Comagine Health

Oregon Behavioral Health Support Program

IQA Secure Residential Treatment Facility (SRTF) Medical Necessity/ Medical Appropriateness Reconsideration Request

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

Fax: 877-575-8309 **Secure email:** ORBHSupport@comagine.org **Mail:** Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Reconsideration Request Date:

Consumer Name: **Medicaid ID#:**

Provider Name: **Provider #:**

Address: **Phone:**

Point of Contact for Reconsideration Request:

Name/title:

Email: **Phone:**

Service request dates for the reconsideration request:

Which Oregon Administrative Rules (OARs) 410-172-0720(7) for SRTF medical necessity/medical appropriateness is this reconsideration request related to?

☐ 1. The individual does not require 24-hour hospital care and treatment.

☐ 2. The individual requires highly structured and secured environmental supports and supervision 24 hours a day, 7 days a week in order to participate successfully in a program of habilitative and rehabilitative activities.

☐ 3. 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:

- ☐ A. Clear intention or specific acts of bodily harm to others.
- ☐ B. Ideation of suicide with intent and ability if not in a secured environment or of self-harm posing significant risk of serious injury.
- ☐ C. 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 judgement and awareness to the degree that the individual may place themselves at risk of imminent harm.

☐ D. Due to the symptoms of a mental illness, there is significant risk that the person will not remain in a place of service for the time needed to receive the services and supports necessary to resolve the symptoms of a mental illness that pose a threat to the person's safety and well-being.

List all documents that are being submitting with the reconsideration (check all that apply):

☐ Clinical/Progress Notes Date from: _____ Date to: _____

☐ Mental health assessment Date: _____

☐ Residential 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

☐ ADL/IADL Logs

☐ Medical Assessment/Evaluation(s) (physical/speech therapy, acute, etc.) Date/s: _____

☐ Other (provide details):

****Please provide a comprehensive summary of the reconsideration request. Details to include page numbers of documentation to support the reconsideration related to identified OAR 410-172-0720(7) criteria.**

Signature

I hereby confirm that all information provided is accurate and current as of the date of the reconsideration request.

Signature	Name and Title	Date

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