

Referrals Overview

Effective 1.1.2011 the process of referral of Lipa members to specialty care will undergo the following modifications:

- No formal Referral required for either an above or below the OHP Line diagnosis
 - Specialists are allowed up to 2 visits within a 12-month period to establish the presence of an OHP covered diagnosis for continuation of specialist care.
 - A referral is still not required to continue to see the member for either a covered or non-covered condition, however,
 - Claims are denied for any provider visits after the second visit if the Claim does not indicate a covered condition as the reason for the visit.
 - Monitoring for effectiveness will occur on the back end (Claim) rather than the front end (Authorization) of the process.
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Referral requirements remain for the following categories of referrals:

- Out of area (including OHSU and Legacy system) providers
- Non-participating providers
- 2nd opinion consult referrals
- Bariatric procedure referrals**

**requires documentation of DMAP criteria

Recommendations for referral management at the specialty office level:

- Use the web [LT-Portal](#) as the tool to determine Lipa eligibility for treatment.
- Use [LipaLine](#) as the tool to determine OHP coverage for condition/service pairings before scheduling the member for the 3rd visit.
- Refer to the [Lipa.net Med-Surg PA List](#) for guidance on categories requiring Prior Authorization. Note the “Quick-check: No Prior Authorization Needed” box on page 9 of this list.