Assistant;

(F) Certified Alcohol and Drug Counselor.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715