Webinar questions and answers

Fee-for-service prior authorization requests for physical health services

Acupuncture

Are internal medicine conditions no longer covered for acupuncture treatment?

To answer this question, you will need to call the Code Pairing and Prioritized Line at 800-336-6016 (option 5). This is the number to call to ask whether a treatment is covered for a specific condition.

Does the Rehabilitation Guideline Note cover acupuncture therapy?

Guideline Note 6 does not apply to acupuncture. The Guideline Notes that are applicable for acupuncture therapy are Guideline Note 56 and 92.

Will CPT 97140 be covered for acupuncture with this new change?

The Oregon Health Authority's (OHA) change in prior authorization processes does not change what codes are and are not covered for acupuncture. The policy for physical therapy coverage has not changed.

How does an acupuncturist contact GOBHI for prior authorization (PA) of substance use disorder treatment?

This training is just about fee-for-service physical health PA requests, for services billed to OHA. OHA does not require PA for acupuncture. We cannot answer questions about what GOBHI requires.

Requirements for substance use disorder treatment are in the Oregon Health Plan (OHP) Behavioral Health provider guidelines at bit.ly/BH-policy. The Behavioral Health Fee Schedule on this page lists specific services that require PA. Both of these refer to OHA's fee-for-service coverage.

Also, for any fee-for-service behavioral health services that require PA, KEPRO would be the contact for questions (not OHA).

Do acupuncturists need to get PA?

OHA does not require PA for acupuncture. However, the coordinated care organization (CCO) may have different requirements. OHA can only speak to the requirements for services that OHA would pay for on a fee-for-service basis.

Do open card members need prior authorization for acupuncture for back pain?

No.

Which plans require prior authorization for acupuncture?

You would need to ask the plans about this. OHA can only answer questions about the fee-for-service (open card) processes and requirements.

Did OHA send the letter from Douglas Luther, MD, of CareOregon? It states that starting 4/15/2018, acupuncture services will require PA from appropriate CCO, and that acupuncture services delivered without PA will be ineligible for payment.

OHA did not send this letter. CareOregon's letter applies to CCO members. It does not apply to fee-for-service members.

Eligibility and enrollment

How would a tribal clinic submit a request for a tribal member who is in a CCO, but has an HNA indicator allowing them to go to a tribal clinic and the clinic receives payment? (Billing is done through MMIS.)

If the tribal member is a CCOA or CCOB member, the CCO is the contact for requesting PA of physical health services, and physical health services are billed to the CCO, not OHA.

If the billing is through MMIS, this means services were billed fee-for-service to OHA (not the CCO). For physical health services, this should only happen when the tribal member has CCOE or CCOG enrollment. This means that you should only submit fee-for-service physical health PA requests to OHA for CCOE or CCOG members.

The "Plan Type" field of the Managed Care/Primary Care Home section of the Provider Web Portal Eligibility Verification Screen will show the member's specific type of CCO enrollment:

- **CCOA:** CCO for physical, dental and mental health care
- **CCOB:** CCO for physical and mental health care
- **CCOE:** CCO for mental health care only
- **CCOG:** CCO for mental and dental only

If a patient has open card and a third party employment insurance, who is the primary payee?

The third party insurance is primary. Medicaid is always the payer of last resort. But if the service would be covered by Medicaid and OHA requires PA, you still need to submit a PA request to OHA. Otherwise, OHA would deny the claim because PA is required.

If a patient has recently dropped off the Oregon Health Plan, but we submitted a PA before that happened, how long would they be eligible for care?

The patient would stop being eligible for care as soon as their OHP eligibility ends. Prior authorization is not a guarantee of payment; the patient must also be eligible for OHP on the date of service. Eligibility may change or end at any time, so it is important to always check eligibility.

Who is fee-for-service?

To determine whether a service needs to be approved fee-for-service by OHA, or by a CCO, you need to check the patient's OHP eligibility and enrollment.

The OHP Eligibility Verification page at bit.ly/verify-ohp has many tools and resources that explain how to tell if a patient is fee-for-service or a CCO member.

For patients who change from a CCO to fee-for-service (FFS), are we able to get retroactive authorization from OHA for the time they were fee-for-service? For example, the CCO approves physical therapy for a patient, who then changes to fee-for-service in the middle of care. We learn this after the appointment has taken place.

No. The only exception is if the member was a verified CCO member on the date of service, then later retroactively became a FFS member for that date of service. This is why it is important to verify OHP eligibility **and** CCO or FFS enrollment before rendering services. The General Rules provide several rules related to this topic:

- **OAR 410-120-1140(1 and 2):** To ensure Division reimbursement of services, providers are responsible to verify that the person is an eligible Oregon Health Plan (OHP) client on the date(s) services are rendered and is enrolled in an OHP benefit package that covers the services they plan to render. Providers who do not verify eligibility and benefit coverage with the Division before serving a person shall assume full financial responsibility in serving that person.
- **OAR 410-120-1280 (1 and 3):** The provider must verify eligibility, and document attempts to obtain coverage information prior to billing the client.
- **OAR 410-120-1320(5):** Authorization for payment may be given for a past date of service if the client was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service and the request for authorization is received within 90 days of the date of the change to the enrollment status.

Does fee-for-service mean open card?

Yes.

Entering and attaching request information

Does physical therapy have an umbrella of codes, like 97110-97530?

No. PA requests for physical therapy must include the specific CPT codes to support the client's treatment plan.

If a patient does not have low back pain, do we still need to add a STarT form?

The STarT back assessment form is only required for those diagnoses that are subject to Guideline Note 56 of the Prioritized List of Health Services.

I cannot submit a surgery request to my facility without authorization. How would I request with no surgery date?

You can put in a tentative date range and explain in the notes that you need to get OHA approval before you can get an actual service date.

Has the required documentation changed for hearing aids? Audiogram, medical clearance, audiology notes, etc.

No.

How important is it to list co-morbid conditions on an authorization request?

If you know the primary diagnosis pairs on a funded line with the requested CPT code(s), you do not need to list co-morbid conditions on the request.

You would need to list co-morbid conditions if:

- The codes do not pair, or pair on an un-funded line, **and**
- You are requesting a Medical Management Review.

In general, the system only looks at one diagnosis on a claim submission, so one diagnosis is used for a prior authorization.

Does it help to submit many diagnosis codes as primary codes if it's a complex case, or is only one diagnosis code allowed?

You can submit multiple diagnosis codes, but there can only be one primary diagnosis code in the system, followed by the other codes. When staff review the request, they can work with the requesting provider to determine the most appropriate code to identify as primary. Explaining in the notes the complexity of the case will also help.

If we put additional diagnosis codes on a billing, will that cause a denial of payment?

It would only cause a denial if the primary code on the claim did not match the primary code on the prior authorization.

Can a PA include multiple providers in one office without having to submit multiple PAs by each provider?

You can list one performing provider in the Performing Provider field of the MSC 3971 form (or, on the Web Portal, "Service Provider") field. On both the form and the Web Portal, there is a Notes section to list additional providers.

New request form (MSC 3971)

Please explain what the unit means on the prior authorization.

This depends on the service(s) you have requested. The program-specific OHP rules and guidelines at bit.ly/ohp-rules explain how units apply to specific services.

For PA Assignment, which box do you check for outpatient surgery in an ASC setting?

Hospital-Outpatient.

Would we use this form for medications as well?

You could use this form for medications. However, you should still fax medication PA requests to the Oregon Pharmacy Call Center (not to the central PA fax numbers). Also, medication authorizations do **not** require an EDMS Coversheet.

Processes for obtaining approval of fee-for-service prescriptions have not changed. Policies, forms, criteria and guidelines are on the Pharmacy Services rule and guidelines page.

Where can I get this form?

All material from this training is at bit.ly/ohp-auths (look under "Webinar: Fee-for-service physical health prior authorizations").

Out-of-hospital births

Waiting until we have all of the information for the initial request causes the PA start date to be further into the pregnancy, so that we cannot get PA for services provided earlier in the pregnancy. Can we send the request earlier without all the info and continue with updates every 30 days?

If you send an incomplete request, OHA cannot approve the PA until all required documentation is received. This includes an ultrasound at 18-22 weeks.

Starting the PA at 13 weeks will not get it approved faster. OHA will still have to wait and receive all documentation for the initial request.

If the patient transfers into your care after 27 weeks and 6 days, the same initial request documentation is required. In addition:

- Late requests for PA may be approved only if they are from a woman moving into Oregon from another state or country where prenatal care was initiated. You must include this information in the request, along with any available prenatal care records.
- Additional documentation is also required, including other standard testing such as Glucose Tolerance Testing, prenatal labs, ano-vaginal cultures for Group B Strep at 35-37 weeks gestation and prenatal, up to and including delivery and those for the newborn.

The *OHA Provider Documentation Checklist for Out-of-Hospital Birth Services* (page 7 of the *Out-of-Hospital Birth Reimbursement Guide*) lists the specific documentation you must submit to OHA, and when.

Do CCO members need a referral from their PCP before seeking care with a fee-for-service provider?

No. But the provider must be enrolled as an Oregon Health Plan provider with OHA.

Once OHA approves out-of-hospital services for a CCO member, OHA will end the member's CCO enrollment so that the fee-for-service provider can bill OHA directly for services.

Prior authorization requirements

If a patient has a new condition develop while being treated under an existing authorization, do we need to request a new authorization?

In general, for services that require authorization by OHA, you only need to submit a new request if the service is different (e.g., a different procedure/modifier combination). To continue existing treatment and address the new condition, you can ask for the existing authorization to be updated (include the existing authorization's Prior Authorization Number).

OHA's prior authorization requirements and process are only for services to fee-for-service members.

For CCO members, you would need to ask the CCO their requirements.

For a same-day urgent radiology request, do we still need to submit for PA?

OHA does not want to delay urgently needed services. Any service needed stat does not require PA. Instead, you would flag the service as an emergency service on the claim.

If it is not an emergency, and you would not bill it as an emergency, you would submit the request for immediate (24-hour) processing. Be sure to submit all required documentation so that it is not delayed due to missing or incomplete documentation.

For new patients needing physical therapy evaluations, would you recommend that we put in an immediate request?

PT/OT initial evaluations and re-evaluations do not require a PA (refer to Oregon Administrative Rule 410-131-0160 in the PT/OT rules for more information about which services require PA).

Is this PA process is for every specialty referral? Where can we get an updated list of specialty PA requirements?

Not all referrals require PA. This process is only for physical health services covered by OHA, not the CCO. For OHA requirements, refer to the rules and guidelines for the program that covers the service (for example, Speech/Hearing rules for audiology requirements).

Starting May 1, do we need to submit PA requests through the web portal instead of WVCH, Health Share of Oregon, and CareOregon?

No, the May 1 changes only apply to physical health services that you would bill to OHA fee-for-service, **and** that require PA.

Services that you would bill a CCO, such as WVCH or Health Share of Oregon, are not affected. You would still refer to the CCO for their requirements.

Prior authorization resources

Where can I find specific requirements for DME?

Go the DME Rules and Guidelines page. The DME rules list requirements for each type of DME (for example, manual wheelchair requirements are in a rule named “Manual Wheelchairs”).

Links to all OHP rules and guidelines pages are in alphabetical order on the OHP Policies, Rules and Guidelines page at bit.ly/ohp-rules (DME is near the top of this list).

Is there a list of imaging codes that do not need prior authorization?

No. OHA recently updated the prior authorization rule in the Medical-Surgical rules to only list codes that require PA.

If your MRI or CT code is **not** on the list of codes that require PA, then you do not need to submit a PA for the code.

In general, if the imaging code is for a cancer diagnosis, PA is **not** required.

Where can I find imaging requirements?

They are part of the Medical-Surgical rules.

Are dental codes in a Prioritized List, like the medical codes? Are they in a separate list?

There is a short list of dental codes posted as a subset of the full Prioritized List. On the main Prioritized List page at bit.ly/ohp-list, this list is called "Dental Services."

Where do we gain access to the Prioritized List?

It is listed in the upper-right corner of the new PA page at bit.ly/ohp-auths, and also has its own short link at bit.ly/ohp-list.

If I want to know if a certain procedure needs PA, will I have to check on the web portal each time, or do you have a grid that shows all CPT procedures that require PA?

For services approved by, and billed to, OHA fee-for-service, you can refer to the rules for the program that covers the service, or call OHA at 800-336-6016 (choose Option 3). OHA does not have a master list of all procedures that require PA.

What is the quickest and easiest way to check to see if the ICD-10 codes pair above the line?

Call OHA at 800-336-6016 (choose Option 4).

Processing time

How long does it take to get an Urgent PA processed? Is this within 72 hours?

Yes, if it is marked "Urgent" and contains all information required for processing (including justification of the urgent request).

I was told that it takes 6-8 weeks to process. Is it now only going to take 24-72 hours?

If the request contains justification that supports 24- or 72-hour processing, **and** contains all required information for OHA to complete a review, then OHA can process it within the requested timeframe.

Routine processing can take up to 8 weeks to process, due to backlog that includes many duplicate requests, as well as requests for services that do not require PA.

Not all things need to be immediate, but two months is a long time to wait for some things.

While some requests may take 2 months, most take between 12 and 21 days. The most common reason for wait time is OHA not receiving requested information. This can be for a couple reasons:

- Information is not submitted with the PA number for the original request, or
- The requesting provider did not receive OHA's request for additional information.

We hope this training and the centralized PA resources will help providers understand what information to submit the first time so that OHA can process requests faster.

Will authorization timelines be standardized (e.g., one month), or will they be for longer?

It's hard to say at this time, because OHA is still in a backlog. We will be better able to estimate a standard turnaround time once we are out of the backlog and hopefully experience fewer reasons for the current backlog, such as:

- Duplicate requests
- Requests with missing or insufficient documentation
- Requests for services that do not require prior authorization

Due to the nature of our processing system, we need to manually review each request that comes in and issue a notice, even if they should not have entered the system in the first place (whether due to being a duplicate or for something that does not require prior authorization).

After a PA request has been submitted online, what is average turnaround rate for review?

OHA's current turnaround time for routine requests is 40 business days, for both fax and online requests. This is because the issues affecting turnaround time are the same for all requests:

- Missing or incomplete documentation on the initial request
- Follow-up faxes of missing or incomplete documentation enter the system as new requests because the existing Prior Authorization Number is not included on the fax. When this happens, the system cannot notify staff about the updated information. Staff also cannot easily find the documentation to link it to the existing request. This is why including the Prior Authorization Number on the EDMS Coversheet is important.

Immediate and urgent requests are always processed within 72 hours, if they are submitted with all required documentation.

Provider Web Portal questions

Would I use this way to submit a PA if the patient has Willamette Valley Community Health?

No, this webinar is only about fee-for-service requests for services covered by OHA. For services covered by a CCO, contact the CCO.

I work in a facility and there are times we cannot view an authorization. Is that because we are not listed as a facility?

Only the Provider Web Portal users linked to the requesting provider number can view authorizations submitted under that provider number (if they have the "Prior Auth Status" role).

If the facility did not submit the PA, then they would need to ask the requesting provider's Web Portal administrator to give the facility's Web Portal users viewing access. To do this:

- The requesting provider's Web Portal administrator would add the facility staff as clerks to the requesting provider's Provider Web Portal account. Instructions to "Add an existing clerk" are on page 16 of the Account Setup guide.
- Facility staff could be assigned only the "Prior Auth Status" role so that they can check for the status of requests submitted by the requesting provider.

Can we change usernames? My username is similar to another user's and causes lockouts.

No. Instead, your location's Web Portal administrator could create a new clerk account for you with a different username.

If you are a clerk for more than one provider, you will need to let all providers know your new clerk account so they can give you access under your new username.

The usernames for Web Portal administrators cannot be changed.

Is the "Service Provider ID" the facility's ID, or the individual in a clinic setting?

This is the ID of the rendering provider.

If we are supposed to request an authorization 1 month prior to service date, which date do I put in for requested date: The day I make the request, or the day I need the service?

On the Provider Web Portal, the "Requested Eff/End Date" fields are for the date(s) you need the service.

When submitting a new PA online, how can we verify what was sent/received?

When you click "Save" on the request you just entered, you will see a confirmation message that includes the Prior Authorization Number. You can save this number to look it up later. Or, you will see it in the list of "Recent Prior Authorizations" when you login or revisit the Prior Authorization panel.

After this first confirmation message, you get to upload documents. When you upload them, you get a confirmation message about the uploaded documents. If you need to upload more documents, you can keep doing so until you are done. You will get a confirmation message each time you complete an upload.

Do we need to enter the Service Provider ID on each line item if we have multiple line items?

Yes, each line item does require a service provider ID.

Is the Referring Provider ID a required field?

Yes, it is required under certain circumstances (for example, therapy services provided in a clinic setting).

Sometimes when I submit a request through the web portal, it kicks me out. Is this browser-specific?

You will get timed out after 20 minutes of inactivity (e.g., you are still entering the PA request but haven't clicked any blue buttons such as "Add" or "Save").

Can you also submit pharmacy PA requests online?

Yes, it is possible to submit fee-for-service PA requests through the web portal. For information about how to submit fee-for-service PA requests for pharmacy services, you would need to contact the Oregon Pharmacy Call Center.

Training

Does this training apply to all requests? Imaging, medical, dental?

Yes.

Is this webinar available online for replay? If so, where can we find it?

After this live webinar series ends, we will post an on-demand version of the webinar that you can replay at any time. The slides and handouts from this webinar are on the Prior Authorization page at bit.ly/ohp-auths. OHA will also post the on-demand version of the webinar here.

Will this video be posted online?

Yes, as part of the on-demand webinar.

How can we get a copy of this workflow?

All material from this training is at bit.ly/ohp-auths (look under "Webinar: Fee-for-service physical health prior authorizations").

Other questions

Is a patient-centered primary care home clinic a fee-for-service organization?

Many clinics serve both fee-for-service and coordinated care organization (CCO) members. You would need to ask the clinic.

Do we still need to fax in the EDMS Coversheet if we have already submitted the online portion?

If you have submitted all information and documentation online using the Provider Web Portal, there should be no need to fax in the EDMS Coversheet.

If you need to submit more documentation later (e.g., if requested by OHA), you would use the EDMS Coversheet to fax it to OHA. Be sure to include the Prior Authorization Number of the request so that OHA can link it to the existing request.

After OHA denies a PA request, can the provider get it corrected by giving additional information over the phone? Or will they need to submit and upload clarifications instead?

OHA cannot process requests or updates over the phone. You can send clarifying information to OHA by fax under the EDMS Coversheet (include the Prior Authorization Number for the denied request).

When will the Prioritized List include HCPCs that apply to DME and not just the ICD-10?

This would be a question for the Health Evidence Review Commission.

If a procedure code is not on the fee schedule but is approved on a PA can we bill that code for payment?

The posted OHP fee-for-service fee schedule is just a snapshot of the codes in MMIS at the time of the fee schedule publication. So a code now open for payment may not be reflected in the posted fee schedule (which was last updated March 2018).

OHA would not approve a code that is not on the fee schedule. However, if this did happen, and you billed OHA for this code, OHA would deny payment.

When will CPT 97127 (Cognitive Rehabilitation) be open for reimbursement?

CPT 97127 is listed as open within MMIS because it is a valid CMS procedure that HERC must consider. However, to align with Medicare reimbursement policies, OHA has provided pathway to payment for this service under procedure code G0515.

A more in-depth explanation of the reasoning behind this change is on the American Speech-Language-Hearing Association website.

G0515 is eligible effective 01/01/2018.