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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 4-2021

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

FILED
01/28/2021 12:35 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Clarify Adult Residential Prior Authorization Criteria and Admissions Procedures for Children's Psychiatric Residential Treatment

EFFECTIVE DATE: 01/28/2021 THROUGH 07/25/2021

AGENCY APPROVED DATE: 01/25/2021

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NEED FOR THE RULE(S):

The temporary rule for 410-172-0690 updates current state and federal guidelines, removes requirement for the Child and Adolescent Service Intensity Instrument (CASII) score and addresses administrative changes.
The temporary rule for 410-172-0720 clarifies adult residential prior authorization criteria, specifically for Secure Residential Treatment Facilities (SRTF) for the Authority's ability to deny prior authorization requests when documented reasonable and significant behaviors have occurred prior to 90 days from the request date, and addresses administrative changes.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in inappropriate placements impacting the public interest, the Authority, CCO's, adults with Serious and Persistent Mental Illness (SPMI) and children with Serious Emotional Disturbances (SED). These rules need to be adopted promptly so that the Authority may take necessary action to ensure capacity for adults with SPMI to have available housing and treatment options and children to receive timely and appropriate residential services.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

RULES:
410-172-0690, 410-172-0720

AMEND: 410-172-0690

RULE TITLE: Admission Procedure for Residential Treatment Services for Children

RULE SUMMARY: The temporary rule for 410-172-0690 updates current state and federal guidelines, removes requirement for the Child and Adolescent Service Intensity Instrument (CASII) score and addresses administrative

changes.

RULE TEXT:

(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 shall make available the following information about the referred child for the Certificate of Need (CONS) process:

(a) A written psychological or psychiatric evaluation completed by a treating Licensed Medical Professional (LMP) within the previous 60 days;

(b) A written psychosocial history;

(c) Documented results of any direct recipient observation and assessment after the referral;

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

(e) Identified care coordinator;

(f) Identified child and family team members;

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

(h) If applicable, documentation regarding lower level of care outcomes;

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

(3) For emergency admissions, the CONS 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.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 430.640

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

AMEND: 410-172-0720

RULE TITLE: Prior Authorization and Re-Authorization for Residential Treatment

RULE SUMMARY: The temporary rule for 410-172-0720 clarifies adult residential prior authorization criteria, specifically for Secure Residential Treatment Facilities (SRTF) for the Authority's ability to deny prior authorization requests when documented reasonable and significant behaviors have occurred prior to 90 days from the request date and addresses administrative changes.

RULE TEXT:

(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 shall be outcome-based and provide service and supports in a structured environment that allows the individual to successfully reintegrate into an independent community-based living arrangement.

(3) Residential treatment may not be used as a long-term substitute for appropriate and available supportive living environments in the community. Lack of appropriate and available supportive community living environments shall be addressed and documented in transition management and planning for the recipient.

(4) Authority-licensed residential treatment programs are reimbursed for the provision of 1915(i) habilitative services as described in 410-173-0015, rehabilitative behavioral health services as described in OAR 410-172-0660, substance use disorder services as described in OAR 410-172-0670, or habilitation or personal care services as described in OAR 410-172-0705.

(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 shall be reviewed and documented by the Authority or their contracted Independent and Qualified Agent (IQA) to determine:

(a) The medical appropriateness for residential services;

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

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

(d) The medical appropriateness of the licensed setting; and

(e) The current level of need.

(7) Prior authorization requests for admission and continued stay for a Secured Residential Treatment Facility (SRTF) shall be reviewed to confirm that the individual meets all the following criteria:

(a) The individual does not require 24-hour hospital care and treatment or continuous nursing care unless an adequate plan to provide the care exists and is included in the prior authorization request;

(b) The individual requires highly structured and secured environmental supports and supervision seven days per week and 24 hours per day in order to participate successfully in a program of habilitative and rehabilitative activities;

(c) Due to a mental illness and as evidenced by clinically documented instances of behaviors displayed within the last 90 days, the individual presents with one or more of the following:

(A) Clear intention or specific acts of bodily harm to others;

(B) Ideation of suicide with intent and ability if not in a secured environment or of self-harm posing significant risk of serious injury;

(C) Inability to care for basic needs that results in worsening or development of a significant health condition, or the individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm; or

(D) Significant risk that the individual will not remain in a non-secured place of service to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's or others safety and well-being.

(8) If the Division determines that a residential service prior authorization request is not within coverage parameters,

the provider shall be notified in writing of the basis for the decision and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission.
(9) If the reconsidered decision is to uphold the denial, the provider, referral source and individual shall be notified in writing of the basis for the decision and the prior authorization shall be denied.
(10) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410-120-1560 through 410-120-1875.
(11) 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 for the recipient to plan any arrangements necessitated by the denial decision.
(12) The Division shall determine re-authorization and authorization of continued stays based upon documentation of at least one of the following:
(a) The recipient continues to meet all elements of medical appropriateness described in these rules;
(b) 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 more independent community-based residential setting; or
(c) The recipient develops new or worsening symptoms or behaviors that require continued stay in the current residential setting.
(13) Requests for continued stay based on these criteria shall include documentation of ongoing reassessment and necessary modification to the current treatment plan or residential plan of care.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 430.640

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