Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (OHA), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Sandy Cafourek	500 Summer St NE, Salem, OR 97301	(503) 945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Medicaid Payment for Behavioral Health Services

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

May 15, 2015	10:30 a.m.	500 Summer St. NE, Salem, OR 97301 Room 166	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT: OARs 410-172-0600, 410-172-0610, 410-172-0620, 410-172-0630, 410-172-0640, 410-172-0650, 410-172-0660, 410-172-0670, 410-172-0680, 410-172-0690, 410-172-0700, 410-172-0710, 410-172-0720, 410-172-0730, 410-172-0740, 410-172-0750, 410-172-0760, 410-172-0770, 410-172-0780, 410-172-0790, 410-172-0800, 410-172-0810, 410-172-0820, 410-172-0830, 410-172-0840, 410-172-0850

AMEND:

REPEAL: OARs 410-172-0000, 410-172-0010, 410-172-0020, 410-172-0030, 410-172-0040, 410-172-0050, 410-172-0060, 410-172-0070, 410-172-0080, 410-172-0090, 410-172-0100, 410-172-0110, 410-172-0120, 410-172-0130, 410-172-0130, 410-172-0140, 410-172-0150, 410-172-0160, 410-172-0170, 410-172-0180, 410-172-0190, 410-172-0200, 410-172-0210, 410-172-0220, 410-172-0230, 410-172-0240, 410-172-0250, 410-172-0260, 410-172-0270, 410-172-0280, 410-172-0290, 410-172-0300, 410-172-0310, 410-172-0320, 410-172-0330, 410-172-0340, 410-172-0350, 410-172-0360, 410-172-0370, 410-172-0380, 410-172-0390, 410-172-0400, 410-172-0410, 410-172-0420, 410-172-0430, 410-172-0440, 410-172-0450, 410-172-0460, 410-172-0470, 410-172-0480, 410-172-0490, 410-172-0500, 410-172-0510 and temporary OARs 410-172-0600(T), 410-172-0610(T), 410-172-0620(T), 410-172-0630(T), 410-172-0640(T), 410-172-0650(T), 410-172-0660(T), 410-172-0670(T), 410-172-0680(T), 410-172-0690(T), 410-172-0700(T), 410-172-0710(T), 410-172-0720(T), 410-172-0730(T), 410-172-0740(T), 410-172-0750(T), 410-172-0760(T), 410-172-0770(T), 410-172-0780(T), 410-172-0790(T), 410-172-0800(T), 410-172-0810(T), 410-172-0820(T), 410-172-0830(T), 410-172-0840(T), 410-172-0850(T)

RENUMBER:
AMEND & RENUMBER:

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

RULE SUMMARY

Rules describe the process for Medicaid providers to receive payment for providing behavioral health services to Oregon Medicaid recipients.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

May 18, 2015 by 5 p.m.	Send written comments to: dmap.rules@state.or.us
Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)	

D Sawitt	David Sawitt	12/23/2014
Signature	Printed name	Date

Note: Hearing Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin.*

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410

Agency and Division Administrative Rules Chapter Number

Medicaid Payment for Behavioral Health Services

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The adoption of OAR 410-172-0600, 410-172-0610, 410-172-0620, 410-172-0630, 410-172-0640, 410-172-0650, 410-172-0660, 410-172-0670, 410-172-0680, 410-172-0690, 410-172-0700, 410-172-0710, 410-172-0720, 410-172-0730, 410-172-0740, 410-172-0750, 410-172-0760, 410-172-0770, 410-172-0780, 410-172-0790, 410-172-0800, 410-172-0810, 410-172-0820, 410-172-0830, 410-172-0840, 410-172-0850 and the repeal of OARs 410-172-0000, 410-172-0010, 410-172-0020, 410-172-0030, 410-172-0040, 410-172-0050, 410-172-0060, 410-172-0070, 410-172-0080, 410-172-0090, 410-172-0100, 410-172-0110, 410-172-0120, 410-172-0130, 410-172-0130, 410-172-0140, 410-172-0150, 410-172-0160, 410-172-0170, 410-172-0180, 410-172-0190, 410-172-0200, 410-172-0210, 410-172-0220, 410-172-0230, 410-172-0240, 410-172-0250, 410-172-0260, 410-172-0270, 410-172-0280, 410-172-0290, 410-172-0300, 410-172-0310, 410-172-0320, 410-172-0330, 410-172-0340, 410-172-0350, 410-172-0360, 410-172-0370, 410-172-0380, 410-172-0390, 410-172-0400, 410-172-0410, 410-172-0420, 410-172-0430, 410-172-0440, 410-172-0450, 410-172-0460, 410-172-0470, 410-172-0480, 410-172-0490, 410-172-0500, 410-172-0510 and the repeal of temporary OARs 410-172-0600(T), 410-172-0610(T), 410-172-0620(T), 410-172-0630(T), 410-172-0640(T), 410-172-0650(T), 410-172-0660(T), 410-172-0670(T), 410-172-0680(T), 410-172-0690(T), 410-172-0700(T), 410-172-0710(T), 410-172-0720(T), 410-172-0730(T), 410-172-0740(T), 410-172-0750(T), 410-172-0760(T), 410-172-0770(T), 410-172-0780(T), 410-172-0790(T), 410-172-0800(T), 410-172-0810(T), 410-172-0820(T), 410-172-0830(T), 410-172-0840(T), 410-172-0850(T)

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

Need for the Rule(s): Medicaid payment for behavioral health services rule governs the Division payments for behavioral health services. Responsibility for administration of behavioral health services payments is transferred from the Addictions and Mental Health Division to the Division of Medical Assistance Programs. The current rule is outdated and does not include important rule requirements for behavioral health services programs. This rule incorporates changes to the requirements providers need to meet in order to receive reimbursement from Oregon Medicaid for behavioral health services.

Documents Relied Upon, and where they are available: The State Plan and Senate Bill 365
https://www.oregonlegislature.gov/bills_laws/Pages/ORS.aspx

Fiscal and Economic Impact: Update of current rule. No impact to mental health programs. The ABA fiscal impact is $7 to $14 million.

Statement of Cost of Compliance:
1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): This is a continuation of already existing rules and no impact on current providers, state agencies or local governments is expected.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
38 Community Mental Health Programs, 1700 enrolled Medicaid providers
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: No additional administrative burden is anticipated.
c. Equipment, supplies, labor and increased administration required for compliance: None anticipated.

How were small businesses involved in the development of this rule? Key informants who are Medicaid providers were consulted.
Administrative Rule Advisory Committee consulted?: Stakeholders consulted. RAC scheduled for April 2015. If not, why?:

D Simmitt DAVID SIMMITT 12/23/2014

Signature Printed name Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

DIVISION 172

MEDICAID PAYMENT FOR BEHAVIORAL HEALTH SERVICES

410-172-0600 **NEW RULES**

Acronyms and Definitions

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

(2) "Adult" means an individual 18 years of age or older or an emancipated minor. An individual with Medicaid eligibility who is in need of services specific to children, adolescents, or young adults in transition must be considered a child until age 21. Adults who are between the ages of 18 and 21 who are considered children for purposes of these rules must have all rights afforded to adults as specified in these rules.

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

(4) "ASAM PPC" means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care.

(5) "Authority" means the Oregon Health Authority.

(6) "Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services.

(7) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

(8) "Behavioral Health Services" means medically appropriate services rendered or made available to a recipient for treatment of a behavioral health or substance use disorders diagnosis.

(9) "Behavioral Health Assessment" means a determination by a Qualified Mental Health Professional (QMHP) of the recipient's need for behavioral health services. It involves collection and assessment of data pertinent to the individual's behavioral health history and current behavioral health status obtained through interview, observation, testing, and reviews of previous treatment records. It concludes with determination of a DSM diagnosis or other justification for behavioral health services.

(10) "Billing Provider (BP)" means an individual , agent, business, corporation, clinic, group, or other entity who submits claims to or receives payment from the Division on behalf of a

rendering provider and has been delegated the authority to act on behalf of the rendering provider.

(11) "Certificate" means the document awarded by the Authority's AMH division signifying that a specific, named organization is judged by AMH to operate in compliance with applicable rules.

(12) "Child" or "Children" means an individual 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 is considered a child until age 21.

(13) "Clinical Nurse Specialist" means a registered nurse approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

(14) "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.

(15) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for individuals with behavioral health or substance use disorder conditions, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(16) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-0000.

(17) "Current Procedural Terminology (CPT)" means the physicians' CPT, which is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(18) "Date of Service" means the date on which the recipient receives medical services or items, unless otherwise specified in the appropriate provider rules.

(19) "Division" means the Division of Medical Assistance Programs of the Oregon Health Authority.

(20) "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.

(21) "Flexible Service" means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the behavioral health condition or substance use disorder condition as documented in the recipient's clinical record.

(22) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of:

(a) Level I — American Medical Association's Physician's Current Procedural Terminology (CPT);

(b) Level II — National codes.

(23) "Health Evidence Review Commission (HERC) means a commission that develops and maintains a list of health services ranked by priority from the most to the least important, representing the comparative benefits of each service to the population served; develops, identifies, and disseminates evidence-based health care guidelines for use by providers, consumers, and purchasers of health care in Oregon; and conducts comparative effectiveness research of health technologies.

(24) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.

(25) "JCAHO (Joint Commission: Accreditation, Health Care, Certification)" means the commission that 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."

(26) "Letter" means the document awarded to providers by AMH indicating the provider has complied with specific program requirements or administrative rule.

(27) "Level of Care" means the type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.

(28) "Level of Care Determination" means the standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.

(29) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(30) "Mental Health Intern" means an individual who meets qualifications for QMHA but does not have the necessary graduate degree in psychology, social work, or in a behavioral science field to meet the educational requirement of QMHP. The individual must:

(a) Be currently enrolled in a graduate program for a master's degree in psychology, social work, or in a behavioral science field;

(b) Have a collaborative educational agreement with the CMHP or other provider and the graduate program;

(c) Work within the scope of practice and competencies identified by the policies and procedures for credentialing of clinical staff as established by the provider; and

(d) Receive, at minimum, weekly supervision by a qualified clinical supervisor employed by the provider of services.

(31) "Natural Support" means resources and supports including, but not limited to, relatives, friends, significant others, neighbors, roommates, or the community who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support." The natural support must have the skills, knowledge, and ability to provide the needed services and supports.

(32) "Non-Paid Provider" means a provider employed by an enrolled entity who is able to order, refer, or prescribe services for an OHP recipient. These providers must comply with the federal database checks requirements listed in 42 CFR 455.436, which requires Division provider enrollment.

(33) "Nursing Services" means health care services provided to the recipient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.

(35) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.

(36) "OLRO" means the Office of Licensing and Regulatory Oversight (OLRO) of the Department of Human Services responsible for the licensing, regulatory and corrective action functions for Developmentally Disabled (DD), Adults and People with Disabilities (APD), and Child Welfare (CW) providers living in community settings including adult foster homes, assisted living facilities, residential care facilities, nursing homes, supportive living and employment programs for people with DD, and private child care agency licensing.

(37) "Paid Provider" means a provider who meets the requirements in this rule for enrollment, billing, and payment.

(38) "Peer Support Specialist" means an individual providing peer delivered services to an individual or family member with similar life experience. A peer support specialist must be a self-identified individual:

(a) Currently or formerly receiving mental health services; or

(b) In recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs;

(c) In recovery from problem gambling; or

(d) A family member of an individual who is a current or former recipient of addictions or mental health services.

(39) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which he or she practices medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

(40) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(41) "Procedure Code" means a code assigned to a service from either of the two national code sets (CPT or HCPCS).

(42) "Provider Organization" means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) The group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;

(e) An agent if the entity solely submits billings on behalf of providers and payments are made to each provider.

(43) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid,

capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(44) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.

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

(a) A bachelor's degree in a behavioral science 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.

(46) "Qualified Mental Health Professional (QMHP)" means a Licensed Medical Practitioner (LMP) or any other provider meeting the following minimum qualifications as documented by the CMHP 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 DSM diagnosis; write and supervise a

treatment plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and group therapy within the scope of his or her practice.

(47) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid recipients; formerly known as a Peer Review Organization.

(48) "Recipient" means an individual currently eligible for medical assistance.

(49) "Recovery Assistant" means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall:

(a) Be at least 18 years old;

(b) Meet the background check requirements described in OAR 410-180-0326;

(c) Conform to the standards of conduct as described in OAR 410-180-0340.

(50) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

(51) "Residential Treatment Facility (RTF)" means a facility licensed by the AMH that is operated to provide services on a 24-hour basis for six or more residents.

(52) "Residential Treatment Home (RTH)" means a facility licensed by AMH that is operated to provide services on a 24-hour basis for five or fewer residents.

(53) "Residential Substance Use Disorder program" means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation and 24-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.

(54) "Secure Residential Treatment Facility (SRTF)" means any Residential Treatment Facility licensed by AMH or portion thereof that restricts a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates, or other closures. Locking devices must be installed in accordance with building code requirements.

(55) "Service Plan" 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.

(56) "Substance Use Disorders Treatment Program" means a program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members or significant others.

(57) "Telemedicine" means the use of telephonic or electronic communications by a provider to deliver health services to a recipient.

(58) "Treatment" means a planned, individualized program of medical, psychological, or rehabilitative procedures, experiences, and activities designed to relieve or minimize mental, emotional, physical, or other symptoms or social, educational, or vocational disabilities resulting from or related to a behavioral health or substance use disorder diagnosis.

(59) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0610

Provider Enrollment

(1) Providers must be enrolled with the Division as a behavioral health provider. Paid providers of behavioral health services must possess a current and valid license, letter, or certificate.

(2) Providers must provide services within the scope of professional standards and practice defined by the providers licensing board or certifying organization.

(3) Providers shall meet all requirements in OAR 410-120-1260 (Medical Assistance Programs Provider Enrollment), OAR 943-120-0310 (Provider Requirements), and OAR 943-120-0320 (Provider Enrollment).

(4) Providers 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

410-172-0620

Documentation Standards

(1) OHP providers must maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request

(2) All records must document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service.

(3) Clinical records must document the recipient's diagnosis and the medical need for the service.

(4) The record must be annotated each time a service is provided and clearly indicate or be signed or initialed by the individual providing the service.

(5) Information contained in the record must be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts.

(6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services must also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services must comply with OAR 309-018-0140 through OAR 309-018-0150.

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

Stats. Implemented: ORS 414.025, 414.065 & 430.640

410-172-0630

Medically Appropriate

(1) In addition to the definition of medically appropriate in OAR 410-120-0000 for behavioral health services, "medically appropriate" means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition.

(2) The Division shall make payment for medically appropriate behavioral health services when the services or supports are:

(a) Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;

(b) Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;

(c) Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;

(d) Not provided solely for the convenience of the recipient, the recipient's family, or the provider of the services or supplies;

(e) Not provided solely for recreational purposes;

(f) Not provided solely for research and data collection;

(g) Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0640

Behavioral Health Services Fee Schedule

(1) The Division shall pay providers based on the Behavioral Health Services Fee Schedule (fee-for-service (FFS) payment rates for behavioral health services) posted on the Authority web site.

(2) Payment shall 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 payers. Payments to other specified providers shall be made according to other approved schedules.

(3) 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 Behavioral Health Services Fee Schedule web site at www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(4) Limitations contained in the Behavioral Health Services Fee 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. The Division shall notify providers of changes in writing.

(5) Payment shall be made for services listed in the Medicaid Behavioral Health Procedure Fee Schedule that are rendered to Medicaid-eligible individuals by a qualified provider during the period in which the provider is enrolled with the Division.

(6) For cost-reimbursed services, the provider must maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported. Providers whose rates are paid based on a collective bargaining agreement are not exempt from this requirement.

(7) Payment by the Division 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 that

payment for the service was not provided in accordance with applicable Oregon Administrative Rules or the service does not meet the criteria for quality or medical appropriateness of the care.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0650

Prior Authorization

(1) Some services or items covered by the Division require authorization before the service may be provided. Services requiring prior authorization are published on the Medicaid Behavioral Health Services Fee Schedule.

(2) The Division shall authorize payment for the type of service or level of care that meets the recipient's medical need and that has been adequately documented.

(3) The Division shall only authorize services that are medically appropriate and for which the required documentation has been supplied. The Division may request additional information from the provider to determine medical appropriateness.

(4) Documentation submitted when requesting authorization must support the medical justification for the service. The authorization request must contain:

(a) A cover sheet detailing relevant provider and recipient Medicaid numbers;

(b) Requested dates of service;

(c) HCPCS or CPT procedure code requested; and

(d) Amount of service or units requested;

(e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 309-019-0140; or

(f) Any additional supporting clinical information supporting medical justification for the services requested;

(g) For substance use disorder services, the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. Providers must use the ASAM;

(h) For Applied Behavioral Analysis services, the Division requires submission of:

(A) An evaluation as described in OAR 410-172-0770(1) from a physician or psychologist experienced in the diagnosis and treatment of autism;

(B) An order for treatment as described in OAR 410-172-0770(1)(e) from a physician or psychologist experienced in the diagnosis and treatment of autism;

(C) A functional analysis and a behavior treatment plan from a BCBA or a BCaBA;

(D) A copy of the Authority's service intensity scale (SIS) supporting the level of service requested.

(i) Residential treatment services for children may require a letter of approval by a designated quality improvement organization (QIO) as defined in this rule;

(j) Some services require additional approval or authorization by a physician, the Authority, or designee. Services requiring additional approval are listed on the Behavioral Health Fee Schedule or described in this rule.

(5) The Division may not authorize services under the following circumstances:

(a) The request received by the Division was not complete;

(b) The provider did not hold the appropriate license, certificate, or credential at the time services were requested;

(c) The recipient was not eligible for Medicaid at the time services were requested;

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

(e) The services requested are not in compliance with OAR 410-120-1260 through 410-120-1860;

(f) Authorization for payment may be given for a past date of service if:

(A) On the date of service, the recipient was made retroactively eligible or was retroactively dis-enrolled from a Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP);

(B) The services provided meet all other criteria and Division or Authority administrative rules and;

(C) The request for authorization is received within 30 days of the date of service.

(6) Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.

(7) Payment authorization is valid for the time period specified on the authorization notice but may not exceed 12 months unless the recipient's benefit package no longer covers the service, in which case the authorization shall terminate on the date coverage ends.

(8) Prior authorization of services shall be subject to periodic utilization review and retrospective review to ensure services meet the definition of medical appropriateness.

(9) All applicants for Title XIX or general assistance must complete Form DMAP 415A or 415B authorizing the release of any records regarding his or her health. When requested by the Division or its medical review contractor, behavioral health providers must submit sufficient medical documentation to verify the medical necessity, quality, and appropriateness of treatment and appropriateness of the length of stay for residential treatment services.

(10) Payments shall be made for the provision of active treatment services. If active treatment is not documented during any period in which the Division has prior authorized services, the Division may limit or cancel prior authorization or recoup such payments.

(11) If providers fail to comply with requests for documents for purposes of verifying medical appropriateness within the specified time-frames, the Authority may deem the records non-existent and cancel prior authorization.

Stat. Auth.: ORS 413.042 & 430.640

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

Service Specific Rules

410-172-0660

Rehabilitative Mental Health Services

(1) Rehabilitative mental health services means medical or remedial services recommended by a physician or other practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or substance use disorder and are intended to restore functioning to the highest degree possible.

(2) Rehabilitative behavioral health services must be recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law.

(3) When appropriate, rehabilitative behavioral health services are provided under ongoing oversight of an LMP.

(4) Paid providers of rehabilitative behavioral health services must meet one of the following qualifications or hold at least one of the following educational degrees and valid licensure:

(a) Physician or Physician Assistant licensed by the Oregon Medical Board;

(b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(c) Psychologist licensed by the Oregon Board of Psychology;

(d) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(e) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(f) Certificate issued by AMH as described in OAR 309-012-0130 through 309-012-0220.

(5) Non-paid providers must be employed by a provider organization certified by AMH as described in OAR 309-012-0130 through 309-012-0220 and meet one of the following qualifications:

(a) Qualified mental health professional;

(b) Qualified mental health associate;

(c) Mental health intern; or

(d) Peer-Support Specialist.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0670

Substance Use Disorder Treatment Services

(1) Substance Use Disorder (SUD) treatment services include, but are not limited to, screening; assessment; individual counseling; group counseling; individual family, group or couple counseling; care coordination; medication-assisted treatment; medication management; collection and handling of specimens for substance analysis; interpretation services; detoxification for substance use disorders; synthetic opioid treatment; and acupuncture.

(2) Paid providers of SUD treatment services shall meet one of the following requirements:

(a) Outpatient substance use disorder providers must have a certificate issued by AMH as described in OAR chapter 415, division 012;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent individuals under ORS 443.400 or a detoxification center as defined in ORS 430.306 must have a certificate issued by AMH as described in OAR chapter 415, division 012;

(c) Synthetic opioid treatment programs must meet the requirements described in OAR chapter 415, division 020;

(e) Substance use detoxification programs must meet the standards described in OAR 415, chapter 050;

(f) Physician or Physician Assistant licensed by the Oregon Medical Board;

(g) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(h) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(i) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(j) Psychologist licensed by the Oregon Board of Psychology;

(k) Acupuncturist licensed by the Oregon Medical Board;

(l) Non-paid providers must be employed by a provider organization licensed or certified by AMH and meet one of the following qualifications for the scope of service provided:

(A) Qualified mental health professional;

(B) Qualified mental health associate;

(C) Mental health intern;

(D) Peer-support specialist.

(m) SUD counselor certified by a national or state accrediting body, including Certified Alcohol and Drug Counselor (CADC) certificate issued by the Addictions Counselor Certification Board of Oregon (ACCBO) including:

(A) CADC I - Requires education, supervised experience hours, and successful completion of a written examination; 150 hours of SUD education provided by an accredited or approved body; 1,000 hours of supervised experience; completion of the NCAC I professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(B) CADC II - A minimum of a BA or BS degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 4,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(C) CADC III - A Minimum of a Master's degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 6,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors.

(3) Treatment staff holding certification in addiction counseling, qualification for the certification must include at least: 750 hours of supervised experience in substance use counseling; 150 contact hours of education and training in substance use related subjects; and successful completion of a written objective examination or portfolio review by the certifying body.

(4) For treatment staff holding a health license described in this rule, the provider must possess documentation of at least 60 (120 for supervisors) contact hours of academic or continuing professional education in SUD treatment.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0680

Residential Treatment Services for Children

(1) Paid providers of children's psychiatric residential treatment services shall:

(a) Hold a Certificate of Approval Pursuant to OAR 309-012-0130 through 309-012-0220 from AMH; and

(b) Be accredited as a psychiatric residential treatment facility for children under age 18 by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the State of Oregon;

(c) Be licensed by the Office of Licensing and Regulatory Oversight (OLRO);

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

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0690

Admission Procedure for Residential Treatment Services for Children

(1) Admission procedures for children eligible for Medicaid shall be reviewed through an independent psychiatric review process established by the Division to certify the need for services.

(2) The referring source or the facility shall make available for the Certificate of Need (CONS) process the following information about the referred child:

(a) A written psychological or psychiatric evaluation completed within the previous 60 days;

(b) A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

(c) Results of any direct recipient observation and assessment subsequent to the referral;

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

(e) Level of Need Determination Process outcome and Child and Adolescent Service intensity instrument (CASII) score;

(f) Identified care coordinator;

(g) Identified Intensive Community-Based Treatment Services (ICTS) provider;

(h) Identified child and family team members;

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

(j) Documentation regarding attempt or failure at lower level of care placement;

(k) Letter from Community Mental Health Partner (CMHP) approving the referral to this level of care;

(l) Documentation that private insurance benefit will not fund stay.

(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 designee.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0700

1915(i) Home and Community-Based Services

(1) Habilitation services are 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, 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.

(2) Psychosocial rehabilitation services are medical or remedial services recommended by a physician or other practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.

(3) Paid providers of 1915(i) services shall meet one of the following qualifications:

(a) Residential treatment home or facility licensed pursuant to OAR chapter 309, division 035;

(b) Adult Foster Home licensed pursuant to OAR chapter 309, division 040;

(c) Certificate issued by AMH pursuant to OAR chapter 309, division 012;

(4) Non-paid providers must be employed or subcontracted with a provider licensed or certified by AMH and meet one of the following qualifications:

(a) Non-paid providers including:

(A) Qualified Mental Health Professional;

(B) Qualified Mental Health Associate;

(C) Mental Health Intern;

(D) Peer-Support Specialist;

(E) Recovery Assistant.

(5) Providers of 1915(i) services may be required to meet Community Mental Health Program (CMHP) liability insurance requirements.

(6) Due to federal requirements for the Authority to ensure the impartiality of paid providers rendering services to 1915(i) eligible members, providers may be restricted from conducting eligibility reviews or developing the behavioral health assessment or service plan.

(7) To be eligible for services under the 1915(i) State Plan HCBS, the individual must meet the following requirements:

(a) Been diagnosed with a chronic mental illness as defined in ORS 426.495;

(b) Been assessed as needing assistance to perform at least two personal care services as identified in these rules due to a chronic mental illness.

(8) Eligibility for 1915(i) services is determined by an external Quality Improvement Organization (QIO) 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

410-172-0710

Residential Personal Care

(1) Personal care services provided to a resident of an AMH licensed residential treatment program include a range of assistance as developmentally appropriate and are provided to individuals with behavioral health conditions that enable them to accomplish tasks that they would normally do for themselves if they did not have a behavioral health condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task) or cueing (redirecting) so that the individual performs the task by him or herself.

(2) Personal care assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(3) Personal care services may be provided on a continuing basis or on episodic occasions.

(4) Paid providers of facility-based personal care services must meet one of the following:

(a) Licensed residential facility pursuant to OAR chapter 309, divisions 035 and 040;

(b) Secure Residential Treatment Facility (SRTF);

(c) Residential Treatment Facility (RTF);

(d) Residential Treatment Home (RTH);

(e) Adult Foster Home (AFH).

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0720

Prior Authorization and Re-Authorization for Residential Treatment

(1) The Authority does not consider a request for a fixed episode of care or standardized length of stay to be medically appropriate. Requested length of stay must be based on an assessment of individual need and the medical appropriateness of the proposed time for treatment.

(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that will allow the individual to successfully reintegrate into an independent community-based living arrangement.

(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.

(4) Authority licensed residential treatment programs are reimbursed for the provision of rehabilitation, substance use disorder, habilitation, or personal care services as defined in these rules.

(5) The Division shall authorize admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

(6) Prior authorization requests for admission and continued stay may be reviewed to determine:

(a) The medical appropriateness of the admission for residential services provided;

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

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

(d) The appropriateness of the licensed setting selected for service delivery;

(e) A level of care determination was appropriately documented.

(7) If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing and shall have ten business days to provide additional written documentation to support the medical necessity of the admission and procedures.

(8) If the reconsidered decision is to uphold the denial, prior authorization shall be denied.

(9) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410-120-1560 through 410-120-1875.

(10) Upon denial of a prior authorization request for continued stay, the Division shall authorize payment for up to 60 days of continued stay for the purposes of supporting transition management and planning for the recipient.

(11) The Division shall determine re-authorization and authorization of continued stay based upon one of the following:

(a) The recipient continues to meet all basic elements of medical necessity and one of the following criteria must be met:

(A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;

(B) The recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;

(C) Requests for continued stay based on these criteria must include documentation of ongoing re-assessment and necessary modification to the current plan of care.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0730

Payment Limitations for Behavioral Health Services

(1) Services shall be subject to periodic utilization review to determine medical appropriateness.

(2) If a review reveals that a recipient received less than active treatment, payment shall not be allowed under these rules, and prior authorization may be cancelled.

(3) The Division shall make no payment for services if the Division or designee has determined the service is not medically appropriate.

(4) Residential treatment services are provided to Medicaid Title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in "institutions of mental diseases (IMD)" who are over age 18 and under age 65. IMDs are defined in 42 CFR 435.1010.

(5) For residential facilities, the Division may not pay for planned or unplanned absences unless the provider can document clinical services were rendered during the temporary absence.

(6) For residential facilities, the Division shall pay for the day of admission but may not pay for the day of transfer or discharge.

(7) Medicaid may not reimburse costs associated with room and board for recipients residing in Authority licensed residential treatment programs.

(8) Consistent with 42 CFR 447.40, payment for a reserved bed is not covered under Medicaid.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0740

Supported Employment

(1) To be eligible for Medicaid reimbursement, supported employment (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 support (IPS) and SE and submit a copy to AMH of a fidelity review conducted by an AMH approved fidelity reviewer that resulted in a score of 100 or better.

(3) Providers implementing IPS supported employment may become a provisionally-qualified SE provider by submitting a request to AMH with a letter of support that indicates receipt of technical assistance and training from an AMH approved IPS SE trainer. Medicaid reimbursement to a provisionally-qualified SE provider ends after 12 months. This option is intended only for providers initiating SE services.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0750

Assertive Community Treatment (ACT)

(1) To be eligible for Medicaid reimbursement, Assertive Community Treatment (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 that indicates receipt of technical assistance and training from an AMH approved ACT trainer. Provisional ability to receive Medicaid reimbursement shall end after 12 months. This option is intended only for providers initiating ACT services.

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

(a) Technical assistance shall be made available for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90-day period, a follow-up review shall 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 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

410-172-0760

Applied Behavior Analysis

(1) ABA services must be recommended by a licensed physician or licensed psychologist who has experience or training in the diagnosis of autism spectrum disorder and holds at least one of the following educational degrees and valid licensure:

(a) Physician licensed to practice in the State of Oregon;

(b) Psychologist licensed to practice in the State of Oregon.

(2) Paid providers of ABA services must hold the following license or registration:

(a) Licensed Behavior Analyst as described in OAR 824-030-0010;

(b) Licensed health care professional who is registered with the Oregon Behavior Analyst Certification Board as described in OAR 824-030-0030.

(3) Non-paid providers of ABA services must hold the following license or registration:

(a) Assistant Behavior Analyst licensed by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0020;

(b) Behavior Analysis Interventionists registered by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0040.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0770

Individual Eligibility for Applied Behavioral Analysis Treatment

(1) Individuals receiving ABA must have an evaluation by a physician or psychologist experienced in the diagnosis and treatment of autism using the current DSM criteria that includes:

(a) A Diagnosis of an Autism spectrum disorder;

(b) Documentation of and results from a standardized tool that has been used to substantiate the autism disorder or questionnaires that have been used to substantiate a diagnosis of self-injurious behavior;

(c) Documented behaviors that are considered to have an adverse impact on the individual's development or communication or the individual demonstrates behavior that is injurious to themselves or others that:

(A) Interferes with everyday functions or activities;

(B) Less intensive treatment or other therapy has been considered or found insufficient.

(d) Any other documentation that would substantiate the diagnosis of autism or self-injurious behavior such as:

(A) Notes from well-child visits or other medical professionals;

(B) Copy of existing or past Individual Education Plans (IEP);

(C) Results from any additional assessments, such as IQ tests, speech and language tests, or tests of auditory function.

(e) A prescription for ABA treatment that includes:

(A) A diagnosis of autism or self-injurious behavior;

(B) A copy of the evaluation described above;

(C) An order for ABA treatment without specifying hours or intensity.

(2) Recipients ages one through twelve are eligible for intensive and less intensive interventions:

(a) Intensive interventions include therapies that address multiple behaviors at once, are more comprehensive in nature, and start at an earlier age;

(b) Less intensive interventions focus on a few targeted behaviors and generally are used with older children.

(3) Recipients age 13 and older are eligible for less intensive services only.

(4) Intensive and less intensive interventions are based on medical appropriateness as defined in these rules.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0780

Behavioral Health Personal Care Attendant Program

(1) Behavioral health personal care attendant services are essential services that enable an individual to move into or remain in his or her own home. Behavioral health personal care attendant services are provided in accordance with an individual's authorized plan for services by a QMHA or QMHP:

(a) Behavioral health personal care attendant services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual's natural support system. Behavioral health personal care attendant services may not be implemented for the purpose of benefiting an individual's family members or the individual's household in general;

(b) Behavioral health personal care attendant services are limited to 20 hours per month per eligible individual;

(c) To meet an extraordinary personal care need, an individual, representative, or legal representative may request an exception to the 20-hour per month limitation. An exception must be requested through the local community mental health program or agency contracted with AMH serving the individual. The Division has up to 45 days upon receipt of an exception request to determine whether an individual's assessed personal care needs warrant exceeding the 20-hour per month limitation.

(2) Personal care services include:

(a) Basic personal hygiene — providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(b) Toileting, bowel, or bladder care — assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, and bowel care;

(c) Mobility, transfers, or repositioning — assisting an individual with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, and encouraging or assisting with range-of-motion exercises;

(d) Nutrition — preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(e) Medication or oxygen management — assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(f) Delegated nursing tasks as defined in OAR 411-034-0010.

(3) When any of the services listed in section (2) of this rule are essential to the health, safety, and welfare of an individual and the individual is receiving personal care paid by the Division, the following support services may also be provided:

(a) Housekeeping tasks necessary to maintain the individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the individual's needs may be considered in housekeeping;

(b) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services (described in OAR chapter 410, division 136) and assistance with mobility and transfers or cognition in getting to and from appointments or to an office within a medical clinic or center;

(c) Observing the individual's health status and reporting any significant changes to physicians, health care professionals, or other appropriate persons;

(d) First aid and handling of emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another individual, and responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(e) Cognitive assistance or emotional support provided to an individual by another person due to confusion, dementia, behavioral symptoms, or mental or emotional disorders. Cognitive assistance or emotional support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(4) Payment may not be made for any of the following excluded services:

(a) Shopping;

(b) Community transportation;

(c) Money management;

(d) Mileage reimbursement;

(e) Social companionship;

(f) Day care, adult day services (described in OAR chapter 411, division 066), respite, or baby-sitting services;

(g) Medicaid home delivered meals (described in OAR chapter 411, division 040);

(h) Care, grooming, or feeding of pets or other animals; or

(i) Yard work, gardening, or home repair.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715 411-034-0090

410-172-0790

Eligibility for Behavioral Health Personal Care Attendant Services

(1) To be eligible for Behavioral Health personal care attendant services, an individual must:

(a) Demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition with personal care services and meet the eligibility criteria described in this rule;

(b) Be a current recipient of a Medicaid OHP full benefit package.

(2) An individual is not eligible to receive Behavioral Health personal care attendant services if:

(a) The individual is receiving personal care services from a licensed 24-hour residential services program (such as an adult foster home, residential treatment home, or residential treatment facility);

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;

(c) The individual's assessed service needs are being met under other Medicaid-funded home and community-based service options of the individual's choosing.

(3) Behavioral health personal care attendant services are not intended to replace routine care commonly needed by an infant or child typically provided by the infant's or child's parent.

(4) Behavioral health personal care attendant services may not be used to replace other non-Medicaid governmental services.

(5) The Authority may close the eligibility and authorization for Behavioral Health personal care attendant services if an individual fails to:

(a) Employ a provider that meets the requirements in this rule;

(b) Receive personal care from a qualified provider paid by the Authority for 30 continuous calendar days or longer.

(6) Behavioral health personal care attendant services may not duplicate other Medicaid services.

(7) Individuals eligible for Behavioral Health personal care attendant services as described must apply through the local community mental health program or agency contracted with AMH.

Stat. Auth.: ORS 413.042 & 430.640

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

410-172-0800

Personal Care Attendant Employer-Employee Relationship

(1) The relationship between a provider and an eligible individual or the individual's representative is that of employee and employer.

(2) As an employer, the individual must create and maintain a job description for a potential provider that is in coordination with the individual's plan for services.

(3) The only benefits available to homecare and personal support attendants are those negotiated in a collective bargaining agreement and as provided in statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare and personal support workers are not state or Division employees.

(4) To be eligible for Behavioral Health personal care attendant services, the individual or the individual's representative must demonstrate the ability to:

(a) Locate, screen, and hire a provider meeting the requirements described in this rule;

(b) Supervise and train a provider;

(c) Schedule work, leave, and coverage;

(d) Track the hours worked and verify the authorized hours completed by a provider;

(e) Recognize, discuss, and attempt to correct any performance deficiencies with the provider and provide appropriate, progressive, disciplinary action as needed; and

(f) Discharge an unsatisfactory provider.

(5) The Authority shall pay for Behavioral Health personal care attendant services to the provider on an individual's behalf. Payment for services is not guaranteed until the Authority has verified that an individual's provider meets the qualifications set forth in this rule.

(6) In order to receive Behavioral Health personal care attendant services from a personal support worker or homecare worker, an individual must be able to meet or designate a representative to meet the employer responsibilities in section (4) of this rule.

(7) Termination and the grounds for termination of employment are determined by an individual or the individual's representative. An individual may terminate an employment relationship with a provider at any time and for any reason. An individual must establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.

(8) After appropriate intervention, an individual unable to meet the employer responsibilities in section (4) of this rule may be determined ineligible for Behavioral Health personal care attendant services.

(9) An individual determined ineligible for Behavioral Health personal care attendant services may request these services at the individual's next annual re-assessment. Improvements in health and cognitive functioning may be factors in demonstrating the individual's ability to meet the employer responsibilities described in section (4) of this rule. The waiting period may be shortened if an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the individual's next annual re-assessment.

(10) An individual may designate a representative to act on the individual's behalf to meet the employer responsibilities in section (4) of this rule. An individual's legal representative may be designated as the individual's representative:

(a) The Authority may deny an individual's designation of a representative if the representative has:

(A) A history of a substantiated abuse of an adult as described in OAR chapter 411, division 20, OAR chapter 407, division 45, or OAR chapter 943, division 45;

(B) A history of founded abuse of a child as described in ORS 419 B.005;

(C) Participated in billing excessive or fraudulent charges; or

(D) Failed to meet the employer responsibilities, including previous termination for failure to meet the employer responsibilities in section (4) of this rule.

(b) An individual may select another representative if the Authority suspends, terminates, or denies an individual's designation of a representative.

(11) An individual with a guardian must have a representative for service planning purposes. A guardian may designate themselves the individual's representative.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0810

Personal Care Attendant Qualifications

(1) A qualified provider is an individual who, in the Authority 's judgment, demonstrates by background, skills, and abilities knowledge and ability to perform or to learn to perform the required work. A qualified provider must:

(a) Maintain a drug-free work place;

(b) Complete the background check process described in OAR 943, division 007 with an outcome of approved or approved with restrictions;

(c) May not be an individual's legal representative;

(d) Be authorized to work in the United States in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules;

(e) Be 18 years of age or older.

(2) A qualified provider may be employed through a contracted in-home care agency or enrolled as a homecare worker or personal support worker under a provider number. The Authority shall establish the rates for services.

(3) Providers that provide Behavioral Health personal care attendant services must:

(A) Be enrolled in the Consumer-Employed Provider Program and meet all of the standards in OAR chapter 411, division 31;

(B) Meet the provider enrollment and termination criteria described in OAR 411-031-0040 for personal support workers.

(2) The Authority shall conduct background rechecks at least every other year from the date a provider is enrolled. The Authority may conduct a recheck more frequently based on additional information discovered about a provider, such as possible criminal activity or other allegations.

(3) Prior background check approval for another Authority provider type is inadequate to meet background check requirements for homecare or personal support workers.

(4) Provider enrollment may be inactivated when a provider fails to comply with the background recheck process. Once a provider's enrollment is inactivated, the provider must reapply and meet the requirements described in these rules to reactivate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0820

Provider Termination

(1) The Authority may deny or terminate a personal care attendant's provider enrollment and provider number as described in OAR 411-031-0050. The termination, administrative review, and hearings rights for homecare workers are set forth in OAR 411-031-0050.

(2) The Authority may deny or terminate a personal support worker's provider enrollment and provider number when the personal support worker:

(a) Has been appointed the legal guardian of an individual;

(b) Has a background check that results in a closed case pursuant to OAR chapter 943, division 007;

(c) Lacks the skills, knowledge, or ability to perform or learn to perform the required work;

(d) Violates the protective service and abuse rules in OAR chapter 411, division 20, OAR chapter 407, division 45, and OAR chapter 943, division 45;

(e) Commits fiscal improprieties;

(f) Fails to provide the authorized services required by an eligible individual;

(g) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by an individual;

(h) Has been intoxicated by alcohol or drugs while providing authorized services to an individual or while in the individual's home;

(i) Has manufactured or distributed drugs while providing authorized services to an individual or while in the individual's home; or

(j) 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.

(3) A personal support worker may contest the Authority's decision to terminate the personal support worker's provider enrollment and provider number:

(a) A designated employee from the Authority shall review the termination and notify the personal support worker of the decision;

(b) A personal support worker may file a request for a hearing with the Authority's local office if all levels of administrative review have been exhausted and the provider continues to dispute the Authority's decision. The local office shall file the request for a hearing with the Office of Administrative Hearings as described in OAR chapter 137, division 3. The request for a hearing must be filed within 30 calendar days of the date of the written notice from the Authority;

(c) When a contested case is referred to the Office of Administrative Hearings, the referral must indicate whether the Authority is authorizing a proposed order, a proposed and final order, or a final order.

(d) No additional hearing rights have been granted to a personal support worker by this rule other than the right to a hearing on the Authority's decision to terminate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0830

Personal care attendant Service Assessment, Authorization, and Monitoring

(1) A behavioral health case manager must meet in person with an individual to assess the individual's ability to perform the personal care tasks listed in this rule.:

(a) An individual's natural supports may participate in the assessment if requested by the individual;

(b) A behavioral health case manager must assess an individual's service needs, identify the resources meeting any, some, or all of the individual's needs, and determine if the individual is eligible for behavioral health personal care attendant services or other services;

(c) A behavioral health case manager must meet with an individual in person at least once every 365 days to review the individual's service needs.

(2) A behavioral health case manager must prepare a service plan identifying the tasks for which an individual requires assistance and the monthly number of authorized service hours. The case manager must document an individual's natural supports that currently meet some or all of the individual's assistance needs:

(a) The service plan must describe the tasks to be performed by a qualified provider and must authorize the maximum monthly hours that may be reimbursed for those services;

(b) When developing service plans, a case manager must consider the cost effectiveness of services that adequately meet the individual's service needs;

(c) Payment for behavioral health personal care attendant services must be prior authorized by a behavioral health case manager and based on the service needs of an individual as documented in the individual's written service plan.

(3) When there is an indication that an individual's personal care needs have changed, a case manager must conduct an in-person reassessment with the individual and any of the individual's natural supports if requested by the individual:

(a) Following annual reassessments and those conducted after a change in an individual's personal care needs, a case manager must review service eligibility, the cost effectiveness of the individual's service plan, and whether the services provided are meeting the individual's identified service needs;

(b) The case manager may adjust the hours or services in the individual's service plan and must authorize a new service plan, if appropriate, based on the individual's current service needs.

(4) A behavioral health case manager must provide ongoing coordination of behavioral health personal care attendant services, including authorizing changes in providers and service hours, addressing risks, and monitoring and providing information and referral to an individual when indicated.

(5) The Authority may not authorize services within an eligible individual's home when:

(a) The individual's home has dangerous conditions that jeopardize the health or safety of the individual or the provider and necessary safeguards cannot be taken to improve the setting;

(b) The services cannot be provided safely or adequately by a provider;

(c) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and necessary safeguards cannot be provided to protect the individual's safety, health, and welfare.

(6) A behavioral health case manager must present an individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when a provider or service setting selected by the individual or the individual's representative is not authorized.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0840

Personal Care Attendant Payment Limitations

(1) The number of behavioral health personal care attendant service hours authorized for an individual per calendar month is based on projected amounts of time to perform specific personal care and supportive services to the eligible individual. The total of these hours are limited to 20 hours per individual per month. Individuals whose assessed service needs exceed the 20-hour limit may receive approval for additional hours.

(2) The Authority shall pay for behavioral health personal care attendant services when all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Authority is authorized.

(3) In accordance with OAR 410-120-1300, all provider claims for payment must be submitted within 12 months of the date of service.

(4) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual's representative.

Stat. Auth.: ORS 413.042, 430.640

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

410-172-0850

Telemedicine for Behavioral Health

(1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient's benefit package:

(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC) and the applicable HSC-approved code requirements, delivered consistent with the HSC practice guideline;

(b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below.

(2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority.

(3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when:

(a)Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or

(b) Those methods and specific services are not specifically allowed pursuant to the Health Evidence Review Commission's (HERC) Prioritized List of Health Services and Practice Guideline.

(4) Providers billing for covered telemedicine services must:

(a) Comply with HIPAA and the Authority's Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;

(b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules set forth in OAR 943, division 14;

(c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;

(d) Comply with the relevant HERC practice guideline for telephone and e-mail consultation. Refer to the current prioritized list and practice guidelines at http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

Stat. Auth.: ORS 413.042, 430.640

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