Frequently Asked Questions

The intent of the published FAQ's is to provide clarification to general questions. If you have a specific question contact the MAU staff at MAUADMIN@OKHCA.ORG. Please provide your contact information including your provider # and a call-back number.

Please do not send duplicate copies of emails or duplicate PA requests as this will delay the turnaround time. Please review the PA status by checking your Provider Portal.

1. **What do we do in case of the need for an EMERGENCY PA?**
   a. We consider an Emergent/Urgent PA to be a loss of life or limb and not due to a scheduling issue.
   b. Providers should submit the PA via the Provider Portal and an email to MAUADMIN@okhca.org. Enter "EMERGENCY PA" in the subject line. In the body provide a contact name and number, the PA number and reason it is an emergency. MAU staff will review PA and contact you as soon as possible.

2. **Uploading Attachments**
   a. As of July 1, 2017, OHCA will accept uploaded documents only. Any documents faxed or mailed after that date will be returned to the provider.
   b. Attachments types allowed are JPG, PDF, TIFF or XPS and are limited to 10MB per each PA request.
   c. If you are requesting multiple codes you can submit 1 set of documents to support all codes being requested, you do not have to submit separate supporting documentation for each line item requested.
   d. Providers must attach documentation prior to the addition of the first service detail line on the PA to insure that your attachments are received

3. **How to validate that a PA has been received by OHCA.**
   a. You can view the status of the PA by using the Secure Provider Portal Prior Authorization tab   View Authorization Status
   b. click on the Advanced Search box
   c. Select the appropriate Authorized   Day Range from the drop down menu
   d. type in the member ID
   e. then select search

4. **Why can you only add 1 diagnosis code to the authorization on the website?**
   a. Currently the PA submission on the Provider Portal only allows the entry of 1 diagnosis code which should be the Primary Diagnosis code that supports the requested service.
   b. Future changes that will be made to the Provider Portal to support the entry of additional diagnosis codes.

5. **Where does the hospital information go?**
   a. When you have procedures/surgeries that are being done in a facility the only provider that will show on the PA is the requesting provider.
   b. The PA is considered a member issued PA which allows both the physician and the facility to be paid off of one PA.
   c. Requesting provider will need to make sure when submitting the request that the Servicing Provider field is left blank, codes have been submitted with appropriate modifiers and units for both the physician and the facility.

6. **What Assignment Code do I use?**
   a. You will need to utilize the most appropriate assignment code that fits the service you are rendering
   b. Please Note – The purpose of the Assignment Code is for determination on whether or not a Servicing Provider is REQUIRED on the PA submission. The Assignment Code will have no bearing on claims payment. The following assignments codes will require a Servicing Provider to be entered:
      i. <u>DME</u> – Used for Durable Medical Equipment, Prosthetics and Orthotics, Hearing Aids etc.
      ii. <u>Home Health</u> – Used for Additional Home Health Visits for children
      iii. <u>Hospice</u> – Used for Hospice Services
      iv. <u>Specialized Nursing</u> – Used for Private Duty Nursing
      v. <u>Vision Care</u> – Used for frames, lenses, and contact lenses

7. **For services that can be billed globally or with a TC and 26 modifiers how do we request each line?**
   a. **Billing Globally** - you will request the code on one line item with 1 unit and no modifier.
   b. **Billing Technical and Professional components** - you will need to request one line item with the code, a TC modifier and 1 unit and a second line with the same code, a 26 modifier and 1 unit.

8. **How to submit a PA request when member's eligibility has been back dated?**
   a. Generally, the member must have active eligibility on our system on the date of service.
   b. If member's eligibility has been back dated you will need to submit a Prior Authorization Request thru the Provider Portal and attached all supporting documentation for the service being requested.
   c. The PA will System Cancel as a Retro Authorization.
   d. You will then need to submit an e-mail to MAUAdmin@okhca.org with the Subject Line "Retro Eligibility – Please Review" to request a case-by-case review.

9. **Will the portal let us submit for an auth if the patient's insurance is not currently active (example – auth submitted on 7/4/2017 and member eligibility ended on 6/30/2017)?**
   a. In the example provided if the provider submits a request on 7/4/2017 for a July date of service the request would System Cancel as the member is not in an Active Case. If the provider submits a request on 7/4/2017 for a June date of service the request would come into the system to be reviewed for medical necessity.

10. **If I have a case that has 14 codes but the portal only allows 12 lines to be entered what do I do?**
    a. You can search the Fee Schedule thru the Portal to see if a code is valid or if it requires a PA. Only submit the PA for the codes that required a PA.
    b. If I still have more than 12 codes you will need to submit 1 PA with 12 lines items with supporting documentation. In the "Remarks" section indicate Part 1 of 2, then submit a 2nd PA for the remaining 2 codes with same supporting documentation and note in the "Remarks" section Part 2 of 2.

11. **If there is an auth that touches dates with another, it will "system cancel" it stating that my dates cannot overlap. What do I do if I need to submit for a second date of service?**
    a. That is correct. Approved dates of service on a PA cannot overlap date of service on another PA request for the same service.
    b. For example, a PA for code 93306 x 1 unit for dates of service 5/4/2017 thru 7/31/2017 is currently approved for the member and service was performed on 5/6/2017. Member now needs the same procedure again on 7/1/2017 which requires a 2nd PA request to be submitted.
       i. You must submit an amendment request to have the 1st PA end date of service adjusted prior to 7/1/2017 such as 6/30/2017.
       ii. Once the 1st PA has been adjusted you will then need to submit a request for the new date of service.

12. **Can a provider still fax in initial (new) PAs for data entry rather than using the portal?**
    a. No. Effective 11/1/2016, providers must initiate all NEW PAs through the Provider Portal (this does not include Behavioral Health, Dental or Pharmacy PAs).
    b. Effective 7/1/2017 provider must upload all documentation at the time they are submitting the PA.
    c. *Initial PAs and/or supporting documentation that are faxed and not submitted through the provider portal will be returned to the provider and not processed.*

13. **Will the provider receive faxed determinations on the PA submissions?**
    a. No, the provider will need to access the provider portal to view the authorization status.

14. **How long do I have to submit my Prior Authorization Request?**
    a. Ultimately a prior authorization should be obtained prior to rendering a service. Providers rendering services prior to receiving an approval assume the risk of not being reimbursed if services do not meet medical necessity. Services rendered prior to a medical necessity determination being made cannot bill the member if the prior authorization is denied.
        i. Therapy – No Retros Allowed
        ii. MRA/MRI/CT/PET – you have 3 business days from the date of service to submit a request
        iii. All other services allow a 5 day retro from the date of service