FAQS for

Reinstating Prior Authorization (PA) Requirements Training

Ohio | Department of Medicaid

Table of Contents

Does this Prior Authorization Requirements Training apply to me?

Is this training relevant to me?

If your group is submitting Fee-For-Service (FFS) claims within the Provider Network Management (PNM) portal and may potentially need to submit a Prior Authorization (PA) for those claims, then yes it does apply.

Are these changes relevant for an out-of-state provider?

If you are in another state but see Ohio residents and you will be using PNM to enter FFS claims, then yes this will apply to you as a provider.

Where can I find a copy of the Prior Authorization Reinstatement Requirements training presentation?

A copy of the presentation slides are located on the Absorb learning management website: https://ohiopnm.myabsorb.com/#/login. Log in, locate the curriculum for Reinstating Prior Authorization Requirements, choose the training session, and the presentation slides can be found in the Resources section of the course.

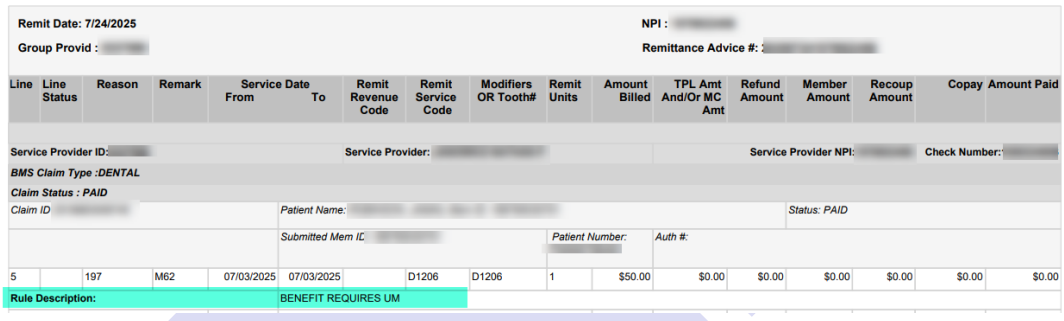
When will these Prior Authorization (PA) Requirements go into effect?

Prior Authorization Reinstatement Dates

When will this Prior Authorization change become effective?

Warning Period: Starting July 1, 2025, claims submitted without the required prior authorization (PA) will receive a detailed warning edit in the Remittance Advice (RA). This is your opportunity to correct submissions before denials begin.

Enforcement Period: Begins August 1, 2025, claims without proper prior authorization will be denied. Here is an example of what a provider might see:



Remit Date: 7/24/2025 NPI :

Group Provid : Remittance Advice #:

Line	Line Status	Reason	Remark	Service Date From	Service Date To	Remit Revenue Code	Remit Service Code	Modifiers OR Tooth#	Remit Units	Amount Billed	TPL Amt And/Or MC Amt	Refund Amount	Member Amount	Recoup Amount	Copay	Amount Paid
Service Provider ID:					Service Provider:								Service Provider NPI:		Check Number:	
BMS Claim Type :DENTAL																
Claim Status : PAID																
Claim ID					Patient Name:									Status: PAID		
					Submitted Mem ID:				Patient Number:		Auth #:					
5		197	M62	07/03/2025	07/03/2025		D1206	D1206	1	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Rule Description:					BENEFIT REQUIRES UM											

Does the August 1, 2025 date pertain to the date of service or the date the claim was submitted?

The date the claim is submitted.

Is the fee schedule going to be updated with the new policy?

There is no update to the fee schedule. Any codes that previously required a PA will need an authorization again as of August 1, 2025.

Will Long Term Care (LTC) facilities need PA for admission, or will we continue to get (LOC's) for payment?

The requirements will be the same as they were before the pause was implemented. If a PA was required then, then it will be required again as of August 1st, 2025.

Which procedures and areas of service will the Prior Authorization (PA) requirements impact?

Will the Fee Schedule still be the guide to determining if something needs a PA?

Yes. The fee schedule can be found here: Fee Schedule & Rates | Medicaid

Where do I go to find a list of procedures that require a PA?

You may locate the covered codes by referring to the appropriate fee schedule available on our website. Each fee schedule includes a specific PA identifier associated with the relevant service code(s).

Do the PA reinstatement requirements apply to dental or medical only?

This will apply to both dental and medical and will impact all FFS submission. PA requirements can be found on the fee schedule here: Fee Schedule & Rates | Medicaid

Are these changes for traditional Medicaid and/or Medicaid MCO's?

The recent updates have sparked questions around their scope and applicability. It's important to note that these changes ***do not*** affect processes related to Home and Community-Based Services (HCBS) waivers, nor do they impact existing procedures under Managed Care Organizations (MCOs). ***Both remain unchanged.***

Instead, the adjustments pertain exclusively to components of **traditional Medicaid** that operate outside of HCBS and MCO frameworks. For providers and stakeholders working within these unchanged areas, no action is required currently.

Does this change apply to Hospice and Home Health services?

There are no changes to home and community-based waiver processes, nor to managed care processes.

How do I find the CPT look-up for services in the office setting as a professional claim? The Medicaid website isn't showing details for professional claims.

You can locate CPT codes through the Fee Schedule on the Medicaid website. It is broken down by service type. Each fee schedule includes a specific prior authorization identifier associated with the relevant service code(s).

Who can we contact regarding where to find the list of codes needing a PA? I followed the instructions for the non-institutional fee schedule but cannot navigate where to find out if a PA is required. Do Behavioral Health (BH) codes require a PA?

The BH codes can be found here - https://medicaid.ohio.gov/resources-for-providers/bh/manuals. If you are unable to locate the information you are looking for on the fee schedule, then you can email the Integrated Help Desk at: IHD@medicaid.ohio.gov.

Where can I find the PA table for Substance Use Disorder (SUD) clinics or BH?

Both websites can locate CPT codes: https://medicaid.ohio.gov/resources-for-providers/bh/manuals or https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates. If you are unable to locate the information you are looking for on the fee schedule, then you can email the Integrated Help Desk at: IHD@medicaid.ohio.gov.

We use certain CPT codes for our practice, and they all stated they did not require a PA. Would this be for every patient for these CPT codes?

Yes, if the fee schedule states that a PA is not required, then it would not be required for any FFS Medicaid patient.

Professional vs. Institutional Authorizations

Professional Authorization should be submitted when an individual healthcare provider (like a doctor, therapist, or nurse practitioner) is requesting approval for the services they personally perform. If the services are billed by an individual provider → Professional

Institutional Authorization should be submitted when a healthcare facility (such as a hospital, clinic, or skilled nursing facility) is requesting approval for services provided as part of the overall care delivered by the facility. If the services are billed by a facility or institution → Institutional

Correspondence and "Refresher" Prior Authorization Knowledge

I've tried to obtain correspondence information and letters from the correspondence section and letters are not there. When I call Medicaid, the customer service rep is unable to help.

We understand how frustrating that can be. For further help, please email: IHD@medicaid.ohio.gov. Including a screenshot of the issue or where you're getting stuck will help us assist you more quickly.

Is there an option to have more than 1 administrator?

Currently, there is not the option to have more than one admin. There is a future enhancement on the horizon that will expand the role of the agent so that there will be more options to assist the single administrator. Please keep an eye out for future communications and training from ODM and Maximus Inc. in regard to "Latest news on PNM login page".

Who is supposed to do the prior authorizations? Can the medical assistant complete this process or does it require the provider to do it?

A medical assistant can complete this process if they are a provider admin or a provider agent. They can submit a PA in PNM.

I've submitted PA's before because I work in SUD treatment. When I have previously attached files to PA's in PNM, they disappear and never make it over to the reviewer. What can be done about this to avoid a delay in review?

We're aware that some users have experienced issues with attachments not transferring correctly to reviewers. This is actively being addressed to improve the process and prevent delays in the future.

In the meantime, we recommend double-checking that files appear in the submission summary before finalizing and keeping a copy of your submission for reference. If needed, you can also follow up with the reviewer or support team to confirm receipt.

What is the expected turnaround time for the PA decision?

The expected turnaround time for a Prior Authorization decision is approximately 10 calendar days for non-urgent services and 48 hours for urgent services.

How long do authorizations last?

Prior Authorizations last for 365 days.

Will we be able to do a name search if we do not have the Medicaid Billing Number?

You can still access information, though name-based searches aren't currently available directly from the prior authorization search screen. To locate a record without a Medicaid Billing Number, you may need to use alternative search options available in other parts of the system or reach out to support for assistance.

Will there be additional fields added within the correspondence search to be able to filter results by PA# or Medicaid recipient ID#?

There will not be any additional fields added to the search dropdown menus in PNM at this time, but the correspondence line will include the PA number for your reference.

What should you put in the dollar amount if you're unsure of the exact amount. Is it alright to estimate or does it need to be exact?

Unless the code has been assigned a max allowable in the system. The acquisition cost and product information are required to establish the allowable. The provider should add a note in the note section to explain the code in their charge.

Questions Specific to Provider Type

Pharmacy

Do the changes in PA Reinstatement apply to pharmacists and/or pharmacy claims, and if so, should pharmacists be using PNM solely for prior authorization?

The PNM system itself is primarily used for provider enrollment, maintenance, and professional claims submission for fee-for-service Medicaid services. While pharmacists are considered Medicaid providers and must be enrolled through the PNM system, pharmacy claims are not submitted through PNM. Instead, all pharmacy claims are managed through the Single Pharmacy Benefit Manager (SPBM).

Pharmacists should still use the PNM system for provider enrollment and updates, but pharmacy benefit-related services and claims are handled separately through the SPBM portal.

Will the pharmacy have access to the PA approval or denial?

Yes, pharmacies do have access to prior authorization (PA) approvals or denials through the Ohio Single Pharmacy Benefit Manager (SPBM) system.

Pharmacists can view PA status and related information via the SPBM Web Portal (spbm.medicaid.ohio.gov)

This portal provides tools and resources for pharmacists, including:

- Access to submitted PA requests
- Status updates (approved, denied, pending)
- Criteria and documentation requirements
- Communication tools for follow-up or clarification

This access ensures that pharmacies can verify whether a medication has been approved before dispensing, helping to avoid delays in patient care.

Optometry

Are there any changes to the way Optometry billing is processed, for either vision or medical care?

PNM now allows direct data entry for fee-for-service (FFS) claims and prior authorizations, including those related to optometry. These changes do not affect managed care claims, which continue to be processed through the respective managed care organizations

Dental

Does OHM have a time frame of when they will start to pay secondary dental claims correctly?

At this time, no official timeline has been published by ODM or its dental benefit managers regarding the resolution of issues with secondary dental claims payments. Providers are advised to:

Continue submitting secondary claims with the primary Explanation of Benefits (EOB) attached, following Coordination of Benefits (COB) rules.

Use the 2019 ADA dental claim form, and include “Primary Insurance EOB attached” in Box 35.

Contact the dental plan provider relations team for claim-specific questions or escalations.

ODM and its partners are aware of the challenges and are working toward system improvements, but no definitive go-live date has been shared for full resolution.

Are there any new dental codes that need PA or are they the same as before?

As of January 1, 2025, ODM has adopted new CDT codes, and some of them do require prior authorization. Notable updates include:

New Code Requiring PA:

- **D9997** – Dental Case Management, Special Needs

Description: Reimbursement for care provided to individuals with disabilities who require additional time and resources during a dental visit.

This code was introduced to support providers delivering individualized care to patients with special needs and is a significant step toward improving access and equity in dental services.

Other New Codes (Check PA Status with ODM):

- **D2956** – Removal of an indirect restoration
- **D6180** – Implant maintenance (full arch)
- **D7252** – Partial extraction for immediate implant placement
- **D8091/D8671** – Orthodontic treatment with orthognathic surgery
- **D9913/D9914** – Administration of neuromodulators or dermal fillers (typically cosmetic)
- **D9959** – Unspecified sleep apnea procedure 2

While not all of these codes require PA by default, coverage and PA requirements may vary by plan and clinical documentation, so providers should verify with the ODM Fee Schedule or the dental benefit administrator.

Service type- I do not see all options for Dental. What do we put for dentures/partials night guards etc.

If the exact service type is not listed in the dropdown or selection menu, use the closest applicable category based on the CDT code and service description. Here are general guidelines:

Recommended Service Types:

Service	Suggested Service Type
Complete Dentures	Removable Prosthodontics
Partial Dentures	Removable Prosthodontics
Night Guards (Occlusal Guards)	Adjunctive General Services

These categories align with how the Ohio Medicaid dental benefit administrators classify services in their clinical criteria and billing manuals

Tips:

- Always match the CDT code to the correct service type.
- If unsure, refer to the Ohio Medicaid Clinical Criteria Guidelines or contact the dental plan's provider services for clarification.
- For night guards, codes like D9944–D9946 typically fall under Adjunctive General Services.

Gainwell, Permedion, and FI

Will all inpatient institutional behavioral health prior authorizations be sent for a FI review? And if so, will additional forms or clinicals be required?

Institutional behavioral health prior authorizations will be reviewed by Permedion, which is a part of FI. In the event of additional info that is required from the provider, Permedion will reach out directly via phone, email, and/or letter.

Quick question I know in the past we would have to go back and check the PA for the result; they did not contact us. Will that still be the process?

Status updates to a Prior Authorization submitted will be found within PNM. Correspondence will be available in PNM for prior authorizations, and the correspondence line will include the Prior Authorization number for ease of reference.

I've tried to obtain correspondence information and letters from the correspondence section and letters are not there. When I call Medicaid, the customer service rep is unable to help.

This will be corrected in the 08/01/2025 release. Correspondence will be available in PNM for prior authorizations. The correspondence line will include the Prior Authorization number for ease of reference.

Additional Resources

For specific procedure codes, Prior Authorization requirements, Absorb, and other training questions:

- If you cannot find the information you are looking for on the fee schedule, then email the ODM Integrated Help Desk (IHD) at: **ihd@medicaid.ohio.gov** or call at 1-800-686-1516

- For help with Absorb or Prior Authorization Reinstatement Requirements training email the Maximus Training Team at: **ohiotrainingteam@maximus.com**
- For additional Prior Authorization Reinstatement Requirements from ODM visit: **https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements**