Utilization Management Manual

Procedure handbook for physical health providers

(Jackson Care Connect, Columbia Pacific CCO,
and members with Health Share of Oregon/CareOregon)

CareOregon®

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Introduction

The utilization management (UM) guidelines in this document explain the process CareOregon uses in the authorization of physical health service for members of Health Share of Oregon, Jackson Care Connect, and Columbia Pacific CCO. The purpose of this handbook is to guide providers in the submission of requests for authorization of covered services and to inform providers of the criteria used by CareOregon in the review process. This includes inpatient and outpatient services and durable medical equipment requests. In addition to Oregon's Prioritized List, CareOregon uses medical directors and InterQual for medical necessity criteria, along with UM policies and procedures in this handbook to make determinations.

Provider instructions

Member eligibility

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.

If OHP is secondary payer, follow primary plan's guidelines for coverage.

For 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.

OHP coverage of services

Please verify the diagnosis/procedure is funded for treatment by using the prioritized list. DHS MMIS provider web portal: ***or-medicaid.gov/ProdPortal/Account/SecureSite/tabid/63/default.aspx***

For ambulatory surgery center (ASC) procedures

Verify the procedure is on the CMS ASC approved procedure list and that the ASC facility is approved by CMS. Visit the CMS (Medicare) website: ***cms.hhs.gov/ascpayment***

Contracts

Provider contracts may have requirements different from those below.

Medical necessity criteria

CareOregon defines medical necessity and medical appropriateness consistent with both the Oregon Administrative Rules and nationally recognized evidence-based standards (InterQual). All services provided to Oregon Health Plan Medicaid recipients must be medically appropriate and medically necessary. For all services, the individual must have a diagnosis covered by the Oregon Health Plan which is the focus of treatment, and the presenting diagnosis and proposed treatment must qualify as a covered condition-treatment pair on the Prioritized List of Health Services.

Medically appropriate services are those services which are:

- Recommended by a licensed health provider practicing within the scope of their license
- Safe, effective, and appropriate for the member based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence
- Not solely for the convenience or preference of a member, or a provider of the services, and
- The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to the individual

All covered services must be medically appropriate for the member, but not all medically appropriate services are covered services.

Medically necessary services are those services that are required by a member to address one or more of the following:

- The prevention, diagnosis, or treatment of a member's disease, condition, or disorder that results in health impairments or a disability
- The ability for a member to achieve age-appropriate growth and development
- The ability for a member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status or
- The opportunity for a member receiving long term services & support (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, and to live and work in the setting of their choice

A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically appropriate services are covered services.

Requests for members under age 21 will be reviewed for medical necessity and/or medical appropriateness, in accordance with EPSDT guidelines.

In addition to the above, the determination of medical necessity is also made by CareOregon on an individual basis using CMS, organizational and InterQual criteria as a guide. Requests for services are also reviewed by nurses, medical directors and/or pharmacists. If a requested service is denied, reduced when previously authorized, or authorized in amount, duration, or scope other than what was requested, the decision to do so will be made by a clinician with clinical expertise in the specific condition.

Prior authorizations

All standard request prior authorization determinations are made within 14 calendar days of the date of the request. In the event a covered condition may result in imminent danger to the member's life, health, or ability to function, prior authorization can be requested as expedited, and a decision will be made within 72 hours. Both standard and expedited requests can be extended an additional 14 calendar days for review if the member or provider requests it, or if CareOregon can demonstrate that additional time for the review is in the member's best interest. If the request for services is approved, CareOregon will notify the requesting provider and give the date of the next medical necessity review, if applicable. If the request for a prior authorization is denied, CareOregon will send a notice of action — benefit denial (NOABD) to the member and the requesting provider. If the services denied had previously been authorized, the effective date of the denial will be 10 calendar days from the date of the determination to deny. There is no prior authorization for urgent or emergent care.

Excluded services

Excluded services are not covered, unless as an exception, and would require prior authorization.

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

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), are not funded. Treatment codes that don't pair with the diagnosis or pairs with DX and is BTL are also non-funded.

For members under 21, requests are reviewed for medical necessity and medical appropriateness, regardless of line placement.

Services **not** requiring prior authorization

CareOregon maintains lists of services and items which may not require prior authorization on their website. Providers should consult the lists to ensure their requests require prior authorization. This is meant to reduce administrative burden and streamline the process when CareOregon-determined clinical review is not necessary.

Emergency services

CareOregon will not require prior authorization for emergency room screening examinations that lead to the examining provider making a clinical determination that, under the prudent layperson standard, an actual emergency medical condition exists.

By its emergency services policy, CareOregon:

- Does not require prior authorization for urgent and emergent services.
- Does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Does not hold members liable to pay for subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.
- Does not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider of the member's screening and treatment within 10 days of presenting themselves for emergency services.
- Does not deny payment for treatment obtained under either of the following circumstances: a) A member had an emergency medical or dental condition; this includes cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition or emergency dental condition. b) A representative of CareOregon instructs the member to seek emergency services.

Post stabilization services

Post stabilization services are covered services provided to a stabilized member after an emergency medical condition in order to maintain the stabilized condition or to improve or resolve the member's condition. CareOregon will cover these services without requiring prior authorization when:

- CareOregon does not respond to a request for pre-approval within one hour, or
- CareOregon cannot be contacted, or
- CareOregon's representative and the treating physician cannot reach an agreement concerning the member's care and our Medical Director is not available for consultation.

The treating provider is responsible for determining when the member is stable for discharge or transfer.

CareOregon's financial responsibility for post stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A plan representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

Prior authorization submission

Providers may submit for authorization via CareOregon's Provider Portal, Connect. Some authorizations may be approved at time of entry or may require medical review. Connect access permissions are given at the discretion of CareOregon depending on provider type, service type, and the provider's knowledge of CareOregon's system of care. Authorizations that are not set to auto-approve may be entered and/or reviewed by CareOregon staff. Requests which cannot be accepted via Connect need to be faxed with applicable forms and documentation (chart notes, physician orders, etc.) to 503-416-3713 for medical requests, or 503-416-3637 for Durable Medical Equipment (DME) requests. Please see the CareOregon website for a comprehensive list of available forms.

Initial authorizations

CareOregon will authorize consultation services without prior authorization to allow providers the opportunity to assess the member and document the member's clinical presentation. Providers will submit requests for authorization of ongoing services when clinically indicated and authorization is required. CareOregon staff will review the documentation and may consult with the provider as needed to confirm that the request involves treatment of a covered diagnosis and is medically necessary.

Required elements of a request for initial and ongoing services are as follows:

- Identification of beneficiary (member information)
- Name of beneficiary's physician, or lead clinical provider
- Date of admission to program or service
- Diagnosis (ICD-10) and CPT codes for the services requested
- Supporting clinical documentation

FAQ

Frequently asked about services are listed below for convenience with relevant UM rules/coverage guidance:

Acupuncture	• Not covered for mental health diagnoses (should follow member's MH carrier authorization and claims requirements — effective 7/1/17) • Effective 4/15/18, acupuncture requires authorization for OHP (new member consultation E/M code no auth required if not seen in past 3 years) • Effective 1/1/21, providers must be contracted with CareOregon to receive payment for services provided to members with primary OHP coverage
Anesthesia	• No authorization needed unless performed as primary procedure (i.e., pain management, etc.)

Cardiac rehabilitation	No authorization required
Chemical dependency services	Chemical dependency services may require an authorization depending on the Coordinated Care Organization. Not covered by Medicare Columbia Pacific Coordinated Care – 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 – *Please review the BH handbook for details* Jackson Care Connect – Coverage for residential and detox treatment through CareOregon. Authorization required upon admission to residential with ASAM scoring 3.1 or higher.
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. • Effective 1/1/21, providers must be contracted with CareOregon to receive payment for services provided to members with primary OHP coverage
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, the procedure must be approved for an ASC setting for claims payment. For a list of ASC approved procedures: ***cms.hhs.gov/ascpayment*** 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

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.
Hemodialysis	No authorization required
Home health	• Evaluations do not require authorization • Home health services do not require authorization • Excluded home health services are not covered
Hospice services	No authorization required
Imaging (MRI, CT)	Authorization required (effective 5/19/20)
Inpatient hospital admissions — elective/pre-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
Mental health services	See Behavioral Health UM Manual
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 (first 28 days after birth)	No authorization required regardless of diagnosis except non-funded treatment
Observation	No authorization is required for the first 48 hours of hospital observation. Observation services provided for longer than 48 hours will require authorization for funding
Obstetrician office visits	No authorization for pregnant members required, regardless of diagnosis
Oncology visits/treatment	No authorization required for ATL 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
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 • No authorization required for evaluations for ATL diagnosis which pairs with CPT code • Authorization required for therapy visits • Services subject to OHP Prioritized List Guide Note 56 (back pain) may be authorized for calendar year. • New requests for BTL conditions will require medical necessity review • Effective 1/1/21, providers must be contracted with CareOregon to receive payment for services provided to members with primary OHP coverage For COA • 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: • No authorization if member has not been seen for 3 years, regardless of diagnosis • No authorization required for follow up visits for ATL diagnoses 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

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 ***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.
Transplants	Authorization required
Vision care — 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 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.
Vision care — OHP	Routine vision care benefit (to determine if member needs glasses or contacts) is limited to members less than 21 yrs old, pregnant adults. • For qualifying members in Tillamook County, 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 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.

Inpatient admissions

Please follow the prior authorization process described above for pre-planned, elective admissions.

Eligibility

When eligibility is unclear at time of admit, facilities should submit the claim and the admission will be reviewed retrospectively. The facility will not be held accountable for lack of notification. Medical necessity rules will apply to the stay appropriate to the date(s) services were provided.

Admission-notification

CareOregon requests notification within 24 hours of admission. Hospitals with an address that is outside a 50-mile radius of the Portland metropolitan area may not be familiar with CareOregon and will be granted leeway. Facilities who provide data to the collective do not need to provide notification to CareOregon. CareOregon uses the feeds from the collective as notification.

Authorization process

CareOregon receives inpatient admission notifications via the collective or by facility fax. Authorizations are generally reviewed within one business day of notification of admission. Clinical staff will use remote access to conduct reviews when made available by facilities. When remote access is not available, or provider does not have access, clinical documentation supporting medical necessity for admission should be submitted via fax to CareOregon.

Required elements may include the following:

- Name of the member/potential member
- Name of the member's physician
- Date of admission
- If applying for Medicaid benefits after admission, the dates of application for and authorization of benefits
- The plan of care
- Date of operating room reservation, if applicable
- Justification of emergency admission, if applicable
- Reasons and plan for continued stay, if the attending physician believes continued stay is necessary
- Initial and subsequent continued stay review dates
- Other supporting material that the utilization review committee believes appropriate to be included in the record

Continued stay

CareOregon performs concurrent review of admissions to AB Hospitals, during extended observation admissions, and in situations when status changes from observation to inpatient. For facilities where remote EHR access is available, CareOregon UM staff will enter the medical record and perform the review. For facilities without remote EHR access, Hospital UR will fax updated clinical information in a legible format to CareOregon UM and will notify CareOregon staff regarding discharge.

Upon review of available clinical information, CareOregon staff may contact hospital UR staff via phone to review bed status or to request additional information. If no additional information is needed, the CareOregon RN will determine the number of days authorized for continued stay, fax updated authorization information to the hospital, and set the next review date. The number of days between clinical reviews will be individualized based on the member's condition and expected course of treatment. Additionally, CareOregon staff will communicate with hospital social workers for discharge planning as appropriate.

Discharge to SNF/LTACH/IPR

Hospital discharge staff should request prior authorization for members requiring skilled nursing facility (SNF), Long-term Acute Care Hospital (LTACH), or Inpatient Rehabilitation (IPR) upon discharge. Requests should be submitted via fax at least 24 hours prior to anticipated discharge and should include request form and applicable chart notes. Please refer to the CareOregon website for the request form.

Discharge

Hospitals that do not provide EHR access will need to notify CareOregon within 24 hours of discharge. Hospitals providing data via Collective will not need to provide discharge notification.

Contact information – initial and concurrent authorization

Review staff is available from 8 a.m. to 5 p.m., Monday through Friday. Requests received outside of business hours will be reviewed the next business day.

Fax: 503-416-4720

Contact Customer Service

503-416-4100 or toll-free 800-224-4840
TTY: 711
Hours: 8 a.m. to 5 p.m.
Monday through Friday

careoregon.org

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