

OHSU HEALTH IDS

Utilization Management

Procedure handbook
for physical health providers
2026

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Additional resources

Visit [OHSU Health IDS Providers and Clinics website](#)

- [Provider manual](#)
- [Auto Authorization](#)
- [PA guidelines](#)
- [Formulary](#)
- [PA drugs](#)

Provider enrollment in OHP

[Verification tool](#)

Utilization Management

Quick reference

Before you submit

- Verify member eligibility on the date of service.
- Confirm the diagnosis and service are funded under the Oregon Health Plan (OHP) [Prioritized List](#).

How to submit prior authorizations

- Primary method: OHSU Health IDS Provider Portal ([Benefit Tracker](#))

Review time

- Standard prior authorization: Within seven calendar days
- Expedited prior authorization: Within 72 hours
- Pharmacy requests:
 - Standard: Within 72 hours
 - Expedited: Within 24 hours
- Emergency services: Prior authorization is not required

Inpatient admissions

- Planned or elective admissions require prior authorization.
- Submit a notification of admission when eligibility is unclear and before submitting a claim.

Discharge planning

Prior authorization is required for discharge to:

- Skilled nursing facilities (SNF)
- Long-term acute care hospitals (LTACH)
- Inpatient rehabilitation facilities (IPR)

Submit requests at least 24 hours before the anticipated discharge, along with the required forms and clinical documentation.

Contact information

Utilization management review staff are available:

- Monday–Friday
- 7:30 a.m. - 5:30 p.m.
- Phone: 844-931-1774
- Fax: 833-949-1887

Oregon Health Authority Medical-Surgical Services

Find helpful information and quick links to schedules, lists and documents at [Medical-Surgical Services Program](#).

Introduction

This handbook explains how [OHSU Health IDS](#) reviews and authorizes physical health services for members enrolled in [Health Share of Oregon](#).

Providers can use this handbook to know:

- When prior authorization is required
- How to submit requests and notifications
- Standard and expedited review times
- Clinical criteria used in utilization management decisions

Utilization management overview

Utilization management (UM) is the process OHSU Health IDS uses to ensure that requested services are:

- Covered benefits under the [Oregon Health Plan \(OHP\)](#)
- Medically appropriate and medically necessary
- Provided in the most appropriate setting

OHSU Health IDS reviews inpatient, outpatient and durable medical equipment (DME) requests using:

- [The Oregon Prioritized List of Health Services](#)
- Medical Coverage Guidelines (MCG)
- Applicable OHSU Health IDS UM policies and procedures

2026 information

This handbook reflects current utilization management procedures. Benefit coverage is subject to member eligibility, Oregon Health Plan rules, and applicable state and federal regulations.

Contracts

Provider contracts may include requirements that differ from this handbook. When conflicts exist, contracted terms supersede general guidance.

Provider Responsibilities

Member eligibility

Authorization approval and claims payment are subject to member eligibility. Eligibility may change after an authorization is issued.

- If eligibility changes before services are provided, the authorization may no longer be valid.
- If OHP is secondary coverage, follow the primary payer's coverage and authorization requirements.

Coverage verification of OHP services

Before submitting a request, providers should confirm that the diagnosis and service are funded under the Oregon Prioritized List of Health Services.

- [Prioritized List website](#)
- [DHS MMIS Provider Web Portal](#)

For ambulatory surgery center (ASC) procedures:

- The procedure must be on the CMS-approved ASC list

[Benefit Tracker Auto Authorization App](#)

When you complete a patient search, you will see a member's plan and benefits.

OHA resources to verify eligibility

- [OHA OOP Eligibility](#)
- [MMIS Provider Portal](#)
- [Step-by-Step Eligibility Guide](#)

NOTE: Members under age 21 are reviewed in accordance with Early and Periodic Screening, Diagnostic and Treatment ([EPSDT](#)) requirements. All requests for this age group are reviewed for medical necessity, regardless of line placement.

Medical Necessity

Medical necessity and medical appropriateness

OHSU Health IDS applies the definitions of medical necessity and medical appropriateness established by Oregon Administrative Rules and nationally recognized evidence-based standards.

For OHP members:

- The diagnosis and proposed treatment must qualify as a covered diagnosis–treatment pair on the Prioritized List of Health Services.
- All covered services must be medically necessary. However, not all medically appropriate services are covered benefits.
- Licensed clinicians make utilization management decisions. If a request is denied or approved at a level different from what was requested, a clinician with appropriate

Medically appropriate services

A service is medically appropriate when it is:

- Recommended by a licensed provider acting within the scope of their license
- Safe and effective; based on generally accepted standards of care
- Appropriate for the member's condition
- Not provided solely for the convenience or preference of a member or provider
- The most cost-effective option that can safely and effectively meet the members' needs

Medically necessary services

A service is medically necessary when it:

- Prevents, diagnoses or treats a disease, condition or disorder
- Supports age-appropriate growth and development
- Maintains or improves functional ability or independence in self-care and daily living
- Allows a member receiving long-term services and support (LTSS) to have access to the benefits of non-institutionalized community living

NOTE: Not all medically appropriate services are covered benefits.

Prior Authorizations

Prior authorization reviews

OHSU Health IDS reviews prior authorization requests within the following timeframes:

- Standard requests: Reviewed within seven (7) calendar days
- Expedited requests: Reviewed within 72 hours when delay may seriously jeopardize the member's health or ability to function

Timeframes may be extended by up to 14 calendar days at the request of the provider or member, or when additional time is in the member's best interest.

Pharmacy requests

- Standard pharmacy requests: Reviewed within 72 hours
- Expedited pharmacy requests: Reviewed within 24 hours

OHP non-funded

Some diagnoses and conditions are not funded under the Oregon Health Plan.

- Diagnosis codes that fall below the funded line (BTL) or are classified as "no line" (not included on the Prioritized List) are not funded.
- Treatment codes that do not pair with the submitted diagnosis or pair with a BTL diagnosis are also nonfunded.

Emergent and urgent

OHSU Health IDS does not require prior authorization for emergency medical screening or treatment that meets the prudent layperson standard.

Emergency services are covered regardless of network participation or notification timing.

Authorizations before claims

- Always submit authorization requests prior to claims submissions
- Claims denied for no auth require an appeal

Excluded services

Excluded services are not covered unless approved as an exception and require prior authorization.

Examples of excluded services include:

- Cosmetic procedures
- Experimental or investigational treatments or procedures, including clinical trials and demonstration projects
- Infertility treatments to establish or re-establish fertility
- Plasma infusions for treatment of multiple sclerosis

Emergency services

OHSU Health IDS:

- Does not limit what qualifies as an emergency medical condition based on diagnosis or symptom lists
- Does not hold members financially responsible for emergency screening or treatment needed to diagnose or stabilize an emergency condition
- Does not deny coverage because the treating provider did not notify the member's primary care provider within a specific timeframe
- Does not deny payment for emergency treatment when:
 - A member presents with an emergency medical or dental condition, or
 - A representative of OHSU Health IDS directs the member to seek emergency care

Submitting authorization requests

Providers submit authorization requests through the OHSU Health IDS [Provider Portal Benefit Tracker](#).

Requests that cannot be submitted through the portal may be faxed with required documentation:

- Medical fax: 503-416-3713
- DME fax: 503-416-3637

Supporting documentation may include clinical notes, orders and diagnostic results.

Authorization determinations

Approved: OHSU Health IDS notifies the requesting provider and indicates the authorized service period.

Denied or partially approved: OHSU Health IDS sends a Notice of Action – Benefit Denial (NOABD) to the member and provider, consistent with regulatory requirements.

Denial of previously authorized service: The effective date of the denial will be 10 calendar days from the date of the determination.

Post-stabilization services

Post-stabilization services are provided after emergency services to maintain the stabilized condition or to improve or resolve the member's condition. OHSU Health Services will cover these services without prior authorization when:

- OHSU Health IDS cannot be reached
- OHSU Health IDS does not respond within one hour
- The treating provider and OHSU Health IDS cannot reach an agreement, and our medical director is unavailable

The treating provider determines when the member is stable for discharge or transfer.

Coverage responsibility for post-stabilization services ends when:

- A plan physician assumes care
- A plan representative and the treating physician reach an agreement concerning the member's care
- The member is transferred or discharged

Initial and ongoing services

Initial consultation services may be provided without prior authorization when needed to assess the member and determine treatment needs. Authorization is required for ongoing services when clinically indicated.

Required elements of a request for ongoing services include:

- Member identification information
- Treating provider name
- Date of service or admission
- Diagnosis (ICD-10) and CPT codes for requested services
- Supporting clinical documentation

NOTE: The most common reason for denials is missing, incomplete or incorrect chart notes.

Admissions

Inpatient admissions

- Planned admissions: Prior authorization is required for planned or elective inpatient admissions.
- Urgent or emergent admissions: Prior authorization is not required. Providers must notify OHSU Health IDS of the admission.
- When eligibility is unclear at the time of admission, facilities should submit a notification of admission as soon as possible and before submitting a claim to support timely review and payment.

Admission authorization process and concurrent review

OHSU Health IDS receives inpatient notifications through the [Benefit Tracker portal](#).

- Admission reviews are generally completed within one business day of notification.
- OHSU Health IDS may conduct reviews through remote EHR access when available.
- Facilities without remote access may be asked to fax documentation.

Concurrent review may include:

- Admission justification
- Continued stay reviews
- Discharge planning coordination

Continued stay review

OHSU Health IDS conducts concurrent reviews for inpatient admissions, extended observation stays, and status changes from observation to inpatient.

Authorized lengths of stay are determined based on clinical need and expected treatment course. Continued stay review intervals are individualized.

Discharge Planning

Discharge planning for post-acute care

Hospital discharge staff should request prior authorization for members who require discharge to one of the following settings:

- Skilled nursing facilities (SNF)
- Long-term acute care hospitals (LTACH)
- Inpatient rehabilitation facilities (IPR)

Requests should be submitted at least 24 hours before the anticipated discharge date and must include the required request form and applicable clinical documentation, such as chart notes and treatment plans.

Authorizations by Service

Alpha order

Acupuncture

- Acupuncture requires prior authorization.
- Authorization is not required for a new member evaluation and management visit if the member has not been seen in the past three years.
- Acupuncture is not covered for mental health diagnoses. Providers should follow the member's behavioral health carrier authorization and claims requirements.

Anesthesia

- Prior authorization is required for anesthesia services associated with endoscopy procedures.
- For other surgical procedures, anesthesia does not require a separate prior authorization when the surgery itself has been authorized.

Cardiac rehabilitation

- Prior authorization is required.

Chemical dependency services

- Coverage and authorization requirements vary by benefit type.
- Medicare does not cover these services.

Chiropractic care

- No prior authorization is required for evaluation.
- Prior authorization is required for treatment.
- Services are subject to the OHP Prioritized List of Health Services, including relevant line placement limitations.

Circumcision

- Prior authorization is required. For OHP members younger than 30 days, the authorization will be approved as a routine procedure. We require a medical necessity review for extenuating circumstances or medical need for members older than 30 days.

Day surgery (facility or ambulatory surgery center)

- Prior authorization may be required. Providers should refer to the list of services requiring prior authorization.
- For ambulatory surgery center procedures:
 - The procedure must be approved for ASC payment.
 - The procedure must appear on the CMS ASC-approved procedure list.
- Secondary procedures required to perform a primary procedure do not require prior authorization if the primary procedure does not require authorization.

Dental surgery (not performed in a dentist's office)

- Prior authorization is required.

Diabetic education

- No prior authorization is required.

Drugs, injectable chemotherapy

- Refer to the pharmacy policy section of the [OHSU Health IDS website](#) for coverage and authorization requirements.

Durable medical equipment

- Providers should refer to the complete prior authorization list on the OHSU Health IDS website.

Health and wellness services

- Routine health exams, tests and immunizations are covered benefits that do not require prior authorization.
- For additional benefit information, refer to the [member handbook](#) on the Health Share of Oregon website.

Hemodialysis

- No prior authorization is required.

Home health services

- Prior authorization is required.
- Excluded home health services are not covered.

Hospice services

- For the first six months of hospice care, no prior authorization is required.

Imaging (MRI, CT)

- Prior authorization is required.

Inpatient hospital admissions

- Elective or pre-scheduled
- Prior authorization is required.
- Urgent or emergent
- Prior authorization is not required.
- Providers must notify OHSU Health IDS of the admission.

Inpatient rehabilitation admissions

- Prior authorization is required.

Medical nutrition office visits

- No prior authorization is required.

Mental health services

- Refer to CareOregon's [Behavioral Health Utilization Management Procedure Handbook](#)

Naturopathic medicine

- Excluded by Medicare.
- For OHP members, services may require prior authorization.
- Services are subject to the OHP Prioritized List of Health Services.

Newborn care (first 28 days after birth)

- No prior authorization is required regardless of diagnosis, except for nonfunded treatment.

Observation services

- No prior authorization is required for the first 48 hours of hospital observation.
- Observation services exceeding 48 hours require authorization for funding.

Obstetrician office visits

- No prior authorization is required for pregnant members, regardless of diagnosis.

Oncology visits and treatment

- No prior authorization is required for funded, above-the-line diagnoses.

Ophthalmology and optometry (medical benefit services)

- For services billed under the medical benefit, the provider must be contracted with OHSU Health IDS for payment.

Out-of-state providers

- Authorization is required for all out-of-state providers, including office visits and referred services.

Primary care provider (PCP) services

- Office visits:
 - No prior authorization is required regardless of diagnosis.
- Procedures performed in an office:
 - Prior authorization may be required. Providers should refer to the list of services requiring prior authorization.

Physical, occupational and speech therapy

- Services are authorized on a calendar-year basis.
 - No prior authorization is required for therapy evaluations for funded diagnoses.
 - Prior authorization is required for therapy treatment visits.
- Requests for nonfunded conditions require medical necessity review.

Prolonged services

- Outpatient prolonged service codes require medical record review for payment.
- Providers must submit supporting documentation with the claim.

Skilled nursing facility admissions

- Prior authorization is required.

Specialist services

- Office visits
 - For OHP members, no prior authorization is required for follow-up visits for funded, above-the-line diagnoses.
 - Referrals and prior authorization are required for out-of-state specialists.
- Procedures performed in an office:
 - Prior authorization may be required. Providers should refer to the list of services requiring prior authorization.

Sterilization procedures and hysterectomy

- A valid consent form must be present for payment.
- Forms and timelines are outlined in the DMAP Medical–Surgical Services Provider Guide.
- Sterilization consent forms are available through the [Oregon Health Authority website](#).
- Sterilization procedures are excluded from Medicare.

Transplants

- Prior authorization is required.

Vision care – Oregon Health Plan

Routine vision care to determine whether a member needs glasses or contact lenses is limited to:

- Members younger than 21
- Pregnant adults

Benefit

- The OHP vision benefit is administered by VSP.
- Questions and authorization requests should be directed to VSP at 800-852-7600.
- OHP covers one pair of glasses every 24 months.

NOTE: Medical eye exams used to diagnose or treat diseases or conditions of the eye are not part of the VSP contract. Providers should follow the UM processes in this handbook to determine whether prior authorization is required.



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