Trillium Community Health Plan

Service Authorization Handbook

Oregon Health Plan - Medicaid

April 2024

MCA_ZZ352 – Revised 4/2024

Medicaid – Oregon Health Plan (OHP)

Authorization or Denial of Covered Services

Trillium's Authorization or Denial of Covered Services policies and procedures for Physical, Behavioral and Oral Health are set forth in this handbook.

Trillium requires its participating providers and subcontractors to adhere to the policies and procedures within this Service Authorization Handbook.

The Pre-Authorization (PA) Check Tool on the Trillium Providers webpage indicates if an item or service currently requires prior authorization and assists in efficient submission of required PA requests, including supporting documentation.

Note: *The Pre- Authorization Check Tool works in real time; a future date cannot be specified.*

Determination decisions are made based on review of Oregon Health Plan (OHP) coverage, first regarding the funding per the Prioritized List, and then evaluated for medical appropriateness, including possible co-morbid conditions that may affect the decision.

- ➔ The OHP Prioritized List requires condition codes for evaluation of coverage

- ➔ Symptom codes are not covered for treatment by OHP and will not result in authorization approval if used as the diagnosis component on a PA request

- ➔ Trillium is committed to best practices in the consistency of reviewing criteria for authorization decisions and considers applicable clinical practice guidelines when making authorization decisions
  CC.UM.02 Clinical Decision Criteria and Application, CC.UM.32 Interrater Reliability, CP.CPC.03 Preventive Health and CPG Policy 04.22, CPG Grid

- ➔ Trillium cannot arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary

Trillium does not deny services based on moral or religious grounds.
OR.MM.159 Covered Benefits

Trillium Ensures:

- ➔ Consultation (peer to peer) with a requesting provider for medical services when necessary
  OR.UM.121 Denial Notices

- ➔ Any and all decisions to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Health Care Professional who has the appropriate clinical expertise in treating the member's physical, behavioral, oral/dental health condition or disease
  CC.UM.04 Appropriate UM Professionals

- ➔ Services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in Oregon Revised Statutes (ORS) Chapter 414 and applicable administrative rules based on the Prioritized List of Health Services and Oregon Administrative Rules (OARs): 410-120-1160, 410-120-1210 and 410-141-3830
  OR.MM.159 Covered Benefits and Services

- ➔ Dental services that must be performed in an outpatient hospital ASC, due to the age, disability, or medical condition of the member, are coordinated and preauthorized
  OR.DCO.100 Dental Services

MEMBERS HAVE BENEFITS AND RIGHTS TO: *OR.MM.159 Covered Benefits and Services*	
• Sexual Abuse Exams without Prior Authorization	• Access urgent and emergency services 24 hours a day, seven days a week without prior authorization
• Access to Behavioral Health assessment and evaluation services without Prior Approval or a Referral from a PCP. Members may refer themselves to Behavioral Health Services available from the Provider Network	• Obtain Medication-Assisted Treatment for Substance Use Disorders, including opioid and opiate use disorders, without Prior Authorization of payment during the first thirty (30) days of treatment o If member is unable to receive timely access to care, the member has the right to receive the same treatment from a non-participating provider outside of or within Trillium's service area and is applicable to each episode of care
• Obtain primary care services in a behavioral health setting and behavioral health services in a primary care setting without authorization	• Refer themselves to a Traditional Health Worker for services

Standard Service Authorization Requests

OR.UM.301 Timeliness of UM Decisions and Notifications

All time frames are maximum. Service Authorization decisions are made as expeditiously as the member's health or mental condition requires and when applicable, no later than the date the extension expires.

- ➔ Determinations for non-urgent, pre-service prior authorization requests are made within 14 calendar days of receipt of the request. The member, or member's representative, and the requesting practitioner are notified of the decision within 14 calendar days of the original request.

- ➔ If Trillium is unable to make a decision due to matters beyond its control (e.g. waiting for an evaluation by a specialist), it may extend the decision timeframe once, for up to an additional 14 calendar days if:

    - The member or provider requests the extension; or

    - Trillium justifies (to State agency upon request) a need for additional information and how the extension is in the member's best interest

- ➔ Within 14 calendar days of the original request, the member or member's authorized representative is notified of the extension, the specific information that is needed, and the expected date the determination will be made. Three attempts are made using two methods to obtain the necessary information during the 14-day period

    - If there is no response or continued lack of necessary information, a determination is made based on the available information. Three attempts are made using two methods to obtain the necessary information during the 14-day period.

- ➔ If the request for authorization is approved or denied, the Medical Director, Pharmacist or designee notifies the requesting provider of the decision by telephone, fax, or email within 14 calendar days, not to exceed the original 14 calendar day determination period or subsequent extension.

    - Practitioners have 48 hours or 2 business days from date of notice to request peer-to-peer discussion
      OR.UM.121 Denial Notices

    - Written notification of determinations, approved or denied are provided to the member within 14 calendar days of receipt of request

    - Denial notices include reason for the denial, right to appeal and instructions for the appeal process
      OR.UM.121 Denial Notices

Urgent Pre-Service Authorization Requests

OR.UM.301 Timeliness of UM Decisions and Notifications

Determinations for urgent pre-service care are issued within 72 hours of receiving the request for service.

➔ If the request does not meet the definition of "urgent care", the request may be processed within the timeframe appropriate for the type of service (i.e., pre-service or post-service request).

➔ Trillium considers the content of the request when determining if a request meets the definition of "urgent care" and determines whether applying non-urgent timeframes could lead to adverse health consequences for the member.

➔ If additional information is necessary, and considered in the member's best interest to obtain, prior to issuing a determination, a one-time extension of up to 14 days may be implemented under the following conditions:

- If the member requests the extension
- Within 24 hours of receipt of the request, the plan asks the member, authorized representative and/or requesting provider of the need for an extension and the specific information necessary to make the decision. Trillium gives the member, provider, or authorized representative 48 hours to provide the information
- If Trillium justifies to OHA upon request, a need for additional information

➔ Trillium makes a decision within 48 hours of receiving the additional information (even if the information is incomplete) or within 48 hours of the end of the specified period given to supply the additional information (even if no response is received from the member or authorized representative), whichever is earlier. Trillium may deny the request if all necessary information is not provided within this time-frame. The appeal process may be initiated at this time, if desired.

➔ If the request is approved, the Utilization Management (UM) Case Manager, or designee notifies the requesting provider of the decision by telephone, fax, or email, not to exceed the original 72-hour determination period or subsequent extension.

➔ If the request for authorization is a denial, reduction or termination, the Medical Director, Pharmacist, or designee notifies the provider by telephone, fax or email within one (1) business day after the decision is made, not to exceed the original 72-hour determination period or subsequent extension.

- Practitioners have 48 hours or 2 business days from date of notice to request a peer-to-peer discussion.
- Written notification of the decision is provided to the member within three (3) calendar days of receipt of request.
- Denial notices include reason for the denial, right to appeal and instructions for the appeal process
  OR.UM.121 Denial Notices

Benefits and Services

➔ Trillium permits out of network Indian Health Care Providers (IHCPs) to refer a Trillium enrolled American Indian/Alaska Native to a network provider for covered services as required by 42 CFR 438.14(b)(6).
OR.MM.159 Covered Benefits and Services

- Trillium complies with applicable payment obligations to IHCPs as required in 25 USC §1621e

➔ Trillium does not and cannot restrict coverage for any hospital length of stay following a normal vaginal birth to less than 48 hours, or less than 96 hours for a cesarean section birth. Exceptions to the minimum length of stay may be made by the physician, in consultation with the mother, and must be documented in the member's clinical record.
OR.MM.159 Covered Benefits and Services

➔ Trillium can require members and subcontractors to obtain Prior Authorization for Covered Services:

- Long Term Service Supports (LTSS) prior authorizations for covered services are reviewed in accordance with 42 CFR §438.210(4) and 42 CFR §441.20 for individuals with ongoing or chronic conditions, or those who require LTSS are authorized in a manner that reflects the members ongoing need for such services.
OR.MM.159 Covered Benefits and Services

- Without limiting a member's rights for family planning services and are provided in a manner that protects and enables a member's freedom to choose a method of family planning, and the services furnished are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished
OR.MM.159 Covered Benefits and Services

➔ Trillium cannot, except as permitted under third bullet point below, prohibit, or otherwise limit or restrict health care professionals who are its employees, or sub-contractors acting within the lawful scope of practice, from undertaking any of the activities set forth below, on behalf om members who are patients of such health care professionals:
OR.MM.159 Covered Benefits and Services

- Advising or otherwise advocating for a member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is medically appropriate even if such care or treatment is not covered under Trillium's contract with the Oregon Health Authority (OHA) or is subject to co-payment;
- Providing all information, a member needs in order to decide among relevant treatment options;
- Advising a member of the risks, benefits, and consequences of treatment or non-treatment; and
- Advising and advocating for a member's right to participate in decisions regarding the member's own health care, including the right to refuse treatment, and to express preferences about future treatment decision

➔ For all covered outpatient drug authorization decisions, Trillium acknowledges that OHA is eligible for the manufacturer rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8), and OAR 410-141-3225.
OR.MM.160 Drug Rebate Program

SERVICE AUTHORIZATION HANDBOOK

REFERENCES | DEFINITIONS | REVISION TRACKING

DEPARTMENTS:	**PRODUCT TYPE:** OHP/MEDICAID
Utilization Management, Provider Network Management (PNM)	
EFFECTIVE DATE: 3/2/2020	**REVISION DATE:** 9/10/21, 3/2/23

REFERENCES:	
42 CFR §438.14(b)(4) and (6)	§1927(d)(5)(A)
42 CFR §438.10	42 USC 1396r-8(d)(5)(A)
42 CFR §438.102	
42 CFR §438.210(4)	
42 CFR §438.210; 42 CFR §438.210(d)(1)	
42 CFR §441.20	
OAR 410-120-1160 Medical Assistance Benefits and Provider Rules OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System OAR 410-141-3830 Prioritized List of HS OAR 410-141-3835 Service Authorization	
CCO 2.0 Contract	
OR.UM.121 Denial Notices	CC.UM.02 Clinical Decision Criteria CC.UM.32 Interrater Reliability
OR.MM.159 Covered Benefits and Services	CC.UM.04 Appropriate UM Professionals
OR.MM.160 Drug Rebate Program	CP.CPC.03 Clinical Practice Guidelines/CPG Grid 04.22
OR.DCO.100 Dental Services	
OR.UM.301 Timeliness of UM Decisions and Notifications	

ATTACHMENTS:

DEFINITIONS:

Service Authorization Handbook: Document that sets forth Trillium's written policies and procedures for authorization or denial of covered services.

REVISION LOG

REVISION:	**DATE:**
Annual Review. No changes.	9/10/2021
Annual Review: Removed reference to IRR Policy CC.UM.02.05 and replaced with IRR CC.UM.32. Reviewed all regulatory references (OAR, ORS, CFR) CPG Grid date updated. Grammar throughout reviewed/updated	3/2/2023

Annual Review: Updated the one-time extension time period for Urgent Pre-Service Authorization to 14 days and including making three attempts using two methods to obtain the necessary information during the 14-day period. Updated the reference section to account for policies being sited throughout the handbook	4/8/2024