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

FILING CAPTION: Clarifies Adult Residential And Children's Psychiatric Residential Treatment Services Prior Authorization And Admission Procedures

EFFECTIVE DATE: 07/26/2021

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

AMEND: 410-172-0690

NOTICE FILED DATE: 05/19/2021

RULE SUMMARY: The Authority's administrative rules set the minimum standards for prior authorization and admission procedures for adults and children's residential services in licensed settings. The rules provide clarification and procedural detail regarding Adult Residential Prior Authorization Criteria and Admissions Procedures for Children's Psychiatric Residential Treatment Services. In particular, OAR 410-172-0690 needs to be updated to match current state and federal guidelines and removes requirement for the Child and Adolescent Service Intensity Instrument (CASII) score. OAR 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.

CHANGES TO RULE:

410-172-0690
Admission Procedure for Psychiatric 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 sour~~Referral to psychiatric residential treatment services shall be because:¶
(a) Medically appropriate treatment of the child's psychiatric condition requires services ~~or the facility shall make available~~n a 24-hour residential basis under the direction of a Licensed Medical Practitioner (LMP) as defined in OAR 309-019-0105; and¶
(b) The services can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed.¶

(3) The referring source shall make available to the third-party reviewer 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~~or progress note from a face-to-face service completed by a treating, LMP within the previous 60 days that recommends treatment in a 24-hour facility ~~to which the child has been referred;¶~~
~~(c) Results of any direct recipient observation and assessment subsequent to the referral~~under the direction of an LMP;¶
(b) A written psychosocial history;¶
(~~d~~c) Other information from the referral source, other involved community agencies, and the family that are pertinent and appropriate ~~to the admission procedure~~;¶
(e~~d~~) ~~Level of Need Determination Process outcome an~~Identified care coordinator;¶
(e) Identifie~~d~~ ~~C~~child and ~~Adolescent Service intensity instrument (CASII) score;¶~~
~~(f) Identified car~~family team members;¶
(f) Service ~~c~~Coordinat~~or;~~ion Plan:¶
(~~g~~A) I~~dentified Intensive Community Based Treatment Services (ICTS) provider;~~ntensive Care Coordination Plan as defined in OAR 410-141-3870; or¶
(~~h~~B) ~~Identified child and family team members~~Wraparound Plan of Care as defined in OAR 309-019-0326;¶
(~~i~~g) ~~Service Coordination Plan or expected dat~~Documentation regarding lower level of care o~~f~~ ut~~com~~~~pletion;¶~~
~~(j) Documentation regarding attempt or failure at lower level of care placement;~~es or justification regarding how 24-hour psychiatric residential based treatment under the care of an LMP will meet the needs of the child; and¶
(~~k~~h) ~~L~~For fee-for-service members, a 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~~4) ~~Certification f~~For emergency admissions, the CON 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.~~
Statutory/Other Authority: ORS 413.042, 430.640
Statutes/Other Implemented: ORS 413.042, 430.640, ORS 414.025, 414.065, ~~430.640,~~ 430.705, 430.715

AMEND: 410-172-0720

NOTICE FILED DATE: 05/19/2021

RULE SUMMARY: The Authority's administrative rules set the minimum standards for prior authorization and admission procedures for adults and children's residential services in licensed settings. The rules provide clarification and procedural detail regarding Adult Residential Prior Authorization Criteria and Admissions Procedures for Children's Psychiatric Residential Treatment Services. In particular, OAR 410-172-0690 needs to be updated to match current state and federal guidelines and removes requirement for the Child and Adolescent Service Intensity Instrument (CASII) score. OAR 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.

CHANGES TO RULE:

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~~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 is not intended to be used as a long-term substitute for lack of 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 ~~rehabilitation, substance use disorder,~~1915(i) habilitative services as described in OAR 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 de~~fin~~scribed in ~~these rules~~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 ~~may~~shall be reviewed and documented by the Authority or their contracted Independent and Qualified Agent (IQA) to determine:¶
(a) The medical appropriateness ~~of the admission~~ for residential services ~~provided~~;¶
(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 ~~selected for service delivery;¶~~
~~(e) A level of care determination was appropriately document~~; and¶
(e) The current level of need. ¶
(7) Prior authorization requests for admission and continued stay for a Secured Residential Treatment Facility (SRTF) shall ~~also~~ be reviewed to confirm that the individual meets all the following criteria:¶
(a) The individual does not require 24-hour hospital care and treatment;¶
(b) The individual requires highly structured and secured environmental supports and supervision seven days ~~a~~per week and 24 hours ~~a~~per day in order to participate successfully in a program of habilitative and rehabilitative activities; and¶
(c) Due to a mental illness and as evidenced by clinically document~~ation from the last 90 days or from an Authority-approved and standardized risk assessment conduct~~ed instances of behaviors displayed within the ~~p~~last ~~year~~90 days, the individual presents ~~a risk in on~~with one or more of the following ~~areas~~:¶
(A) Clear intention or specific acts of bodily harm to others;¶

(B) ~~Suicidal ideation with int~~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 ~~exacerbation~~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) ~~Due to the symptoms of a mental illness, there is s~~Significant risk that the individual will not remain in a non-secured place of service ~~for the time needed~~ 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 ~~and procedures~~.¶
(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 ~~and planning~~ 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 ~~basic~~ elements of medical appropriateness~~;~~¶
~~(b) One of the following criteria shall be met:~~ described in these rules;¶
(~~A~~b) ~~Documentation t~~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;~~ny other residential setting; or¶
(~~B~~c) The recipient develops new or worsening symptoms or behaviors that require continued stay in the current ~~level of care~~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, 430.640, ORS 414.025, 414.065, ~~430.640,~~ 430.705, 430.715