
REFERRAL/AUTHORIZATION GUIDELINES

Commercial Plans

Referral & Authorization Information

- Referral and authorization requests may be phoned in to 503-243-4496, toll free 800-258-2037, or faxed to 503-243-5105. For Municipality of Anchorage the fax number is 1-800-522-7004.
- OEBC Customer Service phone numbers: 503-265-2909, toll free 866-923-0409
- Most referrals are authorized for a one-year time span.
- Retroactive referral requests will be limited to 90 days.
- For more information, see our [referral requirements](#), [authorization requirements](#) or [frequently asked questions](#) at www.odscorporations.com/medical.
- City of Portland (group #s M106, M107, M148, M149, N990, N991, N994, N995) – Please call ODS Medical Intake Department at 503-243-4496 or toll free 800-258-2037
- Northwest Permanente (group # V046) and Public Employees Retirement System (PERS) – Medicare supplement plans (group # 9380-04, 05) – no authorization required.

Services requiring referral – Managed Care (MC) and Point of Service (POS) plans

- Specialist visits.
- Neuropsychological evaluations.
- Effective April 1, 2007 a referral is required for all pain management services.

Note: It is important to refer patients to specialists and/or facilities that are contracted with the member's provider network. Use of non-contracted providers and/or lack of a referral can result in lower benefits or, in some cases, no benefits at all.

SELF-REFERABLE SERVICES

A member can self-refer for the following services:

- Child abuse issues.
- Contraceptive Management
- Dentist/Oral Surgeons for treatment of dental accidents, TMJ as defined by the member's plan, and/or oral surgery as long as service is covered under the member's medical plan. Other medical services will require the treating provider to be in-panel for the member's plan and will require that a PCP referral be in place. See focus list for services that require authorization.
- Diabetic annual retinal exams
- Diabetes self-management, subject to limits of plan.
- Prenatal care
- Sterilization
- Vision – emergency services or any medical eye condition
- Vision – Optometrist and Ophthalmologist
- Women's annual gynecologic exam
- Follow-up treatment resulting from women's annual exam.

Note: Use of non-contracted providers may result in lower benefits or, in some cases, no benefits at all. Payment for self-referable services is dependent on the member's benefits and may be dependent on whether the member has designated a PCP.

REFERRAL REQUEST REQUIREMENTS

Make sure the referral request is complete and contains:

- All pertinent patient information (subscriber, ID #, group #, relation to subscriber, and patient's birth date).
- Date of service.
- Place of service.
- ICD-9 code(s).
- Specialist's full name and address.
- Return fax number, when applicable.
- Date you want the referral to start and date you want the referral to end.

Reminder – a referral is NOT an authorization for surgery. A referral indicates that the PCP would like the specialist to request any necessary authorizations for surgical procedures.

AUTHORIZATION REQUEST REQUIREMENTS

Make sure the authorization request is complete and contains:

- All pertinent patient information (subscriber, ID #, group #, relation to subscriber, and patient's birth date).
- The name 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.
- CPT & ICD-9 (numeric only) codes.
- Length of stay (indicate if outpatient).
- Chart notes, when requested.
- A referral from the PCP (only when the authorization request is being submitted by the specialist).
- **Effective June 1, 2010 Authorization Requests are required for arthroscopy, outpatient upper endoscopy, and sleep study. Some employer groups are not subject to this prior authorization requirement. Please contact Medical Intake Department at 503-243-4496 or toll free 800-258-2037 for additional information.**

SERVICES THAT DO NOT REQUIRE AUTHORIZATION

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| <ul style="list-style-type: none"> • Aspiration • Biopsies • Bone mineral density studies, diagnostic • Breast brachytherapy for breast cancer • Cardiac Catheterizations/Angiograms (outpatient only) • Cardiovascular Stress Test • Chemotherapy (outpatient only) • Colonoscopy with medical diagnosis (not virtual) • Colonoscopy with routine diagnosis, including family history diagnosis (not virtual) plan must have routine benefits (contact customer service for benefits) • Diabetic Shoes (unless >\$500 and/or more than 1 pair per year) • ECG, EKG • Echocardiography • EEG • EMG CPT: 95870 | <ul style="list-style-type: none"> • Infertility treatment (may be a plan exclusion/referrals are required) • Intravenous/intramuscular pain management • Kidney dialysis • Most lab tests • Needle biopsy • Occupational therapy* • Physical therapy* • Punch biopsy • Speech therapy* • Trigger point injections • Ultrasound • X-rays |
| <ul style="list-style-type: none"> • Hydration therapy | |

*Ordering physician must be PCP or referred-to specialist. If the plan has a benefit for therapy visits exceeding 30, medical necessity review will be required for the 31st visit.

Note: For Preferred Provider (PPO), Managed Care (MC) and Point of Service (POS) plans, it is important to refer patients to specialists and/or facilities that are contracted with the patient's provider network. Use of non-contracted providers and/or lack of a referral can result in lower benefits or, in some cases, no benefits at all.

IF YOUR PLAN IS "FULLY INSURED," AS DESCRIBED IN YOUR MEMBER HANDBOOK, ELIGIBILITY IS BINDING FOR FIVE BUSINESS DAYS AND QUOTED BENEFITS ARE BINDING FOR 30 DAYS FROM THE DATE OF AUTHORIZATION. FOR ALL PLANS, SERVICES ARE SUBJECT TO ELIGIBILITY AND PLAN PROVISIONS, INCLUDING PRE-EXISTING CONDITIONS, IN EFFECT AT THE TIME SERVICES ARE RENDERED.

The scope of the referral needs to include diagnostics and/or office treatment if applicable. Even if a service is listed above, coverage may be limited by benefit limitations and exclusions of the member's plan. Please contact Customer Service for clarification.

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FOCUS LIST

**Services that require authorization for all Commercial Plans
Do not use this list for City of Portland groups
(See Referral and Authorization Information)**

The following is a list of services that require authorization to determine medical necessity or plan benefit limitations. Even though a service is not listed below, coverage may be limited. Contact Customer Service for benefit limitations and exclusions. To receive the higher level of benefit, services must be performed by participating providers/facilities on Preferred Provider (PPO), Managed Care (MC) and Point of Service (POS) plans.

Note: If services are not authorized prior to being rendered, certain plans may apply a cost containment penalty even when services are authorized retroactively.

COSMETIC PROCEDURES

Potentially cosmetic procedures may be a plan exclusion unless medical necessity has been established. The following is a partial list.

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| <ul style="list-style-type: none"> • Abdominoplasty • Blepharoplasty and/or brow lift • Botox injections • Breast surgery - augmentation or reduction • Circumcision after 3 months of age • Dermabrasion • Intralesional Injections (i.e. Kenalog) • Laser treatment (except for retinopathy) | <ul style="list-style-type: none"> • Lipectomy • Otoplasty • Panniculectomy • Port wine stain treatment • Rhinoplasty • Scar revisions (includes Kenalog injections) • Silicone breast implant removal • Varicose vein surgery/sclerotherapy |
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DENTAL SERVICES

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| <ul style="list-style-type: none"> • TMJ surgical splints • Treatment of dental accidents | <ul style="list-style-type: none"> • Orthognathic services (excluded from most medical plans) • TMJ surgeries |
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DIAGNOSTIC PROCEDURES

- Genetic Testing
- RAST allergy testing
- Routine Colonoscopy: in the absence of colonoscopy Plan wording, ODS will allow one colonoscopy over the age of 50 every 10 years. Exception: Routine colonoscopy is not covered under any plan that does not have routine benefits or benefits for routine sigmoidoscopy (except City of Eugene M056) – call Customer Service for benefits
- PET scans
- SPECT scans
- CT scans (including CTA)
- MRI (including MRA, MRS, MRM)
- Nuclear cardiology imaging studies
- fMRI

DURABLE MEDICAL EQUIPMENT/APPLIANCES/SUPPLIES

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| <ul style="list-style-type: none"> • Airway clearance devices (i.e. chest percussors, vests, etc) • Augmentative communication device and system • Bone growth stimulator • Braces/Orthotics >\$3,000 (except custom made foot orthotics) • Continuous glucose monitor • Custom compression stockings >\$500 • Custom/special seating system | <ul style="list-style-type: none"> • Low air loss products • Lymphedema pump • Muscle stimulator • Nebulizer, portable and >\$300 • Oxygen (initial certification only) • Patient lift • Phototherapy lights (for dermatologic diagnosis) |
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- Custom wheelchair (also repairs over \$500)
- Dynasplint/JAS (or other mechanical stretching device)
- Enteral feedings/nutritional formulas
- External wearable cardiac defibrillator
- Gradient pressure aid
- Hearing aid (Multnomah County)
- Hospital bed
- Insulin pump
- Intrapulmonary percussive ventilation
- INR Monitor, for home use
- Light box
- Power wheelchair/scooter (also repairs > \$500)
- Prosthetics (except breast prosthetics)
- Sonic Accelerated Fracture Healing System
- Spinal cord stimulator
- Trapeze
- Wound vac (including wound warming cover)

EAR/NOSE/THROAT PROCEDURES

- Cochlear implantation/removal
- Otoplasty
- Rhinoplasty
- Septo-rhinoplasty
- Somnoplasty/coblation
- Uvulopalatopharyngoplasty (UPPP)/Uvulectomy

EXCLUDED SERVICES/PROCEDURES – Contact Customer Service for member’s benefit limitations and exclusions.

EXPERIMENTAL/INVESTIGATIONAL

Services determined by ODS to be experimental/investigational are excluded. Listed procedures are not all inclusive – contact Customer Service for exclusions

- Anodyne Therapy System
- Automated, noninvasive nerve conduction study (e.g. NC-Stat)
- Continuous Glucose Monitor (beyond 3 days)
- Dynamic spine stabilization (Dynesys)
- ExMI (Extracorporeal Magnetic Innervation)
- High Density Lipid Profile
- Home Interferential Muscle Stimulator
- Microcurrent Stimulators (MENS) (e.g. Alpha Stim unit)
- Ossatron/Orthotripsy for plantar fasciitis (extracorporeal shock wave therapy)
- Saliva Hormone Testing
- Sublingual Immunotherapy (SLIT)
- Thermal Imaging/Thermography
- Vertebral Axial Decompression
- Virtual Colonoscopy (routine)

HOME SERVICES

- Home health services
- Home infusion services
- Hospice care
- Palliative care

HOSPITAL EMERGENCY ADMITS

- Notification is required within 48 hours of hospital admission.

IMMUNOTHERAPY/ALLERGY INJECTIONS

- Pre-authorization is required for more than 56 units of CPT 95165 (56 units = 2 treatment sets at 28 doses per treatment set)

IMMUNIZATIONS

- Hepatitis A or Hepatitis B immunization age 18 and older
- Rabies Vaccine

INFUSION SERVICES (OUTPATIENT)

- Amevive Infusion
- Iron
- Intravenous Immune Globulin (IVIG)
- Orencia

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- Reclast and Zometa (Zoledronic acid)
- Remicade Infusion
- Rituximab (for rheumatoid arthritis)
- Soliris
- Tysabri
- OHSU Student plans require authorization on all out-patient infusion services

INJECTABLES

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| • Aranesp | • Intron A |
| • Arixtra | • Kineret |
| • Avonex | • Pegasys |
| • Betaseron | • Peg-Intron |
| • Cimzia | • Rebetrone |
| • Copaxone | • Rebig |
| • Enbrel | • Remodulin |
| • Forteo | • Somavert |
| • Growth Hormone | • Synagis |
| • Hepsara | • Somavert |
| • Humira | • Xolair |
| • Infergen | |

INPATIENT REHABILITATION

INPATIENT SURGERIES AND PROCEDURES- ALL ELECTIVE CASES

OUT-OF-NETWORK REQUESTS PAID AT THE IN-NETWORK LEVEL – Managed Care (MC) and Point of Service (POS) plans only.

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| • Services at out-of-network facilities | • Visits to out-of-network providers or facilities |
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PAIN MANAGEMENT

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| • Epidural pain pump insertion | • Spinal Cord Stimulator (trial and permanent placement) |
| • IDET (Intradiscal Electrothermal Therapy) | • Synvisc, Supartz, Hyalgan, Orthovisc, Euflexxa Injections (all viscosupplementation) |
| • Multidisciplinary pain team evaluation at Progressive Rehab | |

PHARMACEUTICAL

- Obesity/Weight loss drugs

REHABILITATIVE AND RECUPERATIVE SERVICES

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| • Cardiac rehabilitation | • Multidisciplinary pain team evaluation at Progressive Rehab |
| • Pulmonary rehabilitation | |

REPRODUCTIVE SERVICES

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| • DNA testing | • Genetic testing |
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SKILLED NURSING FACILITY

SURGERY – ALL INPATIENT ELECTIVE SURGERIES AND PROCEDURES

SURGERY/TREATMENT – OUTPATIENT

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| • All outpatient surgeries on this focus list | • Prophylactic surgery (e.g. mastectomy) |
| • Cartilage Transplants of the knee | • Thoracic Sympathectomy (for hyperhidrosis) |
| • Capsule Endoscopy | • Kyphoplasty/Vertebroplasty |
| • Hyperbaric Oxygen Therapy | • Cryoablation of breast lesions |
| • Nucleoplasty/IDET | • Stereotactic Radiosurgery (ie Gamma Knife) |
| • Neck/back/spine surgeries | |

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TRANSPLANTS

- All transplants except cornea
- Donor services