INSTRUCTIONS:

1. OHP rules allow up to 14 calendar days to process authorization requests
2. If OHP is secondary payer, follow primary plan's guidelines for coverage
3. All services excluded by OHP require authorization for coverage
4. Authorizations and claims 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.
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. http://www.careoregon.org/Res/Documents/Providers/CO_Auth_Guidelines.pdf
6. OHP members- Please verify the diagnosis/procedure is funded for treatment by using the Prioritized list.
    a. DHS MMIS provider web portal: https://www.or-medicaid.gov/ProdPortal/Account/SecureSite/tabid/63/default.aspx
7. Medicare members- CMS coverage rules apply, including benefit limits. Certain types of excluded services have been added below for convenience but should not be considered an exhaustive list.
8. COA Star members- Services performed by non-par providers require prior authorization. Adventist Providers/Specialists no longer in-network eff. 3/1/2018.
9. For Ambulatory surgery center (ASC) procedures, verify the procedure is 1) 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

Acupuncture	• Excluded by Medicare • Not covered for mental health diagnoses (should follow member's MH carrier authorization and claims requirements- eff 7/1/17) • **Effective 4/15/2018 Acupuncture requires authorization for OHP (See letters at pg. 8-9 for details)**
Cardiac Rehabilitation	No Authorization required
Chiropractic Care	• No authorization required for evaluation • Authorization required for treatment

	• 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	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
Diabetic Education	No authorization required
Drugs, Injectable, Chemotherapy	See the pharmacy policy section of the CareOregon website
Durable Medical Equipment	See DME No Authorization Required List on CareOregon website
Hemodialysis	No Authorization required
Home Health	1) Evaluations do not require authorization 2) Home health services do not require authorization 3) Excluded home health services are not covered
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 CareOregon of admission

Inpatient rehabilitation admissions	Authorization required
Medical Nutrition office visits	No authorization required
Naturopathic medicine	1) Excluded by Medicare, 2) OHP may require authorization, see No Authorization Required- CPT Code list 3) Services subject to OHP Prioritized List Guide Note 56 (Back pain) may be authorized for calendar year (therapy codes) or benefit year.
Newborn care (first 28 days after birth)	No authorization required regardless of diagnosis except non-funded treatment
Obstetrician office visits	No authorization for pregnant members required, regardless of diagnosis
Oncology visits/treatment	No Authorization required regardless of diagnosis
Out of state providers	All rules apply to both in-state and out of state providers
PCP Office visits	No Authorization required regardless of diagnosis
PCP Procedures done in office	May require authorization, see No Authorization Required- CPT Code list
Physical, occupational, and speech therapy	Services authorized on a calendar year For OHP 1) No Authorization required for evaluations for ATL diagnosis which pairs with CPT code 2) Authorization required for therapy visits 3) Services subject to OHP Prioritized List Guide Note 56 (Back pain) may be authorized for calendar year (therapy codes) or benefit year 4) New requests for BTL conditions will require medical necessity review For COA

	1) No Authorization required for therapy evaluations
Procedures performed in office setting	May require authorization, see No Authorization Required- CPT Code list
Prolonged Services	Outpatient prolonged service codes will require medical record review for payment beginning DOS 5/15/18. Submit supporting documentation with claim.
Skilled nursing facility admissions	Authorization required
Specialist Office visits	For OHP: 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 (cont.) For COA: No authorization required
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

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 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.oregon.gov/oha/healthplan/Pages/forms.aspx (search for Sterilization of Hysterectomy to access forms in English or Spanish). Sterilization procedures are excluded from Medicare.

Health and Wellness- Routine health exams, tests, and immunizations are covered benefits that do not require an authorization. See the member handbook on the CCO's website for more information.

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

- Not covered by Medicare
- 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 for residential and detox treatment through CareOregon. Authorization required upon admission to residential with ASAM scoring 3.1 or higher.
- Yamhill Community Care Organization – Treatment is covered by Yamhill County Health & Human Services, please contact YCHS for authorization and coverage requirements.

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- Authorization 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 JCCs website

All related documents and forms can be found at: http://www.jacksoncareconnect.org/for-providers/policies-and-forms

- Yamhill Community Care Organization – Treatment is covered by Yamhill County Health & Human Services, please contact YCHS for authorization and coverage requirements.
- Managed Care members – Coverage with the member's MHO, please contact MHO for authorization and coverage requirements.

Vision Care-

For OHP

Routine vision care benefit (to determine if member needs glasses or contacts) is limited to members less than 21yrs old, pregnant adults.

- 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.

For Medicare

Medicare covers the diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening exam. These services can be provided 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 is 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 changes

4/15/2018	• All new requests for therapy visits for BTL conditions will require medical review beginning 4/15/18 • Added prolonged services to grid

March 15, 2018

Chronic Low Back Pain, OHP Guideline Note 56

Dear Provider:

Health Share, Jackson Care Connect, Columbia Pacific CCO and Yamhill Community Care Organization are modifying processes to more closely align and adhere to the Oregon Health Plan (OHP) coverage criteria specified by Guideline Note 56 from the Prioritized List of Health Services.

Effective April 15, 2018, coverage for Low Back Pain will be defined by the criteria in Guideline Note 56, and services will be covered only when they comply with those criteria. The criteria can be found in the Prioritized List at: http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/1-1-2018%20Prioritized%20List%20of%20Health%20Services.pdf

Guideline Note 56 requires that providers start by assessing members' back pain using a validated assessment tool, such as the STarT Back Assessment, to determine individual member's risk or functional level. Based on that assessment, services covered by OHP will be specified. Further information will be available on the provider portal soon.

Services subject to Guideline Note 56 are shared between several disciplines. Members and providers should keep this in mind when requesting services.

What does this mean?

- For services delivered after April 15, we will require that providers submit the STarT tool, or equivalent, with requests for coverage of services, including but not limited to PT/OT, acupuncture, OMT/CMT, chiropractic services, or Cognitive Behavioral Therapy (when available). **All services will require Prior Authorization.**

- **Assessment tool will be required in order to process authorization requests for services subject to Guideline Note 56. Requests received without an assessment tool will be cancelled and providers will need to resubmit the request.**

- We will adhere to the quantity limits prescribed by Guideline Note 56. Please reference the Note, because this means there are limits to most services based on the risk/functional level determined by assessment tool (e.g., StarT). Beginning April 15, we will align service benefits subject to Guideline Note 56 to a calendar year. This will be consistent with the current administration of the therapy benefit. The intention is to reduce confusion in overlapping therapy benefits.

Sincerely,

Douglas Luther, MD
Senior Medical Director, CareOregon

Re: Benefit Change for Acupuncture

Dear Provider:

Health Share, Jackson Care Connect, Columbia Pacific CCO and Yamhill Community Care Organization will continue to offer acupuncture coverage to our Medicaid members, following the OHP defined benefit parameters. The requirements can be found via the OHP website http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List.aspx or MMIS.

Beginning April 15, 2018, acupuncture services will be covered according to criteria in the current Prioritized List of Health Services. Acupuncture services will require prior authorization from the appropriate CCO for all clinical settings and provider types. Acupuncture services delivered without prior authorization will be ineligible for payment.

For members who need acupuncture for substance abuse disorders (SUD) , please refer them to SUD providers for behavioral health evaluation and treatment.

As before, if you provide services represented by either code 97811 or 97814, we will pay for a maximum of one per claim. These codes, by definition, require reinsertion of needles (not manipulation of those already in place) and sustained one-on-one contact with the patient.

As a reminder, the proper billing and coding of acupuncture services does not allow the routine use of Evaluation & Management (office visit) codes. E&M codes are permitted with an initial encounter, but should be an infrequent occurrence thereafter. We still receive claims with inappropriate E&M billing and appreciate your help in ensuring that coding is correct.

Sincerely,

Douglas Luther, MD
Senior Medical Director, CareOregon