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 in regards to 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 takes into account applicable clinical practice guidelines when making authorization decisions
  
  *CC.UM.02 Clinical Decision Criteria and Application, CC.UM.02.05 Interrater Reliability, CP.CPC.03 Preventive Health and CPG Policy_201905, 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 and Services*
Trillium Ensures:

- Consultation (peer to peer) with a requesting provider for medical services when necessary

**OR.MM.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.MM.162 Dental Services**

<table>
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<th>MEMBERS HAVE BENEFITS AND RIGHTS TO:</th>
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- 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
  - 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.MM.301 Timeliness of UM Decisions and Notifications

All time-frames are maximum. Service Authorization decisions are made as expeditiously as the member’s health condition requires.

- 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 time-frame 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.
  - If there is no response or continued lack of necessary information, a determination is made based on the available information

- 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.MM.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.MM.121 Denial Notices
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 48 hours may be implemented under the following conditions:
  - 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 the member requests the extension

- 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.

- Members are not notified of urgent pre-service authorization approvals.

- 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.MM.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).

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 members clinical record.

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.

Without limiting a members rights for family planning services and are provided in a manner that protects and enables a members 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.

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:

- 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 any and 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.159 Covered Benefits and Services

OR.MM.160 Drug Rebate Program
### SERVICE AUTHORIZATION HANDBOOK

**REFERENCES | DEFINITIONS | REVISION TRACKING**

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<th>DEPARTMENTS:</th>
<th>PRODUCT TYPE: OHP/MEDICAID</th>
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<td>Provider Network Management (PNM)</td>
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**EFFECTIVE DATE:** 3/2/2020

**REFERENCES:**
- 42 CFR §438.14(b)(4) and (6) §1927(d)(5)(A)
- 42 CFR §438.10
- 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 2020 – Exhibit B, Statement of Work, Part 2, §3. Authorization or Denial of Covered Services
- OR.MM.121 Denial Notices
- OR.MM.159 Covered Benefits and Services
- OR.MM.160 Drug Rebate Program
- OR.MM.162 Dental Services
- OR.MM.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**

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