Reviews for Medical Necessity and Medical Appropriateness of Secure Residential Treatment Facility (SRTF) Placements

Frequently asked questions for SRTF providers

SRTF authorizations

There has not been any communication regarding the CH-009 form; however, it appears it was updated in January 2024. Is this form now required prior to placement at a SRTF? Historically, this was only required for individuals transitioning from OSH, has this changed? Is this requirement included in a HSD memo, OAR, ORS, etc?

Oregon Health Authority (OHA) sent a memo to providers on February 14. It is posted on OHA's website. It details the use of the new form and was hyperlinked as well. You can also find it here.

For an SRTF with a waitlist - Do we need to have PA/CH009s for those waitlisted individuals completed and shared with Comagine/IQA for review for future openings after 3/1/2024?

Yes. All referrals to SRTF need a medical necessity/medical appropriateness review.

Does the residential provider have 10 calendar days or 10 business days to submit additional documentation to Comagine when they reach out to the provider, prior to an official authorization denial being sent to the residential provider?

The provider has 10 business days to submit additional documentation.

Medicaid denials

Is the provider able to assist the client in creating/submitting the appeal as they are when they wish to appeal a residential provider's decision about their residency?

Only the client/guardian can do the formal appeal, however the provider can help the client/guardian with an appeal at the individual's request.

Can the process for submitting an appeal and an administrative hearing be provided in writing by HSD?

The appeal process/administrative hearing is in the Notice of Action sent at the time of denial to the individual.

Which day is considered Day 1 of the 60 days of continued authorization after an authorization denial?

Day 1 is the Date of Denial as listed on the Notice of Action sent to the individual.

If the appeal process takes longer than 60 days what does the timeline look like for continued stay payment through Medicaid?

Medicaid will continue fund until the appeal resolves either with an overturning of the denial or affirmation of the denial.

Does the client's current length of stay at the SRTF hold any weight in the denial decision?

No. The length of stay is not considered. Only the items listed in the OAR cited in the memo is considered.

Is there a time period after an authorization is denied before a new authorization can be submitted? For example, if an authorization is submitted and denied, and then the provider believes the individual may now meet medical necessity criteria again, is there a number of days that they could not submit a new authorization?

The provider can submit a request for assessment to the IQA any time the client appears to meet medical necessity.

If a CH-006 is denied for Medicaid funding, will the residential provider still be eligible to receive Medicaid funding for rehabilitative services through the CH-007?

Once it has been determined that the individual's presentation as documented does not meet medical necessity/appropriateness, all payment (habilitative and rehabilitative) for that setting stops from Medicaid.

If OHA has determined a denial per Comagine (from provider documentation) what would be the likelihood of this being overturned by the OHA Administrative review since they have already seen the documentation?

OHA considers each case separately and on its own merits. If additional documentation is found it would be helpful for consideration, however the provider must explain why they disagree with the decision and indicate the specific documentation that supports their argument.

Wouldn't a denial of Medicaid be a barrier to find alternative placement?

Medicaid denial is for the current placement within the 90-day plan of care authorization. It would not influence or affect the client's potential eligibility for placement in other settings within the continuum of care or any future request for a medical necessity/appropriateness review.

Non-Medicaid funding

What documentation will be needed to support a GF request?

OHA will roll out required documentation and process by the end of March. In the meantime, providers must continue to document following documentation standards in 309 and 410 rules.

Will Comagine continue to complete PCSP and LSI for clients who do not meet medical necessity at the SRTF level of care? If not, how will the possible GF payment be determined?

No. OHA has decided in the short term to base General Fund payment on the client's latest LSI score. General Fund is for transitional payment until providers can find a more appropriate setting that meets the client's needs as supported by medical necessity/appropriateness.

It has been stated that the PSRB determines where an individual has been approved to receive services and therefore a SRTF may be denied Medicaid funding due to an individual not meeting medical necessity, but it is highly likely that GF will be available for continued funding for that level of care after the 60 days of continued Medicaid payment concludes. Since a judge also signs a court order for placement for those under Aid and Assist and Civil Commitment, is there a similar likelihood that GF will be provided to support continued SRTF placement for individuals with these court orders?

The court does remand people to specific places under Aid and Assist orders. Similar to PSRB, the provider can seek payment through General Fund. Under Civil Commitment, the individual is under the jurisdiction of OHA (through the Community Mental Health Program) and is not remanded to a specific location. The provider can still seek General Fund payment for transitional purposes to a medically necessary/appropriate setting where the individual wishes to receive care.

Will there be a maximum length of time the general funds will be available for each client? Meaning, will general funds stop payment at some point if the client's discharge is taking an extended amount of time?

Yes. OHA would make this decision based on each client's transitional plan as well as the requirements of any forensic decision by the court/PSRB.