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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 109-2018

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
12/20/2018 12:01 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Extends Period for Requesting Prior Authorization of Behavioral Health Services from 30 to 90 Days

EFFECTIVE DATE: 01/01/2019 THROUGH 06/29/2019

AGENCY APPROVED DATE: 12/19/2018

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NEED FOR THE RULE(S):

The Division needs to amend these rules to comply with CMS 2333-F.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may comply with CMS 2333-F.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

CMS 2333-F: Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans:

https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of

AMEND: 410-172-0650

RULE TITLE: Prior Authorization

RULE SUMMARY: The Division needs to amend these rules to comply with CMS 2333-F.

RULE TEXT:

(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 authorize only 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 0140; or
(f) Any additional clinical information supporting medical justification for the services requested;
(g) For substance use disorder services (SUD), the Division uses the American Society of Addiction 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 Behavior Analysis (ABA) services, the Division requires submission of the following:
(A) ABA services for the treatment of autism spectrum disorder shall have an evaluation as described in OAR 410-172-0770(1)(a–j) and a referral for treatment as described in OAR 410-172-0760(1) from one of the licensed practitioners described in OAR 410-172-0760(1)(a–d) who are, in addition, experienced in the diagnosis of autism spectrum disorder;
(B) ABA services for the treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder shall have an evaluation as described in OAR 410-172-0770(2) and a referral for treatment as described in OAR 410-172-0760(2) from a licensed practitioner, practicing within the scope of their license who has experience or training in the diagnosis and treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder;
(C) A treatment plan, including a functional behavior assessment, as needed, from a licensed health care professional as defined in ORS 676.802(2)(a–h), or by a behavior analyst or assistant behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board, or by an individual holding a declaration of practice through the Oregon Behavior Analysis Regulatory Board as described in OAR 824-010-0005(10).
(i) Residential treatment services for children may require a letter of approval by a designated quality improvement organization (QIO);
(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 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 CCO or PHP;
(B) The services provided meet all other criteria and Division or Authority administrative rules and;
(C) The request for authorization is received within 90 days of the date of service.
(6) Any requests for authorization after 90 days from date of service require documentation from the provider that authorization could not have been obtained within 90 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 prior authorized the services, the Division may limit or cancel prior authorization or recoup the 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.
(11) In applying OAR 410-141-3061, OAR 410-172-0650 (5)(f), and OAR 410-172-0650(6), the Division may construe them as much as possible to be complementary. In the event that OAR 410-141-3061 and OAR 410-172-0650(5)(f) and OAR 410-172-0650(6) may not be complementary, the Division shall apply the following order of precedence to guide its interpretation: OAR 410-141-3061, OAR 410-172-0650(5)(f), and OAR 410-172-0650(6).

STATUTORY/OTHER AUTHORITY: ORS 413.042, 430.640

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715