



Division of Medical Assistance Programs
Policy and Planning Section

Behavior Health Services Administrative Rulebook

Chapter 410, Division 120

Effective August 1, 2014

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410-172-0000 – Scope

These rules specify standards for authorized appropriate reimbursement of Medicaid or State Children’s Health Plan funded addictions and mental health services and supports. This includes payments for community-based services as well as those payments made for acute inpatient services in a general medical setting or a freestanding facility meeting the federal definition as an institute for mental disease reimbursed as a result of a request for payment. The requirements set forth here in OAR 309-016-0600 through 309-016-0820 and referenced rules must be met in order for Medicaid payment to have been made appropriately.

Stat. Auth.: ORS 413.042 & 430.640

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

General Requirements

410-172-0010 – Definitions

(1) "Action" means:

- (a) The denial, limitation or restriction of a requested covered services including the type or level of service;
- (b) The reduction, suspension or termination of a previously authorized service; or
- (c) The failure to provide services in a timely manner, as defined by the Addictions and Mental Health Division of the Oregon Health Authority.

(2) "Active Treatment" means a service provided as prescribed in a professionally developed and supervised Individual Services and Supports Plan to address or improve a condition.

(3) "Addictions and Mental Health Division" means the Division of the Oregon Health Authority responsible for the administration of addictions and mental health services provided in Oregon or to its residents.

(4) "Allowable Cost" means the cost of treatment services based on cost finding principles found in the appropriate OMB Circular such as "Cost Principles for Non-Profit Organization" (OMB Circular A-122) or "Cost Principles for State, Local, and Indian Tribal Governments" (OMB Circular A-87) and including allowable costs incurred for interest on the acquisition of buildings and improvements thereon.

(5) "Appeal" means a request by an Individual or their representative to review an Action as defined in this rule.

(6) "Assertive Community Treatment" (ACT) means an evidence-based practice which utilizes a highly integrated, trans-disciplinary team to deliver comprehensive and effective services to individuals with serious mental illness who have needs that have not been well met by traditional approaches to delivering services.

(7) "Certificate of Approval" means the document awarded by the Division signifying that a specific, named organization is judged by the Division to operate in compliance with applicable rules. A "Certificate of Approval" for mental health services is valid only when signed by the Deputy Director of the Division of Mental Health Services and, in the case of a subcontract provider of a CMHP, the CMHP director.

(8) "Certification of Need" means the procedures established by the Division to certify in writing a child's need for psychiatric residential treatment services.

(9) "Child" or "Children" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, will be considered a child until age 21 for purposes of these rules.

(10) "Children, Adults and Families" (CAF) means the Division serving as Oregon's child welfare agency.

(11) "Clean Claim(s)" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

(12) "Commission on Accreditation of Rehabilitation" (CARF) means an organization that accredits behavioral health care and community providers based on the current edition of the "CARF Behavioral Health" standards manual.

(13) "Community Mental Health Program" (CMHP) means an entity that is responsible for planning and delivery of services for persons with substance use disorders, mental health diagnosis, or developmental disabilities, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(14) "Complaint" means an expression of dissatisfaction from an Individual or their representative to a Practitioner or Provider about any matter other than an Action.

(15) "Council on Accreditation of Services for Families and Children Facilities" (COA) means an organization that accredits behavioral health care and social service programs based on the current edition of the COA "Standards for Behavioral Health Care Services and Community Support and Education Services Manual."

(16) "Disabling Mental Illness" means a mental illness that substantially limits functioning in one or more major life activity.

(17) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(18) "Division of Medical Assistance Programs" (DMAP) means the Division of the Oregon Health Authority responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

(19) "DMAP/AMH" means the Division of Medical Assistance or Addictions and Mental Health Division. Both DMAP and AMH have delegated responsibilities for the administration of Medicaid funded addictions and mental health services and supports.

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A lead agency will be identified to each entity involved in any process when the delegation of such is necessary.

(20) "Diagnostic and Statistical Manual" (DSM) means the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

(21) "Fidelity Review" means an on-site assessment utilizing a standardized, reliable, and valid evaluation tool to determine the degree to which an evidence-based practice is being implemented. Fidelity reviews include staff interviews, consumer and family member interviews, observation of service provision, review of program data, and/or chart reviews as necessary for the practice being reviewed.

(22) "Grievance System" means the overall system in which an Individual can express dissatisfaction and that expression acted on if necessary. The Grievance System includes a Complaint process, and Appeals process and access to the Division of Medical Assistance Programs Administrative Hearing process.

(23) "Habilitation Services" means services 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, recreation, 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.

(24) "Individual" means any person being considered for or receiving services and supports.

(25) "Individual Service and Support Plan" (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the desired outcomes of service.

(26) "Interdisciplinary Team" means the group of people designated to advise in the planning and provision of services and supports to individuals receiving Intensive Treatment Services (ITS) and Enhanced Care Services (ECS) and may include multiple disciplines or agencies. For ITS programs, the composition of the interdisciplinary team must be consistent with the requirements of 42 CFR Part 441.156.

(27) "Joint Commission, The" (TJC) means the commission which accredits psychiatric residential treatment facilities according to its current edition of the "Comprehensive Accreditation Manual for Hospitals" and the "Comprehensive Accreditation Manual for Behavioral Health Care."

(28) "Letter of Approval" means the document awarded to service providers under OAR 309-012-0010 which states that the provider is in compliance with applicable administrative rules of the Division. Letters of Approval issued for mental health services are obsolete upon their expiration date, or upon the effective date of 309-012-0140, whichever is later.

(29) "Licensed Medical Practitioner" (LMP) means a person who meets the following minimum qualifications as documented by the LMHA or designee:

- (a) Physician licensed to practice in the State of Oregon; or
- (b) Nurse practitioner licensed to practice in the State of Oregon; or
- (c) Physician's Assistant licensed to practice in the State of Oregon.
- (d) In addition, whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.
- (e) For ICTS and ITS providers, a "Licensed Medical Practitioner" or "LMP" means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(30) "Local Mental Health Authority" (LMHA) means one of the following entities:

- (a) The board of county commissioners of one or more counties that establishes or operates a Community Mental Health Program (CMHP);
- (b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or
- (c) A regional local mental health authority comprised of two or more boards of county commissioners.

(31) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act.

(32) "Medicaid Management Information System" The mechanized claims processing and information retrieval system that all states are required to have according to section 1903(a)(3) of the Social Security Act and defined in regulation at 42 CFR 433.111. All states operate an MMIS to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

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(33) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are:

- (a) Consistent with the symptoms of a health condition or treatment of a health condition;
- (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;
- (c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and
- (d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.

(34) "National Provider Identifier" (NPI) means a unique 10-digit identifier mandated by the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) for all healthcare providers that is good for the life of the provider.

(35) "Non-Contiguous Area Provider" means a provider located more than 75 miles from Oregon and enrolled with the Division.

(36) "Plan of Care" (POC) means a tool within the Medicaid Management Information System used to authorize certain Medicaid funded services for Individuals.

(37) "Provider" means an organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

(38) "Psychiatric Residential Treatment Facility" means facilities that are structured residential treatment environments with daily 24-hour supervision and active psychiatric treatment, Psychiatric Residential Treatment Services (PRTS), Secure Children's Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute psychiatric treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.

(39) "Psychiatric Residential Treatment Services" means services delivered in a PRTF that include 24-hour supervision for children who have serious psychiatric, emotional or acute mental health conditions that require intensive therapeutic counseling and activity and intensive staff supervision, support and assistance.

(40) "Qualified Mental Health Associate" (QMHA) means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee:

- (a) A bachelor's degree in a behavioral sciences field; or
- (b) A combination of at least three year's relevant work, education, training or experience; and
- (c) Has the competencies necessary to:
 - (A) Communicate effectively;
 - (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and
 - (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

(41) "Qualified Mental Health Professional" (QMHP) means a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

- (a) Graduate degree in psychology;
- (b) Bachelor's degree in nursing and licensed by the State of Oregon;
- (c) Graduate degree in social work;
- (d) Graduate degree in a behavioral science field;
- (e) Graduate degree in recreational, art, or music therapy; or
- (f) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and
- (g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and/or group therapy within the scope of his or her practice.

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(42) "Representative" means a person who acts on behalf of an individual at the individual's request with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian.

(43) "Residential Alcohol and Other Drug Treatment Program" means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation and twenty four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level III of American Society of Addiction Medicine (ASAM) PPC-2R.

(44) "Supported Employment" (SE) means an evidence-based practice which provides services and supports to enable individuals with a serious mental illness to obtain and maintain competitive employment.

(45) "System Of Care" means the comprehensive array of mental health and other necessary services which are organized to meet the multiple and changing needs of children with severe emotional disorders and their families.

(46) "Usual and Customary Charge" means the lesser of the following unless prohibited from billing by federal statute or regulation:

- (a) The Provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;
- (b) The Provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;
- (c) Where the Provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0020 – Clinical Documentation

Providers shall comply with clinical documentation as required in the Integrated Services and Supports Rule (OARs 309-032-1525(3) through 309-032-1535)

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

Stats. Implemented: ORS 414.025, 414.065 & 430.640

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410-172-0030 – Billing

Billing Requirements. Providers shall meet all requirements in Oregon Administrative Rule 410-172-1280 Medical Assistance Programs Billing

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0040 – Submission

(1) Timely Submission Providers shall meet all requirements in Oregon Administrative Rule 410-172-1300 Medical Assistance Programs Timely Submission of Claims

(2) Submission Process

(a) Services may be received directly from any appropriately enrolled or DMAP Provider;

(b) All services shall be billed directly to DMAP in accordance with billing instructions contained in the DMAP administrative rules and supplemental information;

(c) DMAP shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate DMAP administrative rules and supplemental information.

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

Stats. Implemented: ORS 414.025, 414.065 & 430.640

410-172-0050 – Allowable and Non-Allowable Costs

(1) Costs of a services will be subject, but not limited to the allowable and non-allowable costs as determined by cost finding principles found in "Cost Principles for a Non-Profit Organization" (OMB Circular A-122) or "Cost Principles for State, Local, and Indian Tribal Governments" (OMB Circular A-87) with the exception of interest: Mortgage interest on the acquisition of buildings and improvements, which is necessary and proper, will be classified as an allowable cost for a non-profit psychiatric residential treatment facility:

(a) "Necessary" requires that the interest be incurred on a loan made for a purpose reasonably related to patient care.

(b) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(2) In accord with the Deficit Reduction Act of 1984, as outlined in the Social Security Act, Section 1851(V)(I)(O), for determining the allowance for depreciation and interest on capital indebtedness with respect to a non-profit psychiatric residential treatment facility which has undergone a change of ownership, this rule provides that the valuation of the asset after such a change of ownership has occurred shall be the lesser of the allowable acquisition cost of such an asset to the owner of record as of July 18, 1984, or the acquisition cost of such an asset to the new owner. In the case where the asset was in existence prior to July 18, 1984, the value of the asset will be based on the allowable acquisition cost to the first owner of record after July 18, 1984, thereby eliminating upward revaluation of an asset. The recapture of depreciation only up to the full value of the initial asset is allowed.

(3) Non-allowable costs include but are not limited to:

(a) Room and Board except when providing Psychiatric Residential Treatment Services for children and adolescents reimbursed under the Inpatient psychiatric Services for Individuals Under Age 21 section of the Code of Federal Regulations (42CFR440.160).

(b) Educational program services as defined by the Department of Education.

(c) Costs of services otherwise reimbursed as payment(s) in full through DMAP medical programs.

(d) Costs (including legal fees, accounting and administrative costs, travel costs, and costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment made as payment(s) in full has previously been made.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0060 – Payment

(1) The Division of Medical Assistance Programs or the Addictions and Mental Health Division will make payment in compliance with 42CFR 447.10. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Oregon Health Authority Electronic Data Interchange (EDI) rules, OAR 943-120-0100 through 943-120-0200. DMAP may require that payment for services be made only after review by DMAP.

(2) The Division sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the AMH maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) 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. The rates are updated periodically and posted on the Division's web site at <http://egov.oregon.gov/oha/mentalhealth/tools-providers.shtml>

(b) Provider rules may specify reimbursement rates for particular services or items. Provider specific rates are determined based on the Provider's allowable costs of providing the service.

(4) The Authority sets payment rates for out-of-state institutions and similar facilities, such as psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service.

(5) DMAP will not make payment on claims that have been assigned, sold, or otherwise transferred or when the Billing Provider, Billing Agent or Billing Service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a Provider for accounts receivable.

(6) Payment for DMAP Clients with Medicare and Medicaid, excluding qualified Medicare beneficiary programs:

(a) DMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. DMAP payment cannot exceed the co-insurance and deductible amounts due;

(b) DMAP pays the DMAP allowable rate for DMAP covered services that are documented to be not covered by Medicare.

(7) For Clients with Third-Party Resources (TPR), DMAP pays the DMAP allowed rate less the TPR payment but not to exceed the billed amount.

(8) DMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For DMAP such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the DMAP allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain Payment Authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual Provider rules.

(9) The Division will reimburse providers consistent with all requirements in 42CFR447.45 Timely Claims Payment including but not limited to:

(a) The Division must pay 90 percent of all clean claims from Providers within 30 days of the date of receipt.

(b) The Division must pay 99 percent of all clean claims from Providers within 90 days of the date of receipt.

(c) The Division must pay all other claims within 12 months of the date of receipt except in various circumstances listed in 42CFR447.45(4).

(10) Payment by DMAP 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 the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0070 – Overpayment

(1) The Authority Identified. Notwithstanding OAR 410-120-1397 when the Authority determines an overpayment has been made to a Provider, the amount of overpayment is subject to recovery by the Authority. The overpayment amount will be determined at the Authority's discretion through direct examination of claims, through statistical sampling and extrapolation techniques or other means. Procedures for recovery of funds are as described in the Division of Medical Assistance Programs General Rules for the Division of Medical Assistance Programs (OAR 410-120-1505) or by applicable contract language.

(2) Provider identified. When a provider discovers that they requested and may have received reimbursement not in compliance with all applicable rules they must contact the Division's Medicaid Policy Unit and Office of Payment Accuracy and Recovery (OPAR) promptly to report the possible inappropriate payment and discuss the manner by which the appropriateness will be determined as well as programmatic changes and other notifications to be made.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0080 – Notice of Action Requirements of Providers

When a Provider (or authorized staff acting with authority to determine the Individual's needs) takes or intends to take any Action the Individual shall be mailed a written client Notice of Action in accordance with OAR 410-141-0263.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0090 – Administrative Hearing

A Division of Medical Assistance Programs (DMAP) Member or their representative that disagrees with a Notice of Action may request a DMAP Administrative Hearing consistent with OAR 410-120-1865 Denial, Reduction or Termination of Services.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0100 – Provider Appeals

Providers have the right to file an appeal consistent with Oregon Administrative Rule 410-120-1560 Provider Appeals, 410-120-1570 Claims Re-determinations, 410-120-1580 Provider Appeals — Administrative Review and 410-120-1600 Provider Appeals — Contested Case Hearings.

Stat. Auth.: ORS 413.042 & 430.640

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

Rehabilitative Mental Health Services Program

410-172-0110 – Program

Conditions of Provider Participation. Provider shall meet the following requirements:

- (1) Possess the appropriate current and valid License, Letter of Approval and/or Certificate of Approval issued by the Division for the mental health and addictions services provided.
- (2) Develop a Cost Allocation Plan to support the Provider's Usual and Customary Charge
- (3) Provide services in accordance with the Civil Rights Act of 1964, the Americans with Disabilities Act and any other state and federal laws and regulations listed in the contract with the Division.
- (4) Participate in the claim review process outlined in OAR 410-120-1397

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0120 – Individual Provider Enrollment

Providers shall meet all requirements in Oregon Administrative Rule 410-120-1260 Medical Assistance Programs Provider Enrollment and 943-120-0310 Provider Requirements and 943-120-0320 Provider Enrollment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0130 – Sanctions

Sanctions will be imposed on Providers when necessary in accordance with Oregon Administrative Rule 410-120-1400 through 410-120-1460 Medical Assistance Programs Provider Sanctions and Types and Conditions of Sanction

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0140 – Prior Authorization

Authorization of Payment.

(1) Some of the services or items covered by the Division require authorization before payment will be made. Some services require authorization before the service can be provided. Services requiring prior authorization can be found on the Mental Health Procedure Codes and Reimbursement Rates Table located at <http://egov.oregon.gov/oha/mentalhealth/tools-providers.shtml>. The procedure for receiving authorization is detailed in the Provider Manual found on the same website.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in the appropriate Provider rules.

(3) The Division will authorize for the level of care or type of service that meets the Individual's medical need. Only services which are Medically Appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the Provider to determine medical appropriateness or appropriateness of the service.

(4) The Division and its authorizing agencies are not required to authorize services or to make payment for authorized services under the following circumstances:

(a) The individual was not eligible for Medicaid at the time services were provided. The provider is responsible for checking the individual's eligibility each time services are provided;

(b) The Provider does not hold a valid Certificate of Approval from the Division for the service;

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

(d) The service has not been adequately documented (see 309-016-0610); that is, the documentation in the Provider's files is not adequate to determine the type, medical appropriateness, or frequency and duration of services provided and required documentation is not in the Provider's files;

(e) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(f) The services billed are not consistent with those provided;

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(g) The services were not provided within the timeframe specified on the authorization of payment document;

(h) The services were not authorized or provided in compliance with these rules, the General Rules and in the appropriate Provider rules.

(i) The provider was not eligible to receive reimbursement from Medicaid at the time the service was rendered.

(j) The individual's needs can be better met through another system of care, such as Aging and People with Disabilities; the individual is eligible for services under that system of care; the individual has been given notice of that eligibility; and the services necessary to support a successful transition to the alternate system of care have been provided.

(5) Payment made for services described in subsections (a)–(h) of this rule will be recovered (see also Basis for Mandatory Sanctions and Basis for Discretionary Sanctions).

(6) Retroactive Eligibility:

(a) In those instances when Individuals are made retroactively eligible, authorization for payment may be given if:

(A) The Individual was eligible on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules, and;

(C) The request for authorization is received by the Division within 90 days of the date of service;

(b) Services provided when a Medicaid-eligible Individual is retroactively dis-enrolled from a Prepaid Health Plan (PHP) or services provided after the Individual was dis-enrolled from a PHP may be authorized if:

(A) The Individual was eligible on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules; and

(C) The request for authorization is received by the Division within 90 days of the date of service;

(c) 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) The Division will process requests for prior authorization that do not require additional information from the provider or third party consistent with timeliness of payments for clean claims described in 42CFR447.45 and included in 309-016-0630(9).

(8) Prior Authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Individual's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(9) Prior Authorization for Individuals with other insurance or for Medicare beneficiaries:

(a) When Medicare is the primary payer for a service, no Prior Authorization from the Division is required, unless specified in the appropriate program Provider rules;

(b) For Individuals who have private insurance or other Third Party Resources (TPRs), such as Blue Cross, Tri-Care, etc., the Division requires Prior Authorization as specified above and in the appropriate Provider rules when the other insurer or resource does not cover the service or when the other insurer reimburses less than the Division rate;

(c) For Individuals in a Medicare's Social Health Maintenance Organization (SHMO), the SHMO requires Payment Authorization for some services. the Division requires Prior Authorization for services which are covered by the Division but which are not covered under the SHMO as specified above and in the appropriate Provider rules.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0150 – Limitations

Published Payment Schedule.

(1) Payment will 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 payors. Payments to other specified Providers will be made according to other approved schedules:

(a) Limitations contained in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates 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. Providers will be notified of such changes in writing;

(b) Payment will be made for services listed in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule which are rendered to Medicaid-eligible Individuals by qualified staff meeting the definition of OAR 309-032-1520 during the period in which the Provider is enrolled in the Division of Medical Assistance Program.

(2) Reimbursement for specific services that are typically limited in frequency or when occurring on the same day as other services may be reimbursed for a special population of individuals who are at high-risk for long-term institutionalization and have been authorized by the Division for fee-for-service mental health rehabilitative services. Pending CMS approval, the following combination of services, when authorized prior to the service, billed with an HK modifier and when approved for a specific individual by the Division, will be reimbursed.

Procedure code — Additional Services Rendered on the Same Day of Service:

90805 — G0176, G0177, 90857, 90882.

90807 — G0176, G0177, 90857, 90882.

90809 — G0176, G0177, 90857, 90882.

90804 — G0176, G0177.

90806 — G0176, G0177.

90808 — G0176, G0177.

90846 — G0176, G0177, 90857, 90882.

90847 — G0176, G0177.

90853 — G0176, G0177, 90882.

90857 — G0176, G0177, 90882.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0160 – Variances

A variance from those portions of these rules that are not derived from federal regulations, Oregon’s Medicaid State Plan or the General Rules for Oregon Medical Assistance Programs may be granted to an applicant for a period of up to one year in the following manner:

(1) The applicant shall submit to the Division’s Medicaid Policy Unit a written request which includes:

- (a) The section(s) of the rule from which the variance is sought;
- (b) The reason for the proposed variance;
- (c) The alternative practice proposed; and
- (d) A plan and timetable for compliance with the section of the rule from which the variance is sought unless under the discretion of the Division the practice detailed in the variance will be ongoing to be renewed annually.

(2) The Division’s Director shall approve or deny the request for variance in writing.

(3) The Division’s Medicaid Policy Unit shall notify the Provider of the decision in writing within 30 days of receipt of the request.

(4) Appeal of the denial of a variance request shall be to the Director, whose decision shall be final.

(5) Variances may only be granted for up to one year. A Provider requesting a Variance to be continued beyond one year must re-apply.

Stat. Auth.: ORS 413.042 & 430.640

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

Personal Care

410-172-0170 – Individual Eligibility

(1) To be eligible for State Plan Personal Care services under these rules, a person must require assistance from a qualified provider due to a disabling mental health condition with one or more of the Personal Assistance Services identified in OAR 411-034-0020(2)(a)-(f). The qualified provider must be providing these services, paid by the Division in accordance with an authorized service plan.

(2) A person eligible for State Plan Personal Care services under these rules must be a current recipient of at least one of the following programs defined in OAR 461-101-0010:

- (a) Extended Medical (EXT);
- (b) Medical Assistance Assumed (MAA);
- (c) Medical Assistance to Families (MAF);
- (d) Oregon Health Plan (OHP);
- (e) Oregon Supplemental Income Program Medical (OSIPM);
- (f) Temporary Assistance to Needy Families (TANF); or
- (g) Refugee Assistance (REF).

(3) State Plan Personal Care services are not available for individuals in a prison, hospital, sub-acute care facility, nursing facility or other medical institution.

(4) The Division or its designee has the authority to close the eligibility and authorization for State Plan Personal Care services if an individual fails to employ a qualified provider or to receive Personal Assistance Services from a qualified provider paid by the Division for thirty continuous calendar days or longer.

(5) Individuals served under the Medicaid 1915(c) Home and Community-Based Services waiver for the aged and physically disabled, or the 1115(c) Independent Choices waiver, are not eligible to receive State Plan Personal Care services.

(6) Individuals receiving medical and long-term care services through the Program of All-inclusive Care for the Elderly (PACE), as described in OAR chapter 411, division 045, must not also receive State Plan Personal Care services under these rules.

Stat. Auth.: ORS 413.042 & 430.640

Behavior Health Services Rules

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

410-172-0180 – Covered Services

Specific personal care services must be prescribed by a physician or licensed practitioner of the healing arts in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State or designee. The services are provided by an individual who is qualified to provide such services and who is not a legally responsible relative of the Individual. The services may be furnished in a home or other allowable location.

(1) Personal Care tasks include:

(a) Basic personal hygiene — providing or assisting with:

(A) Bathing (tub, bed bath, shower);

(B) Shampoo, hair grooming;

(C) Shaving;

(D) Nail care — hands;

(E) Nail care — feet;

(F) Foot care;

(G) Dressing; and

(H) Skin care — application of emollients if approved by physician, repositioning (see 5b).

(b) Bowel and bladder care:

(A) Assisting on and off toilet, commode or bedpan, diapering;

(B) External cleansing of perineal area;

(C) External cleansing of Foley catheter — after demonstrating technique to RN;

(D) Emptying catheter drainage bag — after demonstrating technique to RN;

(E) Changing colostomy or ileostomy bag for individual with stabilized condition;

(F) Encouraging adequate fluid intake; and

(G) Maintenance bowel care;

Behavior Health Services Rules

(c) Assisting individual to take medications:

- (A) Open and properly reseal medication containers if individual unable to do so;
- (B) Observe to assure individual taking medication as ordered by physician;
- (C) Remind appropriate person when prescription refill needed; and
- (D) Administration of stabilized, maintenance medication(s).

(d) Assist oxygen:

- (A) Maintain clean equipment; and
- (B) Assist with maintaining adequate supply.

(e) Assist with mobility, transfers and comfort:

- (A) Assist with ambulation with or without aids. Assure repositioning every two hours or more often for bedridden or wheelchair-using individuals
- (B) Encourage active range-of-motion exercises when indicated;
- (C) Assist with passive range-of-motion exercise if ordered by physician and RN has observed and approved technique; and
- (D) Assist with transfers with or without mechanical devices.

(f) Nutrition:

- (A) Prepare nutritional meals;
- (B) Plan and prepare special diets as ordered by physician;
- (C) Assure adequate fluid intake; and
- (D) Feed if necessary.

(g) Care of disoriented, mentally or physically disabled individual:

- (A) Assure maximum safety of individuals; and
- (B) Provide or assist with approved activities.

(h) First aid and handling of emergencies;

(A) Discussed and approved at time of first visit; and

(B) Maintain and prioritize emergency notification system.

(i) Perform housekeeping tasks necessary to maintain a healthy and safe environment for the individual.

(j) Arrange and assist individual to and from necessary appointments.

(k) Observation of individual status and reporting of any significant changes to the appropriate case manager or other person as designated by the care plan.

(l) Tasks delegated by a nurse (reference nurse delegation act.

(2) Providers of personal care services must document the services provided in a manner consistent with the Integrated Services and Supports Rule (OAR 309-032-1525 through 309-032-1535).

Stat. Auth.: ORS 413.042 & 430.640

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

20hr Personal Care Program

410-172-0190 – Qualified Provider

(1) A qualified provider is a person who, in the judgment of the Division or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized.

(2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 943, division 007.

(3) A qualified provider paid by the Division must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative consistent with 42 CFR 440.167.

(4) A qualified provider must be authorized to work in the United States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules.

(5) A qualified provider must be enrolled as a PCA with an individual provider number

(6) Criminal History Re-checks:

(a) Criminal history re-checks may be conducted at the discretion of the Division or designee, in accordance with OAR chapter 943, division 007 and will be conducting at least every two years.

(b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Division.

(c) The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated.

(7) Provider must not be included on any US Office of Inspector General Exclusion lists

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0200 – Personal Care Attendant Enrollment Standards

The Division, Division or designee may deny or terminate a Personal Care Attendant's provider enrollment and provider number if the Personal Care Attendant:

- (1) Has been appointed the legal guardian of the individual;
- (2) Is denied as the result of a weighing test performed as part of the criminal history check process described in OAR chapter 943, division 007;
- (3) Lacks the skills, knowledge, or ability to adequately or safely perform the required work;
- (4) Violates protective service and abuse rules in OAR chapter 411, division 020, or OAR chapter 413, division 015 or OAR chapter 943, division 045;
- (5) Commits fiscal improprieties;
- (6) Fails to provide the authorized services required by the eligible individual;
- (7) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by the individual;
- (8) Has been intoxicated by alcohol or drugs while providing authorized services to the individual or while in the individual's home;
- (9) Has manufactured or distributed drugs while providing authorized services to the individual or while in the individual's home; or
- (10) 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.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0210 – Employment Relationship

(1) The relationship between the eligible individual and his or her Personal Care Attendant is that of employer and employee.

(a) The eligible individual carries primary responsibility for locating, interviewing, screening, hiring, scheduling work periods, training and terminating his or her own employees. The individual is also responsible for tracking and confirming the service hours worked by his or her employee.

(b) The eligible individual exercises control as the employer and directs the employee in the provision of the services.

(c) The Division or designee determines whether the employee meets the minimum qualifications to provide the services authorized by the Division and makes direct service payment(s) to the provider on behalf of the individual.

(2) In order to receive State Plan Personal Care services from a Personal Care Attendant, the individual must be able to:

(a) Meet the employer responsibilities described in section (1)(a) of this rule; or

(b) Designate a natural support as the individual's representative to meet these employer responsibilities.

(3) Termination and the grounds for termination of employment are determined by the employer. Eligible individuals have the right to terminate their employment relationships with their providers at any time and for any reason. It is the responsibility of the employer to establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal and any requirements for the employee to provide advance notice before resigning.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0220 – Mandatory Reporting

All reporting requirements mandated under ORS 430.735 through ORS 430.768 must be followed.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0230 – Service Entry

(1) Mental Health Provider Responsibilities:

(a) Assessment and Re-Assessment:

(A) The provider or designated person will meet in person with the individual to assess the individual's ability to perform the tasks listed in OAR 309-016-0705.

(B) The individual's natural support persons may participate in the assessment if requested by the individual.

(C) The Mental Health Provider will assess the individual's service needs, identify the resources meeting any, some or all of the person's needs, and determine if the individual is currently eligible for Personal Care services.

(D) The Mental Health Provider will meet with the individual in person at least once every 365 days to review the individual's service needs.

(E) The assessment must be approved by a practitioner recognized by the Division as a Qualified Mental Health Professional.

(b) Service Planning:

(A) The Mental Health Provider will prepare a service plan identifying those tasks for which the individual requires assistance and the monthly number of approved hours of service. Not to exceed 20 hours per Individual per month.

(B) The service plan will describe the tasks to be performed by the qualified provider and will approve the maximum monthly hours that can be reimbursed for those services.

(C) When developing service plans, Mental Health Providers will consider the cost effectiveness of services that adequately meet the individual's service needs.

(D) The service plan must be approved by a practitioner recognized by the Division as a Qualified Mental Health Professional.

(E) Payment for State Plan Personal Care services must be approved by the Mental Health Provider and submitted to the Division based on the service needs of the individual as documented in the written service plan.

(c) Ongoing Monitoring and Approval:

(A) When there is an indication that the individual's Personal Assistance Service needs have changed, the Mental Health Provider will conduct a re-assessment in person with the individual (and any natural supports if requested by the individual).

(B) Following annual re-assessments and those conducted after a change in Personal Assistance Service needs, the Mental Health Provider will review service eligibility, the cost effectiveness of the service plan and whether the services provided are meeting the identified service needs of the individual. The Mental Health Provider may adjust the hours or services in the plan and will approve a new service plan, if appropriate, based on the individual's current service needs. The Mental Health Provider will then submit the adjusted service plan to the Division.

(d) Ongoing Case Management: The Mental Health Provider will provide ongoing coordination of Personal Care services, including approving changes in service providers and service hours, addressing risks, and providing information and referral to the individual when indicated.

Stat. Auth.: ORS 413.042 & 430.640

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

Facility Based Personal Care Program

410-172-0240 – Service Entry

(1) Program Provider Responsibilities:

(a) Assessment and Re-Assessment:

(A) Program staff will meet in person with the individual to assess the individual's ability to perform the tasks listed in OAR 309-016-0695.

(B) The individual's natural support persons may participate in the assessment if requested by the individual.

(C) Program staff will assess the individual's service needs, identify the resources meeting any, some or all of the person's needs, and determine if the individual is currently eligible for Personal Care services.

(D) Program staff will meet with the individual in person at least once every 365 days to review the individual's service needs.

(b) Service Planning:

(A) The program staff will prepare a Plan of Care identifying those tasks for which the individual requires assistance and the monthly number of requested hours of service.

(B) The Plan of Care will describe the tasks to be performed by the Program staff and will request a maximum monthly number of hours of service.

(C) When developing Plans of Care, Program staff will consider the cost effectiveness of services that adequately meet the individual's service needs.

(D) Payment for Personal Care services must be prior authorized by the Division based on the service needs of the individual as documented in the written Plan of Care.

(c) Ongoing Monitoring and Approval:

(A) When there is an indication that the individual's Personal Assistance Service needs have changed, the provider will conduct a re-assessment in person with the individual (and any natural supports if requested by the individual).

(B) Following annual re-assessments and those conducted after a change in Personal Assistance Service needs, the Provider will review service eligibility, the cost effectiveness of the Plan of Care and whether the services provided are meeting the identified service needs of the individual. The Provider may adjust

the hours or services in the plan and will submit a new Plan of Care, if appropriate, based on the individual's current service needs. The Provider will submit the adjusted Plan of Care to the Division.

(d) Ongoing Case Management: The Provider will provide ongoing coordination of Personal Care services, including changes in service hours, addressing risks, and providing information and referral to the individual when indicated.

Stat. Auth.: ORS 413.042 & 430.640

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

1915(i) State Plan Home and Community-Based Services (HCBS)

410-172-0250 - Program

The provider shall meet the following requirements:

- (1) Possess the appropriate current and valid license, Letter of Approval and/or Certificate of Approval issued by the Division for the mental health and addictions services provided, when required by rule;
- (2) Provide services in accordance with the Civil Rights Act of 1964, the Americans with Disabilities Act and any other state and federal laws and regulations listed in the contract with the Division;
- (3) Participate in the claim review process outlined in OAR 410-120-1397;
- (4) Providers offering mental health rehabilitative services under this program must meet requirements for providers identified in OAR 309-016-0660; and
- (5) Providers must be enrolled with the Division of Medicaid Assistance Programs (DMAP) as a mental health provider. Providers shall meet all requirements in OAR 410-120-1260, Medical Assistance Programs Provider Enrollment; OAR 407-120-0310, Provider Requirements; and OAR 407-120-0320, Provider Enrollment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0260 – Individual Eligibility

Individual eligibility for services under the 1915(i) State Plan HCBS will be determined by meeting the following requirements:

- (1) Financial eligibility under the State’s Medicaid State plan with an income that does not exceed 150 percent of the Federal Poverty level;
- (2) A needs for daily assistance of at least one hour per day to perform at least two Personal Care Services as identified in OAR 309-016-0695 due to a disabling mental illness; and
- (3) Eligibility determined by an external quality review organization, as identified by the Division.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0270 – Service Prior Authorizations

(1) Eligibility for reimbursement through the 1915(i) State Plan Home and Community-Based Services Program requires authorization prior to the services as follows:

(a) For mental health rehabilitative services, as detailed in OAR 309-016-0675 and

(b) For personal care and habilitative services, as detailed in OAR 309-016-0725.

(2) Mental health rehabilitative services and facility-based personal care and habilitative services must be reauthorized every 180 days or whenever there is a change in services offered.

(3) Personal care and habilitative services must be reauthorized every 360 days or whenever there is a change in services provided.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0280 – Conditions of Service Provider Participation

Service provider must:

(1) Provide psychiatric residential treatment services to children eligible for Medicaid benefits under the terms of a written agreement with the Division. The agreement must require that the psychiatric residential treatment facility and the services provided comply with all applicable state and federal requirements.

(2) Support and protect the fundamental human, civil, constitutional, and statutory rights of each child.

(3) Be accredited as a psychiatric residential treatment facility for children under age 21 by JCAHO, CARF, COA, or any other accrediting organization, with comparable standards, that is recognized by the State; be licensed by CAF; hold a Certificate of Approval per OAR 309-012-0130 through 309-012-0220 from the Division and be in compliance with the treatment services standards described in the ISSR.

(4) Provide a program consistent with standards set by JCAHO, CARF, COA, or any other accrediting organization, with comparable standards, that is recognized by the State.

(5) Provide a physical facility suitable for treatment of children with attention to proper safety and sanitation, housekeeping, and general environment. Buildings shall comply with all applicable building, occupancy, electrical, plumbing, and zoning codes.

(6) Obtain certification for the admission of children to the psychiatric residential treatment facility following the Division's Certification of Need procedures.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0290 – Eligibility and Admission Policy

(1) In considering a child for admission for psychiatric residential treatment services, Certification of Need procedures will certify that:

(a) Other treatment resources available in the community do not meet the treatment needs of the child;

(b) Proper treatment of the child's psychiatric condition requires services on a psychiatric residential treatment basis under the direction of licensed medical practitioner;

(c) The services can reasonably be expected to improve the child's condition or prevent further regression so that psychiatric residential treatment services may no longer be needed; and

(d) The child has a principal diagnosis on Axis I of a completed 5-Axes DSM diagnosis that is not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism.

(2) The child must be eligible for medical assistance under Medicaid, according to procedures established by the Division, and meet the criteria for admission to psychiatric residential treatment services as defined by these rules.

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

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0300 – Admission Procedures Related to Payment

(1) Admission procedures for children eligible for Medicaid will 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 will make available for the Certificate of Need (CONS) process, the following information about the referred child:

(a) Letter of support for admission from the identified county of responsibility or qualified tribal representative;

(b) Level of Need Determination screening outcome;

(c) Child and Adolescent Service intensity instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII);

(d) Identified Intensive Community Treatment and Support (ICTS) provider;

(e) ICTS care coordinator;

(f) Child and family team members, and

(g) Copies of related available clinical documents such as updated mental health assessments, individual plan of care and service coordination plans.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0310 – Service Criteria

Children shall be served in the least restrictive, least intensive setting based on their treatment history, degree of impairment, current symptoms and the extent of family and other supports. The provider must recommend the appropriate level of care to the child and parent or guardian when a more restrictive or less restrictive level of care is determined to be medically necessary.

(1) The following criteria are used to determine the appropriateness of continued stay:

(a) The child is making observed progress toward identified treatment goals as documented in the individual plan of care, but the measurable treatment objectives necessary to reach the goals have not been completed;

(b) The child made no documented progress toward treatment goals, but the individual plan of care and measurable objectives necessary to reach the goals have been reviewed by the LMP and modified in order to reevaluate the child's treatment needs, clarify the nature of the identified problems, and/or initiate new therapeutic interventions; or

(c) The child exhibits new symptoms or maladaptive behaviors that justify continuation and can be safely and effectively treated at a community-based residential level of care. The individual service and support plan has been revised accordingly.

(2) A planned transfer will occur when the following criteria are met:

(a) The child's targeted symptoms and maladaptive behaviors have abated to an established baseline level as documented by the attainment of specific goals and measureable objectives in the individual plan of care; or

(b) The child exhibits new symptoms and maladaptive behaviors which may not be safely or effectively treated at this level of care; or

(c) The child is not benefiting from treatment and made no progress toward specific treatment goals or measurable objectives even though appropriate individual service and support plan reviews and revisions were conducted.

(3) Planned transfer will be consistent with the transfer criteria established by the interdisciplinary team and documented in the ISSP. In addition:

(a) Providers will not transfer an individual unless the interdisciplinary team, in consultation with the child's parent or guardian and the next provider, agree that the child requires a more or less restrictive level of care; and

(b) If the determination is made to admit the child to acute care, the provider will not conclude services during the acute care stay unless the interdisciplinary team, in consultation with the child's parent or guardian and the next provider, agree that the child requires a more or less restrictive level of care following the acute care stay.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0320 – Payments

(1) Payments will be made for the provision of active psychiatric residential treatment services, including approved leave for children eligible for such services under Medicaid. If active treatment is not documented during any period in which Division payments are made on behalf of a child, the Division may recoup such payments.

(2) The Division will pay for the day of admission but not for the day of transfer or discharge.

(3) Medicaid eligible children receiving psychiatric residential treatment services will be subject to periodic review by an interdisciplinary team to determine medical appropriateness and quality of services. If a review reveals that a child received an inappropriate level of care, i.e., less than active treatment, payment will not be allowed under these rules.

(4) Payment for planned absences from the program such as home care visits, and transitions shall be allowed if the absences are:

(a) Based on the individual clinical needs of the child; and

(b) Specified in the child's Individual Service and Support Plan's measurable objectives and/or transfer plan; and

(c) Documented in individual service notes; and

(d) The duration of any single planned absence is no more than three consecutive days, unless a longer duration is authorized in writing by the Division.

(5) Payment for unplanned absences from the program such as runaway, hospitalization, and detention (check on eligibility) shall be allowed if;

(a) The provider clearly documents in the child's individual service record regular and ongoing service coordination efforts undertaken by the program during the unplanned absence; and

(b) The provider clearly documents in the child's individual service record that the child will be returned to the program when the unplanned absence is resolved; and

(c) The duration of any single unplanned absence is no more than seven consecutive days, unless longer duration is authorized in writing by the Division.

(6) Payment for unplanned absences from the program shall be disallowed if the child is not returned to the program, unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or provider of the next level of care determines that the child requires a more or less restrictive level of care.

(7) Planned absences from the program which are not indicated in the child's Individual Services and Supports Plan and/or transfer plan shall be considered unplanned absences and payment will be disallowed.

(8) Payments for planned absences must be made consistent with 42CFR447.40.

Stat. Auth.: ORS 413.042 & 430.640

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

Children's Sub-Acute Psychiatric Care

410-172-0330 – Conditions of Service Provider Participation

(1) Provider shall meet all requirements for Medicaid payment in general and specifically for PRTS providers as stated in OAR 309-016-0730 through 309-016-0750.

(2) The admitting physician must have authorized the admission and that authorization is evident in record.

(3) Children's Sub-Acute Psychiatric Care services must be provided consistent with the general standards outlined above (OAR 309-016-0605 through 309-016-0650) and the Rehabilitative mental Health Services requirements outlined above (OAR 309-016-0660 through 309-016-0685).

(4) The cost of Room and Board is not an allowable cost of Children's Sub-Acute Psychiatric Care services.

Stat. Auth.: ORS 413.042 & 430.640

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

**Alcohol and Drug Residential Treatment Services Program
410-172-0340 – Conditions of Service Provider Participation**

The provider shall meet the following requirements:

- (1) Possess the appropriate current and valid License, Letter of Approval and/or Certificate of Approval issued by the Division provided as outlined in OAR 415-012-0020;
- (2) Develop a Cost Allocation Plan to support the Provider's Usual and Customary Charge. Usual and customary charge is defined in OAR 410-120-0000;
- (3) Provide services in accordance with the Civil Rights Act of 1964, the Americans with Disabilities Act and any other state and federal laws and regulations listed in the contract with the Division;
- (4) Participate in the claim review process outlined in OAR 410-120-1397; and
- (5) Possess a contract with the Division to provide Alcohol and Drug Residential Treatment to Medicaid eligible individuals or be a subcontractor of an AMH Alcohol and Drug Residential treatment contractor.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0350 – Individual Provider Enrollment

Providers shall meet all requirements in OAR410-120-1260, Medical Assistance Programs Provider Enrollment, 407-120-0310 Provider Requirements and 407-120-0320, Provider Enrollment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0360 – Payment

(1) Payments will be made for the provision of active A&D residential treatment services, including approved leave for individuals for such services under Medicaid. If active treatment is not documented during any period in which Division payments are made on behalf of the individual, the Division may recoup such payments.

(2) Payment for planned absences from the program such as hospitalizations, home visits, and transitions shall be allowed if the absences are:

(a) Based on the individual clinical needs; and

(b) Specified in the Individual Service and Support Plan's measurable objectives and/or transfer plan; and;

(c) The provider clearly documents in the individual service record ongoing daily treatment service provided by the program during the absence; and

(d) The bed is not filled by any other individual during the absence; and

(e) The duration of any single planned absence is no more than seven consecutive days, unless a longer duration is authorized in writing by the Division

(3) Payment for unplanned absences from the program such as hospitalizations and incarceration (check Medicaid eligibility) shall be allowed if;

(a) The provider clearly documents in the individual service record ongoing daily treatment service provided by the program during the unplanned absence; and

(b) The provider clearly documents in the individual service record that the individual will be returned to the program when the unplanned absence is resolved and the bed is not filled by any other individual during the absence; and

(c) The duration of any single unplanned absence is no more than three consecutive days, unless longer duration is authorized in writing by the Division.

(4) Payment for a reserved bed is not covered under Medicaid consistent with 42 CFR 447.40

(5) Room and Board is not covered under Medicaid

(6) Payment will be made for each daily unit of service billed, reimbursed at the contracted per diem rate. A daily unit of service is defined in OAR 309-016-0750(2).

Stat. Auth.: ORS 413.042 & 430.640

Behavior Health Services Rules

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

410-172-0370 – Sanctions

Sanctions will be imposed on Providers when necessary in accordance with OAR 410-120-1400 through 410-120-1460 Medical Assistance Programs Provider Sanctions and Types and Conditions of Sanction.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0380 – Individual Eligibility

To be eligible for Alcohol and Drug Residential Treatment service under these rules the individual must be a current Medicaid recipient of at least one of the following programs defined in OAR 461-101-0010:

- (1) Extended Medical (EXT);
- (2) Medical Assistance Assumed (MAA);
- (3) Medical Assistance to Families (MAF);
- (4) Oregon Health Plan (OHP), OHP means OHP-CHP, OHP-OPC, OHP-OPP, OHP-OPU and OHP-OP6;
- (5) General Assistance Medical (GAM);
- (6) Oregon Supplemental Income Program Medical (OSIPM);
- (7) Medical Coverage for Children in Substitute or Adoptive Care (SAC);
- (8) Healthy Kids Connect (HKC); or
- (9) Continuous Eligibility (CEC).

Stat. Auth.: ORS 411.060, 411.404, 411.706, 411.816, 412.014, 412.049, 414.025, 414.231

Stats. Implemented: ORS 411.060, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 414.025, 414.231, 414.826, 414.831, 414.839

410-172-0390 – Conditions of Service Provider Participation

Provider shall meet the following requirements:

- (1) Possess the appropriate current and valid License, Letter of Approval and/or Certificate of Approval issued by the Division provided as outlined in OAR 415-012-0000 to 415-012-0090;
- (2) Develop a Cost Allocation Plan to support the Provider's Usual and Customary Charge. Usual and customary charge is defined in OAR 410-120-0000;
- (3) Provide services in accordance with the Civil Rights Act of 1964, the Americans with Disabilities Act and any other state and federal laws and regulations listed in the contract with the Division;
- (4) Participate in the claim review process outlined in OAR 410-120-1397; and
- (5) Center to be in compliance with 415-050-0000 to 415-050-0095.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0400 – Provider Enrollment

Providers shall meet all requirements in OAR 410-120-1260, Medical Assistance Programs Provider Enrollment, OAR 407-120-0310 Provider Requirements, and 407-120-0320 Provider Enrollment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0410 – Payment

(1) DMAP or the Division will make payment in compliance with 42 CFR 447.10. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Oregon Health Authority Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. DMAP may require that payment for services be made only after review by DMAP.

(2) The Division sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the AMH maximum allowable amount or the reimbursement specified in the individual program Provider rules: 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. The rates are updated periodically and posted on the Division's web site

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 414.725 & 414.737, 430.640, 430.705 & 430.715

Behavior Health Services Rules

410-172-0420 – Sanctions

Sanctions will be imposed on Providers when necessary in accordance with OAR 410-120-1400 through 410-120-1460 Medical Assistance Programs Provider Sanctions and Types and Conditions of Sanction

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0430 – Individual Eligibility

(1) To be eligible for Detoxification Treatment services under these rules the individual must be a current Medicaid recipient.

(2) Providers are responsible to verify an individual is a Medicaid recipient as outlined in OAR 410-120-1140

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025 & 414.047

Substance Use Disorder Detoxification Treatment Centers

410-172-0440 – Supported Employment (SE) Overview

(1) Supported Employment is an evidence-based practice for individuals with serious mental illness.

(2) Supported Employment is characterized by:

- (a) Emphasis on competitive employment;
- (b) Every person who is interested in work is eligible for services regardless of symptoms, substance use disorders, treatment decisions, or any other issue;
- (c) Employment services are integrated with mental health treatment;
- (d) Individuals have access to personalized benefits planning;
- (e) Job search begins soon after a person expresses interest in working; and
- (f) Client preferences for jobs, and preferences for service delivery, are honored.

(3) Supported Employment services include, but are not limited to:

- (a) Job development;
- (b) Supervision and job training;
- (c) On-the-job visitation;
- (d) Consultation with the employer;
- (e) Job coaching;
- (f) Counseling;
- (g) Skills training; and/or
- (h) Transportation.

Stat. Auth.: ORS 414.032, 414.615, 414.625 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

410-172-0450

Supported Employment Providers

(1) To be eligible for Medicaid reimbursement, SE services must be provided by a Qualified SE Provider.

(2) To become a Qualified SE Provider, an agency must provide the evidence-based practice of Individual Placement and Support Supported Employment (IPS SE), and submit a copy to AMH of a fidelity review conducted by a Fidelity Reviewer approved by AMH, which resulted in a score of 100 or better.

(3) Providers implementing IPS SE may become a Provisionally Qualified SE Provider by submitting a request to AMH with a letter of support which indicates receipt of technical assistance and training from an AMH approved IPS SE Trainer. Medicaid reimbursements to a Provisionally Qualified SE Provider end after 12 months. This option is intended only for providers initiating supported employment services.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0460 – Supported Employment Fidelity Requirements

(1) In order to maintain designation as a Qualified SE Provider, a provider must submit to AMH an annual fidelity review report, conducted by an AMH approved reviewer, which indicates a minimum score of 100.

(2) Qualified SE Providers achieving a fidelity score of 115 or higher are eligible to extend their review period to every 18 months.

(3) Fidelity reviews will be conducted utilizing the most current Dartmouth College IPS Fidelity Scale available at www.oregon.gov/oha/amh.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0470 – Failure to Meet Fidelity Standards

If a Qualified SE Provider does not receive a minimum score of 100 on a fidelity review, the following shall occur:

- (1) Technical assistance shall be made available for a period of 90-days to address problem areas identified in the fidelity review.
- (2) At the end of the 90-day period, a follow-up review will be conducted by an AMH approved reviewer.
- (c) The provider shall forward a copy of the amended fidelity review report to AMH.
- (3) If the 90-day re-review results in a score of less than 100, the agency's designation as a Qualified SE 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

410-172-0480 – Assertive Community Treatment (ACT) Overview

(1) ACT is an evidence-based practice for individuals with a serious mental illness.

(2) ACT is characterized by:

- (a) A team approach;
- (b) In vivo services;
- (c) A caseload of approximately 10:1;
- (d) Time-unlimited services;
- (e) Flexible service delivery;
- (f) A fixed point of responsibility; and
- (g) 24/7 crisis availability

(3) ACT services include, but are not limited to:

- (a) Hospital discharge planning;
- (b) Case management;
- (c) Symptom management;
- (d) Psychiatry services;
- (e) Nursing services;
- (f) Co-occurring substance use disorder services;
- (g) Vocational services;
- (h) Life skills training; and/or
- (i) Peer support services.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0490 – ACT Providers

(1) To be eligible for Medicaid reimbursement, ACT services must be provided by a Qualified ACT Provider.

(2) To become a Qualified ACT Provider, an agency must provide the evidence-based practice of ACT, 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 which indicates receipt of technical assistance and training from an AMH approved ACT Trainer. Provisional ability to receive Medicaid reimbursement will end after 12 months. This option is intended only for providers initiating ACT services.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0500 – ACT Fidelity Requirements

(1) In order to maintain designation as a Qualified ACT Provider, an agency must submit to AMH an annual fidelity review report by an AMH approved reviewer, with a minimum score of 114.

(2) Qualified Providers achieving a fidelity score of 128 or better are eligible to extend their review period to every 18 months.

(3) Fidelity reviews will be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, available at www.oregon.gov/oha/amh

(4) Providers approved by AMH to bill Medicaid for ACT services prior to January 1, 2013, will be deemed Qualified ACT Providers through July 1, 2014. In order to maintain their designation as a Qualified ACT Provider, these providers must submit to AMH, prior to July 1, 2014, a copy of a fidelity review conducted by an AMH approved ACT Fidelity Reviewer with a minimum score of 114.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0510 – Failure to Meet Fidelity Standards

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

- (1) Technical assistance shall be made available for a period of 90-days to address problem areas identified in the fidelity review.
- (2) At the end of the 90-day period, a follow-up review will be conducted by an AMH approved reviewer.
- (3) The provider shall forward a copy of the amended fidelity review report to AMH.
- (4) If the 90-day re-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