Authorization Guidelines

Last Revised: *April 1st, 2020*

GUIDELINES & INSTRUCTIONS

- Authorizations and claim payments are subject to member eligibility. 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.
- For authorization requirement by CPT code, see *No Authorization Required - CPT Code list*. CPT codes not listed on that list require authorization for payment.
- Provider contracts may have different requirements than below.
- **Ophthalmology/Optometry specialties must be contracted for payment, effective 05/01/2019**

For Medicaid (OHP) Plans (Columbia Pacific, Health Share and Jackson Care Connect):

- OHP rules allow up to 14 calendar days to process authorization requests
- If OHP is secondary payer, follow primary plan's guidelines for coverage
- All services excluded by OHP require authorization for coverage.
- Must verify the diagnosis/procedure is funded for treatment by using OHA's Prioritized List, found on Oregon's MMIS Provider Web Portal

For Medicare Plans (CareOregon Advantage):

- CMS coverage rules apply, including benefit limits. Certain types of excluded services have been added below for convenience, but this is not to be considered an exhaustive list.
- For Ambulatory Surgery Center (ASC) procedures, verify that:
  - The procedure is on the CMS ASC approved procedure list, and
  - That the ASC facility is approved by CMS.
    - Visit the CMS (Medicare) website: www.cms.hhs.gov/ascpayment

Services	CareOregon Requirements
Acupuncture	- Authorization required for COA and OHP
Anesthesia	- No authorization required, unless performed as primary procedure (i.e., pain management, etc.)
Cardiac Rehabilitation	- No authorization required
Chiropractic Care	- Evaluation: No Authorization Required - Treatment: Authorization Required ****Services subject to OHP Prioritized List Guide Note 56 (Back pain) may be authorized for calendar year (therapy codes), or benefit year****
Circumcision	- For OHP members under the age of 61 days, no authorization required
Day Surgery – *performed at Facility or ASC*	- May require authorization, see *No Authorization Required - CPT Code list* - For ASC procedures: o The procedure must be approved for an ASC setting for claims payment o For a list of ASC approved procedures, visit: www.cms.hhs.gov/ascpayment - Secondary procedure(s) 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
Diabetic Education	- No authorization required
Drugs, Injectable, Chemotherapy	- See the *Pharmacy Policy* section of the CareOregon website for authorization guidelines

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Services	CareOregon Requirements
Durable Medical Equipment (DME)	- See *DME No Authorization Required List* on CareOregon website
Hemodialysis	- No authorization required
Home Health	- Evaluation: No authorization required - Home Health Services: No authorization required ****Excluded home health services are not covered****
Hospice Services	- No authorization required
Inpatient Hospital Admissions – *scheduled*	- Requires authorization - CPT code list does not apply
Inpatient Hospital Admissions – *urgent/emergent*	- Prior authorization is not required - Must notify CareOregon of admission
Inpatient Rehabilitation Admissions	- Authorization required
Medical Nutrition – *office visits*	- No authorization required
Naturopathic Medicine	- Excluded by Medicare - OHP may require authorization, see No Authorization Required-CPT Code list - Services subject to OHP Prioritized List Guide Note 56 (Back pain) may be authorized for calendar year (therapy codes) or benefit year.
Newborn Care – *the first 28 days after birth*	- No authorization required regardless of diagnosis, except non-funded treatment
Obstetrics – *office visits*	- No authorization required for pregnant members, regardless of diagnosis

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Services	CareOregon Requirements
Oncology – *visits/treatment*	- No authorization required, regardless of diagnosis
Ophthalmology/Optometry	- For services under medical benefit, the provider must be contracted with CareOregon for payment
Out of State Providers	- All rules apply to both in-state and out-of-state providers
Primary Care Physicians (PCP) – *office visits*	- No authorization required, regardless of diagnosis
Primary Care Physicians (PCP) – *procedures performed in office*	- May require authorization, see *No Authorization Required - CPT Code list*
Prolonged Services	- Outpatient, Prolonged Service codes require medical record review for payment beginning DOS 05/15/2018 and forward: o *Submit supporting documentation with claim*
Therapy – *Physical, Occupational, Speech*	- Services authorized on a calendar year - For OHP: o No Authorization required for evaluations for ATL diagnosis which pairs with CPT code o Authorization required for therapy visits o Services subject to OHP Prioritized List Guide Note 56 (Back pain) may be authorized for calendar year (therapy codes) or benefit year o New requests for BTL conditions will require medical necessity review - For COA: o No Authorization required for therapy evaluations
Skilled Nursing Facility Admissions	- Authorization required

Services	CareOregon Requirements

Specialists – *office visits*	- For OHP:
	  ○ No authorization if member has not been seen for 3 years, regardless of diagnosis
	  ○ No authorization required for visits for Above the line diagnoses (cont.)
	- For COA:
	  ○ No authorization required

Specialists – *in-office procedures* *(see **Oncology**, **Obstetrics** & **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

For OHP:

- 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 establishing or re-establishing fertility*
  - *Plasma infusions for treatment* of Multiple Sclerosis

NON-FUNDED SERVICES

For OHP:

- 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 OR HYSTERECTOMY PROCEDURES

For COA:

- Sterilization procedures are excluded from Medicare.

For OHP:

- A valid consent form must be present for payment. Timelines and forms are in the DMAP Medical-Surgical Services Provider Guide located on OHA's website (search for Sterilization of Hysterectomy to access forms in English or Spanish).

HEALTH AND WELLNESS

- Routine health exams, tests, and immunizations are covered benefits that do not require an authorization. See the member handbook on the appropriate CCO (Coordinated Care Organization) or COA (CareOregon Advantage) website for more information.

Miscellaneous Information

CHEMICAL DEPENDENCY SERVICES

For COA:

- Not covered by Medicare

For OHP:

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

- Columbia Pacific CCO:
  - *Coverage for residential and detox treatment through CareOregon. Authorization required upon admission to residential with ASAM scoring 3.1 or higher.*
- Health Share of Oregon CCO:
  - *Coverage with the member's MHO (Mental Health Organization) – please contact MHO for authorization and coverage guidelines and requirements.*
- Jackson Care Connect CCO:
  - *Coverage for residential and detox treatment through CareOregon. Authorization required upon admission to residential with ASAM scoring 3.1 or higher.*

MENTAL HEALTH SERVICES

For OHP:

- Columbia Pacific CCO:
  - *Effective 06/01/2019, authorization is required for:*
    - *Subacute, Psychological Testing, Children's Psychiatric Day Treatment Services (PDTS), Children's Psychiatric Residential Treatment Services (PRTS), Applied Behavioral Analysis, Eating Disorder Treatment, and Electroconvulsive Therapy (ECT).*
  - *Authorization details can be found in the "Mental Health Level of Care" document located on CPCCO's website.*
  - *All related documents and forms can be found at: https://colpachealth.org./for-providers/policies-and-forms*
- Health Share of Oregon CCO:
  - *Please see careoregon.org/bhproviders for authorization requirements and UM Handbook*

Miscellaneous Information

MENTAL HEALTH SERVICES *(continued…)*

- Jackson Care Connect CCO:
  - *Authorization is required for:*
    - *Subacute, Psychological Testing, Children's Psychiatric Day Treatment Services (PDTS), Children's Psychiatric Residential Treatment Services (PRTS), Applied Behavioral Analysis, Eating Disorder Treatment, and Electroconvulsive Therapy (ECT)*
  - Authorization details can be found in the "Mental Health Level of Care" document located on JCC's website
  - *All related documents and forms can be found at: http://www.jacksoncareconnect.org/for-providers/policies-and-forms*

- Managed Care Members:
  - *Coverage is with the member's MHO – please contact MHO for authorization and coverage requirements*

VISION SERVICES

For OHP:

- Routine vision care benefit (to determine if member needs glasses, or contacts) is limited to members less than 21yrs old, pregnant adults.
- *Authorization is required for:*
  - *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 authorization details may 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.*

Miscellaneous Information

VISION SERVICES *(continued…)*

For COA:

- Medicare covers the diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening exam:
    - *These services may be performed by providers not contracted with VSP, and they do not require prior authorization. Examples include flashes of light, double vision, seeing spots of ghost-like images, dry or watery eyes, unusual difficulty adjusting to dark rooms, conjunctivitis, cataracts, etc.*
- Medicare also covers one pair of eyeglasses or contact lenses only after cataract surgery:
    - *No authorization required for both contracted and non-contracted providers; the claim is submitted to CareOregon Advantage.*
- Routine vision services, including glasses, are contracted to and managed by Vision Services Plan (VSP). They can be reached at 1-800-852-7600:
    - *Routine vision services are an "add on" and not typically covered by Medicare. They are an extra benefit offered to CareOregon Advantage members. Examples of routine vision are near-sightedness, astigmatism and other conditions that indicate the need for glasses or contact lenses.*

Summary of Recent Changes

- Acupuncture:
  - Removed “excluded from Medicare” language