	Q&A – Journey of a Claim, June 2, 2020, 10:00 a.m. (Presenter: Mark Bowman)
Q	**1. Our hospital bills electronically through the clearinghouse, then we must REBILL on the portal attaching documents needed, have other hospitals expressed concern on this electronic process?**
A	*Marvin Dale: That process isn't changing at this time; we have not heard concerns. You will still be able to resubmit through the portal or clearinghouse. Your clearinghouse can also submit your claim electronically with an attachment and then you can just fax your documents to be married up to the claim.* (as per LaDawn Fulgenzi)
Q	**2. To clarify, when needing to send in a HCA17, should we void the paid claim to get an additional line paid?**
A	*Jeff: No, when sending the HCA17, you should not void the paid claim. You can just request the lines which were denied.*
Q	**3. When a patient no longer has the TPL and we've asked them to complete a coordination of benefits, but they refuse how do we work those claims to show Sooner Care is the only insurance?**
A	*Jeff: In this case, you could submit a TPL1 form found on the public site. The TPL Department at OHCA will verify with the primary insurance and can update the member's eligibility. Once their eligibility is updated in our system, you can reprocess the claim and it will show the member has SoonerCare as primary.*
Q	**4. What is an HCA17?**
A	*This is a form used by OHCA as a coversheet for a special process claim. It can be found on the public site www.okhca.org. Click the dropdown in the provider tab and scroll down to forms.*
Q	**5. Where do we find out if the patient has reached the yearly quota of a certain procedure?**
A	*You can check treatment history under the Eligibility tab on the Provider Portal for specific procedure codes.*
Q	**6. How do you submit a single line item correction?**
A	*Use an HCA-17 special batch and only submit the procedure that needs to be appealed.*
Q	**7. 99140 Emergency anesthesia, is there a modifier we can use to make it payable?**
A	*There are no allowed modifiers for 99140.*
Q	**8. If a patient has as global health Medicare and have a coinsurance how do I bill that?**
A	*Global Health is an HMO so you would bill as an HMO co-pay. On the Provider Portal step 1: screen select YES from the HMO co-pay dropdown. On step 3 use 1 line of service. Choose a payable code, 1 unit and the amount will be the co-pay amount. EOB is required as an attachment.*
Q	**9. Ambulance claims where the patient had two transports on one day cannot be keyed together on the portal?**
A	*Correct. Bill the first claim on the portal and it should pay. Bill the second claim and get the duplicate denial. Then send the second claim in on paper with an HCA-17 and BOTH runs to be reviewed.*
Q	**10. Who uses the HCA17?**
A	*HCA-17 is the coversheet used for an appeal for anyone that needs to have a claim reviewed via the special batch process.*
Q	**11. What is the EVV Services Only timely filing box and when should it be utilized?**

A	*We added the ability to file the timely via our portal when needed as FiSERV had no solution for timely filing. The only time a provider of EVV services can bill to us directly is if they need to timely file. They must use the check box so that we can assign an EVV region to the claim so that we do not deny the claim. This is to ensure all claims are being sent to us through the proper process.*
Q	**12. Does Medicaid follow the CMS 72-hour rule on an inpatient claim?**
A	*Marvin Dale: OHCA states that you need to follow the guidance in the letter. You can send it in for review with the HCA17, but it may not make a difference if it was from Telligen, you have to follow their guide. If you have additional questions, they recommend calling OHCA and talking with provider services, but mainly they will state to follow Telligen's guide. (as per LaDawn Fulgenzi)*
Q	**13. On the HMO TPL, you mentioned a box that states, "diagnosis code" and an amount would be entered. I don't think I have seen that. Where is this located on the portal?**
A	*If a member has a Primary Insurance other than Medicare or an HMO, then the provider will choose Include or Denied in the Other Insurance field on step 1 of the Portal. If you received payment from the primary, then you would choose Include. Then on step 2 where the Diagnosis field is located there will be a TPL Amount box to put in the amount paid by the primary.*
Q	**14. If primary has been found, billed and paid but it is past the timely limit I would have sent a HCA-15. Would I still send this in but adding the HCA-17 as a cover sheet?**
A	*You need to make sure you bill SoonerCare within 183 days even if the primary has not paid yet. Then you have a year from DOS to submit. If the primary takes over 1 year to pay, then you could use the HCA-17 to have that reviewed. However, the HCA-17 does not override the TPL edit without proof of timely filing.*
Q	**15. Will you talk about adjustment process when a client's copayment has been changed by DHS months later?**
A	*I am going on the assumption that this is a LTC provider. We ask them to send in the HCA-14, paid remit for claim(s) involved along with the 37C. We then review the requests and determine if we can do an adjustment. If not, we will mail them back to the provider if we are unable to proceed with an adjustment.*
Q	**16. Just to clarify, if we need to attach medical records or attach proof of timely, we can fax the attachments? They need the Oklahoma cover fax sheet OR mail the information needed?**
A	*Yes, you can fax or mail but the OHCA coversheet is required.*
Q	**17. So if a patient has any type of Medicare replace with it being a Humana Medicare or UHC Medicare it is a crossover claim?**
A	*A PPO replacement is processed as a Crossover, an HMO replacement is processed as an HMO.*
Q	**18. I'm having an issue getting my E&M paid when the provider is APRN. Is there something specific that needs to be done on the credentialing contract to tell the system that the provider is authorized to see clients for this service?**
A	*Mark has followed up with this provider.*
Q	**19. Will an HCA 17 form be required for an inpatient cesarean with sterilization when the medical records file is too large to upload?**
A	*No, you can just mail in the attachments.*

Q	**20. For institutional claims, I am unable to edit the claim type, for example, if it has denied as an outpatient claim, but it should be a crossover claim, the claim type is not able to be changed. I thought I heard that the claim type could be changed.**
A	*Once a claim has processed the claim type cannot be changed. You must submit a new claim. You can edit denied claims, but you cannot change the claim type.*
Q	**21. If a patient has GlobalHealth-Generations Medicare Advantage HMO coverage (or any other Medicare Advantage HMO coverage) as Primary and they leave a coinsurance/deductibe/copay amount due, is this billed as an HMO claim or Crossover claim on the Provider Portal?**
A	*You will bill it as an HMO claim. PPO claims would be Crossovers.*
Q	**22. How long will you accept Telehealth/Telemed claims?**
A	*Currently, Telemedicine has been extended through September 30, 2020.*
Q	**23. Can we submit a claim with the HCA-15 or will it be denied if one is attached?**
A	*Looking at the HCA-15, Box 3 is where you will put the Claim ID number. You do not submit the HCA-15 with a claim.*
	24. Is there a list of modifiers that are used? I am having problems with transports from hospital to nursing home or back to residence denying for the modifier HN or HR.
A	*There is no list of modifiers.*
Q	**25. In reference to procedure codes meeting the quota for the year - is there a generic area we can search to see how many times per year a certain procedure is payable?**
A	*There is no list of generic codes showing frequencies.*
Q	**26. It doesn't appear that OHCA always follows CMS NCDs or LCDs. Where can we find diagnosis criteria for certain CPT/HCPCS codes? Such as if a specific CPT is only covered when filed with certain diagnosis codes. Where can we find which dx codes are covered?**
A	*Contact Provider Services 1-800-522-0114, option 1.*
Q	**27. I missed the fax number for attachment to be sent to.**
A	*It is on the Attachment cover sheet. (405)947-3394.*
Q	**28. Will a Nurse Practitioner working in the ED be billed under the supervising Physician?**
A	*Marvin Dale: Each service must be personally rendered, and they would have to have a provider contract for the NP. (as per LaDawn Fulgenzi)*
Q	**29. When fax is chosen as the attachment type, will you repeat how I get access to your coversheet?**
A	*Once you have submitted the claim, the attachment coversheet button will appear. This will allow you to print the coversheet.*

	Q&A – Journey of a Claim, June 9, 2020, 10:00 a.m. (Presenter: Jeff Mims/Mark Bowman)
Q	**1. Not sure if anyone can tell me, but I mailed 2 paper claims with claim review forms on 3/13/20 & these still have not been paid. What is the status on these paper claims being processed due to Covid19? Thank you**
A	*Marvin Dale: f you mailed to the Special Batch PO Box, these are being reviewed. You can contact the call center at 800-522-0114 and check the status or look online. If you still don't see anything, they could have been RTP'd if they didn't have the SoonerCare ID or other*

		required information. Overall, they should have already been reviewed at this point (as per LaDawn Fulgenzi)
Q	**2.**	**What if the services render has several charges what do we do as far as one UB form?**
A		*Jeff: If the services rendered on a UB are more than the spaces allowed, you can submit online via the Provider Portal. UB/via portal will allo up to 99 lines.*
Q	**3.**	**Effective 6/1?**
A		*Marvin Dale: Yes, OHCA has requested that ONLY special process claims for review be submitted on paper, all others should be electronic. And the Special Batch claims will become available on the website soon, then all claims should only be electronically submitted. (as per LaDawn Fulgenzi)*
Q	**4.**	**Does the legacy number have to be on the claim or just on the HCA17 form?**
A		*Marvin Dale: Must be on the BOTH (as per LaDawn Fulgenzi)*
Q	**5.**	**Did you say we have 183 days + 6 months after that? I thought we only have 183 todays total days to submit/process pay?**
A		*Marvin Dale: 183 for timely, then an additional if you have filed the original timely. (as per LaDawn Fulgenzi)*
Q	**6.**	**I have mailed in many appeal's for eligibility that has been back dated. The Award letter was mailed with the HCA 17, some were over 2 to 3 years. All were returned unprocessed. Stated past timely to process.**
A		*Marvin Dale: They must meet the 4 criteria only, if over timely. (as per LaDawn Fulgenzi)*
A		*Rebecca W: You must also have filed within the first 183 days and send proof of timely along with the other forms.*
Q	**7.**	**I am having continuing problems when we fax the attachment being denied timely, and never received attachment. We will send 15 in a day not in a row, and 4 will be processed and the others are denied didn't get. I am frustrated I have sent numerous times, before and after gets processed. I have the confirmation sheets showing it was received. Why is that not accepted? What's the solution?**
A		*Marvin Dale: Two things, if you are using a clearinghouse or billing agency, you want to make certain that they are not holding your claim and you are sending the attachment BEFORE the claim. Second, the system doesn't have a denial that states that documentation doesn't show medical necessity, so it will say that there is no attachment even if it is just the wrong information sent. If you would like to call one of our field staff, we can also confirm if your attachment was truly received or not. Many providers who send electronically via fax have their own coversheet that is applied to the documents. If there is another fax coversheet on top of the information, it can't be accepted by the scanners. (as per LaDawn Fulgenzi)*
Q	**8.**	**For TPL, do we need to bill non-qualifying services to commercial insurance for denial? Example: T1017 Case Management.**
A		*Rebecca W: Yes, you will need to file with the primary before filing with SoonerCare. If the primary denies, you will need to mark denied on the TPL field and upload the EOB stating that the primary denied for non-covered services.*
Q	**9.**	**Was told from last session that non covered procedures can bill the pt. How can rev code 510 and 761 which are non covered be billed to the pt?**
A		*Marvin Dale:We need to look at specific claim information. (as per LaDawn Fulgenzi)*

Q	**10. If I send a fax doesn't show it was received do I call the EDI department with confirmation to see what's missing? I have several that denied in May after sent 4-5 times who would I contact to see if they really received or if there was a attachment issue?**
A	*Marvin Dale: You can call in and the call center can look up to see if there is an attachment on the claim. If the claim has the attachment, then I would request to speak to Provider Services about what was sent and what they may be looking for that was not in the current attachments. (as per LaDawn Fulgenzi)*
Q	**11. Is there somewhere on the portal where the explanation of denials is? Sometimes it is hard to tell what the claim is denied for because there are so many things listed.**
A	*There should be a list within the resources tab on the Provider Portal. You can plug in the HIPAA remark codes and it will provide a description.*
Q	**12. Is there a turnaround time for special batches HCA-17?**
A	*Marvin Dale: There is not a specific timeframe, but I would allow for 45 days. At this time, they are averaging about 2-3 weeks. Please keep in mind that claims that need to be reviewed, MUST have the HCA17 form and all required information on the claim. (as per LaDawn Fulgenzi)*
Q	**13. How long should it take for a suspended claim to pay?**
A	*Marvin Dale: Allow up to 45 days. (as per LaDawn Fulgenzi)*
Q	**14. The letter from DHS which awarded Medicaid to back date?**
A	*Marvin Dale: this is her "award letter information" so yes they would need to be special batch with the HCA17 form and a description of what needs to be reviewed. (as per LaDawn Fulgenzi)*
Q	**15. I've had a patient that on the eligibility screen says they have Medicare but they actually have Medicare replacement plan. The claim denies because I attached the EOB from the Medicare replacement plan and not Medicare EOB but the patient does not have Medicare. How do I resolve this?**
A	*If it's a Medicare replacement, a PPO would be filed as a Crossover. An HMO would be filed as an HMO claim.*
Q	**16. I keep getting denials for the name not matching the system. When trying to research this I find that the patients name is listed differently in the different spots on the portal. We currently copy and paste the eligibility name from the portal and bill with that but they still deny. What name are we supposed to use for billing to avoid these denials?**
A	*The name on the Eligibility page from the Provider Portal is the name required. If you edit the claim on the Provider Portal you can copy and cut the member ID number, hit TAB to get an error and then paste the number in and hit TAB. We will load the name from the Medicaid file.*
Q	**17. When I receive payment on the dental EOB it has the identifier B7: The provider was not certified/eligible for this procedure/service on this date of service. I'm not sure why it keeps showing up and it is confusing when it shows up on paid claims and unpaid claims.**
A	*Our system tries to pay based on every benefit package that a member has. This error is probably hitting against Non-Emergency Transportation or Mental Health and Substance Abuse eligibility.*
Q	**18. When sending timely proof RA is acceptable, is the OHCA website claim copy also acceptable?**
A	*Yes, proof of timely filing can be Claim Copy from the portal, RA or a Date Stamped paper claim which was mailed back to the Provider.*

Q	**19.**	**If you look at the eligibility name it is different than the card and different than in the PA.**
A		*Marvin Dale: Our system requires the member id, otherwise they should be the same. (as per LaDawn Fulgenzi)*
Q	**20.**	**Who can I talk to at OHCA about the name being listed different in different places? I have several examples I can provide.**
A		*Call the OHCA Call Center at 405.522.6205*
Q	**21.**	**Why is it that sometimes when sending TPL info, Medicaid will deny the claim because of the specific denial from the primary payor. We get a lot of denials because the primary denied for non covered, but the EOB does not state "patient responsibility".**
A		*If the reviewer cannot determine the reason for the denial, more detailed explanation may be needed from the primary insurance. Remember providers and members have to follow Medicaid rules pertaining to primary insurance.*
Q	**22.**	**FU to that denial question-- will attaching a letter from the primary explaining it is a non covered benefit for whichever reason?**
A		*To follow-up, Claims are reviewed on an individual basis so it will be up to the reviewer and the explanation on the EOB.*
Q	**23.**	**I just recently had a child not have a change of name or social situation that apparently had his SC number changed. So the PA is under the old number that is now not covered. For payment do we submit a change of number form with previous number and new current number to receive payment of services provided?**
A		*We need to know the specifics on this so that we can determine if the member's cases need to be linked so that the PA will apply to the claim properly or if the PA needs to be amended.*
Q	**24.**	**Can I ask about therapies email addresses?**
A		*Jeff: TherapyAdmin@okhca.org*
Q	**25.**	**Is there a special subject we need to be using when sending emails about therapy?**
A		*No, just explain the situation with as much detail as needed.*