Behavior Rehabilitation Services (BRS) Authorization Process

Question and Answers

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Process changes

Why did the authorization process change?

The process changed for many reasons including:

- State and federal regulations require Oregon Health Authority (OHA) to ensure prior authorization processes are consistent across all Medicaid programs.
- OHA's review of current processes identified where to better align processes with BRS Oregon Administrative Rules (OARs) in chapter 410, division 170.
- OHA, Oregon Youth Authority (OYA) and Oregon Department of Human Services – Child Welfare (ODHS – CW) continued efforts to improve the BRS program.

Did the BRS rules change?

No. There have been no rule changes regarding the prior authorization process. OHA is only updating the process to align with rule.

You can learn more about upcoming rule changes by visiting OHA's BRS website.

What is an LPHA?

An LPHA is a Licensed Practitioner of Healing Arts. LPHA is defined in OAR 410-170-0020 as "a physician or other practitioner licensed in the State of Oregon who is authorized within the scope of the LPHA's practice, as defined under state law, to diagnose and treat individuals with physical or mental disabilities or psychosocial, emotional, and behavioral disorders."

OHA contracts with Comagine Health to perform the duties of an LPHA. Their role is to determine if BRS are medically necessary and medically appropriate as defined in OARs 410-151-0001(3)(4) and 410-170-0040(3).

They do not make the final authorization decision. OHA is responsible for that decision using BRS eligibility criteria described in OAR 410-170-0040(2). OHA also reviews any adverse determinations from an LPHA before making a final decision.

What else is changing?

Urgent requests are no longer available for BRS prior authorizations. Urgency for Medicaid refers to when a child is experiencing a physical or psychological health emergency. Urgency from the Medicaid definition cannot be applied to BRS. Instead, for situations like BRS, Medicaid allows for a preliminary and retroactive request.

OHA has posted updated guidance for the retroactive request process on the BRS website.

How can we get requests through review as quickly as possible?

Through staff feedback and processing requests we have identified these best practices:

Fill out the request form completely.

Please include your email and the child's mailing address. This information is often missing but is required for OHA to process the request.

Explain why you think the child needs BRS.

The Notes section of the request form is an ideal place for the requester to describe why they think the child needs BRS.

- A court order is not sufficient reason for Medicaid to fund the service.
- The explanation should focus on how the child will benefit from the specific scope of BRS and why BRS is medically necessary and medically appropriate, for example what behaviors are best addressed through BRS.

Include all required documentation.

We encourage staff to attend OHA's technical assistance sessions. Also see the Supporting Documentation and Continued Authorization Process portions of this FAQ.

Will there be more trainings on this topic?

Yes, OHA is currently scheduling trainings and informational sessions. Once scheduled this information will be available on OHA's BRS website at https://www.oregon.gov/oha/hsd/ohp/pages/policy-brs.aspx

Where to find required forms and information

Where can I find forms and instructions?

BRS forms, instructions, policy memos, and other resources can be found on OHA's BRS website at https://www.oregon.gov/oha/hsd/ohp/pages/policy-brs.aspx

Why do I need to send emails securely?

You must send emails securely when you are sharing information about an OHP member's care which includes personal and confidential information related to the child's health. Confidential health information is also called protected health information (PHI). PHI includes physical and mental health histories and substance use disorder information. Federal law has special protections for PHI.

Why do I have to include an address for the child?

The child is an Oregon Health Plan (OHP) member. OHA may have to send notices or other information directly to the member.

If the child is homeless, the mailing address should be the location where they can receive mail, or their guardian can receive mail on their behalf.

Where do I find the Medicaid ID for the child?

You can find the child's Medicaid or OHP ID (aka prime) number:

- On the child's Oregon Health ID card (issued to the child or their parent/guardian)
- In the Medicaid Management Information System (MMIS)
- For OYA staff: On request documents (they will autofill pulling from JJIS under the ID Numbers tab)
- For ODHS staff: In OR-Kids under the Person Management tab
- State staff can also seek assistance from support staff

What if the child does not have OHP?

Some children will not be eligible for OHP until they enter BRS under substitute care eligibility as described in OAR 410-200-0110(8)(a)(A).

- If you have verified that the child you are working with does not have a Medicaid ID at the time of BRS referral, you will need to explain this in the Notes section of the request, citing the substitute care rule described above.

Where do I find the provider's Medicaid ID?

The Oregon Medicaid ID number for a provider starts with "500", BRS provider type is an "06" and can be found by:

- Looking up the provider in MMIS
- Looking in the "Active FFS Providers" list on OHA's Provider Enrollment website
- For OYA staff: Looking in the provider's JJIS notebook; staff can also refer to their internal document titled: *BRS Flow Chart*

What if the LPHA requests information I do not have?

Try your best to obtain information or documentation from outside sources to answer the LPHA's questions. This can be a narrative answering the questions or documentation from other sources.

If you do not have any other information or documentation to provide, let the LPHA know. Lack of response could delay the processing of your request.

Why do I have to include my email on the request form if I am sending the email?

Multiple OHA staff process authorization requests. They use the information on the request form to contact the requester. Although some requester's emails can be found in Outlook, OHA staff must comply with HIPAA rules for protecting health information and take extra measures to reduce the risk of errors.

Please fill out the form as directed and include your email address in the requester section.

All emails that include any client specific information must be sent securely. This includes requests to BRS providers, state staff, and county staff.

Medical necessity and medical appropriateness criteria

What is medical necessity and medical appropriateness? Why does it matter?

State and federal regulations require that all Medicaid and OHP covered services paid with Medicaid funds be medically necessary and medically appropriate.

The definition of Medical Necessity for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program covered population can be found in OAR 410-151-0001 (4) and means[1]:

- Health services, items and medical supplies that are required to address one or more of the following for an EPSDT Beneficiary[2]:
  - The prevention, diagnosis, treatment or amelioration of an EPSDT Beneficiary's disease, condition, or disorder that results in health impairments or a disability;
  - The ability for an EPSDT Beneficiary to achieve age-appropriate growth and development. Services that may be EPSDT Medically Necessary to achieve age-appropriate growth and development include but may not be limited to services that are reasonably calculated to improve the EPSDT Beneficiary's ability to participate in work or school, or the prevention, diagnosis, detection, treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability, regardless of whether they are included on the Prioritized List of Health Services (defined

[1] Staff should also refer to the Secretary of State website for the most updated rule language.

[1] EPSDT Beneficiary includes OHP members who under the age of 21

in OAR 410-120-0000) or are below the funding line on the Prioritized List of Health Services;

- The ability for an EPSDT Beneficiary to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
- The opportunity for an EPSDT Beneficiary receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, to participate in their own care planning, and to live and work in the setting of their choice.

- An EPSDT Medically Necessary service must also be EPSDT Medically Appropriate. All covered services must be EPSDT Medically Necessary for the EPSDT Beneficiary.

The definition of Medical Appropriateness can be found in OAR 410-151-0001(3) and for BRS specifically in OAR 410-170-0040(3) and means[3]:

- Health services, items, or medical supplies that are:
  - Recommended by a licensed health practitioner practicing within the scope of their license; and
  - Safe, effective, and appropriate for the EPSDT Beneficiary and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and
  - Impactful in improving access to care, ability to actively participate in care, work, school, or social activities and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or medical supply; and

[3] Staff should also refer to the Secretary of State website for the most updated rule language.

    - The most cost-effective level or type of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.
- All covered services must be EPSDT Medically Appropriate for the EPSDT Beneficiary, but not all EPSDT Medically Appropriate services are covered services.

AND for BRS specifically means that a:

- BRS program is medically appropriate because the individual:
    - Has a primary mental, emotional, or behavioral disorder or developmental disability that prevents the individual from functioning at a developmentally appropriate level in the individual's home, school, or community;
    - Demonstrates severe emotional, social, and behavioral problems, including but not limited to: Drug and alcohol abuse; anti-social behaviors requiring close supervision, intervention, and structure; sexual behavioral problems; or behavioral disturbances;
    - Requires out-of-home behavioral rehabilitation treatment to restore or develop the individual's appropriate functioning at a developmentally appropriate level in the individual's home, school, or community;
    - Is able to benefit from the BRS program at a developmentally appropriate level;
    - Does not have active suicidal, homicidal, or serious aggressive behaviors; and
    - Does not have active psychosis or psychiatric instability.

Is a court order for community placement or BRS enough for a prior authorization?

No, BRS is a Medicaid-funded program. Medicaid only pays for services that are medically necessary and medically appropriate.

The state or county may use their general funds to cover costs for placement or services to youth in the state's custody who were denied a prior authorization for BRS.

What kind of behavior may indicate BRS is appropriate?

It will vary based on the child's individual's needs. The purpose of BRS is to remediate or improve debilitating psychosocial, emotional, and behavioral disorders or conditions. BRS does this by providing such services as behavioral interventions and skills training. Services are delivered in a way that integrates a gender-responsive, culturally sensitive, trauma-informed, and age-appropriate or developmentally appropriate approach.

Based on the purpose of BRS and services provided through BRS, you should detail your opinions or observations on why you think BRS is necessary and appropriate for a child. Put this information in the Notes section of the request form.

What could illustrate that BRS is medically necessary and medically appropriate?

You can provide any information that will fill gaps in the documentation and explain why the youth needs BRS. For example, observations could help describe:

- How the child's needs align with the purpose of BRS and OAR 410-170-0010.
- How the youth is responding to current supports and current status of symptoms that if the child has a history of active suicidality or homicidality, serious aggressive behaviors, psychosis or psychiatric instability:
    - Context of past behaviors or symptoms including frequency, intensity, duration, and environmental factors associated with increasing or decreasing the behaviors or symptoms.
    - Past response strategies to address serious behaviors or symptoms.
    - How the youth is currently handling stressful and frustrating situations or current impulsive behavior.
    - The duration since the last significant event or newness of any behavior.
- Any available holistic context such as:
    - Any comorbid MH/SUD conditions that have since been treated,
    - The child's current connection with other foundational supports:
        - Is youth is getting consistently sufficient sleep or food?

        - Do they have contact with natural supports?
        - Have they withdrawn from substance use?
        - Do they have a different peer group?
    - Traumatic events or experiences
    - Whether the contextual factors persist or not
    - Whether serious aggression is pervasive or linked with a certain individual or setting.

Examples would not include the following:

- Child was court-ordered to be placed in BRS
- Child is homeless and needs supervision

Diagnosis information

Why do we have to have an ICD-10 diagnosis code?

All authorization requests must include an ICD-10 diagnosis code. The diagnosis code helps explain the health condition that makes BRS medically necessary and medically appropriate (OAR 410-151-0001).

Is there a specific ICD-10 diagnosis code for BRS?

No. Many diagnoses may be appropriate for BRS services. The diagnosis is one part of demonstrating medical necessity and medical appropriateness.

The diagnosis should be the most specific health reason that a child requires BRS/out of home services and supports.

Is a diagnosis enough to qualify a child for BRS?

No. No diagnosis alone can describe why a child needs BRS. The child must meet all criteria in OAR 410-170-0040. In addition to a diagnosis, there must be supporting documentation that describes how the diagnosis:

- Affects the child's ability to function at a developmentally appropriate level and
- Requires out of home BRS placement and services.

Examples of supporting documentation include assessments, evaluations, court documents, staff observations, medical records and other documents that describe the child's current health status, behaviors, response to existing and previous supports and services.

Does the ICD-10 diagnosis code on the request have to demonstrate the need for BRS?

Yes, BRS must be medically necessary and medically appropriate. This means BRS must address behaviors connected to the diagnosis or life circumstances.

Diagnoses that are not expected to be directly impacted by BRS, such as diabetes, asthma, or pain in the limb, do not need to be included in the request. Physical health diagnoses will not support the medical necessity and medical appropriateness of BRS.

How long is a diagnosis considered valid for BRS medical eligibility determinations? For example, would a diagnosis from two years ago be an issue?

The diagnosis must be an active or currently relevant diagnosis. If there are *no* current signs or symptoms of the diagnosis documented at the time of the BRS request, then it is not likely relevant to the medical necessity or medical appropriateness of BRS.

Where can you find diagnosis codes?

For non-crisis situations:

You can find this information:

- In the supporting documentation.
- By asking a parent/guardian/other medical professionals.
- By engaging an internal professional who is licensed to diagnose or is certified as a master's level QMHP. The professional should consider:
    - BRS are expressly for child and youth with debilitating psycho-social, emotional and behavioral disorders.
    - OHA interprets this to include children and youth who have experienced a condition or problem associated with increased risk for a mental health

condition, emotional, behavioral, or substance use disorder, or developmental disability.

- This includes conditions represented by the Z series of ICD-10 codes.

For crisis situations:

Work with local mental health or crisis providers to assess the crisis situation and most appropriate options for the youth. This may or may not result in the recommendation for BRS and a diagnosis code.

What if there are no diagnosis codes in the documentation available?

If your documentation has a written diagnosis but no ICD-10 code you can:

- Work with the diagnosing provider to identify the correct code.
- Engage a professional coder for assistance within the scope of their profession.

If these efforts do not result in an ICD-10 diagnosis code, you can complete a BRS Diagnosis Code Assistance Request form. Include it with the BRS authorization request. Both forms are on OHA's BRS website.

The Diagnosis Code Assistance Request is optional and should be used only in the situation described above.

Can I google or use an ICD-10 code cheat sheet to assign an ICD-10 code?

No, only individuals who can diagnosis within the scope of their profession can assign an ICD-10 code to a client. You can complete a BRS Diagnosis Code Assistance Request form. Include it with the BRS authorization request. Both forms are on OHA's BRS website.

What is a Z code?

Z codes are ICD-10 codes that describe life circumstances that can affect health and reasons for needing health care services and are assigned by qualified individuals within the scope of their profession.

Z codes can be used with other diagnostic codes, for example Major Depressive Disorder (F33) and personal history of neglect in childhood (Z62.812). Z codes can also be used alone when there is no other more specific diagnosis.

Diagnosing Z code conditions does not require a mental health assessment.

Examples of life circumstances that may result in a child needing BRS services before they have engaged in behavioral health services include maltreatment, experience of violence, and caregiver substance use.

Is recent self-harm identified as active suicidality?

Self-harm alone does not indicate active suicidal ideation or intent. The request should also identify acute, new, or untreated mental health needs resulting in active suicidal or homicidal statements, plans, or behaviors.

Supporting documentation

What type of documentation should I submit for juvenile justice involved youth?

Requestors should submit any information that shows why the youth requires and would benefit from BRS including but **not** limited to:

- Risk and Needs Assessment (RNA),
- Case plan,
- Relevant screenings,
- Mental health assessments or evaluations,
- Psychological exam,
- Juvenile Crime Prevention (JCP) risk assessment,
- Observations in the Notes section describing medical necessity and medical appropriateness for BRS,
- Other documentation from providers the client is engaged with,
- Medical or behavioral health documentation from parents or guardians, or

- Substance abuse assessments or evaluations.

Can I submit a psychological exam that is over a year old, but is the only exam or assessment I have?

You can submit older documentation to support the current reason the youth needs BRS. Be sure the request includes information or narrative in the notes section of the request about why the youth currently needs BRS, why it is medically necessary, and why it is medically appropriate.

Can you provide examples of helpful narrative or observations?

Yes, overall helpful narrative or observations from the individual requesting authorization for BRS services can be added to the notes section of any request. Here are some redacted examples:

- X is currently in detention... X will remain there until X's commitment hearing placing X into custody of the Oregon Youth Authority on... X was placed in detention for absconding from their residence on... X is on probation with… for Unauthorized Use of a Motor Vehicle. There was a DHS report made recently that X was assaulted. . There were also allegations that X had been raped. On… X's brother, committed suicide.
    - Other documentation submitted included incident reports, but this narrative speaks to the youth's experience of trauma and need for BRS services.

I have a child going through adjudication. The attorney is limiting access to behavioral health assessments or evaluations. What should I do?

Use the documentation you can access to justify the medical necessity and medical appropriateness for BRS by:

- Requesting available documents from other sources.
- Writing observations and information in the Notes section of the request on why, in your professional opinion, this youth needs BRS services.

Prior authorization process

What information is required for preliminary approval of retroactive eligibility?

Your secure email requesting preliminary approval should include:

- Child's name, date of birth and Oregon Medicaid ID
- Requester's name and contact information
- Reason retroactive eligibility is being requested (why a standard request is insufficient)
- Name of the BRS provider accepting the placement
- Planned date of admission
- Summary of why BRS is medically necessary and medically appropriate for the child.

If a child is placed before OHA grants preliminary approval, they will not meet criteria for retroactive eligibility.

A recent memo on OHA's BRS website clarifies the retroactive eligibility process.

How do we seek preliminary approval outside of business hours?

OHA staff is available only during standard business hours. Staff check in the morning and several times throughout the day for any requests.

Outside business hours, organizations and agencies can use non-BRS options until a prior authorization or preliminary approval can be obtained.

What if the actual placement varies from the type of BRS requested?

Upon approval of a request, OHA will follow up and ask about the actual placement type and provider information for our records.

How do I inform OHA of the child's BRS placement or changes in placement?[4]

Send a secure email with the following information to BHMC@oha.oregon.gov:

- Child's legal name and Medicaid ID
- Previous BRS placement information, if applicable:
  - Legal name of provider
  - Discharge date
- Current placement:
- Legal name of provider
  - Provider's Oregon Medicaid ID
- Type of BRS provider
  - Admission date

How will a child turning 21 during a Prior Authorization period effect the end date?

Medicaid covers BRS for children through age 20. If a youth is turning 21 during the standard authorization timeframe the authorization will end the day before the 21st birthday.

If you notice an authorization end date is past the 21st birthday please notify OHA immediately so the notice can be corrected.

How long is an authorization valid if a child is not admitted into BRS right away?

For youth placed in any setting other than BRS, the approval will remain active for 90 days as long as the child's condition or eligibility factors do not change.

If any of these changes happen during the 90 days, the authorization will end:

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[4] State staff are exempt from this requirement.

- There has been a change of condition (a new diagnosis, new behaviors, changes in behaviors resulting in emergency services).
- There is documentation during that 90-day timeframe that the child's condition or eligibility factors have changed, including:
    - The child no longer has a primary mental, emotional, or behavioral disorder or developmental disability that prevents the individual from functioning at a developmentally appropriate level in the individual's home, school, or community;
    - The child no longer demonstrates severe emotional, social, and behavioral problems, including but not limited to: Drug and alcohol abuse; anti-social behaviors requiring close supervision, intervention, and structure; sexual behavioral problems; or behavioral disturbances;
    - The child no longer requires out-of-home behavioral rehabilitation treatment to restore or develop the individual's appropriate functioning at a developmentally appropriate level in the individual's home, school, or community;
    - The child is not able to benefit from the BRS program at a developmentally-appropriate level;
    - The child has had active suicidal, homicidal, or serious aggressive behaviors within the 90 day timeframe;
    - The child has had active psychosis or psychiatric instability within the 90 day timeframe
    - The member has turned 21 and is no longer a child per Medicaid regulations;
    - The child started receiving residential services through a BH or I/DD residential provider with no planned discharge within 90 day timeframe; or
    - The child is no longer eligible for Medicaid/OHP.

What if an authorization is expiring?

OHA is working on a pending notice process to notify requesters, parents or guardians, and youth 18 or older within 45 days of upcoming authorization expirations.

For youth currently in a BRS setting:

If youth will need to remain in BRS beyond the end date of the authorization, state or county staff should submit a BRS Request for Continued Authorization.

For youth not yet in BRS:

State or county staff will need to complete a new BRS Prior Authorization Request no later than 15 calendar days before the current 90 day authorization expires.

- The request can include:
  - Statement in the notes section notifying OHA that the child has not yet began receiving BRS services.
  - Any new documentation or service notes from current providers such as primary care providers, outpatient mental health or substance abuse providers,
  - Any assessments or evaluations performed since last authorization, and
  - Observations on current condition, similarities or changes since the last authorization request.

Requests submitted later than 15 days before the 90-day end date may cause a gap in dates of authorization.

For youth placed but discharged from BRS without completing the program:

If discharge is due to circumstances not related to their condition:

The current authorization will remain active until the current authorization end date or after 90 days of not being in BRS, whichever comes first.

- If the youth is placed in a new setting within that timeframe, the current authorization remains valid. Submit a BRS Request for Continued Authorization.
- If the youth is not placed in a new setting within that timeframe, the current authorization expires. Submit a new BRS Prior Authorization Request. If immediate placement is required, you can follow the retroactive request process.

- Please indicate in the notes section of the request the details of the situation.

If discharge is due to a change in condition or eligibility factors:

Submit a new BRS Prior Authorization Request for future BRS placement. A new request is required to ensure the child continues to meet medical necessity, medical appropriateness, and authorization criteria for BRS.

Continued authorization (aka reauthorization) process

When should state or county staff request continued authorization?

Do this at least 30 calendar days before the end of the current authorization.

Approximately 45 days before you submit the request, start to gather the information you need:

- Request required documentation from the BRS provider to justify ongoing medical necessity and medical appropriateness for BRS:
  - Notify providers of the date you need to receive the information by
  - See the supporting documentation section of the FAQ for additional information.
  - You can submit more than the required documents if it can help justify the need for BRS.
- Complete the **Request for Continued Authorization for Behavior Rehabilitation Services** form:
  - Reach out to your team or to OHA (BHMC@oha.oregon.gov) if you need help completing the form.
  - Double check to make sure the form is completed in its entirety to avoid delays or gaps in coverage.
  - Submit request with required and supporting documentation 30 days before the current authorization end date.

What documentation is required for continued authorization?

Requesters must submit enough documentation to show why BRS services need to continue. At a minimum all requests for continued authorization must include:

- The child's most recent BRS service plan and
- The last 30 days of BRS service notes from the current BRS provider. If the child has been in care for less than 30 days submit all BRS service notes since admission and any other documentation from the BRS provider supporting the ongoing need for BRS services.
    - Service notes that are older than 6 weeks from the date the continued authorization request was received by OHA may not meet the required documentation standards to demonstrate the current status of the youth.

The following information is helpful to provide besides the minimum required. These optional documents can be included if the requester thinks they are necessary to support the continued need for BRS.

- Staff observations or narrative
- BRS Initial Service Plan
- BRS Assessment and Evaluation Report
- Mental health assessment
- SUD evaluation or assessment
- MH status exam
- Youth Correctional Facility – 4413 initial mental status assessment
- Risk and Needs Assessment
- Older BRS Master Service Plans if the current plan is a 90-day update
- Other documentation from providers the client is engaged with

I am a BRS provider who received a request for documentation to reauthorize service. What do I do?

- Your organization can respond to the request for information by the due date indicated in the request or in a timely manner.

- Your staff can offer any additional information or documents to further justify why continued BRS is medically necessary and medically appropriate.
- BRS OAR 410-170-0030(3) requires BRS providers and contractors to "provide access promptly to any information or written documentation in its possession related to the BRS client or its BRS program upon the request of the agency for any reason."

What are service notes?

Service notes are the written documentation from a BRS provider as described in OAR 410-170-0080(5). They describe the services provided including at minimum:

A. The name of the BRS client

B. Date of the service

C. Name and position of the staff member providing the service to the BRS client

D. Length of time staff spent providing the service to the BRS client

E. Description of the service provided

F. Description of the BRS client's participation in the service

Each type of provider is required to provide a minimum of 6 – 11 hours of BRS services per week depending on the type of BRS provider they are. That means 30 days' worth of documentation would illustrate 25 – 48 hours of services described above. If the documentation does not clearly reflect that level of service hours OHA may request the missing information.

Providers do not currently send service notes to OYA and ODHS staff. OYA and ODHS staff must request service notes to include in the reauthorization request.

What is a current service plan?

A service plan is the written individualized plan developed by the BRS contractor or provider. It identifies the services the BRS client must receive. OAR chapter 410, division 170 requires BRS providers to complete these service plans:

- Initial Service Plan (ISP): The ISP identifies the services to provide during the first 45 days in the BRS program or until the Master Service Plan is written.

- Master Service Plan (MSP): The MSP identifies the services to provide beyond the first 45 days in the BRS program. The provider must complete the MSP within the first 45 days of the child's admission to the program and then update the MSP every 90 days.

BRS reauthorization requests must include the most recent service plan completed by the BRS provider. For children who have been in a program longer than 135 days, some requesters have found it helpful to also provide the ISP or previous versions of the MSP to show progress or other changes experienced by the child.

Additional information can be found in OAR 410-170-0070.

What is an Assessment and Evaluation Report?

The BRS provider must ensure a social service staff member completes an assessment and evaluation of the BRS client. An Assessment and Evaluation Report (AER) details the findings of the assessment and evaluation. This must be completed within the first 45 days of admission.

Additional information can be found in OAR 410-170-0070(2).