INSTRUCTIONS:

1. If OHP is secondary payer, follow primary plan’s guidelines for coverage
2. Verify member eligibility, see Authorization Overview document. Member eligibility can change after an authorization has been issued impacting funded coverage. When eligibility changes prior to providing services the authorization will no longer be valid.
3. Refer to the Authorization Overview document for information about CareOregon’s relationship to Coordinated Care Organizations.
4. Verify the diagnosis/procedure is funded for treatment by using the Prioritized list. The prioritized list application can be accessed through the DHS MMIS provider web portal: https://www.or-medicaid.gov/ProdPortal/Account/SecureSite/tabid/63/default.aspx
5. For authorization requirement by CPT code, see No Authorization Required- CPT Code list. CPT codes not listed on this list require authorization for payment.
6. All services excluded by OHP require authorization for coverage
7. OHP rules allow up to 14 calendar days to process authorization requests (OAR 410-141-0263)

### Acupuncture
No Authorization required when performed by contracted clinicians affiliated with a PCP office, for chemical dependency treatment, for members receiving hospice care, or for members diagnosed with HIV

### Cardiac Rehabilitation
No Authorization required

### Day Surgery- performed at facility or ASC
1) May require authorization, see No Authorization Required- CPT Code list
2) For ASC procedures, the procedure must be approved for an ASC setting in order for claims payment. For a list of ASC approved procedures: www.cms.hhs.gov/ascpayment
3) Secondary procedures required to perform a primary procedure does not require authorization if primary procedure does not require an authorization

### Dental Surgery (not performed in dentist office)
Authorization required
<table>
<thead>
<tr>
<th>Service</th>
<th>Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs, Injectable, Chemotherapy</td>
<td>See pharmacy policy section of the CareOregon website</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>See DME No Authorization Required List on CareOregon website</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>No Authorization required</td>
</tr>
</tbody>
</table>
| Home Health                           | 1) Evaluations do not require authorization  
                                         2) All other home health services require authorization |
| Hospice services                      | No Authorization required |
| Inpatient Hospital Admissions- scheduled | 1) Requires authorization  
                                         2) CPT code list does not apply |
| Inpatient Hospital Admissions- Urgent/emergent | 1) Prior authorization is not required  
                                         2) Must notify concurrent review staff of admission |
| Inpatient rehabilitation admissions   | Authorization required |
| Medical Nutrition office visits       | No authorization required |
| Newborn care (first 28 days after birth) | No authorization required regardless of diagnosis except non-funded treatment |
| PCP Office visits                     | No Authorization required regardless of diagnosis |
| PCP Procedures done in office         | May require authorization, see No Authorization Required- CPT Code list |
| Obstetrician office visits            | No authorization for pregnant members required, regardless of diagnosis |
| Oncology visits/treatment             | No Authorization required regardless of diagnosis |
### Physical, occupational, and speech therapy

1. No Authorization required for evaluations for ATL diagnosis which pairs with CPT code

*CareOregon will allow an evaluation and five visits (combined) for members with BTL diagnosis annually with authorization.

### Procedures performed in office setting

May require authorization, see No Authorization Required- CPT Code list

### Skilled nursing facility admissions

Authorization required

### Specialist Office visits

1. No authorization if member has not been seen for 3 years, regardless of diagnosis
2. No authorization required for visits for Above the line diagnoses

### Specialist- in office procedures (see oncology, OB, and medical nutrition for exceptions)

May require authorization, see No Authorization Required- CPT Code list

### Transplants

Authorization required

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### Miscellaneous Information

**Excluded Services** - Excluded services are described in the DMAP Provider Guides. Examples of excluded services include:

- Cosmetic procedures
- Experimental or investigational treatments and procedures, including clinical trials and demonstration projects
- Infertility treatments for the purpose of establishing or re-establishing fertility
- Plasma infusions for treatment of Multiple Sclerosis
OHP Non-funded Services (Prioritized List) - Diagnosis codes that are BTL (fall below the funded line) or are on a “no line” (not on the prioritized list). Treatment codes that don’t pair with the diagnosis or pairs with dx AND is BTL are also non-funded.

Sterilization Procedures or Hysterectomy- A valid consent form must be present for payment. Timelines and forms are in the DMAP Medical-Surgical Services Provider Guide located at http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/130rb122812.pdf

Health and Wellness- Routine health exams, tests, and immunizations are covered benefits that do not require an authorization. See the member handbook on the CareOregon website for recommended exams, screening, and immunization schedules.

Diabetic Self-Management- Diabetic self-management education class/program is covered as a lifetime benefit of $400.00. Diabetic education class/program during pregnancy is covered for each pregnancy.

Chemical Dependency Services- Chemical dependency services may require an authorization depending on the Coordinated Care Organization.

- Columbia Pacific Coordinated Care – Authorization required for all services through Greater Oregon Behavioral Health Initiative.
- Health Share of Oregon – No authorization required. Coverage for residential treatment with PH Tech. Please contact PH Tech for authorization and coverage requirements.
- Jackson Care Connect – No authorization required. Coverage for residential treatment with PH Tech. Please contact PH Tech for authorization and coverage requirements.
- Yamhill Community Care Organization – Treatment is covered by Mid-Valley Behavioral Health Network. Please contact Mid-Valley for authorization and coverage requirements.
- Managed Care members – No authorization required.

Mental Health Services

- Columbia Pacific Coordinated Care – Authorization required for all services through Greater Oregon Behavioral Health Initiative.
- Health Share of Oregon – Coverage with the member’s MHO, please contact MHO for authorization and coverage requirements.
- Jackson Care Connect – Coverage with the member’s MHO, please contact MHO for authorization and coverage requirements.
- Yamhill Community Care Organization – Coverage with Mid-Valley Behavioral Health Network, please contact Mid-Valley for authorization and coverage requirements.
- Managed Care members – Coverage with the member’s MHO, please contact MHO for authorization and coverage requirements.
Vision Care-

**Routine vision** care benefit (to determine if member needs glasses or contacts) is limited to members <21yrs old, pregnant adults, and/or with diagnosis of aphakia, congenital aphakia, keratoconus, post cataract extractions, or post intraocular lens replacement.

- For qualifying members in Tillamook and Lincoln counties community providers submit claims to CareOregon and are paid without authorization. If glasses are needed they are obtained through the provider’s office or SWEEP optical.
- For qualifying members in all other counties, the OHP vision benefit is managed by VSP. Questions and authorizations can be obtained by contacting VSP at 1-800-852-7600.
- OHP limits glasses to 1 pair every 24 months

**Medical eye exams** are to diagnose and treat diseases and conditions of the eye. These services are not part of the VSP contract and providers should follow processes within this document to identify services requiring authorization.