Prior Authorization Handbook

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Instructions for submitting prior authorization requests for Oregon Health Plan providers

July 2020

Oregon HEALTH PLAN

Contents

Introduction

The *Prior Authorization Handbook* is designed to help those who bill the Oregon Health Authority (OHA) for Oregon Health Plan services submit prior authorization requests correctly the first time. This will give you step-by-step instructions so that OHA can review your request more quickly.

Use this handbook with the General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on services specific to your provider type that require prior authorization.

The *Prior Authorization Handbook* is designed to assist the providers who request the following types of services:*

- Behavioral health residential services
- Dental Services
- Durable Medical Equipment
- Home Enteral/Parenteral IV
- Home Health Services
- Medical review of CCO disenrollment requests for continuity of care
- Medical-Surgical Services
- Occupational Therapy
- Pharmaceutical Services
- Physical Therapy
- Private Duty Nursing Services
- School-Based Health Services
- Speech-Language Pathology, Audiology and Hearing Aid Services
- Transplant Services
- Vision Services

*This list may not include all services that require prior authorization. If in doubt, contact Provider Services at 800-336-6016 for assistance, or refer to your provider guidelines.

How to request prior authorization

Prior authorization contacts and resources

For services covered by the OHP coordinated care organization (CCO) or managed care plan, contact the CCO/plan for their PA procedures.

For services covered by OHA on a fee-for-service ("open card") basis, contact the appropriate office below.

Behavioral health services

Applied behavior analysis

KEPRO
Phone: 844-658-1729
Email: OR1915i@kepro.com

For authorization criteria, see the OHP Behavioral Health provider guidelines.

Required forms for applied behavior analysis are on the KEPRO website.

1915(i), State Plan Personal Care (PC20) and behavioral health services

Comagine Health Oregon Behavioral Health Support Program
Phone: 888-416-3184
Fax: 877-575-8309
Email: ORBHSupport@comagine.org

For authorization criteria, see the OHP Behavioral Health provider guidelines.

Required forms on are the Comagine Health website.

Prescriptions and oral nutritional supplements

Oregon Pharmacy Call Center
888-202-2126

For authorization criteria for fee-for-service prescriptions, see the OHP Pharmaceutical Services provider guidelines.

All other services

Provider Clinical Support Unit
800-336-6016 (option 3)

PA requirements for out of hospital birth services are in the Out of Hospital Birth Reimbursement Guide.

PA requirements for medical review of CCO disenrollment requests are in the Medical Review of CCO Disenrollment Requests fact sheet.

For authorization criteria for all other services, view the appropriate OHP rules and guidelines for the service.

OHA fax numbers for PA requests and documentation

* = Requires the EDMS Coversheet (MSC 3970). See Appendix for instructions.

Request type	Fax number
Routine medical and dental requests* Medical review of CCO disenrollment requests*	503-378-5814
Immediate/urgent medical and dental requests*	503-378-3435
All prescription and oral nutritional supplement requests	888-346-0178

Client eligibility and enrollment

OHA will automatically deny prior authorization requests for clients who are not eligible on the date of service or enrolled with an OHP managed care plan that covers the service being requested. To avoid this, verify client eligibility and enrollment before requesting PA.

Prior authorization does not guarantee payment

PA approval does not guarantee eligibility or override program guidelines and limitations. It is always the provider's responsibility to verify recipient eligibility and benefit plan coverage for each date of service.

Web PA instructions

Introduction

The Prior Authorization section of the Provider Web Portal gives providers the ability to submit online prior authorization (PA) requests to OHA. Web PA also allows providers to search, review, and track the status of their PA requests.

Who can submit Web PA requests

The Provider Web Portal is only available to enrolled OHP providers who have registered their National Provider Identifier (NPI) with OHA (if their provider type is eligible for NPI).

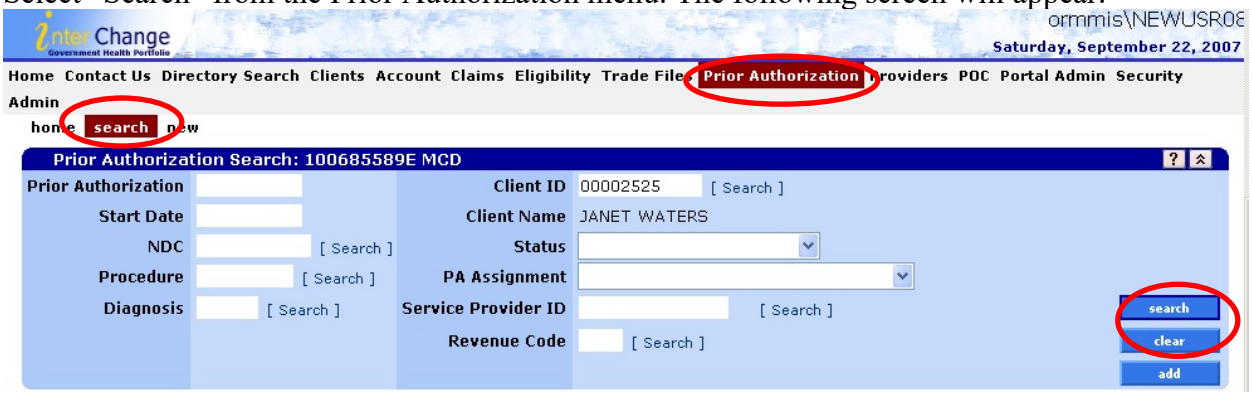
- If you are authorized to submit PA requests on the web, you will have *Prior Authorization Submit* and *Prior Authorization Inquiry* roles listed in the "Available Roles" section of the Clerk Maintenance screen.
- If you want staff to perform Web PA functions for your office, review their clerk roles and add the PA roles to their list of Assigned Roles.

Before you submit a Web PA request

1. Verify the client is eligible on the date of service for the requested services. For services covered by the client's managed care plan, request PA from the plan.
2. Use the Provider Web Portal's PA search function to see if a PA for the same client, dates of service, units and service(s) already exists. If it does, do not submit a new PA.
3. Verify you are signed on and acting on behalf of the correct provider. It is crucial to make sure you are logged on under the correct provider number because this is the only provider who will be able to see the PA on the Provider Web Portal.
4. You must complete and submit the PA request to save the data entered. Partially completed PA request data cannot be saved.
5. The session will end after 20 minutes of inactivity. Any work or changes that have not been submitted will be lost.

How to search for a PA request

Select "Search" from the Prior Authorization menu. The following screen will appear:



The PA search screen allows you to search prior authorization requests to determine if a PA already exists or to determine the status of a PA.

Field descriptions

Field	Description
Prior Authorization	Number assigned to a Prior Authorization request
Start Date	Search criteria that indicate when to begin the PA search
NDC	This field allows the user to narrow the search parameters by NDC code
Procedure	A code to uniquely identify a procedure
Diagnosis	The diagnosis code
Client ID	Identifies the client who received service from provider
Client Name	The client's name
Status	Status of the prior authorization
PA Assignment	Indicates the service type of the prior authorization
Service Provider ID	The National Provider Identifier (NPI) or Oregon Medicaid ID of the service provider
Revenue Code	The Revenue Code

To conduct a PA search

You must enter at least one of the following: Client ID, Prior Authorization Number, Diagnosis, Service Provider, or service code (*e.g.,* Procedure, NDC, or Revenue Code).

Step	Action	Response
1	Enter valid search criteria: • Prior Authorization Number • Client ID • Start Date • NDC • Procedure • Diagnosis • Service Provider and/or • Revenue Code.	
2	Select Search.	If found, the PA will display. If the system is cannot find the PA, "No rows found" displays.

PA search results

PA search results are listed in rows. Each row contains summary information about the PA and shows the PA status. If multiple results display, click a specific row to view the entire PA.

- PA status may be Approved, Pending, Denied, Withdrawn, Informational or Evaluation.
- "Approved" requests will have the authorized Effective and End Dates, Authorized Units and/or Dollars listed when you view the entire PA.

Search Results

Prior Authorization	Client ID	Last Name	First Name	Status	PA Assignment	Start Date	Procedure	NDC	Revenue Code	Service Provider
3002113001	00002525	WATERS	JANET	Approved	WAIVERED SERVICES	04/23/2002	W3033			
3002113001	00002525	WATERS	JANET	Approved	WAIVERED SERVICES	04/23/2002	W3032			
3002109001	00002525	WATERS	JANET	Approved	WAIVERED SERVICES	04/19/2002	W3032			

Field descriptions

Field	Description
Prior Authorization	Prior Authorization number
Client ID	Identifies the client who will receive service(s)
Last Name	The last name of the client
First Name	The first name of the client
Status	PA current status
PA Assignment	Identifies type of service to which a prior authorization request or requests are assigned
Start Date	Indicates the date the PA was submitted
Procedure	A code to uniquely identify a procedure
NDC	The National Drug Code used to uniquely identify a drug
Revenue Code	The revenue code
Service Provider	The National Provider Identifier (NPI) or Oregon Medicaid ID of the service provider

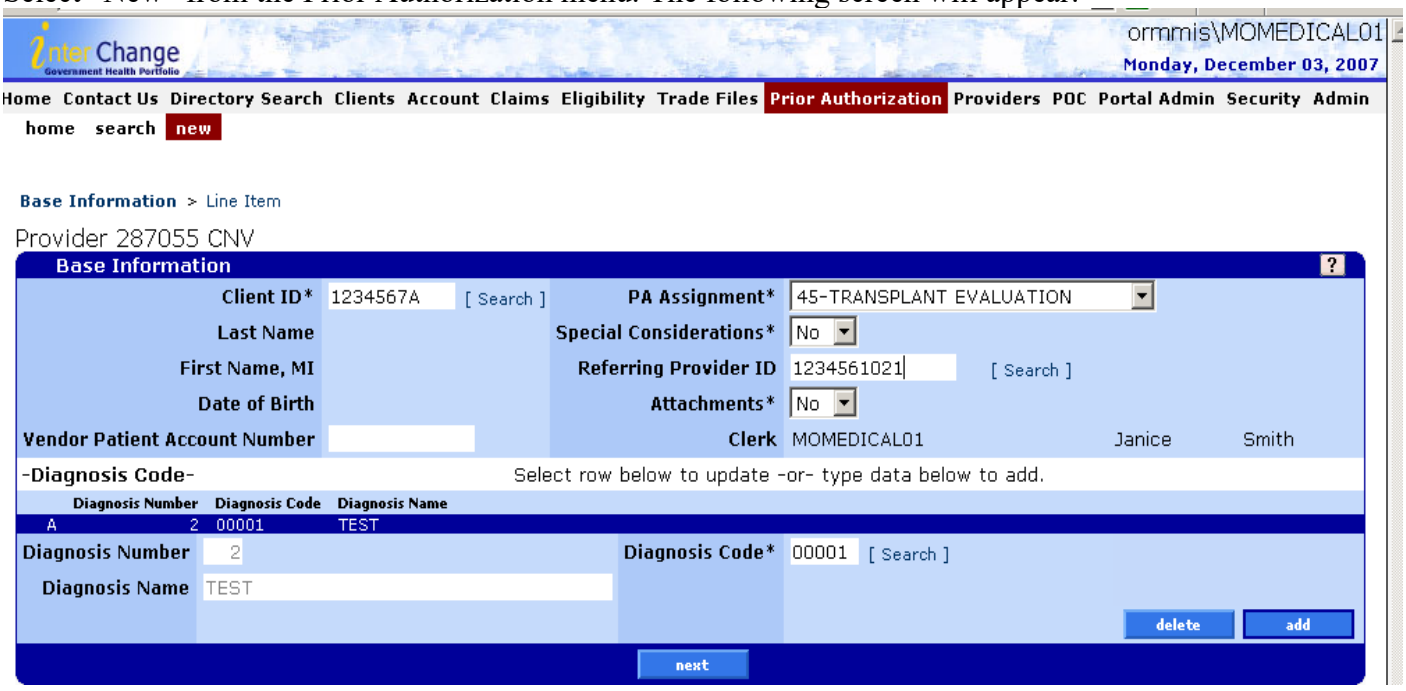
To view PA search results

Step	Action	Response
1	Click the PA row that you want to view	The PA information screen will display

How to submit a web PA request

Step 1: Enter base information

Select "New" from the Prior Authorization menu. The following screen will appear:



This screen (1 of 3) allows you to enter PA base information. It is the first screen of the PA request process.

Field descriptions

Shaded boxes are required to process your PA request.

Field	Description
Client ID*	Identification number of client
First Name	Client's first name
Last Name	Client's last name
MI	Client's middle initial
Date of Birth	Client's date of birth
Vendor Patient Account Number	Your account number for this client
PA Assignment*	Indicates the type of service to which a prior authorization request or requests are assigned (*i.e.,* home health, durable medical equipment, hospital, mental health/addictions)
Special Considerations*	Indicates if there are any special circumstances or considerations surrounding the Prior Authorization
Referring Provider ID	The National Provider Identifier (NPI) or Oregon Medicaid ID of the referring provider

Field	Description
Attachments*	Indicates if there are any attachments (*e.g.*, prescription or physician's order). Refer to your provider guidelines for any attachments you need to submit for PA review. The default value for this field is NO. If there are attachments, you will need to submit them by: • Uploading them using the Attachments button, or • Faxing them under a completed PA Coversheet for Supporting Documentation.
Clerk	Provider clerk that entered the prior authorization. Defaults to logon user. Consists of User Name, First Name, and Last Name.
Diagnosis Number	Click "add" to add each diagnosis. Click "Search" to search for the diagnosis code. If more than one diagnosis code is entered, the system will automatically fill the sequence number: 1 for the first, 2 for the second, etc. • Use ICD-9 codes for dates of service on or before 9/30/2015. • Use ICD-10 codes for dates of service on or after 10/1/2015.
Diagnosis Name	The description of the diagnosis code
Diagnosis Code	Enter diagnosis codes without the decimal

Note: To submit a pharmacy PA, select 'Pharmacy' from the PA Assignment drop-down list. Then on the next screen, select NDC Code from the Service Type Code drop-down list, fill in the NDC field and the NDC Lock field.

To add base information

Step	Action	Response
1	Enter data in the required fields	Note: The Date of Birth, Last Name, First Name and MI will automatically populate
2	Click the "add" button to enter each diagnosis, if applicable.	Diagnosis fields activate
3	Enter diagnosis code(s). Or, use the search link to look up the diagnosis codes	
4	Click the "next" button	Next screen displays

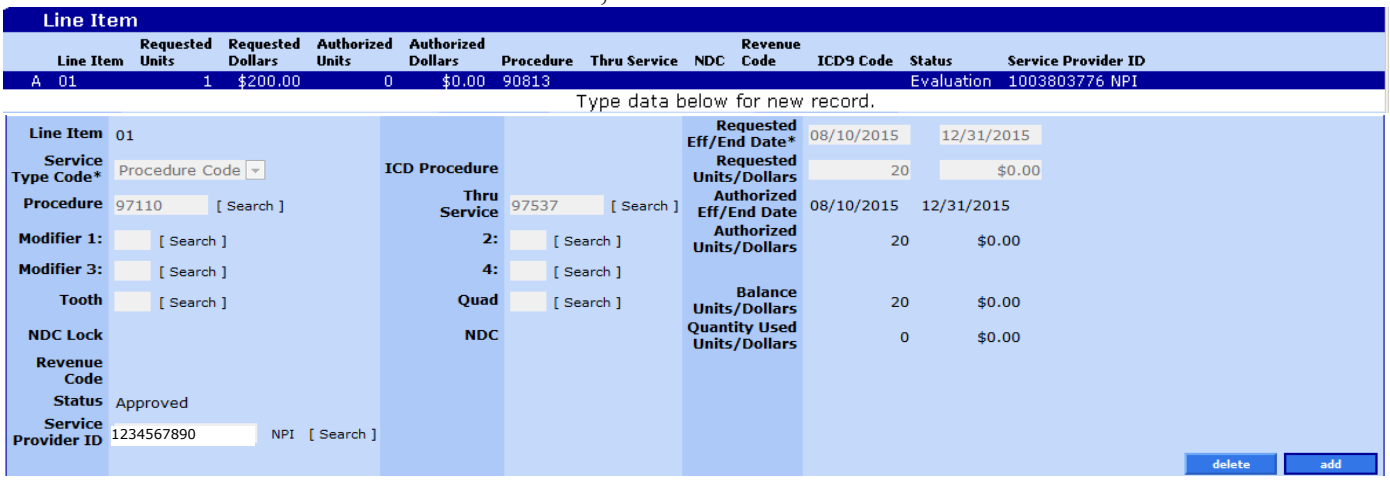
To update base information

Step	Action	Response
1	Click on the line item to be updated	Data populates detail fields in the Base Information screen
2	Change data as needed	
3	Click the "next" button.	Next screen displays

Step 2: Enter PA line items

This screen allows you to enter multiple line items. You must enter a Service Type Code to indicate the type of code (*e.g.,* procedure code, Revenue Code, or National Drug Code) you are requesting PA for.

If you are requesting more than one specific code, then enter a line item for each code. Enter information for the first line item on the screen. To add more lines, click the "add" button.



Field descriptions

Shaded fields are required to process your PA request, if applicable.

Field	Description
Line Item	This represents the line-item (detail) you are working on
Service Type Code*	Drop-down list to indicate the service type code. The type of code you select determines which fields you need to fill in. • ICD Procedure – Activates ICD Procedure field • NDC – Activates NDC Lock and NDC fields • Procedure Code – Activates Procedure, Thru Service and Modifier 1-4 fields • Revenue Code – Activates Revenue Code field
ICD Procedure	Only available if ICD Procedure is selected in the Service Type Code field. • Use ICD-9 codes for dates of service on or before 9/30/2015. • Use ICD-10 codes for dates of service on or after 10/1/2015. The Search function is available on this field. This field will be disabled if a claim has paid against the line item.
Procedure	Only available if Procedure code is selected in the Service Type Code field; this field is required when Procedure code is selected
Thru Service	The thru procedure code is used to represent the last code in a range of procedure codes
Modifier 1	This is a procedure code modifier. Modifiers 1-4 are only visible when Procedure is selected from the Service Type Code
2	This is the 2nd procedure code modifier
Modifier 3	This is the 3rd procedure code modifier
4	This is the 4th procedure code modifier
Tooth	Indicates the tooth number for a dental procedure
Quad	Indicates the tooth quadrant for a dental procedure

Field	Description
NDC Lock	Drop-down list to indicate NDC Lock. Only available when NDC is selected in the Service Type Code field
NDC	Only available if NDC code is selected in the Service Type Code field; this field is required when NDC is selected
Revenue Code	Only available if Revenue Code is selected in the Service Type Code field; this field is required when Revenue Code is selected
Status	The status of the PA line item. It will be in "evaluation" status until OHP staff reviews the PA
Service Provider ID	The service provider's identification number: National Provider Identifier (NPI) or Medicaid Provider ID (MCD)
Requested Eff Date*	This is the requested Prior Authorization start date
Requested End Date*	This is the requested Prior Authorization stop date
Requested Units	This is the number of units requested
Requested Dollars	This is the dollar amount requested
Authorized Eff Date	This is the authorized Prior Authorization start date
Authorized End Date	This is the authorized Prior Authorization stop date
Authorized Units	This is the number of units authorized for the Prior Authorization
Authorized Dollars	This is the dollar amount authorized for the Prior Authorization
Balance Units	Number of units not yet billed and paid for the prior authorization
Balance Dollars	Dollar amount not yet billed and paid for the prior authorization
Quantity Used Units	Number of units already billed and paid for the prior authorization
Quantity Used Dollars	Dollar amount already billed and paid for the prior authorization

To add a line item

Step	Action	Response
1	Select the Service Type Code from the drop-down list (*i.e.,* NDC, procedure code, revenue code)	Data entry fields are activated based on service type code selection
2	Enter date in applicable fields	
5	Click "add" tp add another service or click the "next" button	Next screen displays

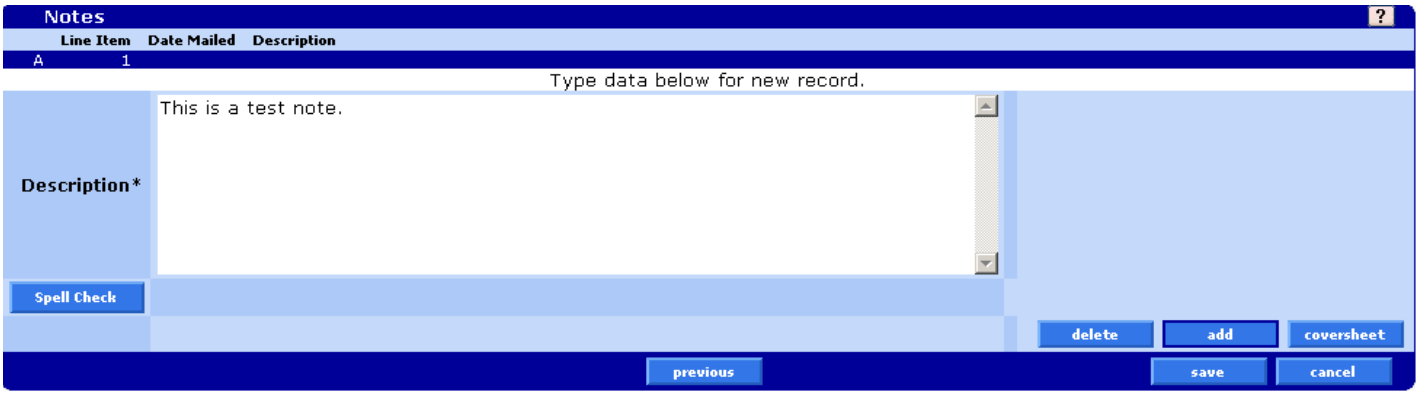
To update a line item

Step	Action	Response
1	Select the line item to be updated	Data fields populate
2	Select the service type code from the drop-down list (*i.e.,* NDC, procedure code, revenue code)	Data entry fields are activated based on service type code selection
3	Enter updated data in applicable fields	
4	Click the "next" button.	Next screen displays

Step 3: Enter PA notes

This screen allows you to add notes for consideration when reviewing your PA request. You can add a line for each note. Each note can contain 4,000 characters.

- **For Immediate (24-hour) or Urgent (72-hour) processing,** please add a note stating whether the request is immediate or urgent, and why. Always do this for requests that need faster processing.
- Attach documentation to support the request.



Field descriptions

Field	Description
Description	Free form text (note); up to 4000 characters

To add notes

Step	Action	Response
1	Click the ”add” button	Notes screen activates
2	Enter data in the Description field	
3	Click the ”save” button	Data saves, and the PA Number displays

To delete notes

Step	Action	Response
1	Click the line item to be deleted	Data populates in the Notes screen
2	Click the ”delete” button	Dialog displays to confirm deletion
3	Click the OK button	Item deletes

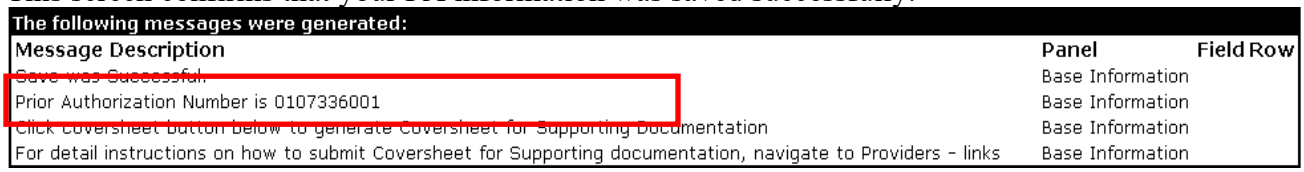
To update notes

Step	Action	Response
1	Click the line item to be updated	Data populates in the Notes screen
2	Enter updated data in the Description field	
3	Click the ”save” button	Data saves

Step 4: Review PA confirmation

After submitting a PA request online, a PA confirmation screen will display above the Notes screen with the prior authorization number and the PA status.

This screen confirms that your PA information was saved successfully.

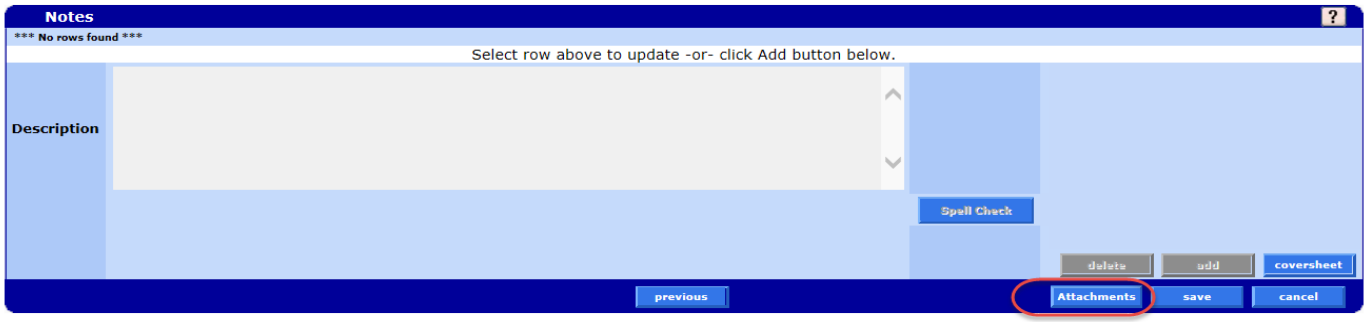


Step 5: Complete and submit supporting documentation

After you submit your PA by clicking the "Save" button, you can submit supporting documentation in two ways.

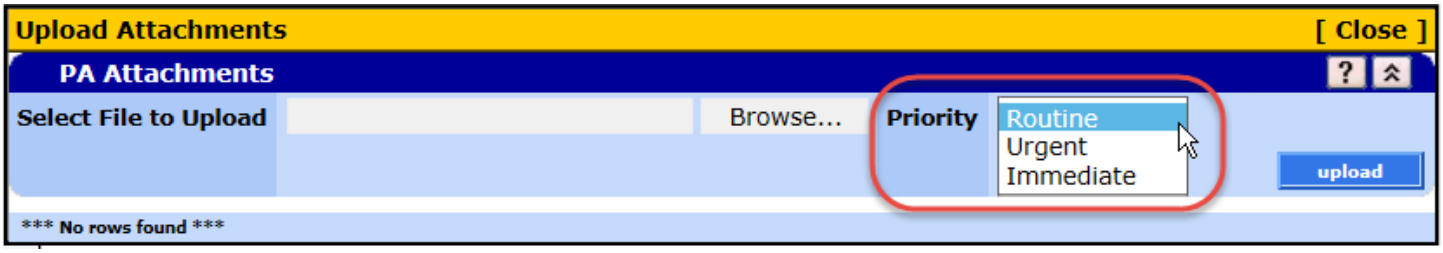
Attachments button

Click the "Attachments" button:



To upload documents:

- Click on the "Browse" button at the end of the "Select File to Upload" field.
- Select the file. Files must be PDF, TIF/TIFF, or TXT and not exceed 10 MB.
- Choose the Priority. The default priority setting is "Routine." For 72-hour processing, choose "Urgent." For 24-hour processing, choose "Immediate."
- When you have selected the file, click the **upload** button.
- Repeat these steps for each attachment.



Confirmation screen

Once you upload documents, you will get a confirmation message that lists the filename of each document you uploaded.

- This is the only time you will see a list of the documents you uploaded.
- You cannot log in and view them later.

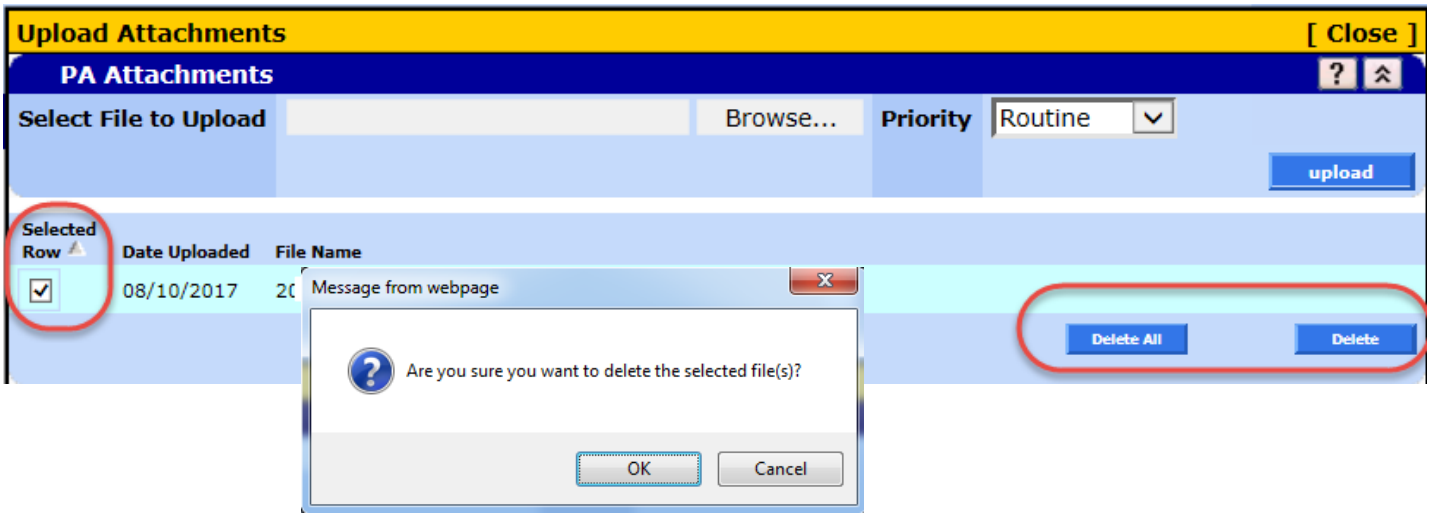
If you need to delete any documents, you need to do it at this screen.

To keep record of the documents you uploaded:

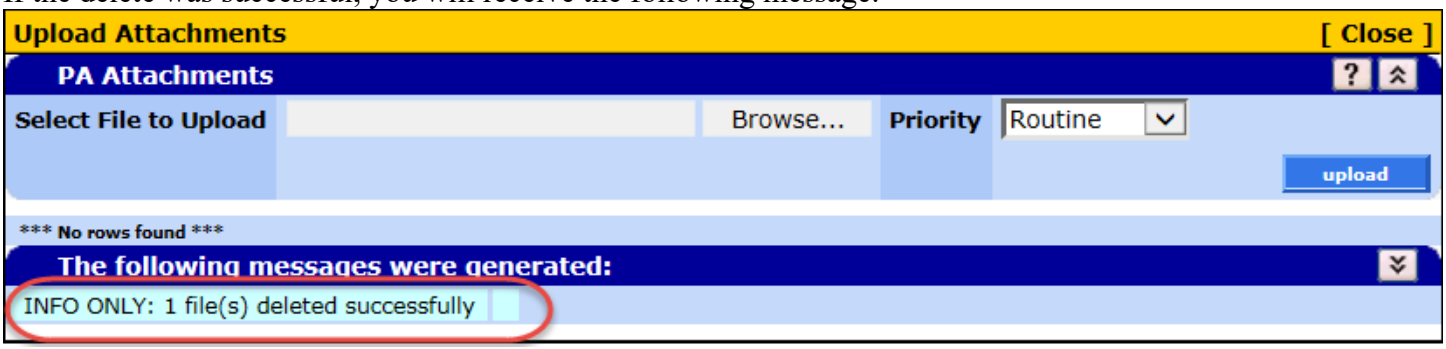
You can take a screenshot of the message (for example, use the "Print Screen"/"Prt Scrn" button on your keyboard to do this).

To delete uploaded documents:

- To delete one document, mark the row you want to delete, then click **Delete**.
- To delete all documents, click **Delete All**.
- To confirm the deletion, click "OK" at the resulting screen.



If the delete was successful, you will receive the following message:



Coversheet button

Click the "Coversheet" button on the Notes screen to print the EDMS Coversheet and use it as a coversheet for supporting documentation you need to send. This coversheet is required for all documentation sent to OHA.

- When the coversheet is selected from the Notes page, the PA number and Document Type will automatically populate on the form.
- Make sure to also complete the Client and Provider ID fields on the form. This allows OHA to associate the request with the appropriate provider and client.

What happens after OHA receives your PA request

Once you submit your PA request on the web, the status of the PA will initially be "evaluation." This means the PA is waiting for initial review.

- Until OHA reviews and approves your request, the PA number on the PA confirmation screen can ONLY be used to track the status of the PA.
- You can check the status of the PA as often as you want. See PA search to track the status of the PA.
- Once all necessary documentation has been received and processed, the PA will be updated indicating a status with any associated restrictions noted. The PA expiration date is also stated.
- If the PA is approved, the PA request status will change to "approved." Only after the PA is approved can you use the prior authorization number to submit a claim. Be sure to note the approved units and dates.
- If the PA is denied, no updates or modifications can be made to the original PA. You must submit a new PA for consideration.

How to copy an approved PA request

You can copy existing PAs using the Copy PA button at the bottom of the screen. Once copied, you can update the PA data and submit the copied PA as a new PA.

Step	Action	Response
1	Search for a PA for the client or service you want to request PA for	A list of matching PA requests displays
2	Select the PA request you want to copy	PA information for the request displays, with a "Copy PA" button at the bottom of the page
3	Click the "Copy PA" button at the bottom of the page	A copy of the completed PA displays "Save" and "Cancel" buttons replace the "Copy PA" button
4	Update all required and/or applicable fields • Base information • Line items • Notes	
5	Click the "save" button	A message at the top says the save was successful A new PA number displays in the PA number field at the top of the screen The "Copy PA" button appears at the bottom of the screen

Appendix

MSC 3971 (DHS/OHA Prior Authorization Request) form instructions

This form is the paper option for submitting medical and dental PA requests.

- Do not use this form for requesting medical review of CCO disenrollment requests.
- Only use this form if you cannot complete an electronic PA submission.

To ensure timely processing of PA requests:

- **Complete all required fields, as applicable.** OHA will not be able to create a PA request in the computer system if required fields are incomplete.
- **Refer to the provider guidelines for your program** for the required information and documentation you need to submit, and the fax number you need to send your request to. Most PA requests are sent to one of the central PA fax numbers (503-378-5814 for routine requests or 503-378-3435 for immediate/urgent requests).

Field descriptions for the DHS/OHA PA Request Form (MSC 3971)

Information in bold is required, as applicable, for all PA requests sent to the central PA fax numbers. Not all PA requests go to the central fax numbers. Refer to your provider guidelines for program-specific requirements and fax number(s) to use.

EDMS Coversheet	**From (contact name)** Phone **Date** No. of pages **Provider ID** **Recipient ID** **Prior Authorization Number (for updates to existing requests)**	PA Processing Time Frame – Default processing is routine processing, and may take up to five days. • Immediate is 24 hours • Urgent is 72 hours
Box I – Request Information	**Client Name** **Client ID** **DOB** **Requesting Provider NPI** **Performing Provider NPI** **Referring Provider NPI**	**PA Assignment** **Length of treatment** **Frequency** **Time per session** **Primary diagnosis code** **Date of service**
Box II – Line Item Information	**Service Code (Revenue Code, Procedure Code, CDT Code, etc.)**	**Description** **Units**

Box III – Dental information	Tooth number and quadrant, if applicable	
Box IV – Pharmacy Information	Drug Name Strength	Quantity Directions
Box V – Additional Notes	*Written justification or other helpful notes* – Refer to your provider guidelines for requirements.	

MSC 3970 - EDMS Coversheet

This sheet is required as the cover for any and all documentation and requests sent to the central fax numbers (503-378-5814 for routine requests and 503-378-3435 for immediate/urgent requests). It allows OHA to scan your correspondence into the Electronic Document Management System (EDMS).

OHA will not accept fax requests submitted without this cover sheet. To avoid delays in processing:

- **Make sure each PA request you send has its own EDMS Coversheet.** This allows OHA to track each request as a separate document. You cannot send multiple requests under a single coversheet or combine document types. For your convenience, this form is now the first page of the MSC 3971 form.
- **Always enter your National Provider Identifier (NPI) and the client's ID number** in the "Documentation Identification Numbers" section of this form.
- **Always mark the "Prior Authorization" box** in the "Document Type" section of this form for all PA-related submissions. This is the only way the EDMS will recognize your PA request for entry into the system.

OHP 3978 - Pharmacy Prior Authorization Request

This form is the paper option for submitting pharmacy PA requests. Only use this form if you cannot complete an electronic PA submission. Prescribers should submit their PA requests for fee-for-service prescriptions and oral nutritional supplements with required documentation to:

Oregon Pharmacy Call Center
888-202-2126
Fax: 888-346-0178

This form **does not** require an EDMS Coversheet.

Information needed to request PA

Complete the form as follows. The Oregon Pharmacy Call Center may ask for some or all of the following information, depending upon the class of the drug requested:

OHP 3978 section	Information needed
Section I: Request information	Requesting provider name and National Provider Identifier • FQHC/RHC and AI/AN providers Also enter the pharmacy or clinic NPI for your facility Type of PA Request: Mark "Pharmacy" • FQHC/RHC and AI/AN providers -Mark "Other," followed by provider type (FQHC, RHC, IHS or Tribal 638) Client ID and name
Section II: Service information	Estimated length of treatment: • Date of PA Request Begin and End Dates of Service Diagnosis code • Use ICD-9 codes for dates of service on or before 9/30/2015. • Use ICD-10 codes for dates of service on or after 10/1/2015.
Section III: Drug/product information	Drug name, strength, size and quantity of medication • Participating pharmacy: Include the dispensing pharmacy's name and phone number (if available)
Section IV: Line item information	Complete for EPIV and oral nutritional supplements only
Section V: Patient questionnaire	Complete for oral nutritional supplements only

Prior Authorization Notices

OHA issues the following types of Prior Authorization Notices:

- Notice of Acceptance (PAU-0101-D): The PA number is in Field 11.
- Notice of Denial (PAU-0111-D).
- Other notices that inform the provider that information is needed to complete the PA request, or that no PA is required.

The PA number will always be a ten digit number.

Description of the fields of the Notice of Acceptance (PAU-0101-D):

1.	The date OHA generated this notice
2.	Provider's name and address as they appear on OHA records
3.	The client's name
4.	Description of the type of service authorized
5.	CPT and/or HCPCS codes for the authorized service
6.	Procedure code descriptions for the authorized service
7.	The amount and units requested by the provider on the original PA request
8.	The amount and units approved by OHA • If a specific dollar amount is printed here, that means OHA will not pay more than this limit. OHA may pay less depending on the actual services billed • "System Rate" is printed when OHA sets no specific dollar limit. This means OHA will pay up to its maximum allowable rate, depending on services billed In both cases, if there is a third-party payer, OHA's payment is reduced by the previous payment.
9.	Name of servicing provider
10.	The client's 8-digit ID number (for billing OHA)
11.	PA Number: When billing on paper for the authorized service, place this number in Field 23 on the CMS-1500 or in Field 19 on the OHP 505, when appropriate
12.	The valid date range for the authorized service; the date of service must fall between these two dates, and the client must be eligible on the date of service
13.	When the prescribing or referring provider's name is listed in this field, it must be used when billing OHA; the service may require a referring provider number when the client is restricted to a Primary Care Manager (PCM) or the service requires referral
14.	Additional notes: A space for notes entered by the reviewer for the provider
15.	The client's name and address
16.	The DHS branch office serving the client
17.	The DHS/OHA office and reviewer who approved the PA
18.	If OHA sends copies of this notice to other entities, that information will display here

DHS|OHA Service Authorizations
500 Summer St NE
Salem, OR 97301

Date of Notice: 8/09/2012 (1)

Provider Name (2)
Street Name
City, State ZIP

Notice of Prior Authorization

DHS authorizes the following item(s) or service(s) to Jane Doe (3) for the dates of service listed below.

PROVIDER: Prior authorization (PA) does not guarantee payment. All rules for service must be met. See your program's Oregon Administrative Rules (OARs). In addition:

- The client must be eligible on the date(s) of service.
- The client must receive service(s) within the dates approved below.
- When you bill DHS, any third-party payments will reduce the billable amount. You must make full use of any other resource before billing DHS.
- CAF-Child Welfare clients must receive consent for surgery from the CAF-Child Welfare branch.
- Attach all required reports and forms to your claim. See your provider rules.

This letter contains protected health information (PHI) from DHS and is covered by the Electronic Communications Privacy Act, 18 U.S.C. Sec. 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in the letter. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.

PA Assignment: (4)	Physical Therapy Services			
CODES	DESCRIPTION	REQUESTED AMT/UNITS	APPROVED AMT/UNITS	SERVICING PROVIDER NAME
97110 (5)	THERAPEUTIC PROC, ONE OR MORE AR (6)	$181.44/009 (7)	$181.44/009 (8)	THEO THERAPIST (9)
CLIENT ID #	AA####A (10)			
PRIOR AUTH #	0123456789 (11)			
Dates Valid: From	8/09/2012 (12)	Through	10/31/2012 (13)	
Requesting/Referring Providers	REFERRER, MD (14)			

Additional Notes:
<Notes entered by the reviewer for the provider may be entered here>

Jane Doe
Street Name (15)
City, State ZIP

DHS Branch:	Anytown (16)		
Address:	### Street Name	Division:	DMAP - Medical Unit 800-642-8635 (17)
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: Referring Provider (18)

Description of the fields of the Notice of Denial (PAU-0111-D):

1.	The date OHA generated this notice
2.	Provider's name and address as they appear on OHA records
3.	The client's name
4.	Description of the type of service authorized
5.	Date the service was denied
6.	CPT and/or HCPCS codes for the authorized service
7.	Procedure code descriptions for the authorized service
8.	The amount and units requested by the provider on the original PA request
9.	Name of servicing provider
10.	The reason OHA denied the PA request, with Oregon Administrative Rule references as appropriate
11.	The client's 8-digit ID number (for billing OHA)
12.	Request number: The 10-digit number referencing the PA
13.	The name of the prescribing/referring provider
14.	Additional notes: A space for notes entered by the reviewer for the provider. For example, if the reason for denial specifies incomplete documentation, the reviewer can use this space to explain the specific documentation required
15.	The client's name and address
16.	The DHS branch office serving the client
17.	The DHS/OHA office and reviewer who denied the PA
18.	If OHA sends copies of this notice to other entities, that information will display here

DHS|OHA Service Authorizations
500 Summer St NE
Salem, OR 97301

Date of Notice: 08/09/2012 (1)

Provider Name (2)
Street Name
City, State ZIP

Notice of Denial

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DHS has denied the prior authorization (PA) request to provide the following item(s) or service(s) to Jane Doe: (3)

PA Assignment:	Physical Therapy Services (4)	Denial Date:	08/09/2012 (5)
CODES (6)	DESCRIPTION (7)	REQUESTED AMT/UNITS (8)	SERVICING PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	$181.44/009	THEO THERAPIST (9)
REASON FOR DENIAL (10)	The information submitted does not substantiate the medical appropriateness for the service provided/requested. (OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0080)		
CLIENT ID #	AA####A (11)		
REQUEST #	0123456789 (12)		
Requesting/ Referring Providers	REFERRER, MD (13)		

Additional Notes: (14)
<Notes entered by the reviewer for the provider may be entered here>

Jane Doe
Street Name (15)
City, State ZIP

DHS Branch:	Anytown (16)		
Address:	### Street Name	Division:	DMAP - Medical Unit 800-642-8635 (17)
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: Referring Provider (18)

PA status descriptions

Agency Authorized	
Appr thru Admin Rev	Approved through administrative review
Approved	
Auto-Denied	Denied because the request was in "Pending" status for 30 days
Cancelled	
Client Withdrawn	
Den thru Admin Rev	Denied through administrative review
Denied	
Evaluation	Default status for new PA requests; waiting for staff review
Hold	
Information Received	Additional information sent by provider; waiting for staff review
Informational	No PA is required for the service
Mod thru Admin Rev	Modified through administrative review
Modified	
Pending	Reviewer needs additional information from provider; PA waiting for provider information to resume review
Ready for Review	
Rejected	
Restored Waiting App	
Withdrawn	Either the PA was withdrawn by the provider, or it was found to be a duplicate