Comagine Health

Oregon Independent and Qualified Agent and Related Services
Provider Portal Quick Start Guide - Secure Residential Treatment Facility Medical Necessity Authorization Reviews

This is a Quick Start Guide for Providers submitting a request for the Secure Residential Treatment Facility (SRTF) Medical Necessity/Medical Appropriateness Authorization Review Request program via the Comagine Health Provider Portal (CHPP). No personal health information is used in this guide.

Pre-requisites:

- Provider must have access to the CHPP.
- See Oregon Behavioral Health Support Program Providers page to register for the CHPP.
- Individual must have a Member Profile established in the CHPP.
- Follow the steps to confirm a member profile or to request one, outlined below.
- Individual must have active Medicaid State Mental Health Services (SMHS) eligibility.
    - If the individual does not have active Medicaid SMHS eligibility, contact ORBHSupport@Comagine.org, with "PORTAL" in the subject line, or call 1-888-416-3184, and select Option 2 for assistance. Comagine Health, as the Independent and Qualified Agent (IQA), may be able to assist with the 150% Federal Poverty Limit (FPL) form submission and process.

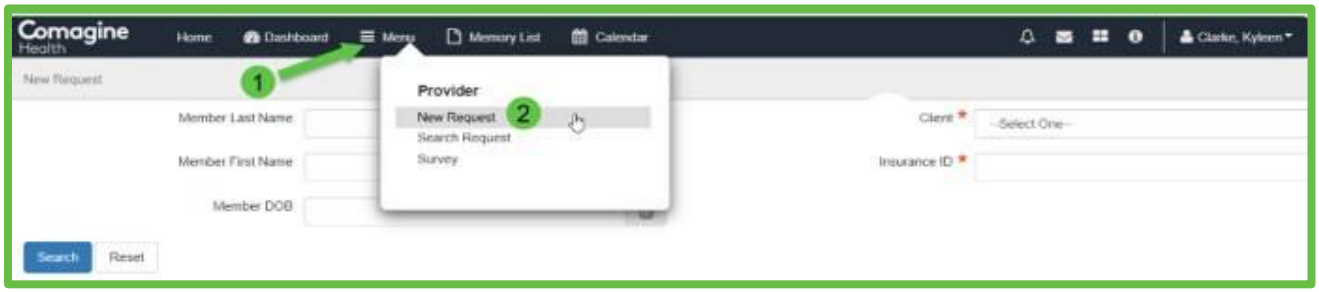
The following steps pertain to Pre-Admission, Initial, and Continued Stay requests for SRTF Medical Necessity/ Medical Appropriateness Authorizations. These are defined as:

- **Pre-Admission:** Individual has not yet been admitted to a SRTF.
- **Initial:** Individual has admitted to a SRTF for the first time or there has been a break in approval authorizations.
    - If applicable, review the Medical Necessity Appropriateness Approval Determination Letter for Pre-Admission authorization approval dates.
        - If authorization has ended, proceed with SRTF Medical Necessity Authorization request submission.
        - If within 30 days prior to the approved authorization end date, proceed with submission for SRTF Medical Necessity Authorization request. The request start date is one day after the current Medical Necessity Authorization ends. (Example: Last approved authorization date is 4/1/26, the next request start date is 4/2/26.)
        - If more than 30 days prior to the approved authorization end date, submit the referral request to complete the functional needs assessment and person-centered service plan. Reference the **BH Non-1915i CHPP Provider Steps QSG** on the Oregon Behavioral Health Support Program Providers page.
            - The next Medical Necessity Authorization request can be submitted within 30 days prior to the current authorization end date.
- **Continued stay:** Medical Necessity/Medical Appropriateness Authorization Review Request dates are concurrent to the previous authorization approval.

If you need assistance with the SRTF Medical Necessity request submission, outreach Comagine Health at ORBHSupport@Comagine.org, or call 1-888- 416-3184.

Steps to Submit Request

1. Sign into the CHPP (Comagine Health Provider Portal) with your Username and Password. If you have not been issued a Username and Password, contact ORBHSupport@Comagine.org , with "PORTAL" in the subject line, or call 1-888- 416-3184, and select Option 2.
   1) Select **Menu**.
   2) Select **New Request**.



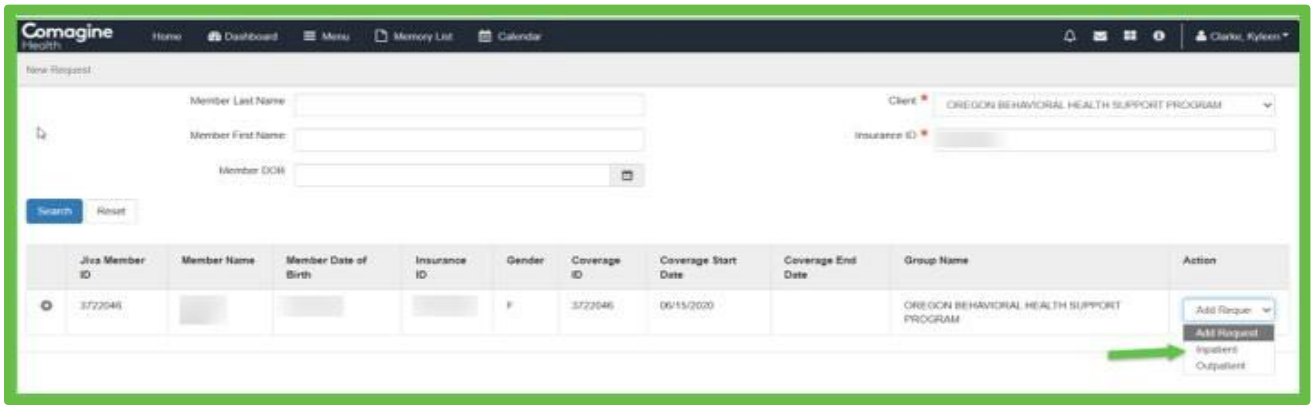
2. Search for the Individual using:
   3) **Client** – Choose **Oregon Behavioral Health Support Program**.
   4) **Insurance ID** – Enter the individual's **Medicaid ID number**.
   5) Click **Search**.
   6) If a search results in "No Search Results Available", the member will need to be added.



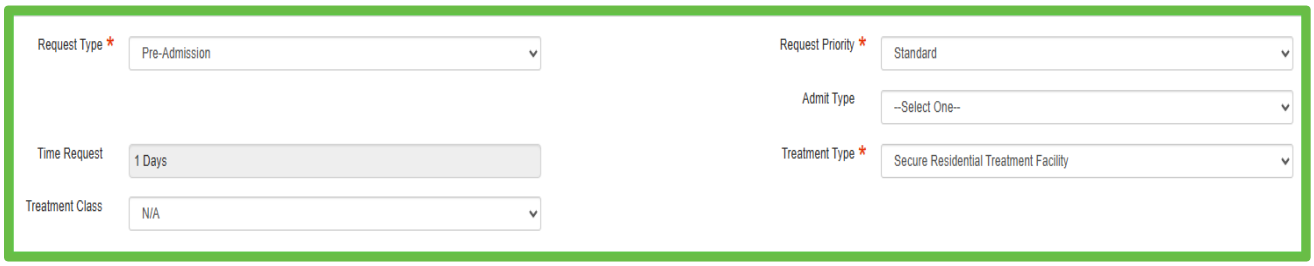
- Note: Providers cannot add a new member to the CHPP on their own. If **Add New Member** is selected, you will receive an alert (see screenshots below). If you need to add a new member, call Comagine Health at 1-888-416-3184 and select Option 2, or send a secure email to ORBHSupport@Comagine.org with "PORTAL" in the subject line to request a member add.



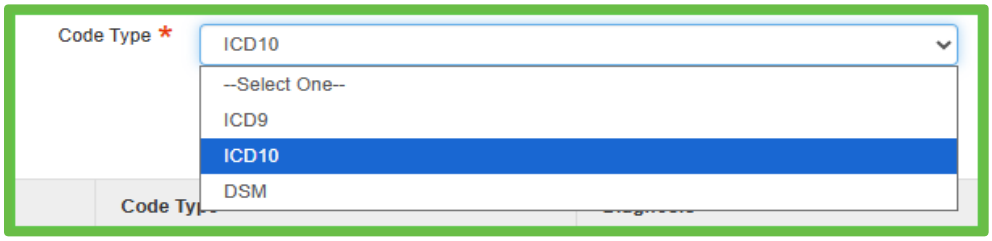
7) When the search results return, verify the member's information: **Member Name, Date of Birth,** and **Insurance ID.**



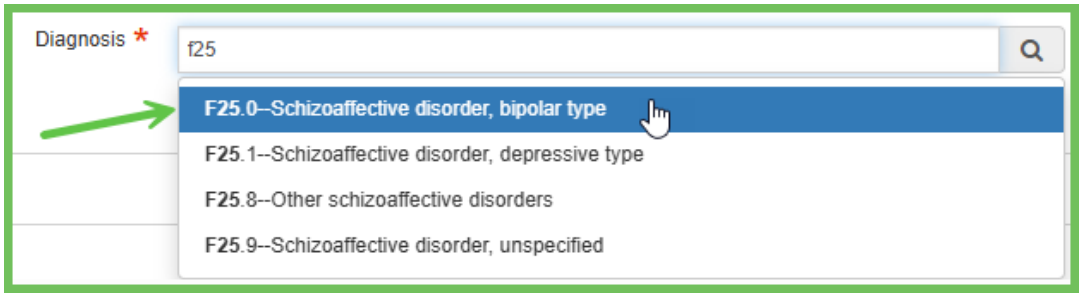
3. Under **Action,** select **Add Request** and choose **Inpatient** (for all request types) from the drop-down menu.
4. Enter the required **Episode Details:**
   - **Request Type:** Pre-Admission (*Use for all submission types - Pre-Admission, Initial, and Continued Stay*).
   - **Request Priority:** Standard (auto populates).
   - **Admit Type:** Skip.
   - **Time Request:** Skip.
   - **Treatment Type:** Secure Residential Treatment Facility.
   - **Treatment Class:** N/A (Field must be completed though no red asterisk is present).



5. Under the **Diagnosis** section, enter the primary diagnosis identified on the Mental Health Assessment.
   - **Code Type:** Enter the code type for the primary diagnosis identified in the supporting documentation.
     - ICD10 auto-populates. From the drop-down menu select the appropriate code type - ICD10 or DSM.



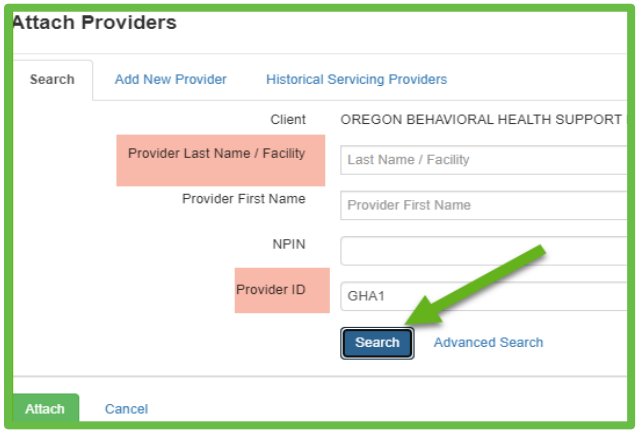
- **Diagnosis:** Enter the primary diagnosis identified in the supporting documentation.
  - Enter either the numeric diagnosis code or start typing the name of the diagnosis, and a drop-down menu of choices will appear. Click on the appropriate choice to populate this field.



  - If multiple diagnoses are entered, the primary diagnosis will be indicated with a gold star.

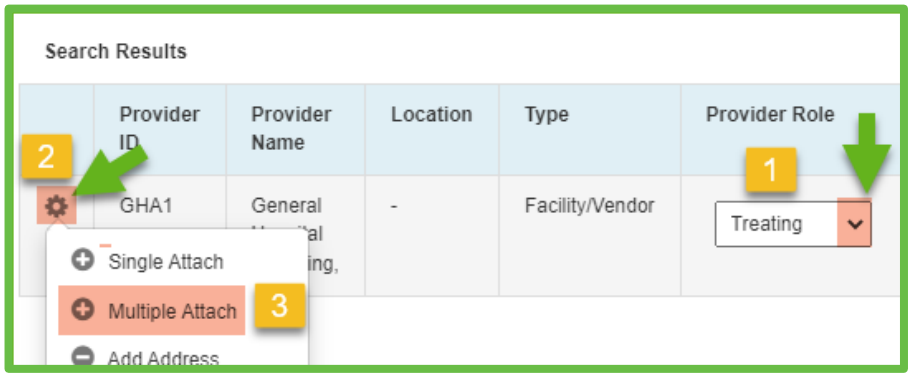
6. Under **Provider Details:**

- Select the **paperclip icon**  to add yourself as a **Requesting Provider**.
  - This will attach you to the request as the **Requesting** provider. An **Admitting** provider (the referring provider – typically the county) and a **Treating** provider (the provider currently rendering services) must also be attached, using the steps below.
  - Note: For a **pre-admission** request (where the individual has not yet admitted to an SRTF) use code: OR000 – (Oregon BH Med Nec Provider) for both the **Admitting** and **Treating** Provider.
- Select **Attach Providers.**
- Enter **Provider ID numbe**r (MCD number) or the **Provider name** in appropriate field (entering the Provider ID number is the preferred method).
- Click **Search.**



- Locate the correct provider under the **Search Results** (on the right side of screen). Then complete the following steps:

1) Review the **Provider Role** for the **Treating** and **Admitting** providers to ensure it is correct. If incorrect, click on the drop-down arrow to choose appropriate **Provider Role** (either Treating or Admitting).
2) Click **gear icon** next to the Provider.
3) Select **Multiple Attach**.



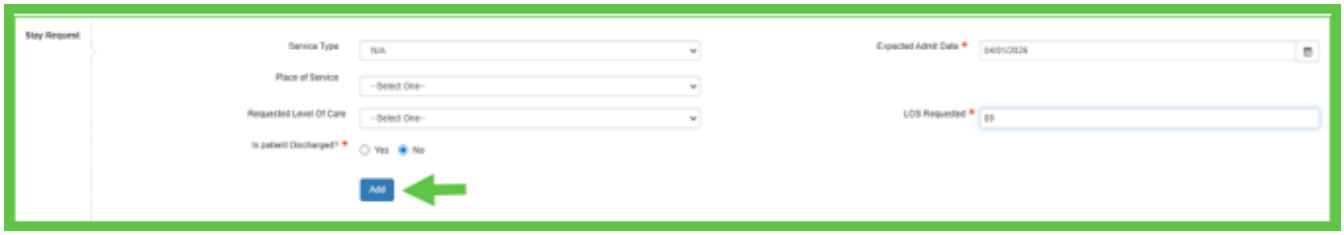
- From the same screen, enter the next Provider ID number or Provider name in the appropriate field and click **Search**.
- Locate the correct second provider under the **Search Results** (on the right side of the screen).
- Repeat steps 1-3 above to enter the second provider.
- Select **Attach**.
- After this, there should be three (3) attached providers:
  REQUESTING – This is the submitting provider.
  ADMITTING – This is the referring provider (typically the county or the provider/facility) **or** Provider # OR000 (*Oregon BH Med Nec Provider*) if the individual is not yet admitted to a Secure Residential Treatment Facility.
  TREATING – This is the provider currently rendering services **or** Provider # OR000 (*Oregon BH Med Nec Provider*) if the individual is not yet admitted to a SRTF.



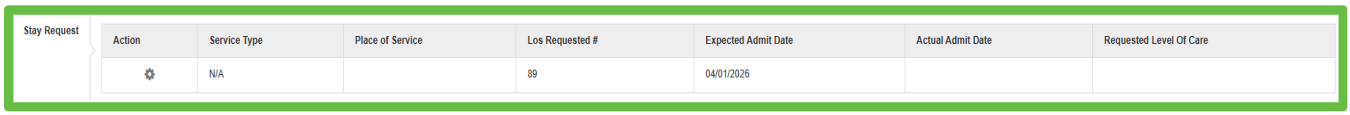
7. Under the **Stay Request** section, enter the following information:

- **Service Type:** N/A (skip).
- **Expected Admit Date:** First day of the 90-day authorization request dates. **If Pre-Admission:** Today's date.

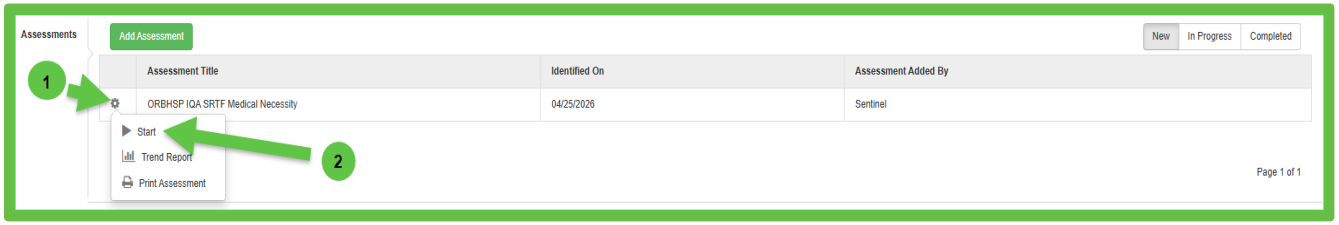
- **Place of Service:** Skip.
- **Actual Admit Date:** Skip.
- **Requested Level of Care:** Skip.
- **LOS Requested:** 89 (Note: Jiva counts Day 1 as the Authorization Start Date).
- **Is patient Discharged?:** Select No (even if the individual has discharged).
  - Note: If Individual has discharged, the submission will be reviewed as a retro-authorization request. For further questions, please contact the IQA at ORBHSupport@Comagine.org or call 888-416-3184.
- When complete, click **Add.**



- After selecting **Add**, the page will update to reflect added stay request, as well as adding an Assessments section after the Service Request section.



8. The **Service Request** section can be skipped.
9. Complete the **Assessments** section:
   - If Assessment section is not visible, scroll back up to the **Stay Request** section and ensure you have clicked **Add.**
   - An assessment will auto populate according to the Treatment Type selected earlier. **Do not select Add Assessment.**
     1) For Medical Necessity/Medical Appropriateness Authorization, click on the gear icon ⚙ next to the **ORBHSP IQA SRTF Medical Necessity** assessment.
     2) Choose **Start** from the drop-down menu.



The following are the questions and directions for completion of the assessment ORBHSP IQA SRTF Medical Necessity. Note: In the assessment, the red asterisk * denotes questions that are required to be answered.

***1. Select type of SRTF review:**

Select the appropriate request type.

- **Pre-Admission**
  - Individual has not yet admitted to an SRTF.
- **Initial**
  - Individual has admitted to an SRTF for the first time or there has been a break in approval authorizations.
  - *If selected, questions 1a. – 1e. will appear:*

    ***1a. Facility/Program Name:**
    - Enter the name of the Facility/Program in the box. Enter NA if unknown.

    ***1b. Facility/Program MCD:**
    - Enter the Facility/Program MCD number in the box.

    ***1c. Facility/Program Mailing Address:**
    - Enter the Facility/Program full mailing address in the box. Enter NA if unknown.

    ***1d. Facility/Program Email Address:**
    - Enter the Facility/Program email address in the box. Enter NA if unknown.

    ***1e. Facility/Program Phone Number (000-000-0000):**
    - Enter the Facility/Program phone number in the box. Enter NA if unknown.

- **Continued Stay**
  - Medical Necessity/ Medical Appropriateness Authorization Review Request dates are concurrent to the previous authorization approval.
  - *If selected questions 1f. – 1j. will appear:*

    ***1f. Facility/Program Name (if applicable):**
    - Enter the name of the Facility/Program in the box. Enter NA if unknown.

    1g. Facility/Program MCD (if known):
    - Enter the Facility/Program MCD number in the box.

    ***1h. Facility/Program Mailing Address:**
    - Enter the Facility/Program full mailing address in the box. Enter NA if unknown.

    ***1i. Facility/Program Email Address:**

- Enter the Facility/Program email address in the box. Enter NA if unknown.

***1j. Facility/Program Phone Number (000-000-0000):**

- Enter the Facility/Program phone number in the box. Enter NA if unknown.

2. Select documentation to be uploaded with referral submission:** ***Select all documents that will be uploaded for the Medical Necessity referral submission.

- Mental/Behavioral Health Assessment
- Psychiatric Assessment
- Nursing Assessment
- Conditional Release/Community Evaluation for individuals involved with Psychiatric Security Review Board (PSRB)
- Legal Guardianship/Authorized Representative Documents
- Progress Notes (daily clinical, nursing, psychiatric, etc.) from 90 days prior to requested authorization start date
- Risk Management Plan (for identified risks, i.e., suicide, choking, fall, elopement, etc.)
- Incident Reports
- Medication Administration Records (MAR)
- Involuntary Medication Order
- Seclusion and Restraint Order

***3. What is the County of Responsibility?**

Select appropriate box for Individual's CCO.

- Baker
- Benton
- Clackamas
- Clatsop
- Columbia
- Coos
- Crook
- Curry
- Deschutes
- Douglas
- Gilliam
- Grant
- Harney
- Hood River
- Jackson
- Jefferson
- Josephine
- Klamath
- Lake
- Lane
- Lincoln
- Linn
- Malheur
- Marion
- Morrow
- Multnomah
- Polk
- Sherman
- Tillamook
- Umatilla
- Union
- Wallowa
- Wasco
- Washington
- Wheeler
- Yamhill

***4. What is the current Legal Status?**

Select the appropriate Legal Status.

- Voluntary
- Voluntary by Guardian
- Civil Commitment
- PSRB
- Aid and Assist

***5. Is there a Legal Guardian/Authorized Representative?**

- Yes: *If selected questions 5a. – 5e. will appear:*

  ***5a. Name:**
  - Enter the Guardian or Authorized Representatives full name in the box.

  ***5b. Relationship to Individual:**
  - Enter the Guardian or Authorized Representatives relationship to the Individual in the box. Enter NA if unknown.

  ***5c. Address:**
  - Enter the Guardian or Authorized Representatives full mailing address in the box. Enter NA if unknown.

  ***5d. Email Address:**
  - Enter the Guardian or Authorized Representatives email address in the box. Enter NA if unknown.

  ***5e. Phone Number (000-000-0000):**
  - Enter the Guardian or Authorized Representative phone number in the box. Enter NA if unknown.

- No

Enter the Submitting Provider Contact Information:

***6. Contact Name:**
- Enter submitting provider contact name in box.

***7. Email Address:**
- Enter Submitting provider email address in box.

***8. Phone Number (000-000-0000):**
- Enter Submitting provider phone number in box.

9. Fax Number (000-000-0000):

- Enter Submitting provider fax number in box.

Enter the Care Coordinator Contact Information:

***10. Is there a Care Coordinator (CC)? (Ex. ENCC, CCO/FFS Care Coordinator, Residential Specialist)**

- Yes: *If selected questions 10a. – 10d. will appear*:

  ***10a. CC Name:**

  - Enter CC's name in box.

  ***10b. County:**

  - Enter CC's county in box.

  ***10c. Email Address:**

  - Enter CC's email address in the box. Enter NA if unknown.

  ***10d. Phone Number (000-000-0000):**

  - Enter CC's phone number in box. Enter NA if unknown.

- No

Enter the SRTF Admission and Continued Stay Criteria:

***11. The individual does not require 24-hour hospital care and treatment.**

Select appropriate answer for Individual.

- Individual does not require 24-hour hospital care and treatment
- Individual does require 24-hour hospital care and treatment

***12. The individual requires highly structured and secure environmental support and supervision 24 hours a day, 7 days a week to participate successfully in a program of habilitative and rehabilitative activities.**

Select appropriate answer for Individual.

- Yes
- No

***13. Due to a mental illness, and as evidenced by clinically documented instances of behaviors displayed within the last 90 days, the individual presents with one or more of the following:**

Select <u>all</u> appropriate answers for Individual.

- Clear intention or specific acts of bodily harm to others.
- Ideation of suicide with intent and ability if not in a secure environment or of self-harm posing significant risk of serious injury.
- Inability to care for basic needs that results in worsening or development of a significant health condition, or the individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm.

- Significant risk that the individual will not remain in a non-secured place of service to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's or others' safety and well-being.
- None of the above.

***14. The individual is under an involuntary medication order.**

Select appropriate answer for Individual.

- Yes: *If selected please be sure to upload Document(s) in the Document Section with detailed information.*
- No

***15. The individual has orders for seclusion and/or restraints, if needed.**

Select appropriate answer for Individual.

- Yes: *If selected please be sure to upload Document(s) in the Document Section with detailed information.*
- No

16. In a few sentences, please summarize the individual's specific behaviors, risks, or needs that require a secure setting. (250 max characters)

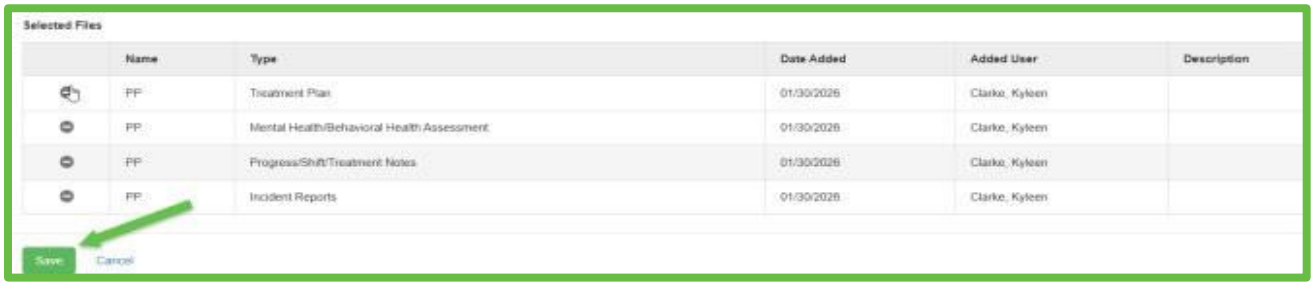
Please enter information in the box.

Select **Complete.**

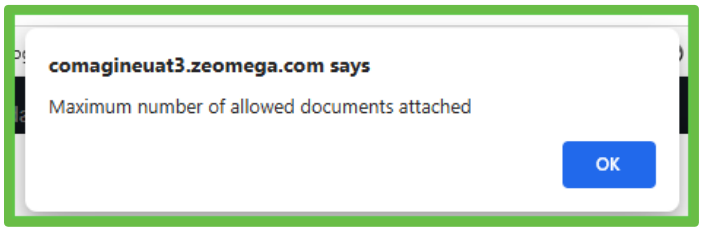
---

10. Attach **Documents**. Note: Recommend files be updated as PDF and no larger than 10 Mb (or 10,000 Kb).

- Select **Add Documents**. Enter the following:
  - **Document Title:** Individual's Initials.
  - **Document Type:** Select appropriate document type.
    - Example: Mental Health/Behavioral Health Assessment
  - **Document Description:** Skip.
  - **Select Document:** Browse, select appropriate file.
- Click **Add**.
- Once all selected files are added, select **Save**.

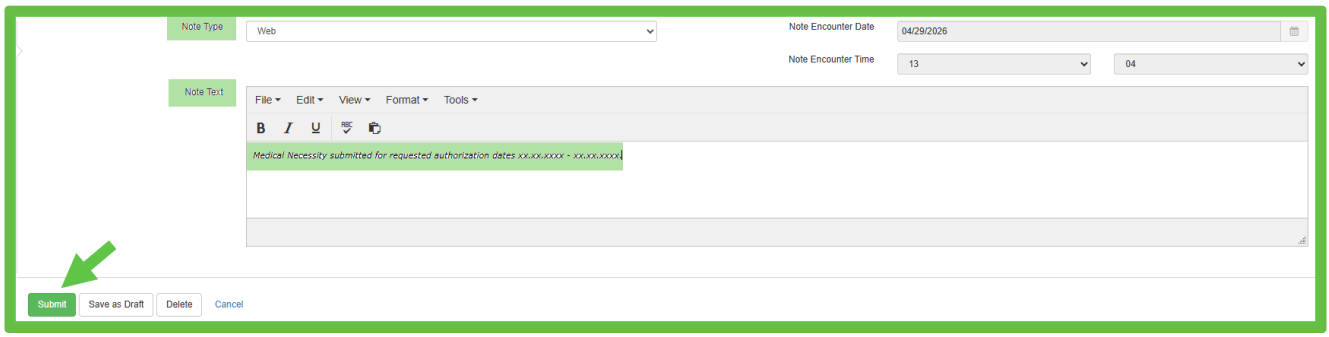


- Please note, you are only able to initially upload four (4) documents, as noted by the alert (pictured below).
  How to upload additional documents is covered in later steps.



11. Enter the **Note Text** as follows:

- **Note Type:** Web (auto populates).
- **Note Encounter Date:** Skip (date auto populates).
- **Note Encounter Time:** Skip (auto populates).
- **Note Text:** *Medical Necessity submitted for requested authorization dates xx.xx.xxxx - xx.xx.xxxx.*



- Select **Submit**.

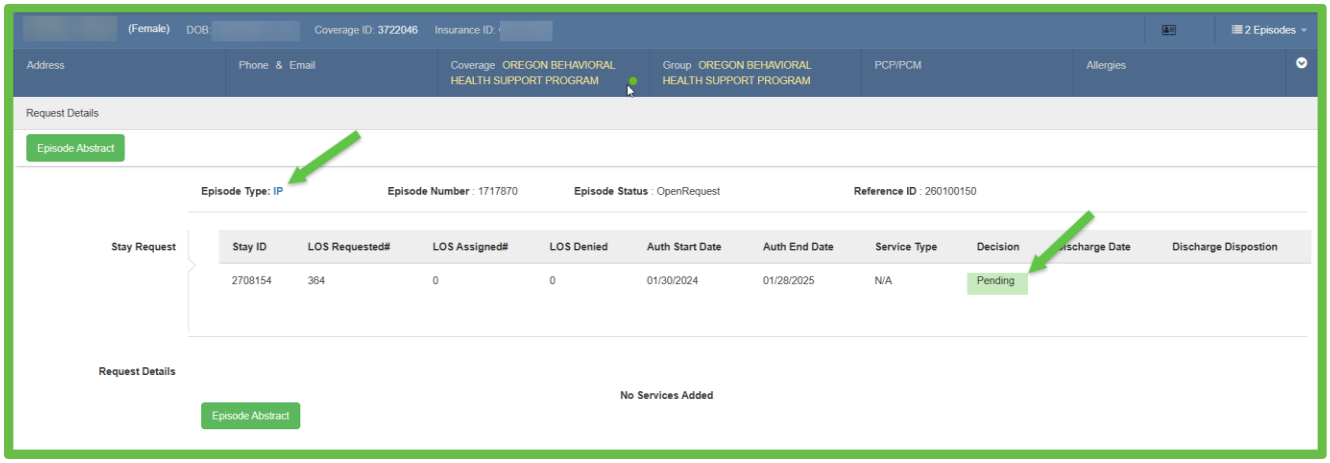


Congratulations! You have submitted a Medical Necessity Request via the CHPP.

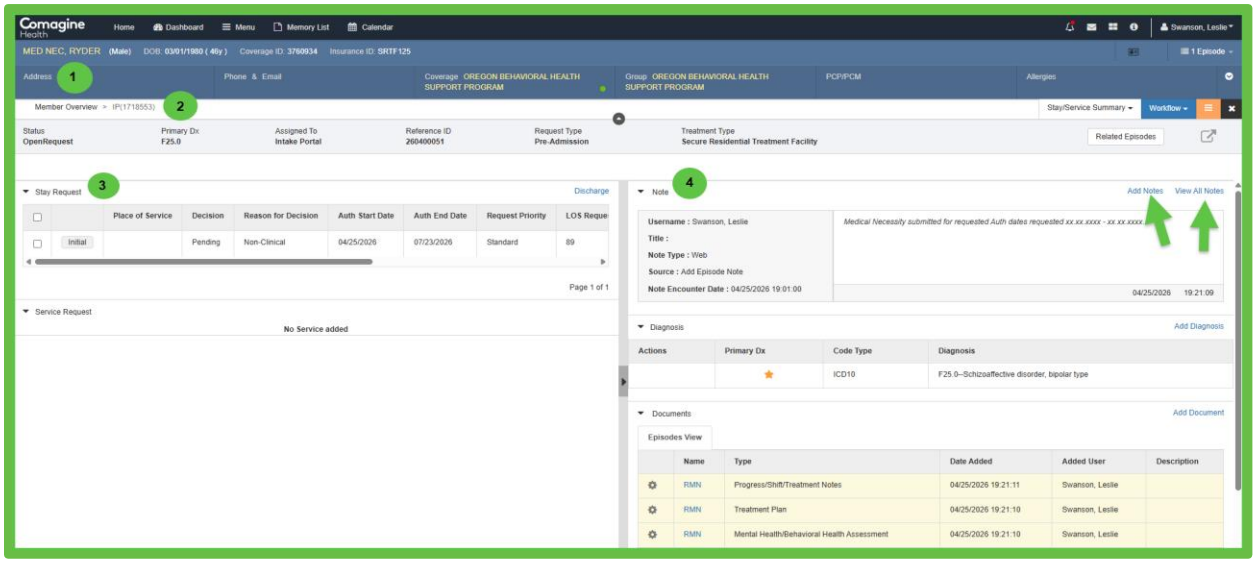
View Summary Page

A summary page will populate after submission.

- Decision – **Pending** indicates this was submitted to Comagine Health.

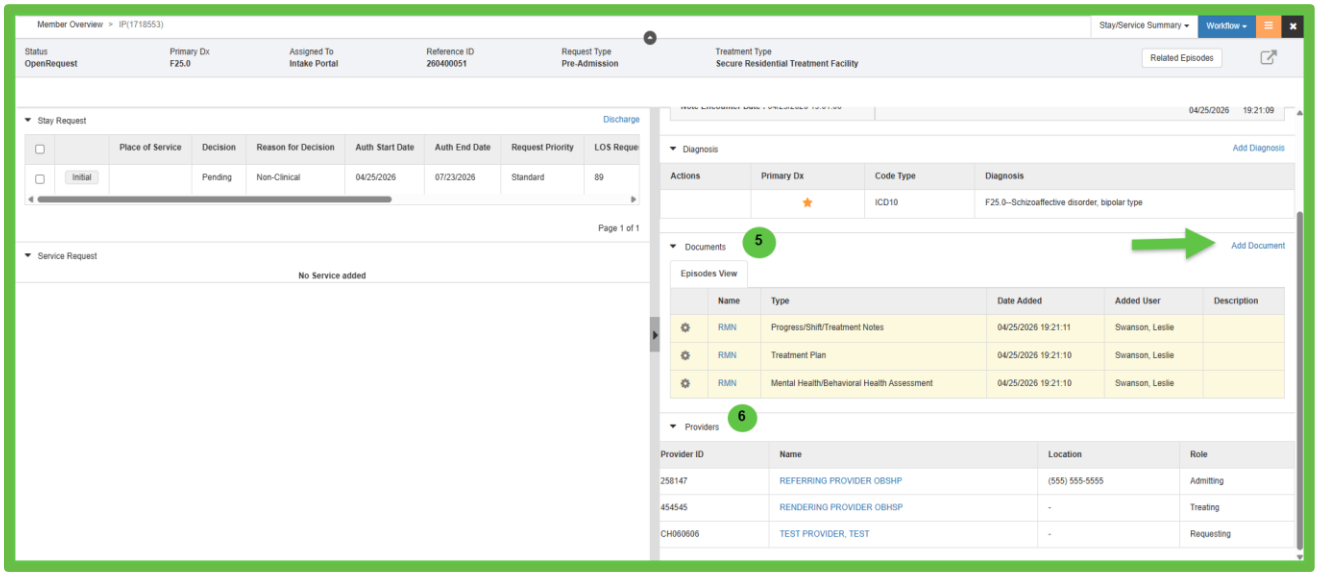


- Select **IP** next to **Episode Type** to open individual's episode in the CHPP.
  1) Individual's demographic information.
  2) **Jiva Episode Number –** Once a referral is submitted, the individual will have an episode number. If questions arise about individual's specific Medical Necessity/Medical Appropriateness Authorization Review Request, this is an identifier Comagine Health may ask for.
  3) **Stay Request –** Captures the authorization dates requested.
  4) **Note -** Web Notes that captures communication within Jiva between Comagine Health, Oregon Health Authority and Providers.
     - **View All Notes** – View of all web note communications.
     - **Add Notes** – Utilize for future communication with Comagine Health. Steps outlined later.



  5) **Documents –** View of all documents that were submitted.
     - To add additional documents, select **Add Document** and follow steps previously completed for uploading a document.

6) **Providers –** Overview of providers attached to episode.



Web Notes

To send a **Web Note** to Comagine Health:

- Select **Add New Note**. Once this is selected, a note page will auto populate.

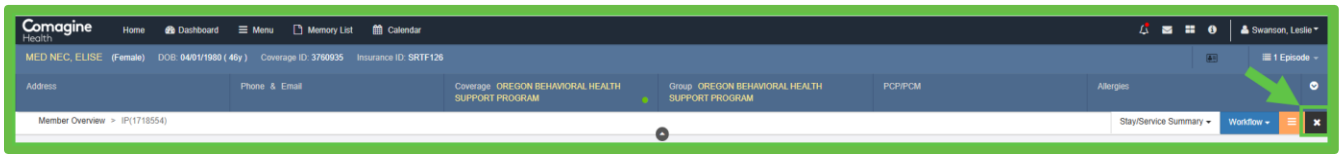


1) **Note Type –** Web Note will be the only option.
2) **Note Encounter Date –** Auto populates with today's date. Do not change.
3) **Note Encounter Time –** Auto populates. Do not change.
4) **Note Text –** Field to communicate with Comagine Health.
5) **Save –** Two options to save the note. Saving the note sends it forward to the IQA.
6) **Cancel** - Two options to cancel the note. If **Cancel** is selected, a new note will need to be created.

- Complete the following fields.

a. **Note type:** Web Note.
b. **Note Text:** Communication for Comagine Health.
   - Example: Additional supporting documents have been uploaded to assist the IQA review.
c. Select **Save.**

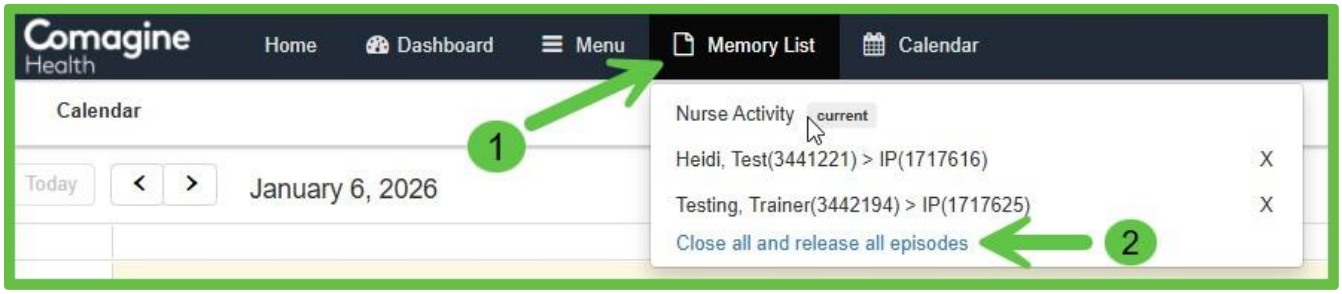
Once you are done with the submission, or follow-up in the episode, you will **X** out of the episode. While you are in the episode, other parties (including Comagine Health) are unable to work in the episode.



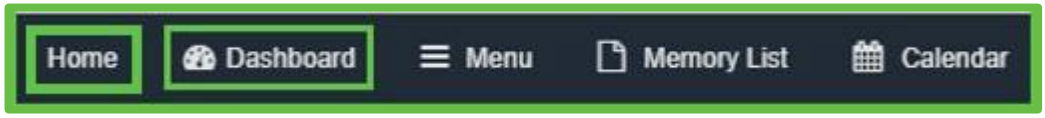
Memory List

Always remember to clear the Memory List. If an episode is in your **Memory List**, other parties (including Comagine Health) are unable to work in the episode.

1) Select **Memory List** from web page header. This will trigger a drop-down list of any episodes the user has opened.
2) Select **Close all and release all episodes**.



- To get back to your Dashboard at any point, select **Home** *then* **Dashboard** located on the top left of your screen.



Version Information

Version Number	Date Revised	Description	Author
1.0	04/26/2026	Initial Medical Necessity	Leslie Swanson
1.1	10.14.26	Update to required documents.	Leslie Swanson