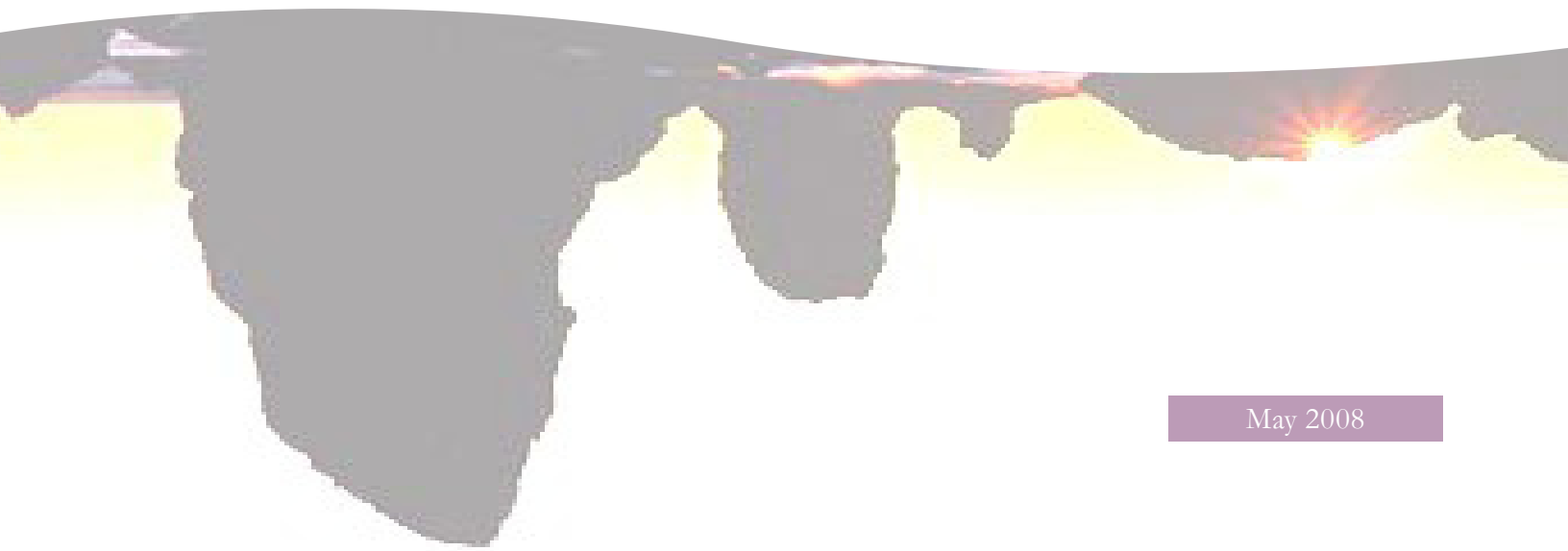
DMAP Worker Guide IX

Prior Authorization



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Prior Authorization

Some medical services and equipment require prior authorization (PA) by various DHS agencies or the client's managed care plan before they can be delivered to a client. These services and equipment include:

- Non-emergency medical transportation (including client mileage, meals and lodging)
- Some durable medical equipment and medical supplies
- Most physical therapy and occupational therapy
- Private duty nursing
- Most home health
- Most speech and hearing
- Some visual services
- Some home enteral/parenteral IV
- Some dental services
- Some transplants
- Out-of-state services
- Some surgeries

Where to get prior authorization

The charts on the next pages list services requiring prior authorization and who can authorize those services for which populations. Procedures for processing PAs are the same for all benefit packages, except when a client is in a managed care organization (MCO) that covers the service. If a client belongs to an MCO, the provider should contact the plan directly for prior authorization on health care services covered under the client's benefit package.

If a primary care provider refers a client to an out-of-state provider, be sure that service has the needed prior authorization.

Client group	Services authorized	Responsible party
All clients enrolled in an MCO when the service is included in the plan's contract	All services for which the plan receives a capitation payment	Managed Care Organization (MCO)
DHS clients for non-emergency medical transportation (for clients enrolled in an FCHP or PCO, the plan is responsible for all ambulance, including non-emergency)	Transportation	Local contracted transportation brokerage or DHS branch staff in counties where no brokerage is contracted
Children in subsidized adoption	Medical Transportation; Administrative Exams	DMAP Claims Management
SPD clients not enrolled in an MCO	Medical Transportation	SPD branch staff
All clients not enrolled in an MCO Any client receiving a therapeutic class 7 or 11 drug	Drugs related to National Drug Codes (NDCs); Oral nutritional supplements	First Health Services
CAF and SPD clients not enrolled in an MCO or Medically Fragile Children1 and DHS FFS Medical Case Management2 clients	Durable Medical Equipment (DME) and Supplies (for specific items, (OAR 410-125) Physical/ Occupational Therapy (OAR 410-131); Private Duty Nursing Home Health (OAR 410-132); Speech and Hearing (for specific items (OAR 410 Division 129); Visual Services (OAR 410-140); Home Enteral/ Parenteral IV (OAR 410-148)	DMAP Medical Unit
DHS clients not enrolled in a Dental Care Organization or an MCO which covers dental	Dental services	DMAP Dental Coordinator
DHS clients not enrolled in an MCO	Transplants; Out-of-state services	DMAP Clinical Unit
DHS clients not enrolled in an MCO	Surgeries and services listed in OAR 410 Division 130 and Supplement as requiring Acumentra prior authorization	Acumentra (formerly OMPRO)
Children case managed by the MFCU and identified with a case descriptor MFC	All medical services requiring prior authorization, except transportation, transplants, out-of-state services, dental and visual services	Medically Fragile Children's Unit
DHS FFS Medical Case Management clients	All medical services requiring prior authorization	Innovative Care Management (ICM)

Prior Authorization Contacts

Fee-for-service, FFS or "open card"

(*i.e.*, for services not covered by a Managed Care Organization)

Service	PA Authority	Phone/Fax
Dental	DMAP Dental Coordinator	800-527-5772 or 503-945-6506
Drugs/pharmacy and EPIV oral nutritional supplements only	First Health Services Managed Access Program (MAP)	800-344-9180 800-250-6950 Fax
Durable medical equipment/ supplies **Hearing aid services** **Home health (nursing only)** **Home enteral/parenteral (except oral supplements)** **Physical/occupational therapy** **Speech, hearing, audiology**	**Medically Fragile Children**: FMC Unit **Medical Case Management clients**: Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients**: DMAP Medical Unit	971-673-2985 or 971-673-3000 971-673-2971 Fax 800-862-3338 or 503-654-9447 503-654-8570 Fax 800-642-8635 or 503-945-6821 503-378-5814 Fax
Out-of-state services	DMAP Clinical Unit	503-945-5802
Surgical procedures	**Medical Case Management clients**: Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients:** Acumentra Health 2020 SW Fourth Ave, Ste 520 Portland 97201	800-862-3338 or 503-654-9447 503-654-8570 Fax 800-452-1250 or 503-279-0159 from outside Oregon 800-325-8933 503-279-0190 Fax
Transplants	**Medical Case Management clients**: Innovative Care Management (ICM) 10117 SE Sunnyside Rd, Box F409 Clackamas, OR 97015 **All other clients:** DMAP Clinical Unit	800-862-3338 or 503-654-9447 503-654-8570 Fax 503-945-6488
Transportation	Local transportation brokerage or branch	See DMAP Worker Guide XII
Vision	DMAP Medical Unit	800-642-8635 or 503-945-6821 503-378-5814 Fax

Authorizing Services on Computer System

For medical services branch staff must:

- Determine if the client is eligible.
- Determine the client's benefit package.
- Determine if the client is in a managed health care plan and, if so, which plan (ELGX and KON1 screens).
- Determine if procedure codes and diagnosis codes are valid; (LVL3-DIAG screen).
- Check the list to find out where the diagnosis/treatment pair is in relation to the OHP Prioritized List cutoff line (HSCX screen).

How It Works

Step 1 – Is the client medically eligible and does the client's Benefit Package include the service being requested? (ELGR)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to Step 2.

Step 2 – Is the client enrolled in a managed care plan? (ELGX)

No – Go the step 3.

Yes – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Step 3 – Is the client in a long-term care facility? (ELGF)

No – Go to Step 4.

Yes – Review the provider guide to determine if the service is in the all inclusive rate. If it is in the all inclusive rate, deny the request. (See Section 10-denial codes) If it is not all inclusive, proceed to step 4.

Step 4 – Is the procedure code valid? (LVL3)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 5.

Step 5 – Is the diagnosis code valid? (DIAG)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 6.

Step 6 – Is the service covered by the Oregon Health Plan prioritized list and included in the client's benefit package? (Use HSCX to determine if diagnosis/treatment pairing is a benefit according to the Health Services Commission Prioritized List.

Prioritized List reflects diagnosis and procedures that may not be a covered benefit for DMAP.)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 7.

Step 7 – Process the request using the appropriate MMIS screen (ELGP) and provider rules.

MMIS Screens

The following screens are used in prior authorizing services for OHP clients. Please refer to the CAF Computer Guide, Chapter XXII, for specific screen information.

- OHPS – A menu of OHP screens.
- HSCX – Entering a diagnosis and procedure code for the date of service identifies whether a treatment is above or below the line. However, the diagnosis and procedure code must be verified on the DIAG and LVL3 screens and indicate an active status for MMIS payment.
- ELGR – To verify Medicaid eligibility and benefit package.
- ELGX – Indicates whether a client is enrolled or is being enrolled in a plan or has private insurance.
- KON1 – The names and pertinent information on plans.
- ELGP – Prior authorization screen. The computer will automatically furnish the PA number and generate a notice of approval or denial to the client, provider, and branch.
- DIAG – Indicates if this diagnosis code has an active status for MMIS payment.
- LVL3 – Indicates if this procedure code has an active status for MMIS payment.
- XREF – To locate a client by name or Social Security number.
- ELGF – Long Term Care indicates current and historical information about a client's stay in a nursing facility.
- MEDC – Indicates medical criteria that affect the adjudication of claims.
- PRVX – To locate a provider by name.
- PRV1 – Used to identify provider eligibility.