Comagine Health

Oregon Behavioral Health Support Program

IQA 1915(i) Assessment Reconsideration Determination

Please send inquiries to Comagine Health via one of the following methods:

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Date of Determination:

Provider Name: Provider #:

Address: Phone:

Point of Contact for the Appeal

Name/Title: Phone:

Email:

Consumer Name: Medicaid ID#:

Appeal Summary:

Supporting Documentation Reviewed:

- Clinical/Progress Notes Date/s included Date From: To:
- Mental Health Assessment Date:
- Psychiatric/Psychological Evaluation Date:
- Incident Reports (can include police reports)
- Behavioral Health Treatment Plan/Behavior Support Plan Date:
- Residential Care Plan Date:
- Consumer History and Physical Date:
- Medication Logs (MARs)
- ADL/IADL Logs
- Medical assessment/evaluation(s) (physical/speech therapy, acute, etc.) Date/s:
- Other (provide details):

Comments (please explain if documents submitted were not reviewed):

IQA Determination (please select one):

- Approved with Rate Change: LSi changed to: Rate:
- Approved no Rate Change: LSi changed to:
- Approved PCSP Amended
- Denied no Change in LSi Score (please explain and reference OAR's below as applicable):
- Denied no Change to PCSP (please explain and reference OAR's below as applicable):
- Approved Other (please explain):

☐ Denied Other (please explain and reference OAR's below as applicable):

Documentation deficits: The submitted documentation does not support a change in the consumer's LSi or LOCUS score. See below for further details.

☐ **Documentation supporting medial appropriateness of services** The Division will authorize for the level of care or type of service that meets the client'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. ***OAR 410-120-1320(3)(4)(b)(c)***

- ☐ The Division will authorize for the level of care or type of service that meets the client'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. ***OAR 410-120-1320(3)***
- ☐ The Division will not make payment for authorized services under the following circumstances: ***OAR 410-120-1320(4)***
- ☐ The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency; ***OAR 410-120-1320(4)(b)***
- ☐ The service has not been adequately documented (see 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the provider's files; ***OAR 410-120-1320(4)(c)***

☐ **Consumer's Mental Health Assessment.** ***OAR 309-019-0135 (3)(b-f)***

- ☐ Each assessment shall include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services. ***OAR 309-019-0135 (3)(b)***
- ☐ For substance use disorders services, each assessment shall be consistent with the dimensions described in the ASAM and shall document a diagnosis and level of care determination consistent with the DSM and ASAM. ***OAR 309-019-0135 (3)(c)***
- ☐ When the assessment process determines the presence of co-occurring substance use and mental health disorders or any risk to health and safety ***OAR 309-019-0135 (3)(d)****:*
  (A) Additional assessments shall be used to determine the need for additional services and supports and the level of risk to the individual or to others; and
  (B) Providers shall document referral for further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.
- ☐ Providers shall update assessments when there are changes in clinical circumstances ***OAR 309-019-0135 (3)(e)***; and;
- ☐ Any individual continuing to receive mental health services for one or more continuous years shall receive an annual assessment by a QMHP. ***OAR 309-019-0135 (3)(f)***

☐ **Consumer's current History and Physical**

☐ **Most recent Behavioral Health Treatment/Residential Care Plan *OAR 309-035-0185 (3)(b)(c)(d)(5)(6), OAR 309-040 0390(5)(B)(E)(F), OAR 410-172-0710(4)***

a. **Client Protocol(s):**

b. **Safety Plan(s):**

c. **Behavior Support Plan:**

☐ The residential service plan shall be based upon the findings of the individual assessment, be developed with participation of the individual and representative, and be developed through collaboration with the individual's primary mental health treatment provider. With consent of the individual or representative, family members, representatives from involved agencies, and others with an interest in the individual's circumstances shall be invited to participate. All contacts with others shall be made with proper, prior authorization from the individual ***OAR 309-035-0185 (3)(b);***

☐ The residential service plan shall include the following ***OAR 309-035-0185 (3)(c)***:

(A) The necessary steps and actions of the provider for the implementation and provision of services consistent and as required by the person-centered service plan;
(B) Identify the individual's service needs, desired outcomes, and service strategies to address the following: physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability, and community navigation, all areas identified in the person-centered service plan and any other areas.

☐ The residential service plan shall be signed by the individual, the individual's representative, the program administrator or other designated program staff person, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan ***OAR 309-035-0185 (3)(d)***

☐ The provider shall maintain progress notes within each individual's service record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes identified in the residential service plan. The provider shall enter a progress note in the individual's record at least once each month. ***OAR 309-035-0185 (5)***

☐ The provider shall review and update the assessment and residential service plan at least annually. On an ongoing basis, the provider shall update the residential service plan as necessary based upon changing circumstances or upon the individual's request for reconsideration. ***OAR 309-035-0185 (6)***

☐ Identify the individual's service needs, desired outcomes, and service strategies to advance all areas identified in the person-centered service plan, the individual's physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation, as well as any other area of concern or the other goals set by the individual; ***OAR AFH 309-040-0390(5)(B)***

☐ The RCP shall be signed by the individual, the provider, or the provider's designee, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan; ***OAR AFH 309-040-0390(5)(E)***

☐ The provider shall review and update each individual's RCP every six months and when an individual's condition changes. The review shall be documented in the individual's record at the time of the review and include the date of the review and the provider's signature. If an RCP contains many changes and becomes less legible, the provider shall write a new care plan. ***OAR AFH 309-040-0390(5)(F)***

☐ Personal care assistance relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as defined in these rules. ***OAR 410-172-0710(4)***

☐ **Progress notes** Progress notes shall be maintained within each consumer's record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes as identified in the individual's personal care plan. Providers receiving Medicaid funds are required to document all services rendered to the consumer daily. ***OAR 410-120-1360(2)(a)(b), OAR 410-172-0705 (16)(a-e)(i), OAR 410-172-0620 (1-6), OAR 309-035-0185 (5), OAR 309-040-0390 (10)(i)***

☐ The provider or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records shall develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested. Payment

shall be made only for services that are adequately documented. Documentation shall be completed before the service is billed to the Division and meet the following requirements: ***OAR 410-120-1360 (2)***

☐ All records shall document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service is provided, and the individual providing the service. Patient account and financial records shall also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported; ***OAR 410-120-1360 (2)(a)***

☐ Clinical records, including records of all therapeutic services, shall document the client's diagnosis and the medical need for the service. The client's record shall be annotated each time a service is provided and signed or initialed by the individual who provided the service or shall clearly indicate the individual who provided the service. For purposes of medical review, the Authority adopts Medicare's electronic signature policy as outlined in the CMS Medicare Program Integrity Manual. Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, the individual provider rules, and any relevant contracts; ***OAR 410-120-1360 (2)(b)***

☐ The Division may pay for services under the standardized rate methodology only when all the following requirements have been met with respect to the service:
(a) All individuals must receive daily supervision;
(b) Tier 2 must receive an average of three or more hours of active engagement daily;
(c) Tier 3 must receive an average of five or more hours of active engagement daily;
(d) Tier 4 must receive an average of six or more hours of active engagement daily;

(e) Tier 5 must receive an average of seven or more hours of active engagement daily;
(i) A residential treatment program must document at least daily the specific individual personal care and other habilitative services including skills building and other activities provided to enhance community integration, the individual's response to services provided, and planned activities related to the individual's assessment and PCSP; ***OAR 410-172-0705 (16)(a-e)(i)***

☐ OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request. ***OAR 410-172-0620 (1)***

☐ All records shall 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. ***OAR 410-172-0620 (2)***

☐ Clinical records shall document the recipient's diagnosis and the medical need for the service. ***OAR 410-172-0620 (3)***

☐ The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service. ***OAR 410-172-0620 (4)***

☐ Information contained in the record shall 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. ***OAR 410-172-0620 (5)***

☐ For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150. ***OAR 410-172-0620 (6)***

☐ The provider shall maintain progress notes within each individual's service record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes identified in the residential service plan. The provider shall enter a progress note in the individual's record at least once each month. ***OAR 309-035-0185 (5)***

☐ Progress notes shall be maintained within each individual's record and document significant information relating to all aspects of the individual's functioning and progress toward desired outcomes as identified in the

individual's personal care plan. A progress note shall be entered in the individual's record at least once each month. ***OAR AFH 309-040-0390 (10)(i)***

☐ **Incident Reports** The provider shall develop an individual record for each individual. The provider shall keep the individual record current and available on the premises for each individual admitted to the AFH. The provider shall maintain an individual record consistent with the following requirements: ***OAR AFH 309-040-0390 (10)***

☐ A written incident report of any unusual incidents relating to the AFH including but not limited to individual care. The incident report shall include how and when the incident occurred, who was involved, what action was taken by staff, and the outcome to the individual. In compliance with HIPAA rules, only the individual's name may be used in the incident report. Separate reports shall be written for each individual involved in an incident. A copy of the incident report shall be submitted to the CMHP within five working days of the incident. The original shall be placed in the individual's individual record; ***OAR AFH 309-040-0390 (10)(g)***

☐ Records documenting the legal operation of the program shall include but not limited to: Incident Reports ***OAR 309-035-0130 (2)(h)***

☐ **Tiers/Engagement Service Hours** The submitted documents do not support the provider's request for a higher tier assignment for the consumer. For the consumer to receive a specific tier, the consumer's engagement hours and LSi score must meet the following guidelines: ***OAR 410-172-0705 (11)***

(a) Tier 2 for an individual with an LSI of 40 or less;

(b) Tier 3 for an individual with an LSI of 41-60;

(c) Tier 4 for an individual with an LSI of 61-79.

All individuals must receive daily supervision;

(a) Tier 2 must receive an average of three or more hours of active engagement daily;

(b) Tier 3 must receive an average of five or more hours of active engagement daily;

(c) Tier 4 must receive an average of six or more hours of active engagement daily;

(d) Tier 5 must receive an average of seven or more hours of active engagement daily;

Signature

Completed By:

_____	_____	_____
Signature	Name and Title	Date

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