Rev September 2023

Effective September 2023

EOCCO Referral and Authorization Instructions

The EOCCO Referral and Authorization Guidelines provide information on -referable services, prior authorization requirements and services that do not require authorization. This information is subject to change and can be accessed from the EOCCO website at https://www.eocco.com/providers/referral-auths.

REFERRAL & AUTHORIZATION INFORMATION

Referral and prior authorization requests may be phoned in to 503-265-2940, toll free 888-474-8540, or faxed to 833-949-1886

Referral and prior authorization requests for members residing in Morrow and Umatilla may be faxed in to 541-215-1207 through 9/30/2023. Effective 10/1/2023 please submit requests to 503-265-2940, toll free 888-474-8540, or faxed to 833-949-1886

Most referrals are approved for a 180 day time span

DUAL ELIGIBLE MEMBERS

For Members who are eligible for both EOCCO and a Medicare or a commercial insurance plan, a referral or prior authorization is not required except for the following:

Any service or procedure not covered by Medicare or the commercial insurance plan

All transplants: solid organ, autologous or allogenic bone marrow

Bariatric Surgeries

Medication requiring prior authorization

Services below the line or not covered by EOCCO (when consideration for coverage is being requested)

*****NOTE: the primary insurer's EOB must be submitted with claims*****

SERVICES REQUIRING REFERRAL

The service(s) that are below the line or non-funded on DMAP's Prioritized List of Health

Services Services not listed on DMAP's Prioritized List of Health Services

PCP to PCP referrals outside of call share

Requests to out-of-network specialists and ancillary providers

Standard Prior Authorization requirements apply.

SERVICES THAT DO NOT REQUIRE A REFERRAL (when performed by participating providers)

Member's assigned PCP refers to an in-network specialist or an in or out-of-network orthopedic provider The service(s) are covered on DMAP's Prioritized List of Health Services (above the line)

The specialist must receive a verbal request from the member's assigned PCP before seeing the member walk-ins will not be allowed

In-office surgeries are included, if above the line (prior authorization requirements still apply)

Specialists wanting to refer members to another in-network specialist or ancillary provider (PT, OT, SPT) will request the prior authorization directly from EOCCO and inform the member's assigned PCP

Referral requirements are waived for members within the first 30 days of EOCCO membership

Referrals for Hospital Dentistry are not required

Members through age 21 do not require a referral except to an out of network provider.

Services are subject to eligibility and plan provisions in effect at the time services are rendered. EOCCO does not cover services or supplies not covered by The Oregon Health Plan.

For more Information on referrals, please see the EOCCO Provider Manual, pages 11-15
https://www.eocco.com/providers/manuals-guidelines

SELF-REFERABLE SERVICES (when performed by a participating provider)

- Sexual Abuse exams
- Urgent and emergency care
- Women's annual gynecologic exam
- Family planning and birth control
- Prenatal Care
- Routine vision exams for eligible members
- Immunizations

Please also check to see if the service(s) requires prior authorization. Obtaining a referral does not change the requirement for the services(s) to be prior authorized.

REFERRAL REQUEST REQUIREMENTS

Make sure the referral request is complete and contains:

- ✓ All pertinent member information (name, ID #, group # and member birth date) PCP information (name, TIN, phone, fax and contact name)
- ✓ Diagnosis code
- ✓ Specialist information (full name, TIN, phone, fax, contact name and address) Return fax number, when applicable
- ✓ Start and end date of the referral (Cannot be for a future service date)

Reminders – a referral is NOT a prior authorization for procedures or services. A prior authorization is a request for treatments or procedures to be performed by the referred-to specialist. Refer to the Focus List on page 4 for services that require prior authorization.

THE PRIORITIZED LIST

These instructions and the new list of services that require authorization will become effective yearly January 1st. EOCCO adheres to the administrative rules and guidelines set forth by the State of Oregon.

- Review and revision will occur quarterly
- Effective 1/1/2023 lines 1-472 are above the line (ATL) and considered a priority for payment by the State of Oregon
- Lines 473 – 662 are Below the Line (BTL), and are not considered a priority for payment by the State of Oregon
- It is important to note that the appearance of a code either ATL or BTL is not a guarantee of an authorization, payment, or denial. EOCCO reviews each request based on the individual medical necessity which is unique in every case
- Unlisted codes can either be EXEMPT (symptom codes or diagnostic codes), EXCLUDED (statutorily non-health), or codes that have not been addressed by the State for inclusion on the Prioritized List of Services
- The Prioritized List is subject to change. For information regarding pending and future line placement, guidelines or Administrative Rules, please refer to the DMAP website here: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

SERVICE AUTHORIZATION INSTRUCTION AND GUIDELINES

Services are subject to eligibility and plan provisions in effect at the time services are rendered. EOCCO does not cover services or supplies not covered by The Oregon Health Plan.

- The list of services requiring a prior authorization is a complete list. Updates will be made frequently and as indicated by new emerging technologies and procedures, or as DMAP makes changes to the Prioritized
    - List of Health Services. Notification of such additions will be provided
- All elective inpatient procedures require a prior authorization, regardless of placement of the diagnosis on the Prioritized List. Retroactive authorization requests will be denied unless it is established that the practitioner and the hospital did not know and could not reasonably have known that the patient was enrolled with EOCCO at the time of admission. Please see the EOCCO Provider Manual, page 17, for more information: https://www.eocco.com/providers/manuals-guidelines
- Long Term Acute Care Hospitals (LTACH), Inpatient Rehabilitation and Skilled Nursing Facility (SNF) stays require prior authorization
- Services and procedures performed by an out of network provider require a prior authorization
- Outpatient services not listed on the prior authorization list do not require a prior authorization for In
    - Network providers, but are subject to the Prioritized List
- Medication Codes beginning in J do not require a prior authorization unless it is specifically cited on the list of codes requiring a prior authorization, as part of the self-injectable plan, or Magellan Rx plan. Please call EOCCO pharmacy customer service at 888-474-8539, or medical customer service at 888-788-9821 if you have any questions
- Home health and home infusion services require a prior authorization
- EOCCO works with Magellan Rx for home infusion services. For more information please see page 36 of the
    - EOCCO Provider Manual: https://www.eocco.com/providers/manuals-guidelines
- Enteral and parenteral nutrition requires a prior authorization
    - For liquid nutrition, please submit the request with units. 1 unit per 100 calories x how many
        - calories required per day x how many days the request extends. For powder cans, please request
        - with feedings per can and calories required per feeding

Emergency Room Visits do not require a prior authorization

Inpatient Notification is required within 1 business day

For physical health admits we strive to process notifications of emergent/urgent admissions within 24 hours of receipt. Continued review of the admission is dependent on the actual length of stay. When a member stays beyond 2 nights a care coordinator will follow up with the facility and conduct a clinical review. The Care Coordinator will request clinical documentation and review all available information to determine medical necessity of ongoing stay

SERVICE AUTHORIZATION REQUEST REQUIREMENTS

Make sure the prior authorization request is complete and contains:

- ✓ All pertinent member information (name, ID #, group #, and member's birth date)
- ✓ PCP information (name, TIN, phone, fax and contact name)
- ✓ The name and TIN of the facility where the procedure is to be performed
- ✓ The date of the procedure or date of admission
- ✓ Surgeon's or specialist's full name and TIN
- ✓ **CPT** & **diagnosis codes must be included**
- ✓ Length of stay (indicate if inpatient)
- ✓ Chart notes
- ✓ A referral from the PCP must either be included, or already be in place, if applicable
- ✓ For forms and more information, please visit: https://www.eocco.com/providers/referral-auths

CONTACT INFORMATION:

General Referral and authorization requests may be phoned in to 503-265-2940, toll free 888-474-8540, or faxed to 833-949-1886

NON-COVERED SERVICES

Non-covered services are determined by the State of Oregon, and are included in the Prioritized List of Health Services and omitted from the Oregon Health Plan fee schedule. Additionally, some services are considered experimental and investigational, and are also non-covered. It is not all inclusive and is subject to change.

CHEMICAL DEPENDENCY (GOBHI)

- Inpatient Hospital Medical Detox
- Subacute Medical Detox
- Outpatient Treatment (evaluation does not require prior authorization)
- Synthetic Opiate Treatment
- Phone: 541-298-2101 Toll Free: 888-474-8539
- http://www.gobhi.org/

INFUSION SERVICES (outpatient)

- Some specialty IV infusion medications require prior authorization through Magellan Rx Specialty Pharmacy
- The Current Magellan Rx specialty drug list is available on the EOCCO website
- Call Magellan Rx at 1 800-424-8114 or visit website at https://www1.magellanrx.com/

INJECTABLES (certain Injectables require prior authorization)

- Some specialty injectable medication require prior authorization through Magellan Rx Specialty Pharmacy
- Current Magellan Rx specialty drug list is available on the EOCCO website: https://www.eocco.com/providers/pharmacy
- Call Magellan Rx at 1 800-424-8114 or visit website at https://www1.magellanrx.com/
- FAQ https://www.modahealth.com/pdfs/faq_injectables.pdf

ADVANCED IMAGING (eviCore)

- Prior authorization is required for advanced imaging
- Web submissions (preferred method): https://www.evicore.com/
- Phone: 844-303-8451
- Fax: 844-540-2406
- For more information https://www.modahealth.com/medical/utilizationmanagement.shtml

PHARMACEUTICAL

For medications that require prior authorization contact EOCCO Pharmacy Customer Service at 503-265-2939 or 1-888-474-8539 or by fax at 503-670-8349

2ND OPINIONS

EOCCO provides for a second opinion from a qualified healthcare professional within the network or arranges for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee.

MEDICAL CRITERIA

When reviewing a referral and/or authorization request, EOCCO may utilize one or more of the following criteria to base the decision to approve or deny the request; Oregon Administrative Rules and supplemental information administered by the Division of Medical Assistance Programs, the Prioritized List of Health Services, ***EOCCO*** Medical Necessity Criteria, Milliman Criteria and/or Medicare criteria.

ADDITIONAL INFORMATION

For additional questions about referral and/or prior authorization requirement, please call 888-474-8540 or for members residing in Morrow and Umatilla Counties, please call 541-215-1208.

Additional information can also be found in the EOCCO provider manual at link: https://www.eocco.com/providers/manuals-guidelines