Clinical Policy: Requests for Authorization – Oregon Health Plan (OHP)

Reference Number: OR.CP.MP.500
Effective Date: 9/2019
Last Review Date: 2/2025
Line of Business: Oregon Health Plan, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
To ensure that Trillium staff and any delegated entities making Utilization Management decisions for Oregon Health Plan (OHP) members follow the Oregon Health Plan Prioritized List and subsequent policies/criteria/guidelines to make medical necessity decisions.

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Policy

I. It is the policy of Trillium Community Health Plan (Trillium) affiliated with Centene Corporation® that an authorization is to be reviewed using the following hierarchy:

A. **Request for Authorization**
1. Review the OHP Prioritized List funding level for each submitted diagnosis and supporting diagnosis by utilizing the following tool: http://lipaline.lipa.net/default.aspx /.
   a. Search Trillium Line Finder and document if the following OHP criteria are met.
      i. The condition is funded, or the condition and service/procedure fund and pair match.
      ii. Applicable guidelines associated with the ICD 10 codes submitted are met.
2. Review clinical policy, if any, for submitted service. For DME requests, review the OARs in the DME Chapter Rules instead of clinical policy.
3. Review InterQual for submitted services.
4. Send to Medical Director for medical necessity review. Medical Director will also review to determine if the comorbidity rule has been met (see Definitions section for complete rule).

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	09/2019	09/2019
Updated OARs per Oregon Health Plan (MCE and CCO) Administrative Rulebook Chapter 410, Division 141	03/2020	03/2020
Updated References from Oregon Health Authority (OHA) Rulebooks to Oregon Secretary of State website. OHA no longer maintains the administrative rulebooks. Updated DME Rulebook to DME Chapter Rules. Removed if met/if not met from each step	04/2021	05/2021
Annual review, no changes	04/2022	05/2022
Annual review, no changes	02/2023	02/2023
Annual review, no changes	01/2024	02/2024
Annual review, updated Comorbidity Rule under Definitions from OAR 410-141-3820 (10) to (11) in alignment with DMAP 35-2024.	02/2025	02/2025

References

1. Oregon Health Authority/Oregon Secretary of State
   https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87
2. OAR 410-141-3820 – Covered Services, includes Co-morbid
3. OAR 410-141-3825 – Excluded Services and Limitations
4. OAR 410-141-3830 – Prioritized List of Health Services

Definitions

1. **Prioritized List** - The Health Evidence Review Commission (HERC) Prioritized List of Health Services is the listing of physical and mental health services with "expanded definitions" of practice guidelines and statements of intent as presented to the Oregon Legislative Assembly
2. **Comorbidity Rule OAR 410-141-3820 (11)**
   (11) Coverage of services for unfunded conditions based on effect on funded comorbid conditions:
   (a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:
   (A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and
   (B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and
   (C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.
   (b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (11);
   (c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis;
   (d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:
   (A) Treating health care provider opinion;
   (B) Medical research; and
   (C) Current peer review.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

CLINICAL POLICY
Requests for Authorization – Oregon Health Plan (OHP)

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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