Oregon **Health** Authority

Retainer Payment Process for Providers

Prior Authorization process

Use the latest [Retainer Payment](#) and [Extension Request](#) forms. For Medicaid-eligible individuals, submit an MMIS Prior Authorization (PA) request using procedure code T2033. Include clinical documentation as outlined in Oregon Administrative Rule [410-142-0705(21)(c)](#). For all requests, clinical documentation must include:

- Hospital records (current hospitalization)
- Treatment plan
- Other clinical documentation to support request
- Last 60 days of progress notes

Request Type	Process
Initial request (30 days or less of leave)	Submit Retainer Payment request when member leaves the facility no later than two days after absence.
Extension request (30+ days of leave)	Submit Extension Request when you find out that the member will be gone longer than 30 days. Include the new date the facility expects the member to return to the facility. • Complete the Client Status portion of the Extension Retainer Payment form. • Attach to the approved MMIS PA.
Planned temporary absences for recurring treatment	Submit a Retainer Payment request in advance of the absence. • Include the need for the absence as outlined in the treatment plan (e.g., for Young Adults in Transition, the treatment plan includes short recurring stays to reunify with family).
Non-Medicaid individuals and non-Medicaid-covered services	Refer to Behavioral Health Contracts Invoicing Analyst: • Requests for non-Medicaid covered individuals seeking temporary absence for medical/clinical reasons • Requests for individuals seeking temporary absence for non-Medicaid-covered reasons, such as legal absence.
Denied requests	Medicaid Retainer Payment denials are **not** eligible for non-Medicaid funding requests.
Approved requests	Update and resubmit the approved PA with updated clinical notes: • Once the individual returns to the residential program, or • To report that the individual is not returning to the program, or • To request an extension if absence exceeds 30 days.

Billing

Submit claim in MMIS using procedure code T2033 at the home/facility's Tier 1 Rate (listed in the [Behavioral Health Fee Schedule](#)) for the approved dates of absence. The approved PA must contain an end date before you can bill MMIS.

Contacts

- Medicaid follow-up questions: FFS.BH@dhsoha.state.or.us
- Rate Review Committee: ABH.ResidentialCapacityReporting@dhsoha.state.or.us
- Non-Medicaid requests: ABH.ResidentialCapacityReporting@dhsoha.state.or.us

Retainer Payment Process

Provider	OHA

Clinical Utilization Management Reviewer (CUMR) reviews for required documentation.

Within two business days submits request with required documents:
- Retainer Payment Request Form (30 or less day of leave from facility) and clinical documentation of absence
- Extension Retainer Request Form (30+ days of leave from facility), clinical documentation justifying the extension, and estimated transition plan

If request is incomplete, contacts provider for missing documentation *OAR 410-172-0705(21)(c)*

If request is complete, CUMR:
- Conducts clinical review
- Refers non-Medicaid requests to the Invoicing Analyst

For Medicaid requests, CUMR approves, denies or withdraws MMIS PA request
- For approvals, update status to "Approved." Make an internal note of approval dates, revise internal note and place within the external note (this will go out to provider)

For non-Medicaid requests, Invoicing Analyst sends approval or denial and places comments in MMIS for provider records.

Receives denial or approval from OHA

If approved, bills for approved dates

If denied, corrects request to include required information

Resubmits request with updated information:
- Once member has returned to facility or
- If the member does not plan to return to facility

Initial Requests and Extension Requests