



OHP Members 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 be performed, 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 busy specialty clinics 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 OHP Plus and OHP Standard Authorization Guidelines.

- Q.5. Does a specialist office visit require an authorization?**
A.5. Not always. It depends on whether the visit is for a consult or a treatment, whether the diagnosis is above or below the line, and whether treatment pairs with the diagnosis and is above or below the line. Please see the CareOregon OHP Plus and Standard Authorization Guidelines.
- Q.6. The OHP authorization guidelines state that a specialist office visit “consult” 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.6.a. How is “consult” defined?**
A.6.a. It is defined as the first time the member has seen the specialist and is usually requested by a PCP to assist in diagnosing or recommending treatment options.
- Q.6.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.6.b. If you don’t know, then submit an authorization request to CareOregon.
- A.6.c. For below the line or no line diagnosis, what can be done during the “consult” visit that does NOT require a prior authorization?**
A.6.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.6.d. Does this rule apply to a specific specialist or does it apply to the clinic?**
A.6.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.7. For Specialist office visits that require an authorization, who needs to submit the authorization request?**
A.7. CareOregon will accept authorization requests from the PCP or specialist office. However, we recommend that the specialist office submit the request directly to CareOregon because we respond to the office that sends in the request. If the PCP office staff makes the request, we will notify the PCP office and the PCP office 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.8. How do I know what preventive services are covered?**
A.8. See the CareOregon Member Handbooks (Plus and Standard) that are posted on the CareOregon web site, <http://www.careoregon.org/member/index.html>.
- Q.9. Do therapy evaluations require an authorization?**
A.9. 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.10. If an evaluation and treatment are performed during the same visit, for the treatment (i.e., occupational, physical, and speech) is an authorization required if the diagnosis is above the line?

A.10. Yes it is. Rehabilitation therapy treatment always requires an authorization before claims will be paid.

Q.11. Optometrists often are Board Certified to do diabetic and glaucoma screening, in addition to performing routine vision screening for determining whether a member needs glasses. Are these services included in the VSP contract?

A.11. No they are not. VSP is only contracted by CareOregon to provide routine vision services, such as refraction and dispensing of glasses. Medical eye exam claims, such as diabetic and glaucoma screening, need to be submitted to CareOregon for payment. An authorization is required.

Q. 12. Does outpatient chemical dependency services require a referral from the member's primary care provider (PCP) and does the service require a prior authorization (PA)?

A.12. 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. Some treatment may require a PA. See the CareOregon Provider Manual for details.

Q. 13. Does an emergency room visit require a prior authorization?

A.13. 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. 14. Does an urgent/emergent hospital admission require prior authorization?

A.14. 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.