Revised January 1, 2014

OHP and Advantage Members

Refer to the Authorization Overview document for information about CareOregon's relationship to Coordinated Care Organizations.

Prior Authorization Requirements
FREQUENTLY ASKED QUESTIONS (FAQS)

Q.1. **What is the difference between a referral and an authorization?**

A.1. **Referral:**
It is defined as the act of one professional recommending that another professional evaluate or provide treatment to the member. For example, the primary care provider refers the member to see a specialist. Or, the specialist refers the member back to their primary care provider.

Authorization:
It is defined as the process of obtaining confirmation that the service that will, or has been performed, is a covered benefit and will be paid for by CareOregon.

Q.2. **Does CareOregon require referrals in order for claims to be paid?**

A.2. No we do not.

Q.3. **If CareOregon does not require referrals, does anyone else require them?**

A.3 Some specialist offices will not schedule member appointments without a referral from the member's primary care provider (PCP). Often it is because it's a busy specialty clinic and they want to ensure that the PCP has evaluated the member and is of the opinion that they need to be seen by the specialist. Also, some ancillary providers may require a referral or provider order before scheduling diagnostic testing (e.g. mammograms).

Additionally, CareOregon promotes the medical home model and encourages members to discuss with their PCP the need for specialist evaluation and treatment before scheduling appointments. If the PCP determines that a referral to a specialist is medically appropriate, they will refer the member. This is stated in the Member Handbooks and by the CareOregon Customer Service staff when members ask about referrals to specialists.

Q.4. **Does CareOregon require authorizations in order for claims to be paid?**

A.4. For some services. For a list of services requiring authorizations, please see the CareOregon Authorization Guidelines for the member's primary insurance; Advantage Plus or Star **OR** CareOregon OHP Plus.

Q.5. **PCP office visits and procedures do not require an authorization according to the Authorization Guidelines. Does that include ALL services provided at the PCP office/clinic?**

A.5. No it does not. The Authorization Guidelines for non-PCP direct services apply. So if an authorization is required for a service (e.g. physical therapy treatment), then an authorization is required even though it's being provided at the PCP office/clinic.

Q6. **For PCP or specialist visits/procedures provided in an "office setting" that do NOT require an authorization, does this include "offices" within a hospital or other facility?**

A.6 Yes it does. Many providers have offices within a hospital or other facility. From an authorization standpoint, those "facility" offices are treated the same as a clinic or other physical structure that is setup to function as an "office".

Q.7. **Chemotherapy involving non-FDA approved agents require an authorization regardless of the CPT code listing in the Grid. Whereas chemotherapy for a FDA approved agent, where the CPT code is listed in the CPT Grid, does NOT require an authorization. If the CPT code is listed in the Grid and the agent is FDA approved, is an authorization required for an inpatient admit?**

A.7. Yes an authorization is required for ALL elective inpatient admits. If the admission is medically urgent, meaning that a delay in obtaining a prior authorization would place the member at risk for an adverse clinical outcome, then the hospital needs to notify CareOregon's concurrent review staff by either calling or faxing the information to them. The concurrent review staff reviews the reason for the admission and will notify the hospital of their authorization decision.

Q. 8. **Does an emergency room visit require a prior authorization?**

A.8. No it does not. However, emergency room visits are subject to retroactive claims review and the "prudent layperson" rule is applied. In other words, if a prudent layperson would be of the opinion that their condition required urgent/emergent care, then the claim will be paid. On the other hand, if a prudent layperson would recognize that their condition, or their child's condition, did not require urgent/ emergent care (e.g. cold, diaper rash, tooth pain, etc), then only an assessment fee will be paid.

Q. 9. **Does an urgent/emergent <u>hospital admission</u> require prior authorization?**

A.9. No it does not. However, the hospital does need to notify CareOregon's concurrent review staff by either calling or faxing the information to them. The concurrent review staff reviews the reason for the admission and will notify the hospital of their authorization decision.

ADVANTAGE (PLUS and STAR) Members Only

Prior Authorization Requirements

FREQUENTLY ASKED QUESTIONS (FAQS)

Q.1. **As of January 1, 2011, the CareOregon Advantage Plan changed to a HMO-POS. What impact does that have on the authorization requirements?**

A.1. For primary care providers and specialists who practice in Oregon and Washington, members may see both participating and non-participating providers without an authorization for Medicare covered services provided in their office.

Q.2. **Since no authorization is required for Oregon/Washington PCPs and specialists, does the provider need to be loaded in QNXT?**

A.2. No! No authorization is required even IF the provider is not in QNXT.

Q.3. **Does this include ALL specialist types?**

A.3. It only applies to providers listed in the CareOregon Advantage Authorization Guidelines (e.g. MD, DO, etc).

Q.4. **Does this apply to ALL services provided in the PCP or specialist office?**

A.4. It only applies to services directly provided by the PCP or specialist in their office. It does NOT apply to ancillary services (e.g. physical therapy) that are available in their office. And, it does not apply to surgeries or procedures that are not done in their office. See the Authorization Guidelines and CPT code list for additional information.

Q.5. **Are there other services that do NOT require an authorization when provided by a non-participating provider?**

A.5. Yes there are. Hemodialysis in Oregon facilities and routine laboratory tests.

Q.6. **To make sure that I have this straight, if a code is on the CPT code list as NOT requiring an authorization BUT the ASC/hospital day surgery facility is non-participating with CareOregon, am I correct that an authorization is required?**

A.6. Yes you are. Even though the code is on the No Auth CPT code list, because the ASC/hospital day surgery facility is NOT contracted with CareOregon, in order for their claim to be pay they need an authorization.

OHP Members Only

Prior Authorization Requirements

FREQUENTLY ASKED QUESTIONS (FAQS)

Q.1. **Does a specialist office visit require an authorization?**

A.1. Not always. It depends on whether the visit is a **new** patient visit or follow-up visits, whether the **primary** diagnosis (reason mbr is being seen) is above the line (ATL) or below the line (BTL) and whether the treatment/procedure pairs with the **primary** diagnosis (reason for the treatment/procedure) and is above or below the line. Please see the CareOregon OHP Plus Authorization Guidelines for additional details.

Of note, a member may have several diagnoses, some ATL and some BTL. The need for an authorization is dependent on the reason for the visit (diagnosis) and whether that diagnosis is ATL or BTL. For example, a member may have diagnoses of diabetes and low back pain. The member is scheduled to see an endocrinologist for the diagnosis of diabetes. Diabetes is ATL so an authorization is not required even though the diagnosis of low back pain is BTL. On the other hand, this same member maybe scheduled for follow-up specialist office visits for the treatment of low back pain, since that diagnosis is BTL, an authorization is required for claims payment.

Q.2. **The OHP authorization guidelines state that a specialist office, new patient visit, does not require an authorization if the member has not been seen by the specialist within the past 3 years, regardless of diagnosis. My questions are:**

Q.2.a. **How is "new" defined?**

A.2.a. It is defined as the first time the member has seen the specialist and the visit is usually requested by a PCP to assist in diagnosing or recommending treatment options.

Q.2.b. **What if I don't know if the member has or has not seen the specialist within the last 3 years and the diagnosis is below the line or is on no line?**

A.2.b. If you don't know, then submit an authorization request to CareOregon.

A.2.c. **For below the line or no line diagnosis, what can be done during the "new" patient visit that does NOT require a prior authorization?**

A.2.c. The diagnostic procedures listed in the CPT code list do not require a prior authorization. ALL treatment procedures that involve a below the line or "no line" diagnosis or don't pair with the diagnosis ALWAYS require a prior authorization.

Q.2.d. **Does this rule apply to a specific specialist or does it apply to the clinic?**

A.2.d. It applies to the specialty clinic. In other words, if OHSU Gastroenterology clinic has seen the member within the last 3 years and the member is calling to schedule an appointment for a diagnosis that is **below the line** or **on no line**, then an authorization would be required.

Q.2.e. **What about someone who has a diagnosis of temporomandibular joint dysfunction (TMJ) and wishes to have an evaluation by a dentist who has not seen them yet, is an authorization required for this below-the-line diagnosis?**

A.2.e. Yes it is. The "new" patient visit in the Authorization Guidelines OHP Plus only applies to the specialist providers listed in the Guidelines **(MD, DO, etc)**. It does not apply to dentists.

Q.3. **For Specialist office visits that require an authorization, who needs to submit the authorization request?**

A.3. CareOregon will accept authorization requests from the PCP or specialist office. However, we recommend that the specialist office submits the request directly to CareOregon, because we respond to the office that sends in the request. If the PCP office staff makes the request, CareOregon notifies the PCP office, who then notifies the specialist office. This can result in delays. Additionally, if chart notes are required to process the request, working directly with CareOregon increases efficiency and avoids unnecessary delays.

Q.4. **How do I know what preventive services are covered?**

A.4. See the CareOregon Member OHP Plus Handbook posted on the CareOregon web site, **http://www.careoregon.org/member/index.html.**

Q.5. **Do therapy (PT, OT, ST) evaluations require an authorization?**

A.5. For **below the line** or **no line** diagnosis, an authorization is required for all evaluations. If the diagnosis is **above the line**, up to two (2) initial evaluations in any 12-month period can be done without an authorization; and up to four (4) re-evaluations in any 12-month period can be done without an authorization.

Q.6. **If an evaluation and treatment occur during the same therapy (PT, OT, ST) visit, does the treatment require an authorization if the diagnosis is above the line?**

A.6. Yes it is. Rehabilitation therapy treatment always requires an authorization for claims payment to occur.

Q.7. **Optometrists are licensed vision provider specialists that do eye exams for prescribing glasses and contacts as well as providing "primary eye care" services. My questions are:**

Q.7.a **What are "primary eye care" services?**

A.7.a They include diagnosing eye diseases such as glaucoma, cataracts and retinal diseases; diagnosing related systemic conditions that affect eyes such as high blood pressure and diabetes; and examining, diagnosing and treating visual conditions such as nearsightedness, farsightedness, astigmatism and presbyopia.

Q.7.b **Is authorization required for ALL optometrist office visits?**

A.7.b It depends; see CareOregon Authorization Guidelines – OHP Plus, for vision benefit details and authorization requirements. For members who do NOT have a vision benefit (non-pregnant adults), eye care services do require authorization in order for claims to be paid.

Q.7.c **What services are considered "routine" vision versus "primary eye care" or "medical eye" services?**

A.7.c Routine vision services are visits intended for the purpose of screening for disorders of refraction and accommodation (e.g. ICD9 codes 367-367.9; V72.0, etc.) and the need for glasses or contact lens. These services are not funded for non-pregnant OHP Plus adults.

Q. 8. **Do outpatient chemical dependency services require a referral from the member's primary care provider (PCP)?**

A.8. If the member thinks they need treatment for a drug or alcohol problem, they can either talk with their PCP or they can self refer to a participating CareOregon drug and alcohol dependency provider.