



Date: February 11, 2022

To: Coordinated care organizations (CCOs)

From: Dave Inbody, CCO Operations Manager
Medicaid Programs

Subject: OHP coverage of post-COVID (sometimes called “long COVID”) treatment

CCOs must cover medically appropriate treatments for all post-COVID conditions, including:

- Condition and treatment pairs below the funding line of the [Prioritized List of Health Services](#) and
- Other treatments that the Oregon Health Plan (OHP) would not otherwise cover.

No later than March 14, 2022, CCOs must begin to adjudicate claims in a manner consistent with the guidance in this memo. The Oregon Health Authority (OHA) will work with CCOs on a case-by-case basis to resolve any post-COVID claims that should have been covered for dates of service from October 22, 2021, through March 14, 2022.

Why is this happening?

[The Centers for Medicare & Medicaid Services issued guidance October 22, 2021](#), clarifying that state Medicaid programs must:

- Cover medically necessary treatments and therapies for post-COVID conditions, sometimes called “long COVID,” and
- Make determinations for medical necessity on a case-by-case basis, considering the particular needs of the individual and the judgment of health care professionals.

What should you do?

For post-COVID treatments you already cover, continue to cover these services without an additional medical necessity review. This includes treatments that pair above the funding line, such as treatments for covered lung, heart, or kidney disorders.

For post-COVID treatments you do not already cover, establish a process for making medical necessity determinations. Communicate the process to your providers and use this process to determine coverage.

- The process should not create unreasonable or arbitrary barriers to member access to these services.
- CCOs have latitude to choose the type of process. Acceptable processes include prior authorization, concurrent reviews, or pre-payment reviews.
- CCOs must also accept requests for reconsideration after claims denial. A process that only uses post-denial claim reconsiderations is not acceptable.

While not required, OHA encourages CCOs, when possible, to identify claims that do not require providers to make an authorization request (e.g., claims that do not require supporting documentation to make a determination). For example, condition and treatment pairings below the funding line billed with ICD-10 code U09.9 (Post COVID-19 condition, unspecified) as a secondary diagnosis are covered and may not need additional review.]

Questions?

If you have questions about this announcement, [please contact your CCO Account Representative](#).

Thank you for your continued support of the Oregon Health Plan and the services you provide to our members.