OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

INTRODUCTION TO SOONERCARE Q&A
April 2022

1. If the provider does not request prior authorization, can the patient be billed?
A. No, a member can only be billed if the service is a non-covered service.

2. If a claim is denied, how long do you have to submit a corrected claim?
A. If the denied claim was filed within the timely filing limit (six months from date of service), providers have an additional 183 days to adjudicate the claim.

3. If I have an Expansion Healthy Adult Program member and SoonerCare Choice or PCP information doesn't show on the eligibility screen, do they require a referral?
A. No. An expansion member who is *not* enrolled in SoonerCare Choice is considered fee-for-service and does not require a referral.

4. If we are interested in becoming an agency partner who do we contact?
A. An agency partner must be either a state or federal organization. Non-profits that are neither state nor federal organizations and can become community partners by emailing CommunityPartners@okhca.org. Visit OHCA's Partner Resources page for more information.

5. Does the Expansion Healthy Adult Program cover vision materials such as glasses or contacts?
A. Glasses or contacts are covered for members 0-20. If the expansion member is 19 or 20 years old, vision services are covered.

6. Will the eligibility tab on the portal show if the patient has a copay?
A. If a member is excluded from cost sharing requirements or has met their monthly cost sharing cap amount based on paid claims for the month, a message will display on the eligibility screen indicating that no copay is due. If a member has an outstanding copay for the month, a message indicating the member may be subject to copay will display. The amount of copay due can be found on a processed claim or remittance advice.

7. When a patient applies online and additional info is needed, will the effective date be the date of application or when the additional info is received?
A. Eligibility begins on the day the application was submitted.

8. If a client is approved after enrolling online, may they see the chosen provider immediately that day?
A. Yes.

9. How do you get a prior authorization for admitting to a long term care facility?
A. Pre-determinations for SoonerCare members admitted to a long-term care facility can be found within the Long Term Care Facilities page under PASRR Determinations. Additionally, the level of care unit can be reached at 405-522-7133 or 405-522-7674.

10. Where can an extra copy of the approval letter be found?
A. The Letters tab on the OHCA secure provider portal will allow access to the welcome letter. If you need assistance accessing the portal, contact the internet helpdesk at 800-522-0114, option 2, 2.

11. Will Medicaid cover a therapist visit for a home health agency?
A. No. OHCA policy 317:30-5-547 states "Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency."

12. What are the limitations in care for Soon-to-be-Sooners patients? Are medications to treat comorbidities that affect the pregnancy covered (i.e., blood thinners, etc.)?
A. Use Search Fee Schedules under the Resources tab on the secure provider portal and select Soon-to-be-Sooners plan to determine if a medication or procedure is covered.

13. If a code is not on the fee schedule does that mean it is an excluded service?
A. Yes, however, please ensure you are using the most up-to-date code.

14. Will there be a time that documents are required for income, or are we still listed under COVID guidelines?

A. Yes, the time for member documents is now. If a member has received a letter from OHCA, please advise them to call the SoonerCare helpline at 800-987-7767 to speak to a customer service representative. Currently, while still under the public health emergency (PHE), OHCA is not ending eligibility for members but is asking them to contact us to update their information in anticipation of the PHE ending.

15. Once a claim shows as "suspended" on the portal, what is the turnaround time to know if a secondary claim will be paid?
A. Up to 45 days depending on the level of review needed.

16. Does Dental cover anything other than cleaning and extraction?
A. Children have access to full dental fee schedule. Adults 21 and over enrolled in both traditional and expansion Medicaid have access to limited dental benefits, see the Dental Provider page and the Adult Limited Dental Benefit Guide for policy and coverage information.

17. Is it necessary to bill Oklahoma Medicaid if the primary insurance pays more than what Oklahoma allows on their fee schedule?
A. Yes. This will allow the provider to be reimbursed by Medicaid if the primary insurance recoups the claim after the SoonerCare timely filing limit (183 days). Additionally, the provider will require tracking information to notify the member of any patient responsibility.

18. Does the 4-visit limit apply to children 0-18?
A. The 4-visit limit does not apply to children 0-20 years old.

19. If a claim is denied due to “physician is not credentialed at the time of service”, but the provider is in the process of getting credentialed, will OHCA reprocess the claim?
A. No. Providers are responsible for re-submitting denied claims for adjudication after the contract is approved.

20. Since Medicaid pays prior to Indian Health Services, if Medicaid denies for a non-covered service, are we allowed to bill the patient/IHS?
A. OHCA recognizes that I/T/Us are the payer of last resort and are not considered creditable health insurance. If the member does not have other creditable health insurance coverage and the service is truly a non-covered benefit, the member would be responsible for the charges.

21. If a patient visits an optometrist for a vision exam and they bill a 92004 (new patient exam) and that provider sends the patient to our office for another exam, will they cover another 92004 since it is a separate office?
A. The limit for 92004/92014 is one PER PROVIDER per calendar year. Therefore, the second provider should be able to bill 92004 (new patient) or 92014 (established patient) if appropriate.

22. Our practice is opening a secondary location with 10 new dentists. What is the turnaround time for contracts?
A. Typically, contracts are processed within 30 days of submission with all required documents. However, when multiple contracts are within their renewal periods, the time can increase to 4-6 weeks.

23. How long are amendment requests on authorizations expected to take?
A. Due to the high volume of prior authorization requests and requests for amendments, providers should expect a higher than normal turnaround time for amendment requests.