2019

Prior Authorization and Appeals Guide

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Effective: January 1, 2019

Authorization Requirements

Trillium Community Health Plan (Trillium)

- Oregon Health Plan (OHP)
- Medicare Advantage (DSNP)

All services are subject to benefit plan coverage, member eligibility and medical necessity, irrespective of whether prior authorization is required. When faxing a request, please attach pertinent medical records, treatment plans, and test results to support the medical appropriateness of the request. Trillium reserves the right to review utilization patterns retrospectively and to address adverse trends with providers.

Referrals to participating specialists – For covered diagnoses, providers are not required to obtain prior authorization. However, the member must still coordinate their care through their primary care physicians (PCPs).

Submit requests to Trillium via the **Provider Portal** at: provider.trilliumhealthplan.com.

The Trillium Prior Authorization form must be completed in its entirety and include sufficient clinical information or notes to support medical necessity for services that are requested.

To verify if a service requires an authorization, use the Pre-Authorization tool located on the Trillium website in Provider Resources.

https://www.trilliumohp.com/providers/preauth-check/medicaid-pre-auth.html - OHP

https://www.trilliumohp.com/providers/preauth-check/medicare-pre-auth.html - Medicare

Type of Service	Authorization Requirement
Elective procedures or scheduled admissions	Verify authorization requirements using the Pre-auth tool
Observation stays	Notification within 1 business day of admission OHP benefit limit of 48 hours Medicare: Authorization required after 48 hours
Urgent or emergent services or admissions	Notification within 1 business day. Admission request required within 2 business days following admission.
Skilled nursing, inpatient rehab, long-term acute care	Authorization required
Inpatient Behavioral health services	Authorization required
Outpatient Behavioral health services	Verify authorization requirements using the Pre-auth tool
Outpatient services	Verify authorization requirements using the Pre-auth tool
Services rendered in the home	Authorization required
Hospice Care	Authorization required
High- Tech imaging	Verify authorization requirements using the Pre-Auth tool – Managed by NIA, request authorizations at: www.Radmd.com
All out-of-network services	Authorization required

Please refer to the Trillium Pre-Authorization Tool accessible via the Provider Resources page at:

https://www.trilliumohp.com/providers/preauth-check/medicaid-pre-auth.html - OHP

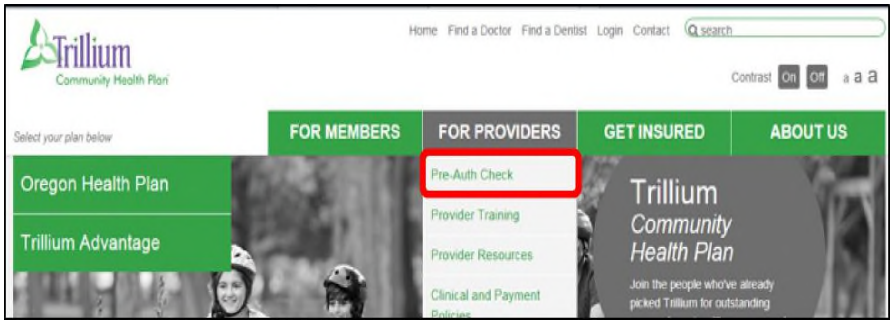
https://www.trilliumohp.com/providers/preauth-check/medicare-pre-auth.html - Medicare

Authorization Contact Information

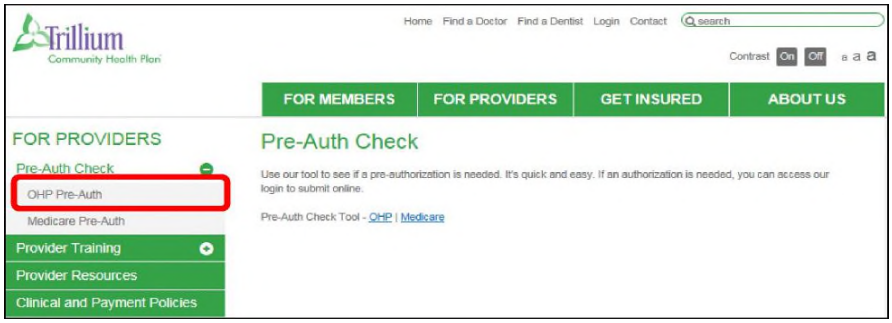
Customer Service for: → **Provider Status** → **Member Eligibility and Benefits** → **Claims**	**OHP/Medicaid** **Phone:** 1-877-600-5472 **Medicare** **Phone:** 1-844-867-1156
Prior Authorization Requests and Submitting Additional Clinical Information	**Fax** PA requests and clinical information to: **OHP/Medicaid** **Fax:** 1-866-703-0958 **Medicare** **Fax:** 1-844-371-7765 For **Expedited Medicare** requests **call 1-844-867-1156**
National Imaging Associates, Inc. (NIA) **(For advanced imaging requests)**	**OHP/Medicaid & Medicare:** 1-888-879-5922 **Online submission:** www.Radmd.com
Trillium Behavioral Health (TBH)	**OHP/Medicaid** **Phone:** 1-877-600-5472 **Fax:** 1-866-683-5621 **Medicare** **Phone:** 1-844-867-1156 **Fax:** 1-866-683-5621

INSTRUCTIONS

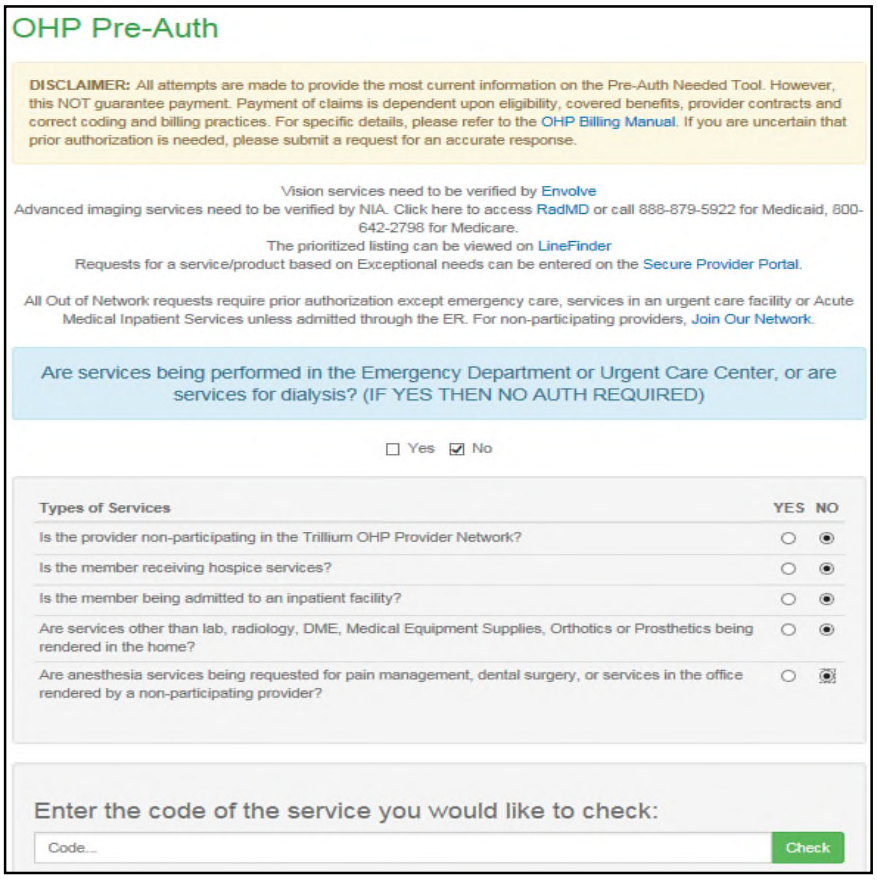
OHP/MEDICAID PRE AUTHORIZATION LOOK UP TOOL



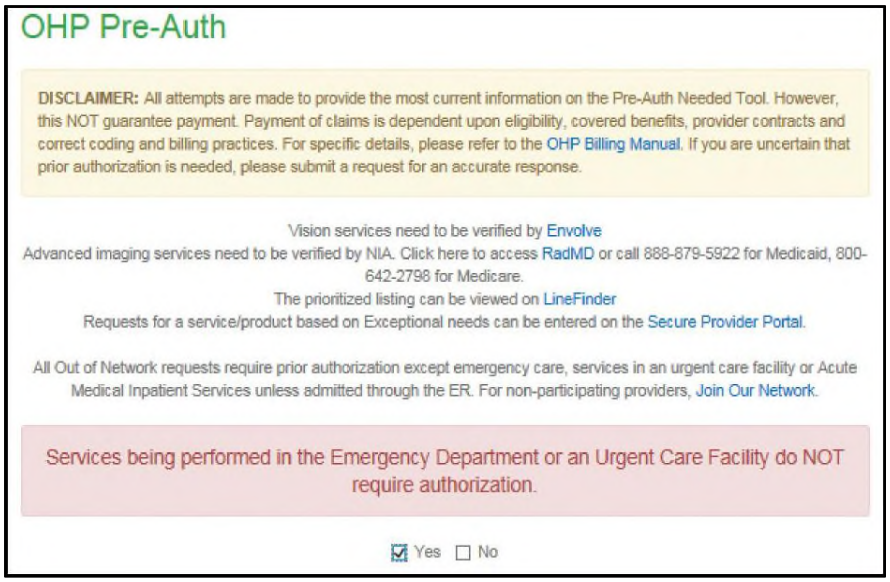
1. Open the web page https://www.trilliumohp.com/, hover over **'For Providers'** and click **'Pre-Auth Check'**



2. Click **'OHP Pre-Auth'**

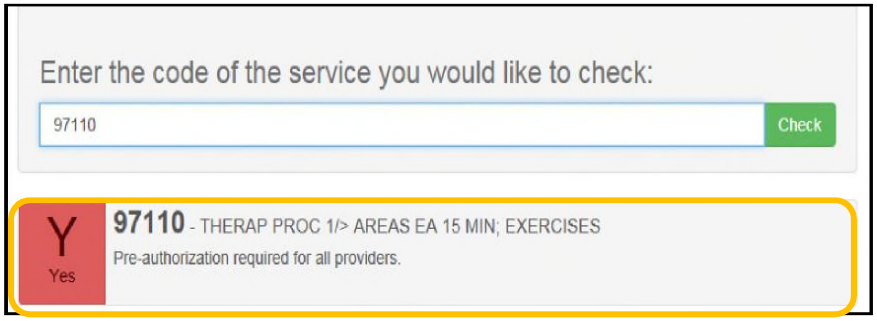


3. Answer the question in the blue box by checking **'Yes'** or **'No'**
   If you select **'No'**, more questions will appear. Answering **'No'** to all of the questions will then open the CPT/HCPC Code box. Enter a code and click **'Check'**

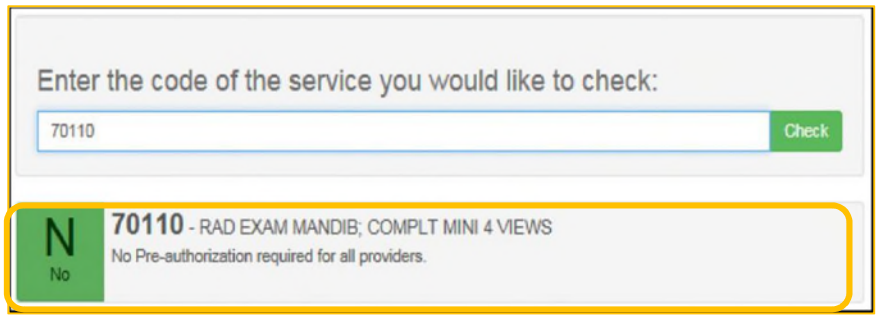


4. If you select **'Yes'** to the question in the blue box or any of the **'Types of Services'** questions, the red message will appear

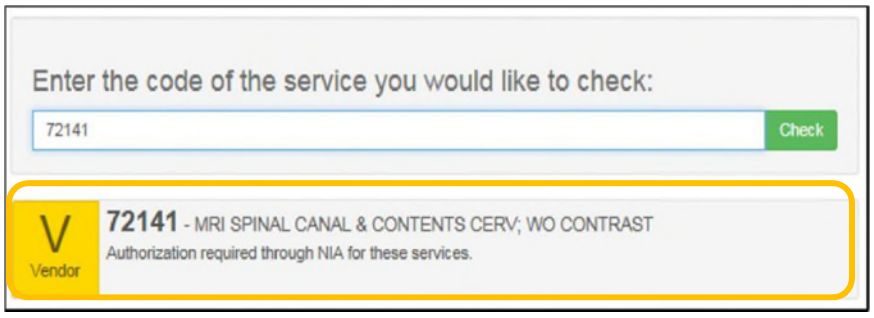
CPT/HCPC Code Examples



Example of a code that **requires** an authorization



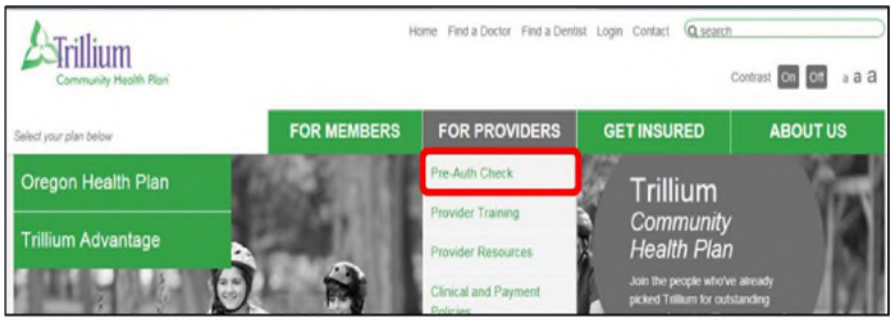
Example of a code that **does not require** an authorization



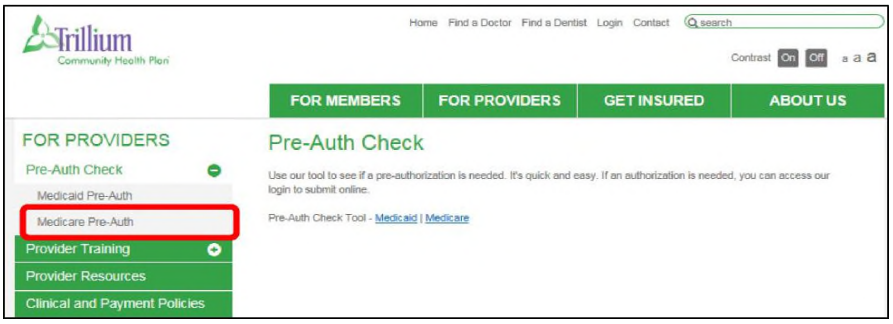
Example of a code that **requires submission** through National Imaging Associates (NIA)

INSTRUCTIONS

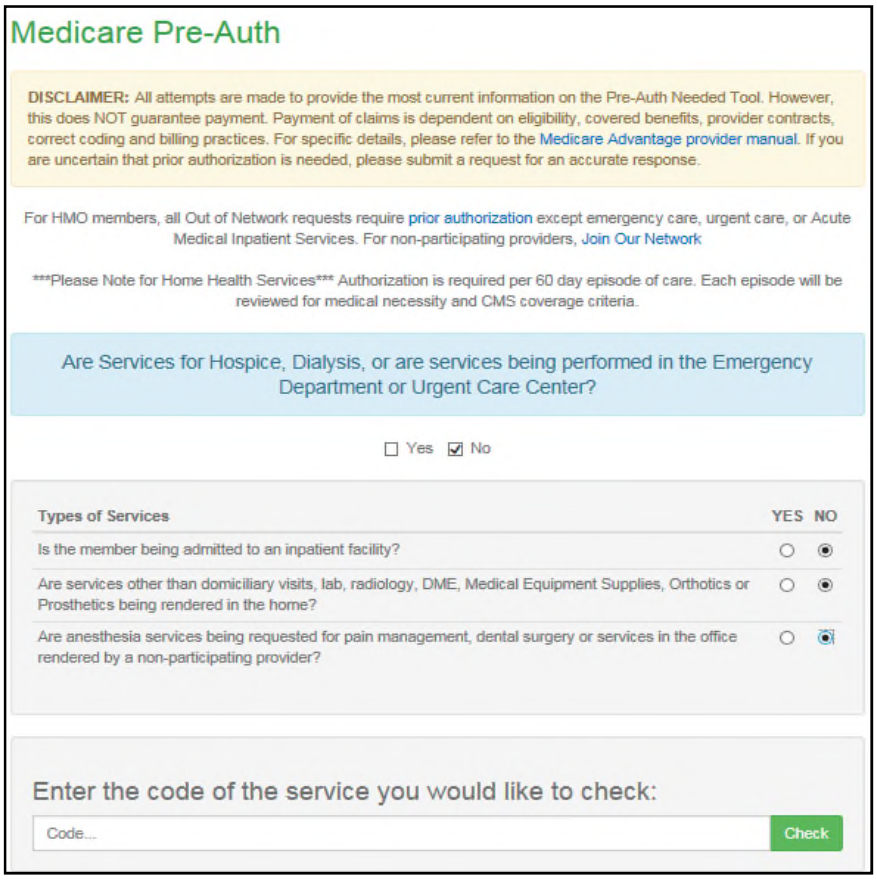
Medicare Advantage Pre Authorization Look Up Tool



1. Open the web page https://www.trilliumohp.com/, hover over **'For Providers'** and select **'Pre-Auth Check'**



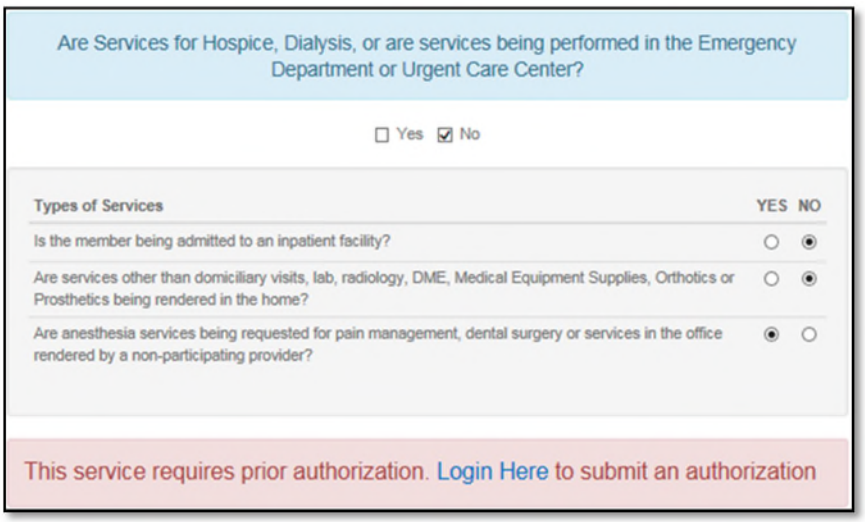
2. Click **'Medicare Pre-Auth'**



3. Answer the question in the blue box by checking **'Yes'** or **'No'**

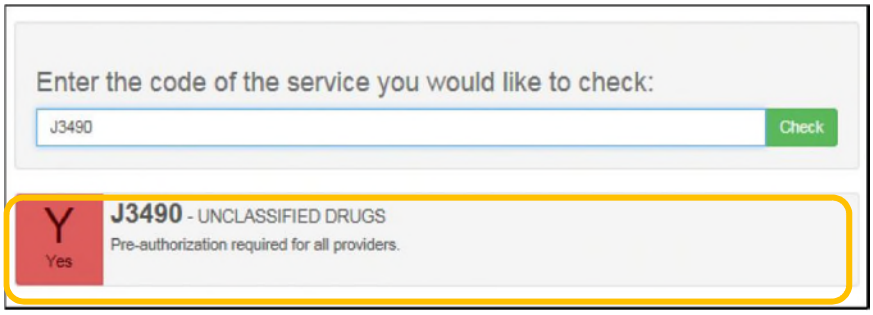
   If you select **'No'**, more questions will appear. Answering **'No'** to all of the questions will then open the CPT/HCPC Code box. Enter a code and click **'Check'**

4. If you select **'Yes'** to the question in the blue box the red message will appear

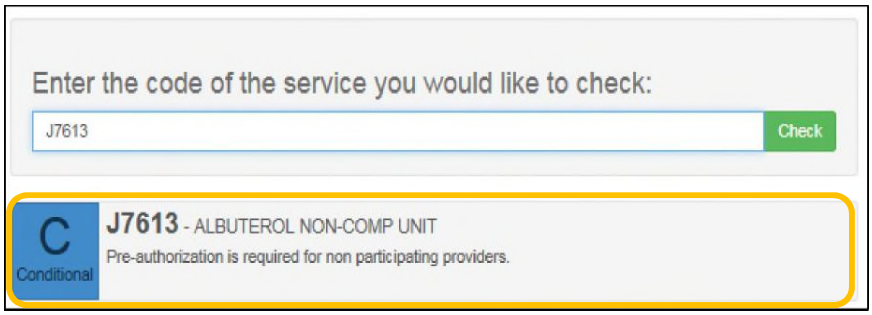


5. If you answer **'Yes'** to any of the questions under the blue box you will then receive this red message

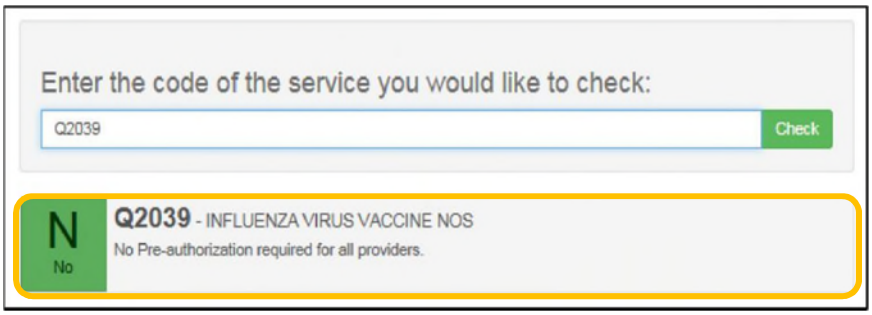
CPT/HCPC Code Examples



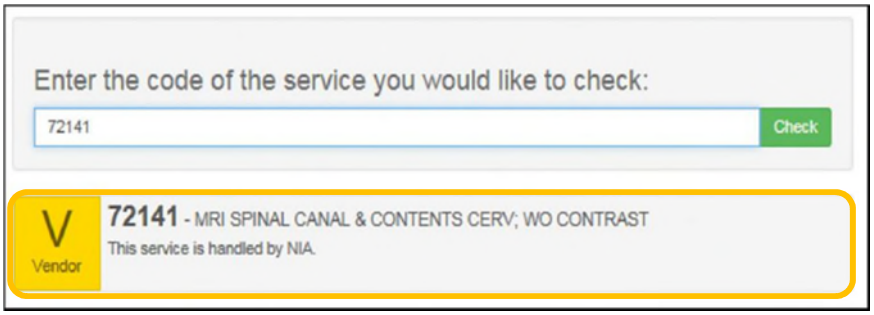
Example of a code that **requires** authorization



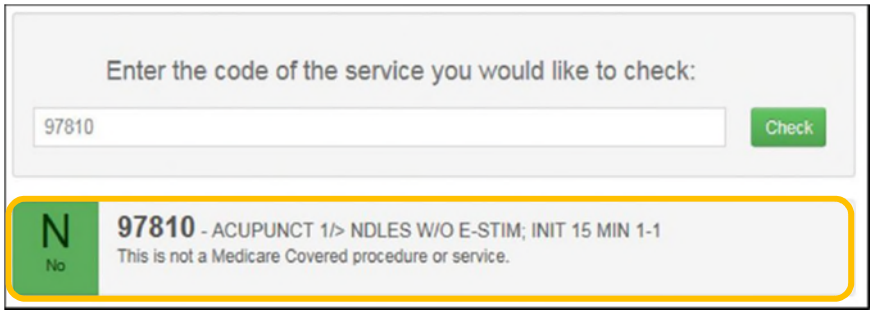
Example of a code that is **conditional**



Example of a code that **does not require** an authorization

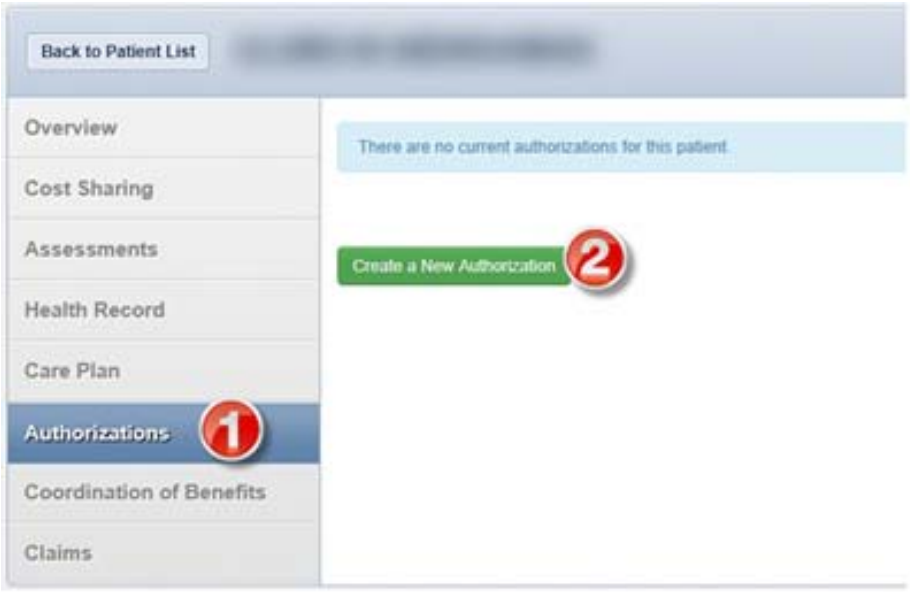


Example of a code that **requires submission** through National Imaging Associates (NIA)

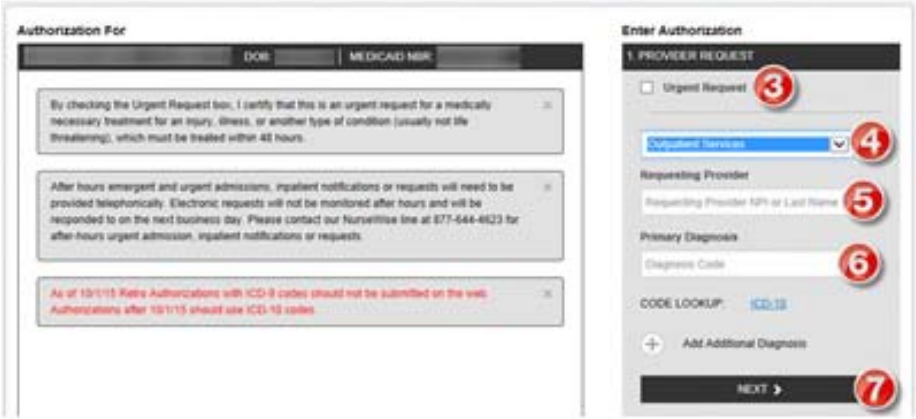


Example of a code that is **excluded** by Medicare

Provider Portal Authorization Instructions

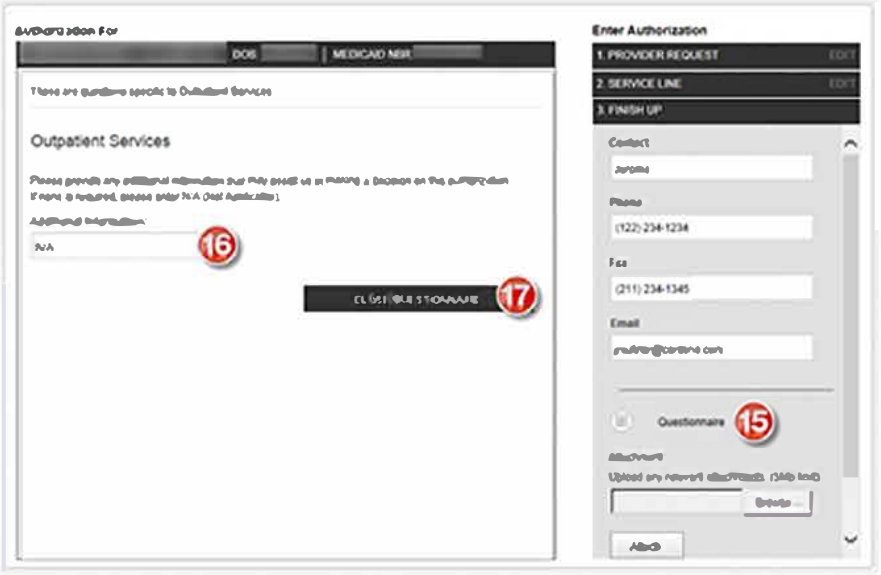


1) Select **AUTHORIZATIONS**
2) Select **CREATE NEW AUTHORIZATIONS**



3) Check box if prior authorization is an **URGENT REQUEST**
4) Select **SERVICE TYPE** from drop down menu
5) Enter **REQUESTING PROVIDER** last name or NPI number, click TAB
6) Enter the ICD-10 **PRIMARY DIAGNOSIS** code, click TAB
7) Click **NEXT**

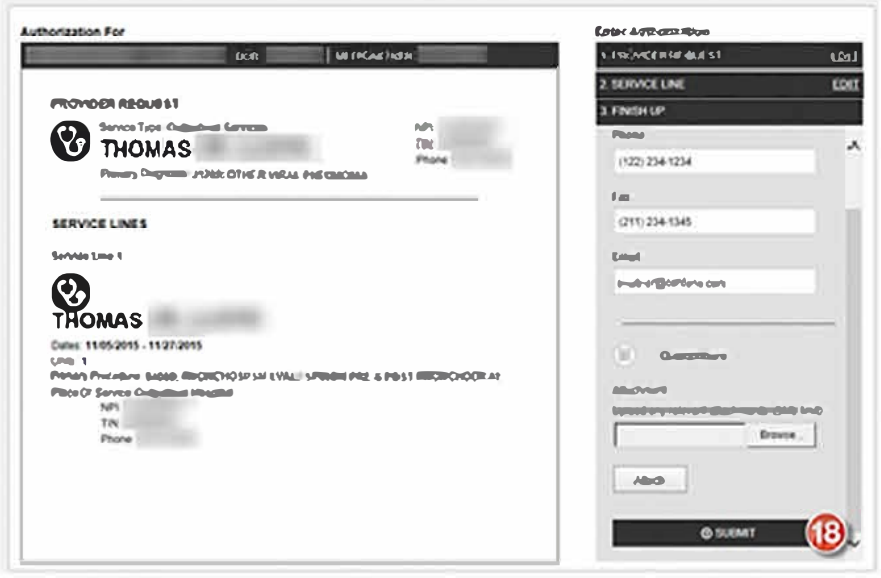
8) If the **SERVICING PROVIDER** is the same as the requesting provider, click the box to auto-populate the provider's information
9) If the **SERVICING PROVIDER** is different than the requesting provider, enter the provider's last name or NPI, select TAB
10) Click in the **START DATE** box to select when services should begin
11) Click in the **END DATE** box to select when services should end
12) Enter the requested number of **UNITS, VISITS, DAYS** for services
13) Enter the CPT code for the **PRIMARY PROCEDURE**, select TAB
14) Select a **PLACE OF SERVICE** from the drop down menu. Scroll to the bottom of the screen, click **NEXT**



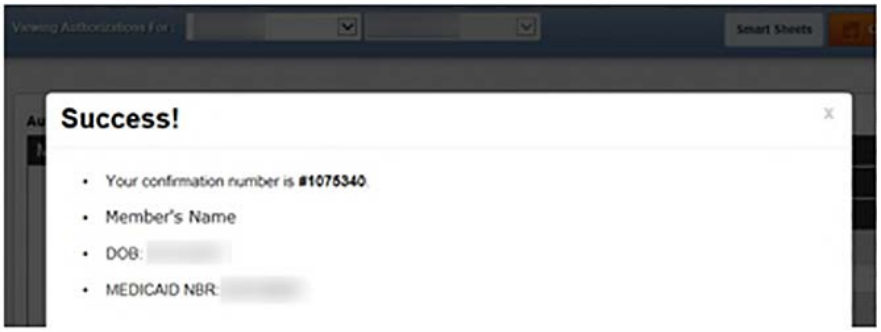
15) Click the **QUESTIONNAIRE** icon, and the form will appear on the left side of the screen

16) Enter additional information or N/A if appropriate

17) Click **CLOSE QUESTIONNAIRE**

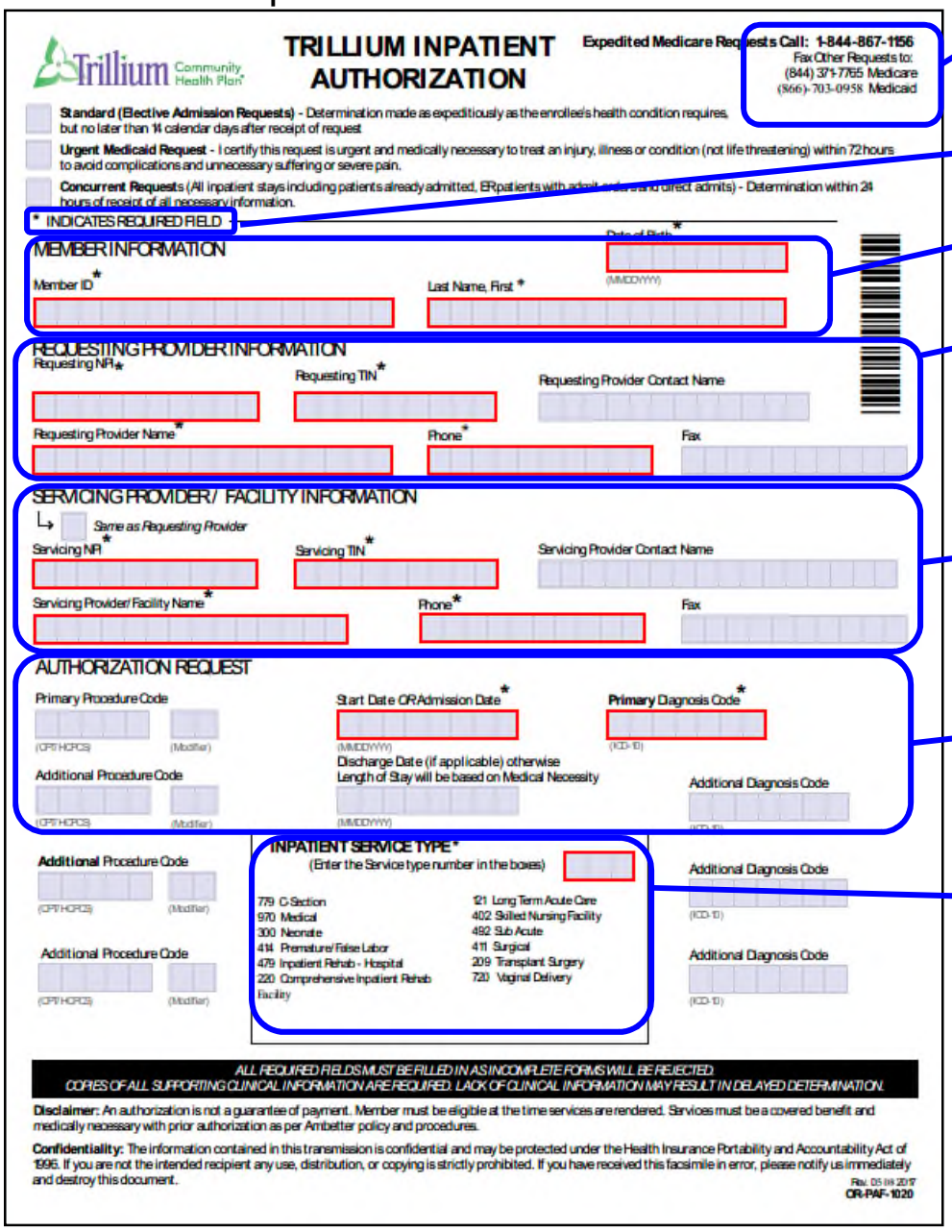


18) Click **SUBMIT**



Confirmation of Prior Authorization provides confirmation number, member's name, date of birth and member ID

Instructions: Inpatient Prior Authorization



TRILLIUM INPATIENT AUTHORIZATION

Expedited Medicare Requests Call: 1-844-867-1156
Fax Other Requests to:
(844) 371-7765 Medicare
(866)-703-0958 Medicaid

Standard (Elective Admission Requests) - Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request

Urgent Medicaid Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

Concurrent Requests (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits) - Determination within 24 hours of receipt of all necessary information.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION
Member ID*
Last Name, First *
Date of Birth *
(MMDDYYYY)

REQUESTING PROVIDER INFORMATION
Requesting NPI*
Requesting TIN*
Requesting Provider Contact Name
Requesting Provider Name*
Phone*
Fax

SERVICING PROVIDER/ FACILITY INFORMATION
Same as Requesting Provider
Servicing NPI*
Servicing TIN*
Servicing Provider Contact Name
Servicing Provider/ Facility Name*
Phone*
Fax

AUTHORIZATION REQUEST
Primary Procedure Code
(CPT/HCPCS)
(Modifier)
Start Date OR Admission Date*
(MMDDYYYY)
Primary Diagnosis Code*
(ICD-10)
Additional Procedure Code
Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity
Additional Diagnosis Code
Additional Procedure Code
Additional Diagnosis Code
Additional Procedure Code
Additional Diagnosis Code

INPATIENT SERVICE TYPE*
(Enter the Service type number in the boxes)

779 C-Section	121 Long Term Acute Care
970 Medical	402 Skilled Nursing Facility
300 Neonate	492 Sub Acute
414 Premature/False Labor	411 Surgical
479 Inpatient Rehab - Hospital	209 Transplant Surgery
220 Comprehensive Inpatient Rehab Facility	720 Vaginal Delivery

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 05 18 2017
CR-PAF-1020

Fax Numbers

All fields marked with an asterisk are required

Member's identifying information

Identifying information for the Requesting Provider and contact information for the person filling out the form

Identifying information/contact information for the Facility in which the member is/will be inpatient

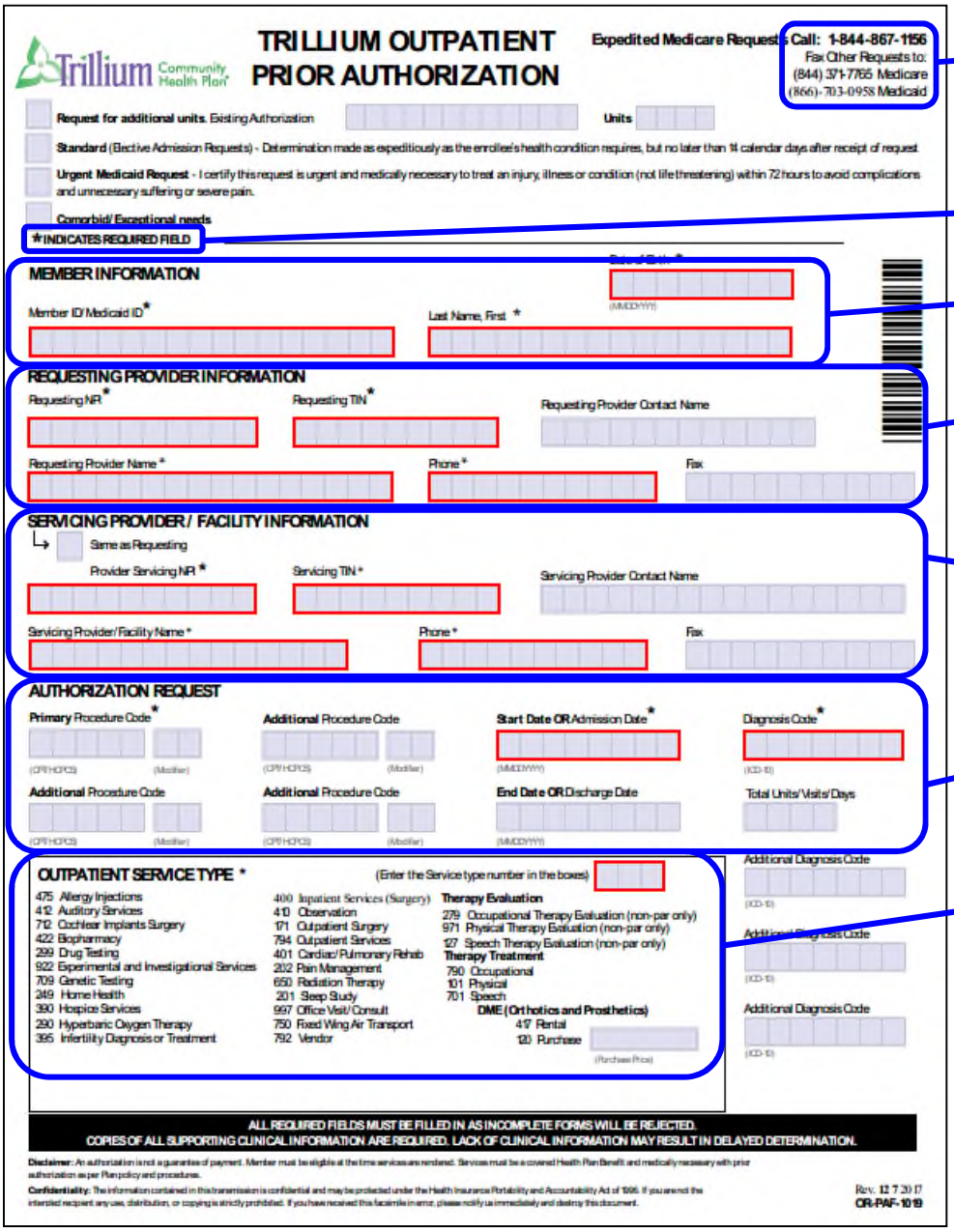
Details of inpatient stay being requested

Enter the service type that matches the inpatient stay requested

Psychiatric admission authorization requests are submitted on the Behavioral Health Inpatient Form found at the website noted below

1. Fill out form (form can be found at www.trilliumohp.com > For Providers > Provider Resources)
2. Fax completed form and supporting clinical documents (i.e. test results, chart notes, admission/discharge notes, etc.)
    a. Concurrent requests (used when the member has already been admitted to the Servicing Facility) will receive notification of determination within 24 hours of receipt of request.
        - Requests received without clinical documents necessitate follow up with requesting provider and may take up to 72 hours to receive notification of determination.
    b. Urgent requests will receive notification of determination within 72 hours of receipt of request.
    c. Standard requests will receive notification of determination within 14 days of receipt of request.
3. The status of an authorization request can be obtained through the Trillium Provider Portal (link to portal can be found at www.trilliumohp.com > For Providers > Provider Resources) or by calling Trillium Provider Services at 541-485-2155

Instructions: Outpatient Prior Authorization (including Skilled Nursing Facility Care)



TRILLIUM OUTPATIENT PRIOR AUTHORIZATION

Trillium Community Health Plan

Expedited Medicare Request: Call: 1-844-867-1156
Fax Other Requests to:
(844) 371-7765 Medicare
(866)-703-0958 Medicaid

Request for additional units. Existing Authorization ____ Units ____

Standard (Elective Admission Requests) - Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request

Urgent Medicaid Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

Comorbid/ Exceptional needs

*INDICATES REQUIRED FIELD

MEMBER INFORMATION
Member ID/Medicaid ID*
Last Name, First *
Date of Birth * (MM/DD/YYYY)

REQUESTING PROVIDER INFORMATION
Requesting NPI*
Requesting TIN*
Requesting Provider Contact Name
Requesting Provider Name *
Phone*
Fax

SERVICING PROVIDER / FACILITY INFORMATION
Same as Requesting
Provider Servicing NPI *
Servicing TIN *
Servicing Provider Contact Name
Servicing Provider/Facility Name *
Phone *
Fax

AUTHORIZATION REQUEST
Primary Procedure Code* (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Start Date OR Admission Date* (MM/DD/YYYY)
Diagnosis Code* (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
End Date OR Discharge Date (MM/DD/YYYY)
Total Units/Visits/Days
Additional Diagnosis Code (ICD-10)
Additional Diagnosis Code (ICD-10)
Additional Diagnosis Code (ICD-10)

OUTPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

475 Allergy Injections
412 Auditory Services
712 Cochlear Implants Surgery
422 Biopharmacy
299 Drug Testing
922 Experimental and Investigational Services
709 Genetic Testing
249 Home Health
390 Hospice Services
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment

400 Inpatient Services (Surgery)
410 Observation
171 Outpatient Surgery
794 Outpatient Services
401 Cardiac/Pulmonary Rehab
202 Pain Management
650 Radiation Therapy
201 Sleep Study
997 Office Visit/ Consult
750 Fixed Wing Air Transport
792 Vendor

Therapy Evaluation
279 Occupational Therapy Evaluation (non-par only)
971 Physical Therapy Evaluation (non-par only)
127 Speech Therapy Evaluation (non-par only)
Therapy Treatment
790 Occupational
101 Physical
701 Speech
DME (Orthotics and Prosthetics)
417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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Rev. 12.7.20.17
CR-PAF-1019

Fax Numbers

All fields marked with an asterisk are required

Member's identifying information

Identifying information for the Requesting Provider and contact information for the person filling out the form

Identifying information/contact information for the Provider or Facility performing the service/providing the item

Details of what is being requested

Enter the service type that matches the service being requested. If none of the listed codes apply, use "794" for Outpatient Services (ShelterCare placement falls under "794"–Outpatient Services)

1. Fill out form (form can be found at www.trilliumohp.com > For Providers > Provider Resources)
2. Fax completed form and supporting clinical documents (i.e. test results, chart notes, prescription, etc.)
    a. Urgent requests will receive notification of determination within 72 hours of receipt of request.
    b. Standard requests will receive notification of determination within 14 days of receipt of request
3. The status of an authorization request can be obtained through the Trillium Provider portal (link to portal can be found at www.trilliumohp.com > For Providers > Provider Resources) or by calling Trillium Provider Services at 541-485-2155

Behavioral Health Authorization and Care Management

TRILLIUM BEHAVIORAL HEALTH

Trillium Behavioral Health (TBH) staff can be reached by calling Trillium Community Health Plan at:

Phone: (541) 485-2155 Oregon Health Plan (OHP) Members
Phone: (541) 431-1950 Medicare Members

Choose the **"Provider"** option when prompted and ask to speak to the Behavioral Health Department.

→ For **Authorization** questions, ask for a Utilization Management (UM) Community Service Worker (CSW)
→ For **Care Coordination** questions, ask for a Care Management (CM) Community Service Worker

Be prepared to provide HIPAA verification (i.e. NPI or Tax ID).

PRIOR AUTHORIZATION REQUESTS

Always use the Trillium Pre-Auth Check tool: https://www.trilliumohp.com/providers/preauth-check.html

Behavioral Health providers can submit new and concurrent Prior Authorization (PA) requests one of three ways:

1. **Enter** an authorization through the secure Provider Portal and electronically attach clinical documentation.
    - For assistance with portal access and usage, contact Trillium's Provider Relations team at:

      Phone: **(541) 485-2155**

2. **Fax** a paper BH PA request form with clinical documentation to TBH, at:
    - Fax: (**866) 683-5621**

3. **Telephone** a TBH CSW to verbally initiate an authorization request
    - Be prepared with CPT codes/units/dates and clinical justification information

Reasons to call TBH for support with Authorizations:

→ Inquire if documentation or PA request was received
→ Check on the status of a PA request
→ Initiate or modify a PA request
→ Return a CSW's call to clarify the details of a PA request
→ Return a UM Staff member's call to discuss additional clinical information related to a PA request

For detailed information about authorization processes for each level of care, review TBH Policies and Procedures. Please contact TBH Staff to request copies.

→ Outlines specific clinical information needed to accompany PA requests
→ Summarizes clinical criteria for authorizations
→ States allowed authorization lengths for initial and concurrent requests
→ Outlines internal TBH CM processes

Standard requests are processed within 14 days of receipt of the request. As a general rule, it is good practice to submit preservice requests 14 days prior to scheduling the service to allow for the processing timeline.

CARE MANAGEMENT REQUESTS

For behavioral health care coordination or care management needs, please call a TBH Community Service Worker.

- Reasons to call TBH for support with Care Coordination/Care Management:

  → Interdisciplinary Care Team Meetings
  → Discharge Planning
  → Level of Care Recommendations
  → Individual Care Planning
  → Discuss Member Needs/Benefits
  → Problem-solve Care Gaps and Barriers to Access
  → Request a List of Contracted Providers
  → Explanation of Levels of Care Requiring Authorization
  → Information Regarding Waitlists and Openings

CLAIMS QUESTIONS

For claims questions or to report claims you believe were denied in error, please call Trillium Community Health Plan at:

Phone: (541) 485-2155 Oregon Health Plan (OHP) Members
Phone: (541) 431-1950 Medicare Members

Choose the **"Provider"** option when prompted and ask to speak to someone who can assist you with a provider claims issue. Stay on the phone until you obtain a case number regarding your claims inquiry. Be prepared with: date of service, claim number, CPT code, units billed, and rendering provider information (i.e. NPI, Tax ID).

Trillium Community Health Plan Resources/Website - www.trilliumohp.com

For resources available on the Trillium website, click on For Providers → Provider Resources

→ Outpatient and Inpatient Prior Authorization Request Forms
→ PA Look-up Tool and LineFinder

INSTRUCTIONS
Authorization Request for Inpatient Behavioral Health Services

Fax Number

All fields marked with an asterisk are required

Member's identifying information

Identifying information for the Requesting Provider and contact information for the person filling out the form

Identifying information or contact information for the Facility in which the member is/will be inpatient

Details of inpatient stay being requested

Enter the service type that matches the service being requested

1. Fill out form (form can be found at www.trilliumohp.com > For Providers > Provider Resources > Behavioral Health)
2. Fax completed form and supporting clinical documents (i.e. chart notes, admission/discharge notes, etc.)
   a. Concurrent requests (used when the member has already been admitted to the Servicing Facility) will receive notification of determination within 24 hours of receipt of request
      - Requests received without clinical documents necessitates follow up with Requesting Provider and may take up to 72 hours to receive notification of determination
   b. Urgent requests will receive notification of determination within 72 hours of receipt of request
   c. Standard requests will receive notification of determination within 14 days of receipt
3. The status of an Authorization request can be obtained through the Trillium Provider Portal at www.trilliumohp.com > For Providers > Provider Resources, or by calling Trillium Provider Services at 541-485-2155

INSTRUCTIONS

Authorization Request for Outpatient Behavioral Health Services

Fax Number

All fields marked with an asterisk are required

Member's identifying information

Identifying information for the Requesting Provider and contact information for the person filling out the form

Identifying information or contact information for the Facility in which the member is/will be outpatient

Details of outpatient stay being requested

Enter the service type that matches the service being requested

1. Fill out form (form can be found at www.trilliumohp.com > For Providers > Provider Resources > Behavioral Health)
2. Fax completed form and supporting clinical documents (i.e. chart notes, etc.)
   a. Urgent requests will receive notification of determination within 72 hours of receipt of request
   b. Standard requests will receive notification of determination within 14 days of receipt of request
3. The status of an authorization request can be obtained through the Trillium Provider Portal (link to portal can be found at www.trilliumohp.com > For Providers > Provider Resources) or by calling Trillium Provider Services at 541-485-2155

Trillium Community Health Plan High-tech Imaging and Supporting Information

National Imaging Associates and RadMD

High-tech imaging questions and requests for Trillium Community Health Plan (Trillium) OHP and Medicare members are handled by National Imaging Associates (NIA). NIA manages a user-friendly, real-time tool called RadMD (www.RadMD.com) that provides you with instant access to the high-tech imaging authorization and supporting information you need, in an easily accessible Internet format.

To create a provider account with NIA, go to www.RadMD.com and click on the 'New User' link. If you need assistance in creating your account, there are links in the 'Useful References' on the RadMD homepage.

Once you have created an account and signed in, you will have access to:

- View Request Status
  Here you can view the status of a previously submitted request
- Clinical Guidelines
  Here you will find clinical guidelines for the various services NIA reviews for
- Health Plan Specific Educational Docs
  Here you can download policies and procedures specific to both ordering providers and imaging facilities. These include quick reference guides and FAQs. You can also view information designed to assist you in using the RadMD Web site to obtain and check authorizations.

WHO DO I CONTACT IF I HAVE QUESTIONS?

For Technical Support with RadMD:

- Email RadMDSupport@MagellanHealth.com
- Or call 1-877-80-RadMD (1-877-807-2363)

For Authorization Questions:

- **Trillium OHP: 877-600-5472**
  - Select 3 for Provider
    - Select 1 for High-tech imaging
- **Trillium Medicare: 844-867-1156**
  - Select 2 for Provider
    - Select 2 for High-tech imaging

National Imaging Associates, Inc.[1] (NIA)
Authorization Process for Expedited Urgent Requests

NIA has helped hundreds of Trillium Community Health Plan members receive clinically appropriate imaging studies, helping ensure they avoid unnecessary exposure to harmful radiation and making it far less likely that patients will be subjected to "false positive" findings that can jeopardize the safety of the members we're entrusted to serve.

In order for NIA to properly recognize an urgent or emergent situation, we need to be aware of the member's specific clinical situation and the indications described must meet the definition of an urgent or emergent condition. We encourage providers to contact us via telephone (1-888-879-5922) to initiate an expedited prior authorization request. When contacting NIA, please be prepared to provide clinical details that would justify an expedited review:

- Symptoms and their duration
- Physical exam findings
- Treatments or procedures already completed

Expedited/Urgent Review Process
The expedited/urgent review process is intended for the evaluation of a condition that requires prompt medical intervention to prevent additional consequences to the health/wellbeing of the member. Conditions that demonstrate a requirement for prompt medical attention include, but are not limited to:

- Any condition that cannot be postponed for a period of time (24 hours) without risking progression to an emergent condition.
- Any condition that cannot be postponed for a period of time (24 hours) without risking loss of life, limb or risk of permanent disability.
- Any condition that in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

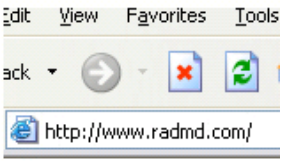
If your office has additional training needs related to any aspect of the outpatient imaging management program for Trillium Community Health Plan members or requires assistance navigating the authorization process, please feel free to contact your NIA Provider Relations Manager:

Kevin Apgar
1-800-450-7281, ext. 65080
kwapgar@magellanhealth.com

[1] *National Imaging Associates, Inc. (NIA) is a subsidiary of Magellan Healthcare, Inc.*

RadMD® Access for Ordering Providers to Request Prior Authorization

To get started, simply go to:



1 Go to www.RadMD.com

Open your Internet browser and navigate to RadMD.com.

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2 Click the New User button on the right hand side of the home page

Complete form only for yourself. Shared accounts are not allowed.

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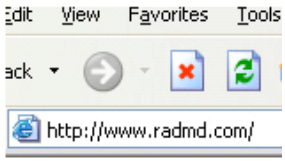
3 What best describes your company

Select link “Physician’s office that orders procedures”



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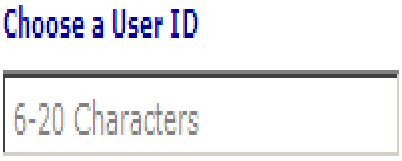
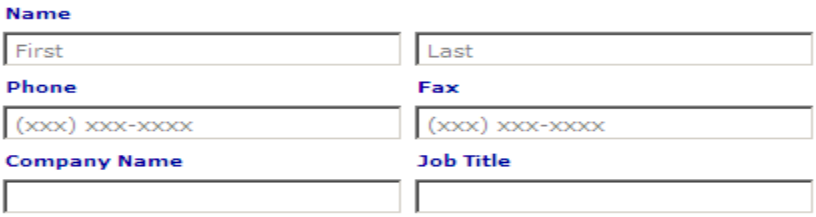
4 Create a User ID for yourself

You will use this User ID to Sign- In to initiate authorizations using RadMD.



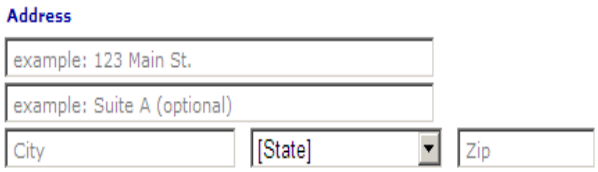
5 Complete information

Complete your name, phone number, fax number, company name and job title.



Enter your e-mail address:

Fill out your office address:



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6 Provide your supervisor information

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7 Submit Application

- Submit the request by clicking submit application.
- Once the application is submitted, you will receive an immediate e-mail from RadMD Support confirming receipt of your request.
- You will receive another e-mail within 72 hours with additional instructions which will included your approved Account ID and a link that will allow you to create a passcode.
  - (*If you have not received an e-mail within 72 hours, check your junk e-mail for some firewalls may prevent the delivery of this e-mail confirmation)*
- Your approved Account ID number and Passcode will allow you to sign into RadMD to initiate authorizations for future requests and/or submit documentation for authorizations or audits.

RadMD® for Ordering and Imaging Providers

RadMD® Makes Things Easy…for You

RadMD is a user-friendly, real-time tool offered by National Imaging Associates, Inc. (NIA) that provides you with instant access to the high-tech imaging authorization and supporting information you need, in an easily accessible Internet format. Whether submitting imaging exam requests or checking the status of ordered exams, you will find RadMD to be an efficient, easy-to-navigate resource.

Benefits of RadMD Access

Both ordering and imaging providers can access a range of online tools and associated imaging information on the **RadMD.com website**:

- Secure access to protect your data and your patients' personal health information.
- Up-to-the-hour authorization information, including:
  - Date request initiated
  - Date exam approved
  - Authorization validity period
  - Valid billing codes (CPT®), and more.
- NIA's evidence-based clinical review criteria, our *Diagnostic Imaging Guidelines*.
- NIA's *Snapshots* provider newsletter.
- Technical support available if you have questions.

Information for Ordering Providers

Plus, ordering physicians can access a number of key tools:

- Straightforward instructions for submitting exam requests, including the ability to submit multiple requests in the same online session.
- Appropriate ICD-10 code lookup.
- Continuous updates on authorization status, which reduces time spent on the phone with NIA.
- Fast authorization decisions available to you online.
- Ease of searching for and selecting convenient imaging facilities.

To get started, go to **RadMD.com**, click the *New User* button and submit a "RadMD Application for New Account." Your RadMD login information should not be shared. This further protects members' personal health information.

Information for Imaging Providers

Additionally, imaging facilities benefit from being able to quickly view the approved authorizations for their patients, facilitating prompt service for patients who require imaging procedures.

To get started, go to **RadMD.com**, click the *New User* button and submit a "RadMD Application for New Account."

If you are an Imaging Facility or Hospital that performs radiology exams, an administrator must accept responsibility for creating and managing logins. Your RadMD login information should not be shared.

For Help…

For assistance or technical support, please contact **RadMDSupport@MagellanHealth.com** or call 1-877-80-RadMD (1-877-807-2363). **RadMD** is available 24/7, except when maintenance is performed once every other week after business hours.

RadMD Quick Start Guide

Request an Exam

This Quick Start Guide is a tool to assist ordering physicians and staff in obtaining prior authorizations for imaging procedures quickly and easily via the RadMD website. To start, open your Internet browser and visit RadMD.com. Click *Login* on the right side of the screen. Enter your *Account ID* and *Password,* then click *Login.*

1. Request an Exam

From the main menu under *Request*, click *Request an Exam.*

Identify the Patient

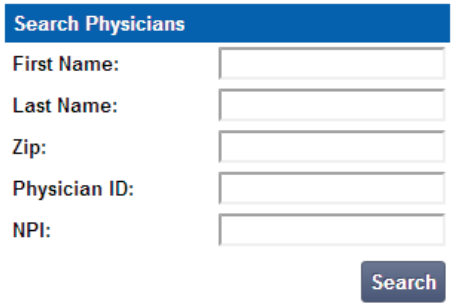
Enter the patient's information.

Click *Save and Continue.*

2. Identify the Physician

Enter physician search criteria.

Click *Search.*



3. Identify the Exam(s)

Select the *Exam(s)* from the list.

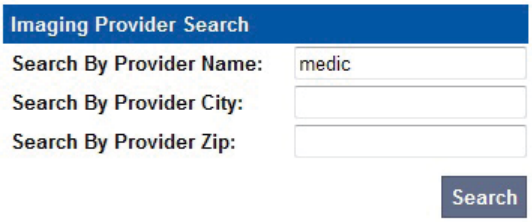
Click *Add* to choose an exam(s).

Click *Save and Continue.*

4. Identify the Place of Service

Enter Search criteria for a provider location.

Click *Search.*



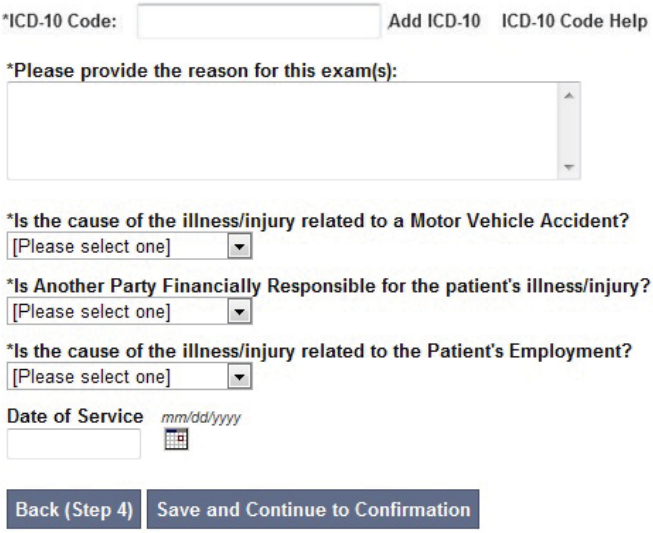
5. Reason for Request

Enter at least one ICD-10 code.

Provide a reason in the text box.

Answer all of the questions.

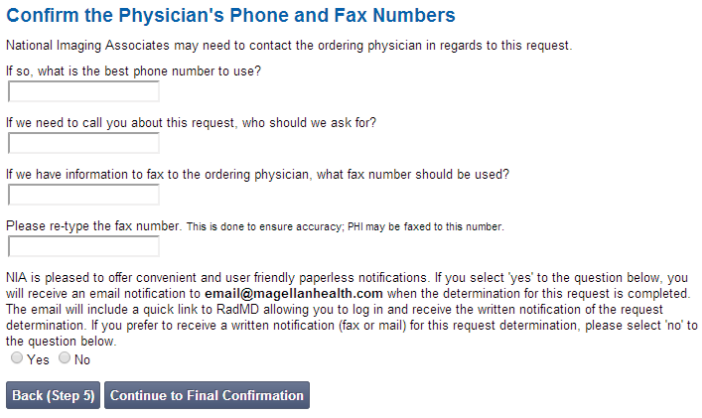
Click *Save and Continue.*



6. Confirm the Physician's Phone & Fax Numbers

Enter any physician callback phone and fax numbers.

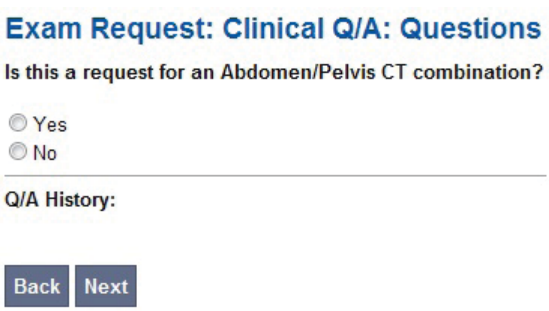
Click *Continue to Final Confirmation.*



7. Clinical Questions: Clinical Q/A

Answer questions specific to the procedure.

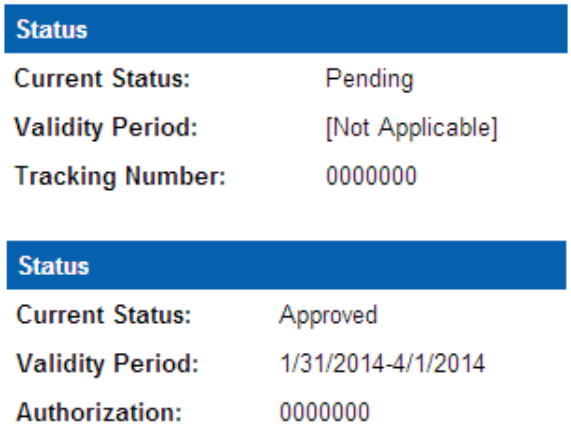
Click *Next* after answering each question.



8. Request Complete

Final page confirms the request and displays current status.

Click *Start New Exam* or *Back to Main Menu* or *Upload Clinical Document*.



For pended requests, providers can fax or upload clinical documents to National Imaging Associates, Inc. (NIA)

Faxed clinical information should be accompanied by the OCR fax cover sheet. Files that can be uploaded include:

- Microsoft Word documents (.doc files)
- Image files (.gif, .png, .jpg, .tif, and .tiff files)
- Adobe Acrobat files (.pdf files)
- Text documents (.txt files)

Files must be less than 10 MB in size.

Questions? Comments? Need help?

Send an email to RadMDSupport@MagellanHealth.com. Or call toll-free 877-80-RADMD (877-807-2363). RadMD is available 24/7, except when maintenance is performed once every other week after business hours.

RadMD New Upload Feature

RadMD® Makes Things Easy..for You

National Imaging Associates, Inc. (NIA) has introduced a new feature that allows clinical information to be uploaded directly on RadMD. Utilizing this upload feature on RadMD expedites your request, since the information is automatically attached to the case and forwarded to our clinicians for review. The following is a step-by-step guide that will help you navigate through this new, easy to use feature.

Upload After Completing an Auth Request

When a request is completed and additional clinical information is needed to make a determination, a RadMD user will have the opportunity to use the document upload capability. Figure 1 shows the RadMD page at the end of the request process with the Upload Clinical Document button.

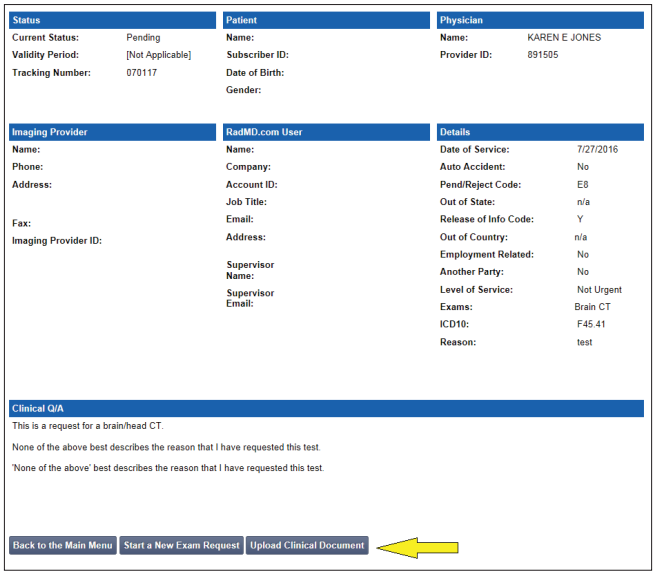


Figure 1 - Upload After Request is Completed

Selecting the Upload Clinical Document button will take the user to the document upload page shown in Figure 2.

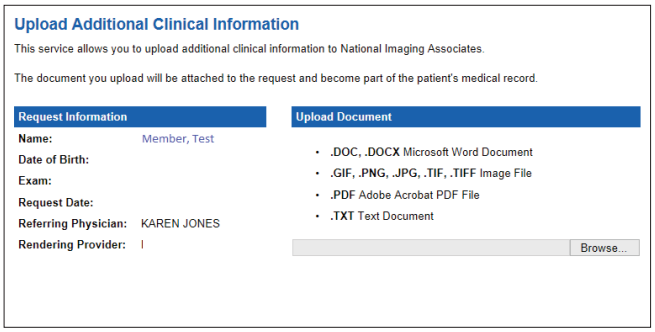
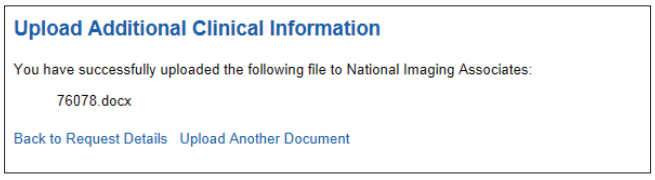


Figure 2 - Clinical Document Upload Screen

From this screen, the user will be able to browse to find a file to upload and then upload the document. If the upload is successful, the page shown below will appear.



At this point, the user can repeat the process and upload additional documents or return to viewing the details of the auth.

After a document is uploaded, the system will notify the NIA clinical review team and the information provided via the document will be taken into account when making a determination on the auth request.

Upload When Checking Auth Request Status

RadMD users will also have the opportunity to upload documents when they are checking the status of an auth request where additional clinical data is needed before a determination can be made.

Figure 3 shows the RadMD Main Menu and the button available for checking the status of an auth request.

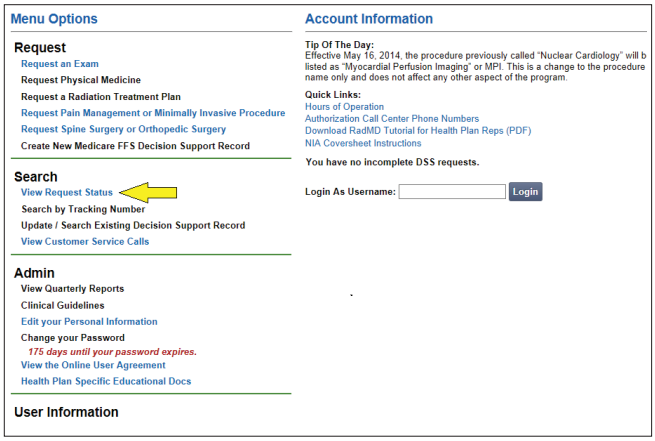


Figure 3 - RadMD Main Menu

- Files that can be uploaded include:
  - Microsoft Word documents (.doc files)
  - Image files (.gif, .png, .jpg, .tif, and .tiff files)
  - Adobe Acrobat files (.pdf files) and
  - Text documents (.txt files)
- Files must be less than 10 MB in size

RadMD users can also get detailed status of their auth requests and e-mails from NIA acknowledging the receipt of faxes and documents.

On the auth status page, the user will have to select an auth to see its status and to be able to upload documents (See Figure 4 below).

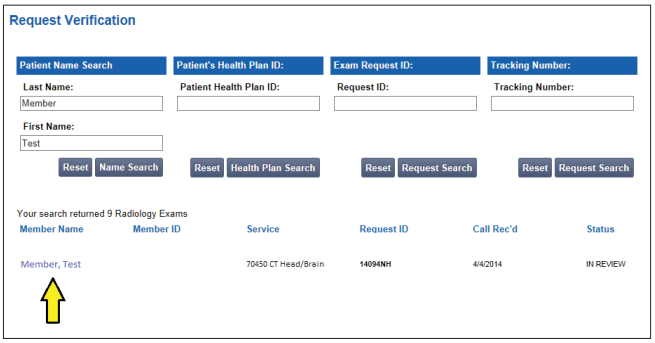


Figure 4 - Select an Auth to See Its Status

The button to upload documents with additional clinical information will be available from the auth status page (See Figure 5 below).

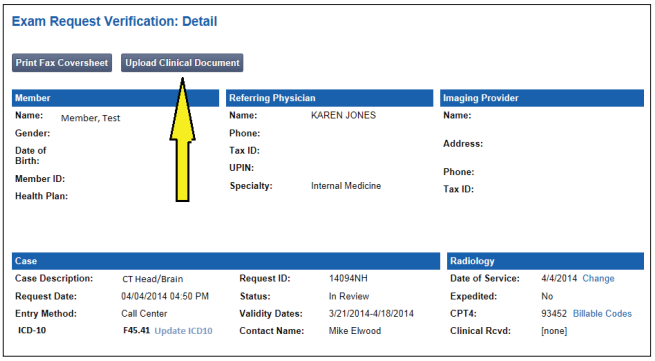


Figure 5 - Auth Status Page

Clicking on the Upload Clinical Document button will take the user to the Document Upload page.

For Assistance or Technical Support

Contact RadMDSupport@MagellanHealth.com or call 1-877-80-RadMD (1-877-807-2363). RadMD is available 24/7, except when maintenance is performed once every other week after business hours.

Provider Resources for Pharmacy Authorizations

	Medicare	OHP/Medicaid
Prior Authorization Form	Medicare PA Form Link	OHP PA Form Link
Mail Order Forms: **Homescripts** **CVS Caremark**	Homescripts Mail Order Form Link CVS Mail Order Form Link	–
Mail Order Phone: **Homescripts** **CVS Caremark**	1-888-239-7690 1-888-624-1139	Postal Prescription Services (PPS) 1-800-552-6694
Mail Order Website	–	Postal Prescription Services (PPS) (Portland, OR)
Acaria Specialty Pharmacy Phone	1-800-511-5144	1-800-511-5144
Acaria Specialty Pharmacy Fax	1-877-541-1503	1-877-541-1503
How to Link to Formulary	Medicare Formulary Link	OHP Formulary Link
	➔ Prescription Drug Benefits and Formulary ➔ Formulary ➔ HMO SNP Formulary	➔ For Providers ➔ Provider Resources ➔ Trillium Formulary (List of Covered Drugs for 2019) – Oregon Health Plan
How to Link to Criteria	Medicare Criteria Link	OHP Criteria Link
	➔ Drug and Pharmacy Information ➔ Prior Authorizations, Step Therapy and Quantity Limits	➔ For Providers ➔ Provider Resources ➔ Clinical & Pharmacy Criteria
Provider PA Questions Phone	1-844-202-6824 (Envolve)	1-877-600-5472 (Trillium)
Physician Administered Medications Look Up Tool	Medicare Lookup Tool	OHP Lookup Tool

Case Management and Care Coordination

The mission of Medical Management is to enhance member health and deliver quality service and cost-effective healthcare through collaboration with members, providers and the community.

The program's scope encompasses all healthcare delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities (SNF), home care services, outpatient care, and office visits.

MEDICAL MANAGEMENT CUSTOMER SUPPORT TEAMS

The Utilization Management, Pharmacy, and Case Management teams are available for providers to contact directly for all questions relating to the Trillium Medical Management Department. This includes questions on pharmacy, utilization management, care coordination, patient transitions, community care services referrals, care plans, or to reach someone specifically from the member's care team.

To access Trillium's Utilization Management, Pharmacy, or Case Management teams, providers and their staff can call Provider Services at (877) 600-5472 and select the appropriate transfer option. Providers can also securely send questions via the provider portal.

The Utilization Management team facilitates (or reviews) the benefits available to the member under the appropriate rules. The focus is on determining whether a service constitutes a covered benefit, whether criteria for coverage have been met, and whether the service is the most cost-effective option among those available. Clinical Specialists with appropriate licensure typically perform this function.

CARE COORDINATION

Trillium's Care Coordination program focuses on member specific needs, utilizing available benefits and supplementing with community resources as needed to assist members overcome barriers to health and achieve outcomes in their personal plan of care. Case Managers work in collaboration with internal and external resources, as well as providers to identify, and then facilitate improvement in, an individual member's health status related to physical and behavioral health needs. Issues of fragility, health literacy, social isolation, and related psychosocial issues that may impact health conditions and healthcare are assessed for impact on the member and the member's ability to engage in managing their health.

Health Risk Assessments (HRA) are completed telephonically, as well as via a paper version that can be mailed to the member. The information gathered from the HRA is used to develop a member-centric care plan and identify potential programs from which the member might benefit.

Care Coordination (continued)

An interdisciplinary approach is taken to meet the diverse needs of our membership by including all healthcare partners and social service agencies. This can be completed by coordination of a team meeting, inviting all parties of the member's care team, including the member himself/herself. Interdisciplinary care team (ICT) meetings improve the development of an effective care plan for the member to ensure their physical and behavioral health needs are met. As a provider, it would be beneficial to attend ICT's when invited, as the provider perspective is important in assessing and developing a proactive plan to assist the member achieve his/her goals. Should you wish to attend a scheduled ICT, but not be available when it is scheduled, please contact the care team to evaluate opportunities to schedule another available opportunity.

Case Management has a variety of specialized coordination programs. Entry into Case Management is optional for the member, so although there may be a referral into the program, the member may choose not to participate. In these cases, coordination directly with the provider could occur.

CARE PLANS

Care Plans are developed with member-specific goals in mind. Members are engaged to assess their health care goals and create actionable outcomes that will improve their overall health. Communication and coordination with the Primary Care Provider (PCP) are integral to success, and care plans are shared with PCP's following ICT meetings, as well as by request.

CASE MANAGEMENT PROGRAMS	
Chronic Pain	❖ Program serves members that have opioid use greater than 3 months, multiple medications for pain, including 2 or more medications in the same class (anti-inflammatories, muscle relaxants, narcotics or non-narcotic medications) pain greater than 4/1-10 pain scale, chronic pain diagnosis by a Provider, medical diagnosis of pain greater than 6 months. Services may include: coordination of care, assessment, provide resources and referrals to physical and behavioral health providers and community stakeholders.
Complex and Intensive Case Management	❖ Serves members with special medical, behavioral and psychosocial needs. Services may include: Complex and Intensive Case Management case management, assessment, coordination of care, transitions of care and interdisciplinary care team which is involved in planning, provision and monitoring of the member's care and services.
Transplant Program	❖ Program serves members who have needs surrounding pre- & post-transplant periods. Services may include education, case management, assessment, resource/referrals for physical and behavioral health needs, coordination with Utilization Management, post-transplant transition of care, and coordination.
Diabetes Programs	❖ Program serves members who are pre-diabetic and diabetic. Services may include diabetes education, case management, assessment, provided resources and referrals to physical health and specialty providers and community stakeholders.
DSNP	❖ Program serves members in Lane County with special medical, behavioral and psychosocial needs. Services include: case management, assessment, coordination of care, transitions of care, complex case management, and interdisciplinary care team which is involved in planning, provision and monitoring of the member's care and services.
ED Diversion	❖ Program provides care coordination for members who have been identified as 3 emergency department visits within a rolling 30 days. Services may include: identification of barriers to primary care, education to members on available resources such as urgent care, NurseWise and access to PCP, coordination of care efforts, assessments, provided resources and referrals to physical and behavioral health providers and community stakeholders.
Member Connections	❖ Program involves face-to-face coordination with members in their space, including home visits. Services could include: location services to outreach members who have not responded to telephonic outreach, need further engagement during transitions of care or other instances in which face-to-face support is needed. This program is specifically referred through case management team and cannot be engaged directly.

CASE MANAGEMENT PROGRAMS (Continued)	
Foster Care	❖ Program serves foster care members ages 0-17. Services include: oversight to ensure that physical, dental and behavioral health appointments are made, coordination of care and resource supports to members and foster families, interface with Department of Human Services (DHS) to address needed services and supports for members and foster families.
Start Smart for your Baby	❖ Program serves currently pregnant and post-partum members. Services may include: case management, assessment, coordination of care, resources and referrals to physical and behavioral health providers and community stakeholders.
Pediatric Case Management	❖ Program serves members from birth to age 18. Services may include: case management, assessment, coordination of care, resources, and referrals to behavioral health providers and community stakeholders. Continuity of care during transition to adult services is also available as needed.
Transition of Care	❖ Programs assists members that are transitioning from one level of care to another level of care by contacting member and their providers to review and address medical, behavioral, and socioeconomic concerns. Services could include: medication reconciliation, coordination of care between providers, member outreach to confirm needs are met.

The Trillium Member Handbook describes the Care Coordination program and advises members to contact Trillium if they believe they need services.

Providers may refer their Trillium patients to Case Management services by telephone, fax, e-mail, or through the secure Trillium Provider Portal.

Referral Request forms are available on Trillium's Provider Resources webpage at trilliumohp.com/providers/helpful-links

Telephone:	(877) 600-5472 (Toll Free)
	(541) 485-2155 (Local)
Fax:	(844) 805-3991
E-Mail:	Trillium_Medical_CaseMgmt_Referrals@TrilliumCHP.com

Case Management Referral Request

PHONE: 1-877-600-5472

FAX: 1-844-805-3991

EMAIL: Trillium_Medical_CaseMgmt_Referrals@TrilliumCHP.com

P.O. Box 11740
Eugene, OR 97440-3940

Complete all fields below and fax or e-mail all applicable medical records to assist with the referral (i.e. Medication List and Recent Chart Notes)

OHP/Medicare Member ID: _____ DOB: _____

Patient's Name: _____

Patient's Address: _____

Patient's Phone: _____ OK to leave a message? ☐ Yes ☐ No

Interpreter Needed? ☐No ☐Yes, what language? _____

Referring Physician/Provider Name:_____

Clinic/Agency Name: _____Phone:_____

PCP (if different from Referrer): _____

Referral Diagnosis:_____ICD-10 Code:_____

How would you like us to assist the patient?

_____

_____

_____

_____

_____

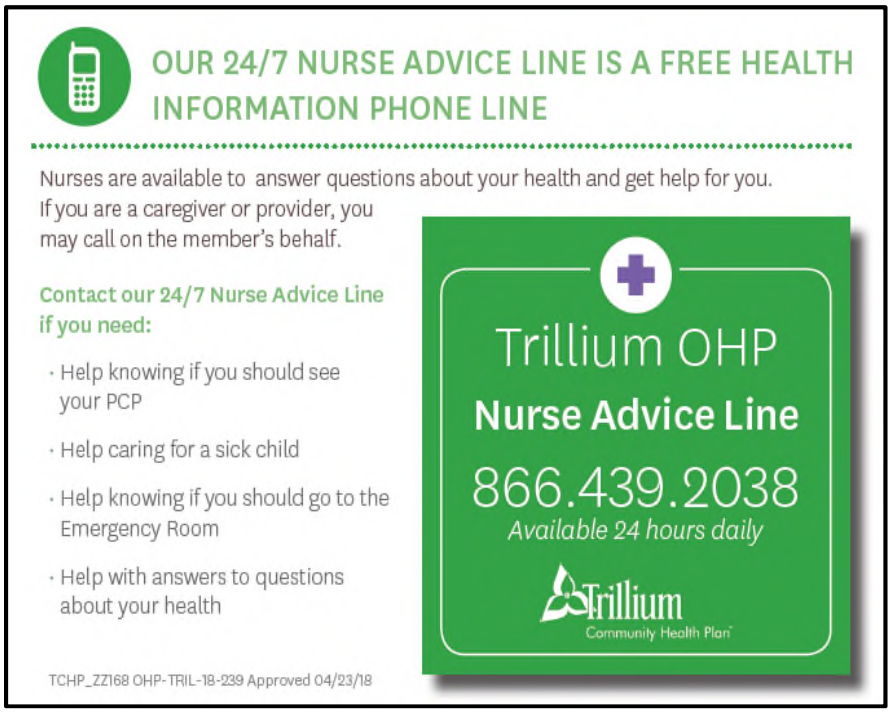
_____

_____

Form Completed By:_____Date: _____

Medicare Nurse Advice Line

OHP/Medicaid Nurse Advice Line



APPEALS & GRIEVANCES
PROVIDER CONTACT INFORMATION

	OHP/Medicaid		**Medicare**
Phone Numbers:	541-485-2155 (local) 877-600-5472 (toll free) 877-600-5473 (TTY) 877-367-1332 (Grievance Hotline)	**Phone Number:**	844-867-1156
Fax:	541-984-5696	**Fax:**	844-273-2671
Email:	appeals@trilliumchp.com	**Email:**	DSNPAppealsGrievances@Centene.com
Mailing Addresses:	OHP Trillium CHP ATT: **Appeals** P.O. Box 11740 Eugene , OR 97440 Trillium Community Health Plan ATT: Grievances P.O. Box 11740 Eugene, OR 97440	**Mailing Address:**	Medicare Trillium CHP ATT: Appeals/Grievances 7700 Forsyth Blvd Saint Louis, MO 63105

CLAIMS DISPUTES
PROVIDER CONTACT INFORMATION

Claims dispute forms can be accessed on Trillium Community Health Plan Website under Provider Resources https://www.trilliumohp.com/providers/helpful-links.html		
	OHP/Medicaid	**Medicare**
Mailing Addresses:	Trillium Community Health Plan ATT: Disputes P.O. Box 5030 Farmington, MO 63640-5030	Trillium Medicare ATT: Disputes, Corrections, Reconsiderations P.O. Box 4000 Farmington, MO 63640-3822