USER MANUAL

# Prior Authorizations - Fee for Service

Ohio Department of Medicaid

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# Introduction

This user manual provides the steps and functions of submitting a prior authorization for a medical procedure in PNM. Fee-for-service submissions will occur through PNM. Submissions for Managed Care Organizations or the OhioRISE plan are not submitted through PNM and can be submitted by a trading partner/clearinghouse via relevant Electronic Data Interchange (EDI) transaction.

This document also covers the process of searching for a previously submitted prior authorization to review status and understand approved amounts and timeframes.

## General Guidelines for Using This Resource

1. Chaperone A Federally Qualified Health Center (FQHC) submitting a prior authorization for dental services, will submit using the 'Dental' prior authorization type. However, since tooth number, oral cavity, and tooth surface details are not able to be entered under the 'Professional' claim form, information regarding the tooth procedures will need to be listed as notes under the 'Service Details' panel. A note will also need to be listed under the 'Provider Notes' section, indicating that the Dental PA submission is for an FQHC.

2. The processes outlined in this document are not applicable to prior authorizations for MyCare Ohio or Single Pharmacy Benefit Managed (SPBM).

3. For a Provider Agent user to submit prior authorizations, the role/action *"Prior Authorization Submission"* must be assigned to the Agent by the Provider Administrator for the Medicaid ID under which the PAs are submitted.

4. For a Provider Agent user to search for prior authorizations, the role/action *"Prior Authorization Search"* must be assigned to the Agent by the Provider Administrator for the Medicaid ID under which the PAs were submitted.

5. If providers request a prior authorization for procedure code *T1033*, the prior authorization request will be denied.

6. A prior authorization may be requested for procedure code *T1032* when the maximum units of 48 have been billed direct and/or exceeded. See OAC (Doula Services) 5160-8-43.

7. Decimals are not allowed on prior authorization submissions. Be sure when entering codes (ex. diagnosis codes) that they are entered without decimals.

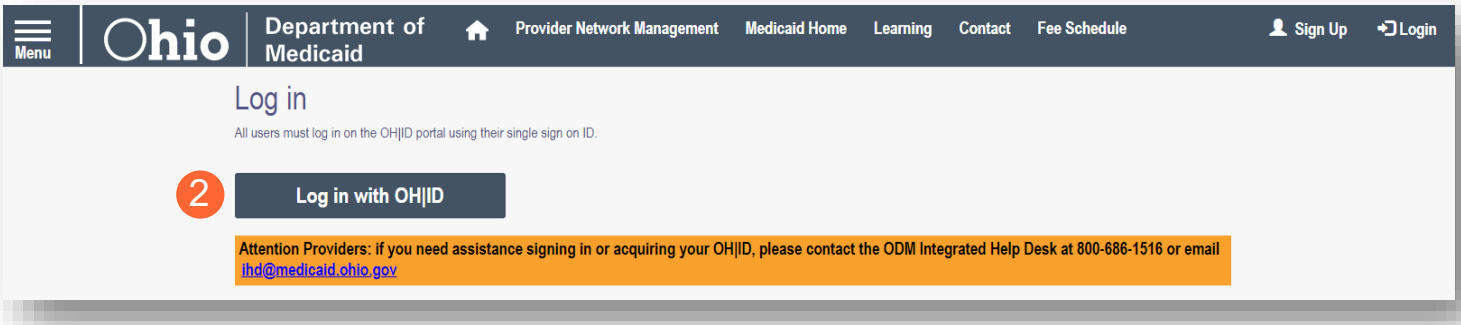
Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

# Provider User Initial Login

In this section of the user guide we will review the initial steps of logging into PNM. All users will log into the PNM system by using IOP (Innovate Ohio Platform).

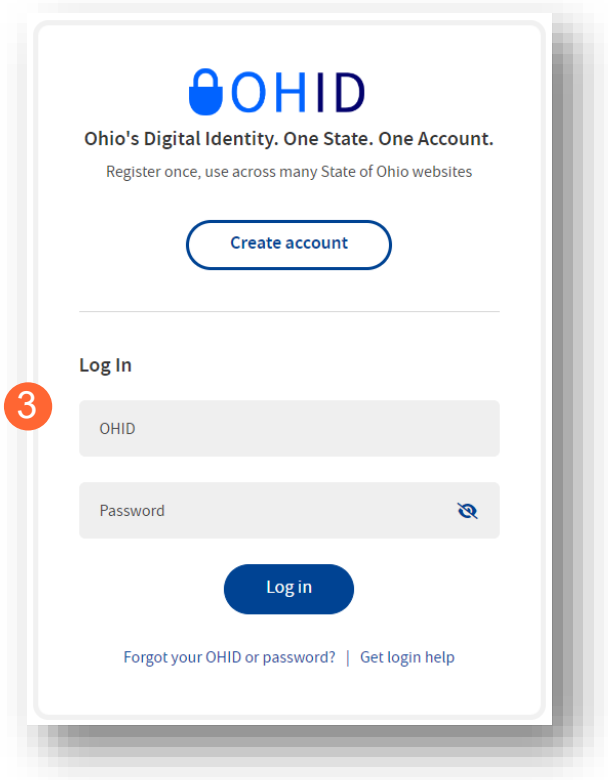
**Step 1**: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx.

**Step 2:** Click **Log in with OH|ID**.

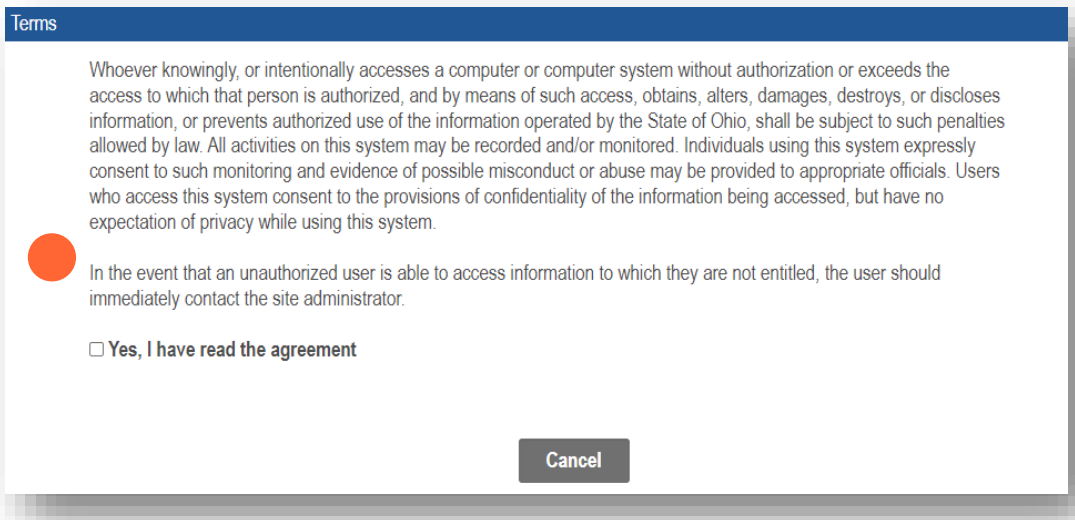



**Step 3:** The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

- If you have not created an IOP account previously, you can click **Create Account** and follow the steps to create a new account.



**Step 4:** You will be redirected to the PNM system. Read the Terms of Use and click "Yes, I have read the agreement" to proceed into PNM.




## Provider Home Page

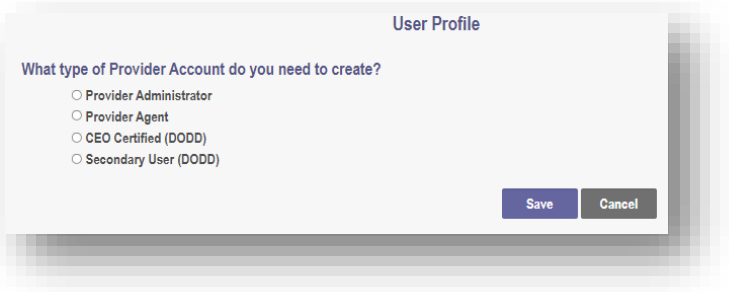
There are two provider roles in PNM:

- **Provider Administrator:** *(Also known as CEO Certified for DODD)* A role assigned to a user in PNM that allows that user to create new enrollment applications, update provider records, and complete revalidations among other tasks. The Administrator role will also be able to grant accesses/actions to other users in PNM, known as Agents.

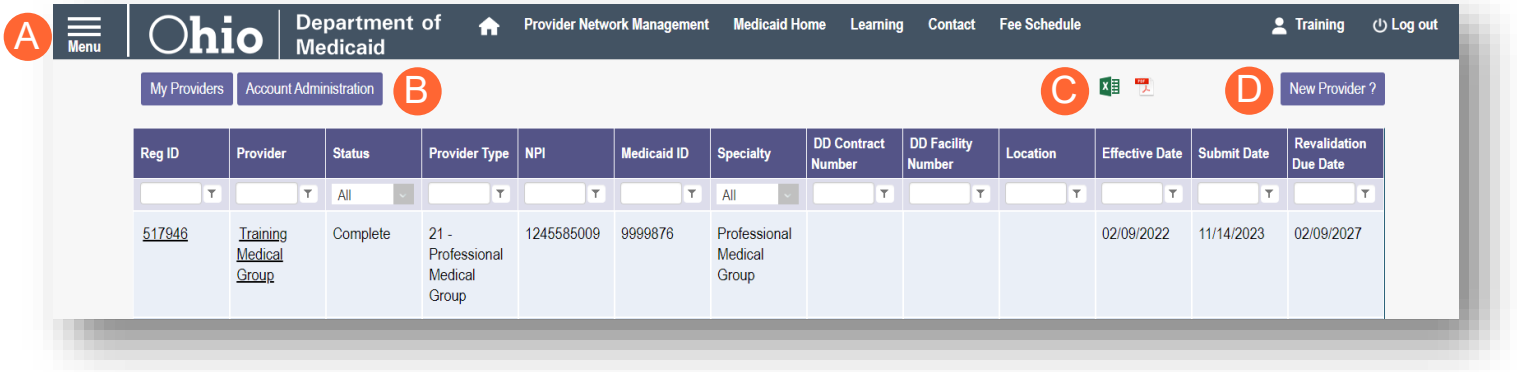
    - There is one Administrator role per NPI/Medicaid ID. However, a single user with the Administrator role can administer to multiple providers (NPIs/Medicaid IDs).

- **Provider Agent:** *(Also known as Secondary User for DODD)* A role assigned to a user in PNM that allows that user to complete specific actions such as updating a provider record, revalidation, claims submission, prior authorization, the viewing of reports, etc. These actions are assigned to each Agent by the Administrator for the Medicaid ID.

*A user must select a role the first time they log into PNM.*



When first logging in to the PNM system there are a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.




**Menu**: The menu can be accessed by clicking on the three bars in the top left corner of the screen. The Menu provides a variety of key topics to choose from such as the Provider Directory, Learning Resources, and Contact Us (A).

**Account Administration:** This button allows a Provider Administrator to set up Agent users, assign them actions/roles, or transfer the Provider to another Provider Administrator user *(button only displays for users holding the Provider Administrator or CEO Certified role)* (B).

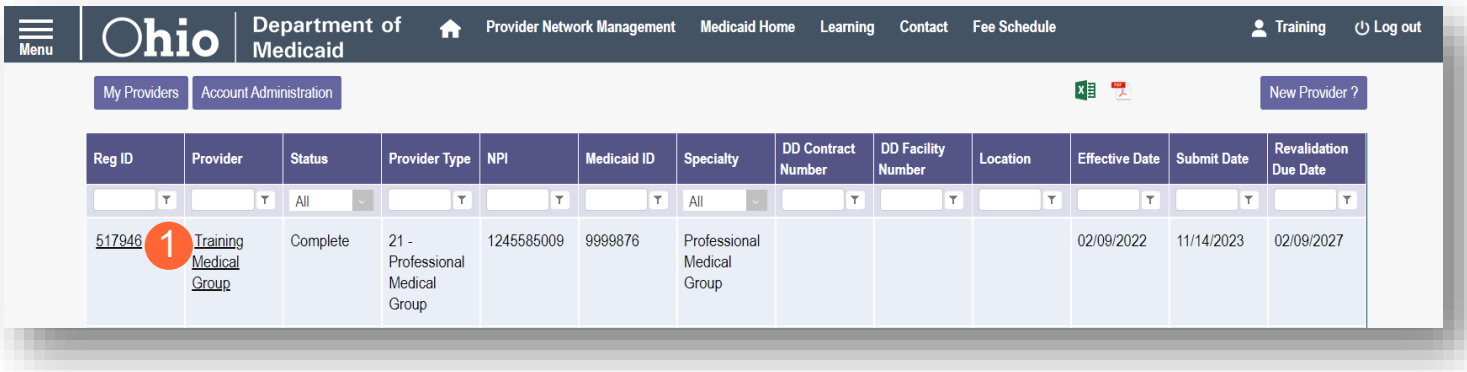
**Excel and PDF Icons:** These buttons allow you to export the list of providers appearing on your dashboard. Click the 'green' icon to export the list in an Excel format or the 'red' icon to export the list in a PDF format (C).

**New Provider?:** This button is used to start a New Enrollment Application (first time enrolling with ODM, ODA, or DODD) for any new Ohio Medicaid provider that you will be responsible for administering *(button only displays for users holding the Provider Administrator or CEO Certified role)* (D).

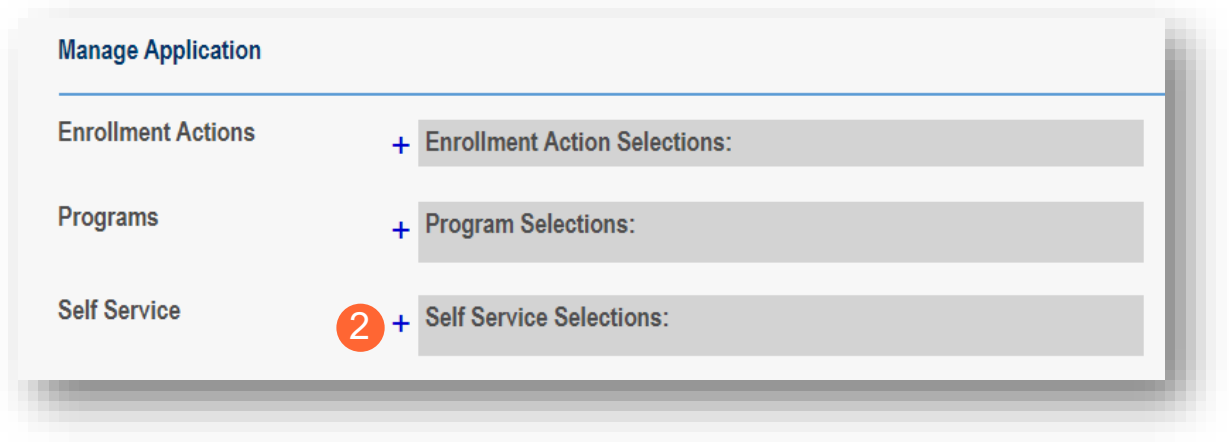
## Accessing the Provider Self Service Panel

This section displays the necessary steps for accessing the Self Service functionalities for a provider file.

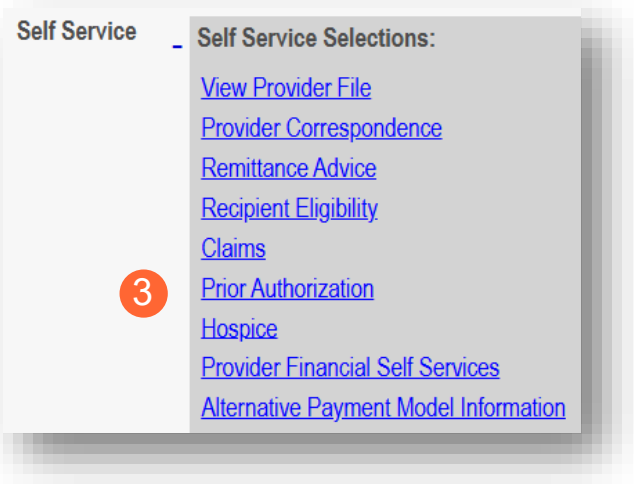
**Step 1:** From the Provider Homepage/Dashboard, click the hyperlink under Reg ID or Provider to manage the file of the Provider you wish to access.



**Step 2:** Under the Manage Application section, click the '+' icon to expand the Self Service Selections.




**Step 3:** Click the hyperlink for "Prior Authorization."




## Search for an Existing Prior Authorization

**IMPORTANT: To perform a search and inquire/view a submitted Prior Authorization, a user is required to be logged into PNM with access to the Requesting Provider (the user is the Provider Administrator or Provider Agent for the Medicaid ID under which the Prior Authorization was submitted).**

**A Requesting Provider is the provider who submitted the Prior Authorization and may, or may not, be the Servicing/Rendering Provider.**

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 1:** Enter search criteria in the boxes provided.

Note: Newly submitted prior authorizations may take up to 30 minutes to display in a search inquiry.

- The 'Payer Name' is a required field. Options to select include:
  - 

- Enter the Payer Name, along with any of the other fields. Some examples are below:
  - Payer Name, Prior Authorization Number
  - Payer Name, Medicaid Billing Number, Status
  - Payer Name, Patient Tracking Number
  - Payer Name, Medicaid Billing Number, Submission Date

- If using a Medicaid Billing Number in the search, the full 12-digit number needs to be entered.

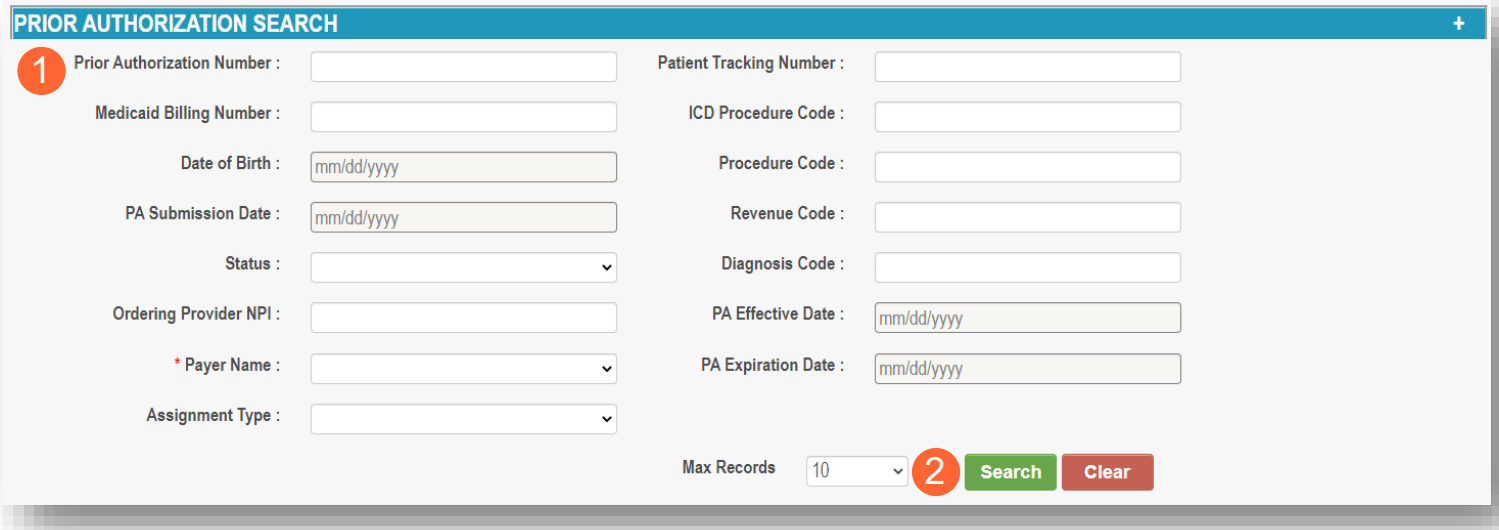
- If selecting a Status, the following options display:
  - Approved
  - Closed
  - Denied
  - InProcess
  - Partially Approved
  - Pend
  - Pending Additional Info
  - Saved
  - Status of "Saved", Patient Tracking Number, Payer Name

Note: Saved, unsubmitted, prior authorizations can also be searched for by entering the below minimum search criteria. Updates/changes can be made to previously saved records.

- If selecting an Assignment Type, the following options display:
  - 01-Compression Garments
  - 02-Decubitus Care Equipment
  - 03-Dental
  - 04-Dressings, Surgical
  - 05-Enteral Nutrition and Supplies
  - 06-Hearing Aids
  - 07-Hospital Beds
  - 08-Incontinence Supplies
  - 09-Miscellaneous Equipment
  - 10-Orthotics (MTA)
  - 11-Orthotics/Prosthetics (Nurses)
  - 12-Repairs
  - 13-Respiratory (MTA)
  - 14-Respiratory (Nurses)
  - 15-Speech Generating Devices
  - 16-Supplies (Miscellaneous)
  - 17-Therapies
  - 18-Vision
  - 19-Wheelchairs
  - 20-Orthodontics
  - 21-Transportation
  - 23-PDN
  - 34-Hospital Inpatient
  - 35-Hospital Outpatient
  - 37-Psychiatric Inpatient
  - 38-Increase State Plan Home Health
  - 39-Physician Services
  - 40-Medicaid School Program
  - 43-Medical Nutrition Therapy
  - 44-Chiropractic / Acupuncture
  - 45-Psychotherapy
  - 46-Applied Behavioral Analysis
  - 47-ACT Enrollment
  - 48-IHBT Enrollment
  - 49-Medical Services
  - 50-SUD Partial Hosp Services
  - 52-Services for ACT Enrollees
  - 53-SUD Residential Services
  - 54-Mental Health Services
  - 55-Hospital OP-Behavioral Health
  - 56-Services for IHBT Enrollees
  - 57-ASC
  - 58-Laboratory Services
  - 59-Hospital High-Cost Carve-Out
  - 60-Non-Institution High-Cost Drugs

**Step 2:** After criteria is entered, click **Search**.

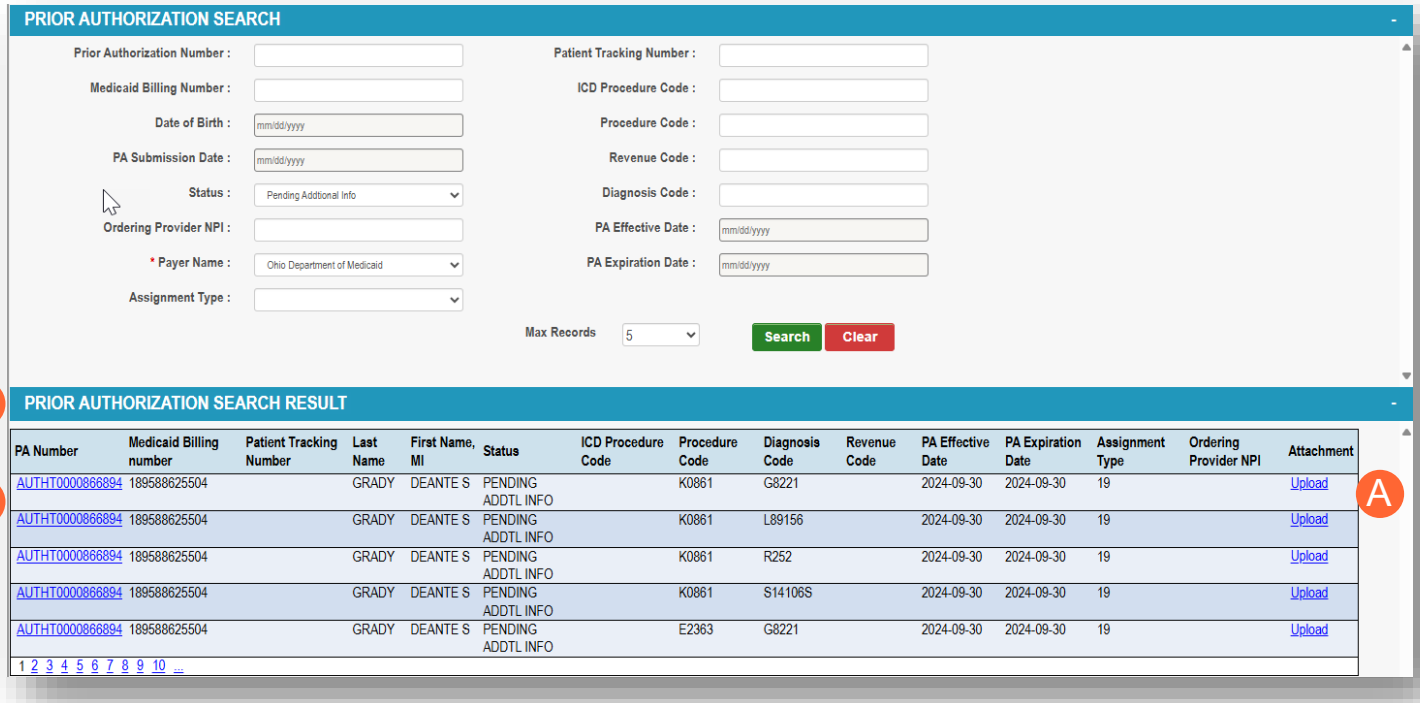
Note: You can adjust the Max Records for the search to up to 100.




**Step 3:** Search results will display at the bottom of the page. If multiple pages of search results display, click on the page numbers at the bottom of the page to view its corresponding page.

Note: For prior authorization search results in **Pending Additional Info status**, the Attachments column appears with an 'Upload' hyperlink. Attachments can be uploaded to using the '**Upload**' hyperlink **(A)**. This process is explained on page 42 in the Attachments section.

**Step 4:** Identify a specific prior authorization then, click on its corresponding PA Number hyperlink or Patient Tracking Number hyperlink.

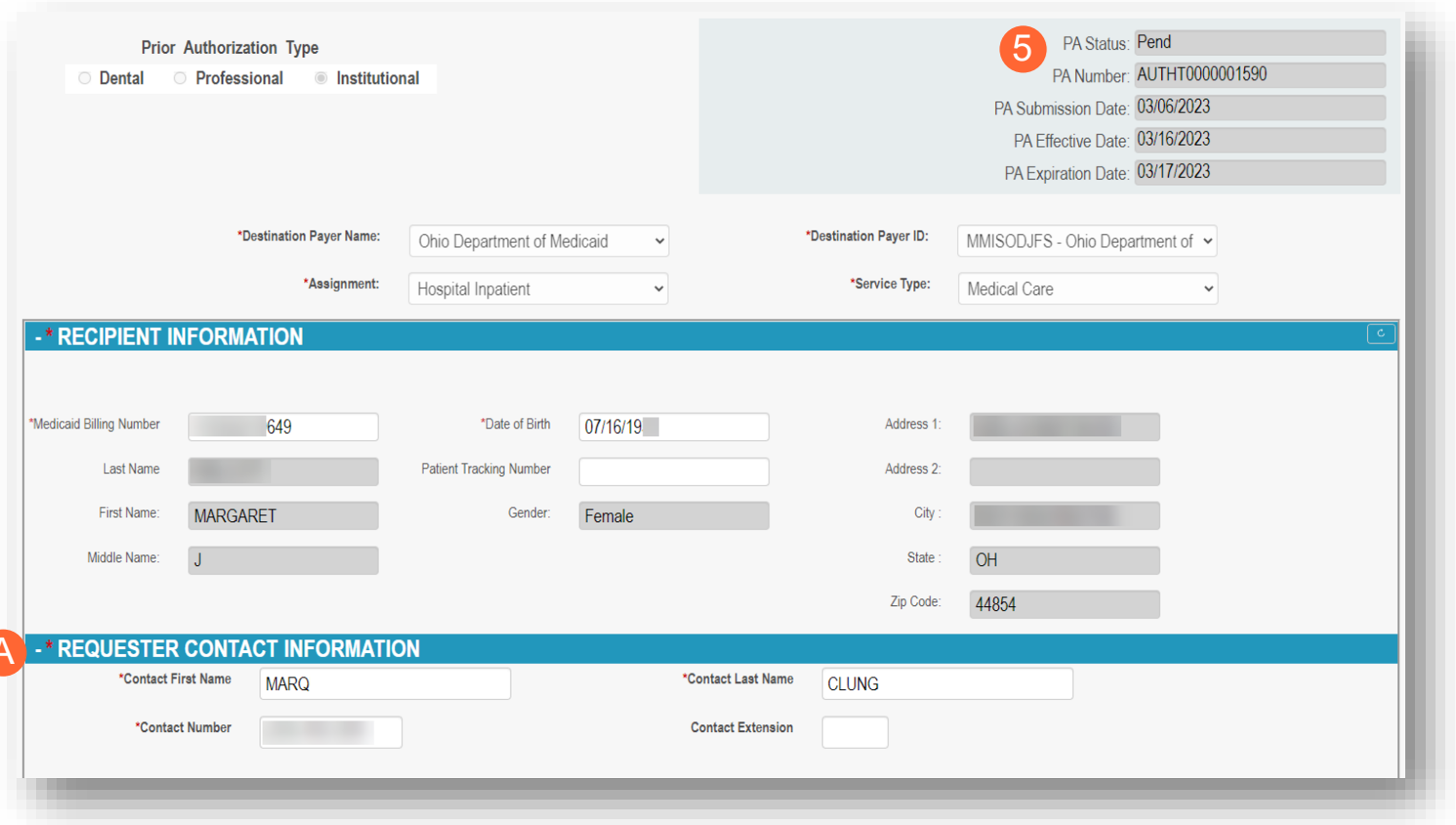


Note: To clear search data and begin a new search, click the red **Clear** button.

Note: On the PA search, a user may see multiple search results with the same AUTH number. This is based on diagnosis codes. For example, if a PA is submitted with 5 diagnosis codes, 5 search results under the same AUTH number will display. (If a PA is submitted with 3 diagnosis codes and each of those have 3 different ICD 10 codes, you will see 9 search results under the same AUTH number). It doesn't matter which search result line/link is chosen to view; it will display the same AUTH information.

**Step 5:** Review the returned information in the boxes on the top-right of the page.

- Click the '+' icon to expand any section to view returned data in any of the sections **(A)**.




## Status Definitions

A summary of prior authorization statuses and their definitions.

- **Approved** – This status displays when all service lines have received a status of Approved.
- **Closed** – This status displays when a PA submission has been cancelled.
- **Denied** – This status displays when all services lines have received a status of Denied.
- **InProcess** – This status displays for a submitted PA.
- **Pending Additional Info –** This status indicates that a PA is submitted, and the PA reviewer/approver is seeking additional information. The ability to upload additional documentation is provided in this status.

- **Partially Approved** – This status indicates at least one service line has received a status of Approved, Denied, or Closed.
- **Pend** – This status indicates that the PA submitted is awaiting additional review.
- **Saved** – This is the status of a prior authorization that was started but saved and not submitted.

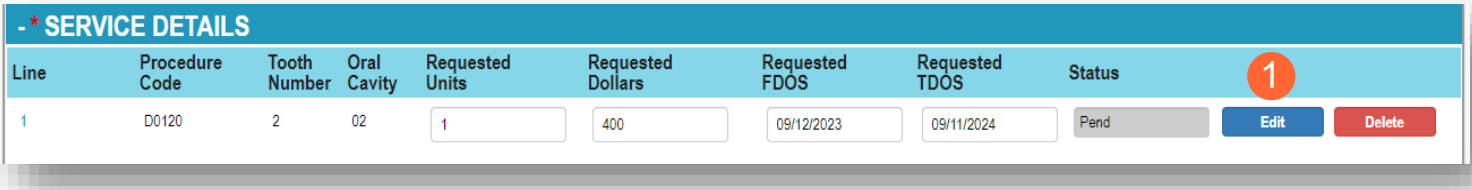
## Editing Service Line Details

*Service lines details can be edited when the PA Status is "Pend" or "InProcess."*

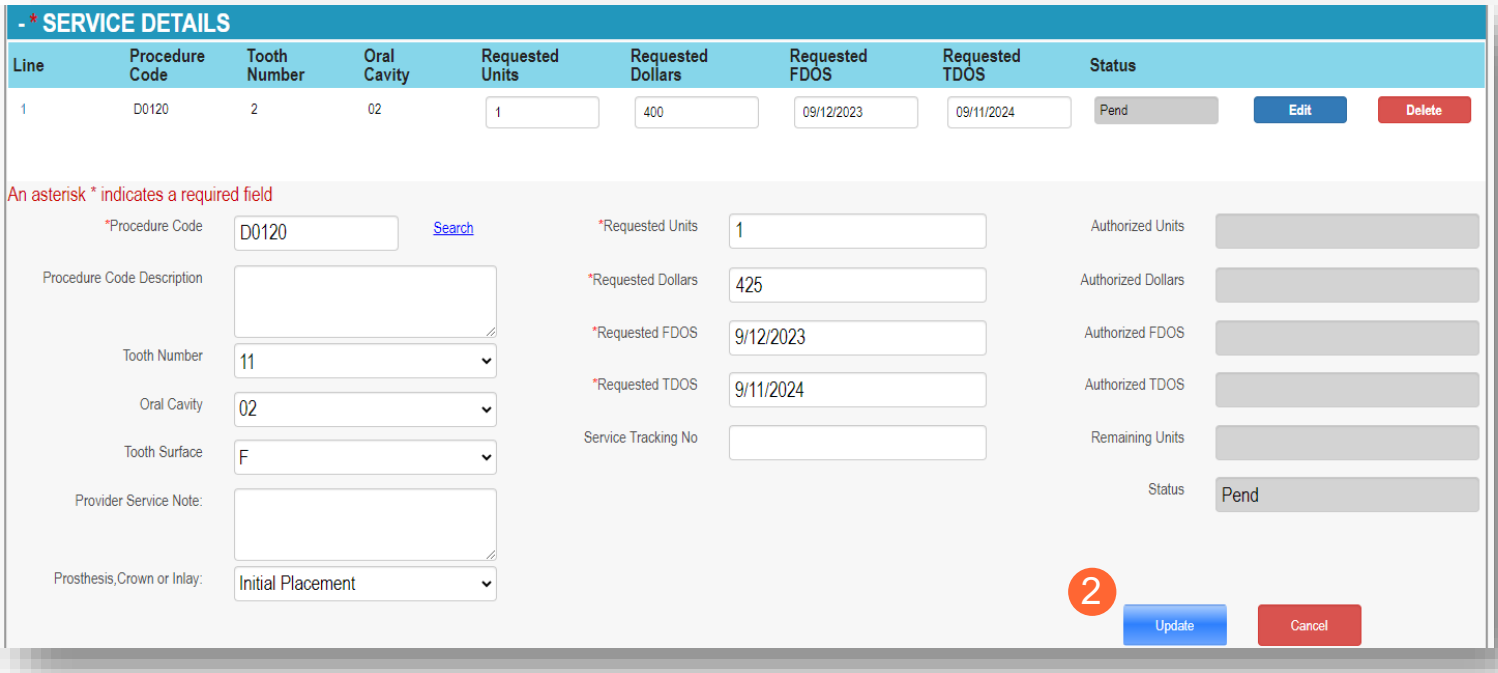
Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 1:** Click **Edit** to edit any service line details.

Note: If there are multiple service lines listed under the Service Details panel, the 'Edit' and 'Delete' buttons will appear next to each line.

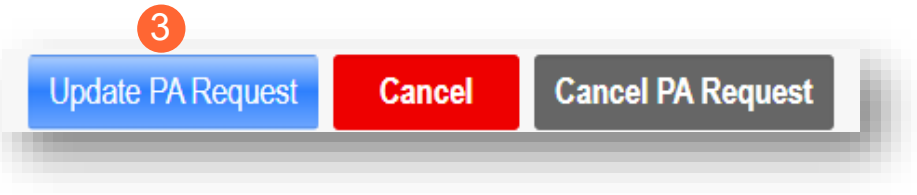



**Step 2:** After making the edits to the service details, click **Update**.



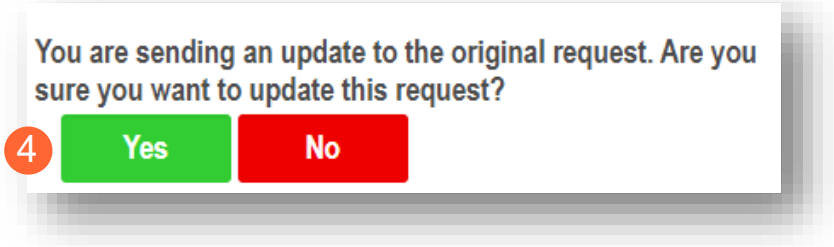
Note: If updates are made, the status of the prior authorization will update from 'Pend' to 'Submission Pending.'

**Step 3:** Once all updates have been made, click **Update PA Request** at the bottom of the page.




**Step 4:** A pop-up window displays confirming updates are made to the prior authorization.

- To proceed with the updated prior authorization, click **Yes**.
- To cancel to update to the prior authorization, click **No**.

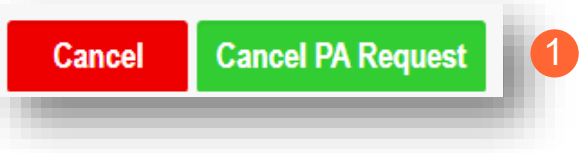




## Cancelling a Prior Authorization

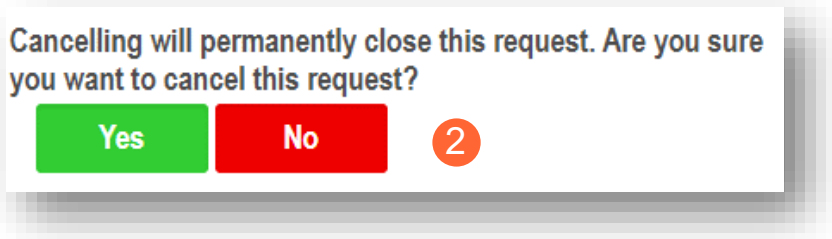
*A prior authorization can be cancelled if the PA Status is "Pend" or "InProcess."*

**Step 1:** After searching for and accessing the prior authorization, scroll to the bottom of the page and click **Cancel PA Request**.




**Step 2:** A pop-up window displays confirming the cancellation of the prior authorization.

- To proceed with the cancellation, click **Yes**.
- To keep the prior authorization request open, click **No**.



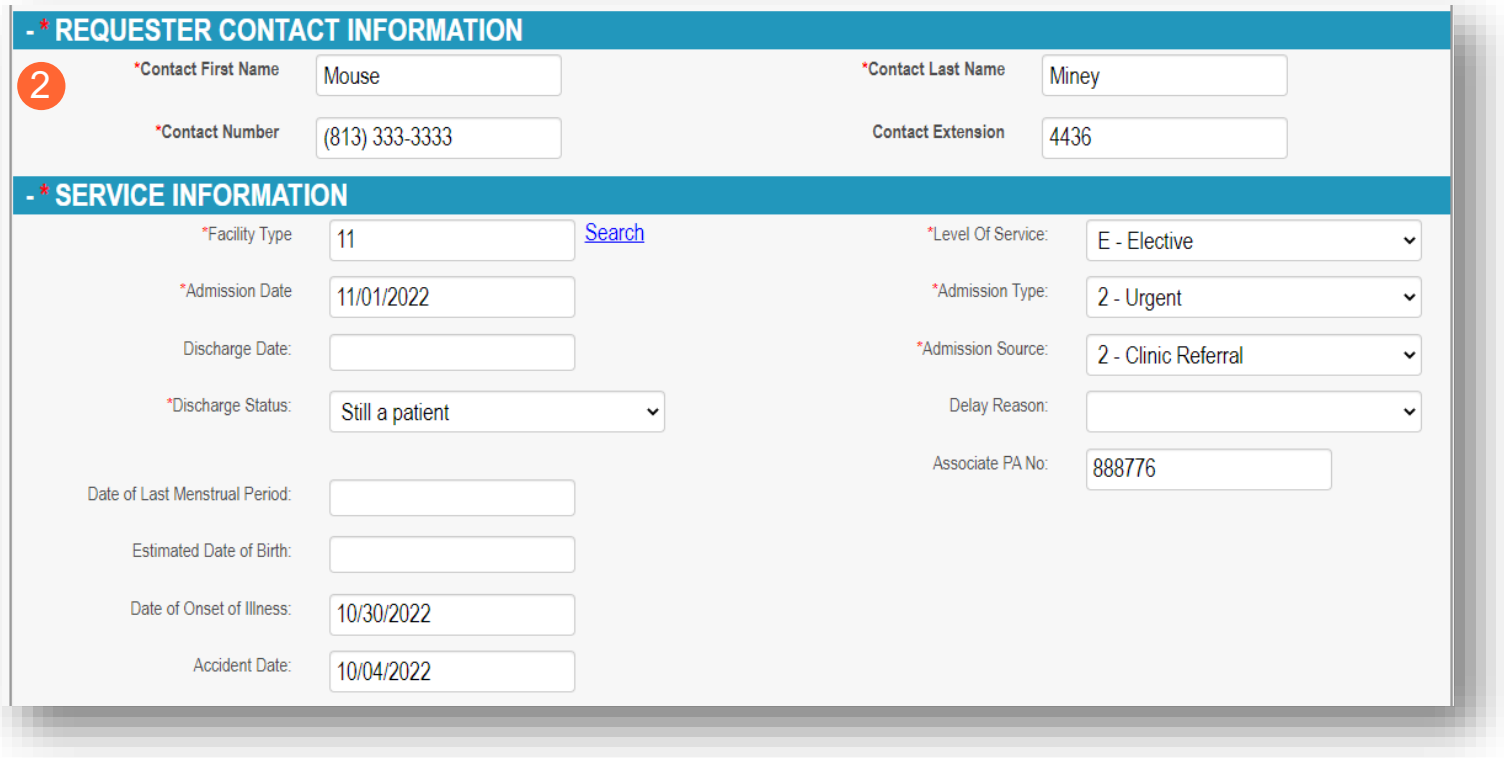
# Copying a Prior Authorization

*A prior authorization with the PA Status of "Approved" can be copied.*

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

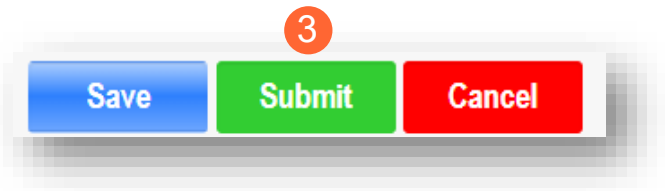
**Step 1:** After searching for and accessing the prior authorization, scroll to the bottom of the page and click **Copy**.


**Step 2:** All fields on the prior authorization page become editable. Make any changes to the data as necessary.




**Step 3:** When all data has been entered for the prior authorization, click **Submit** at the bottom of the page.

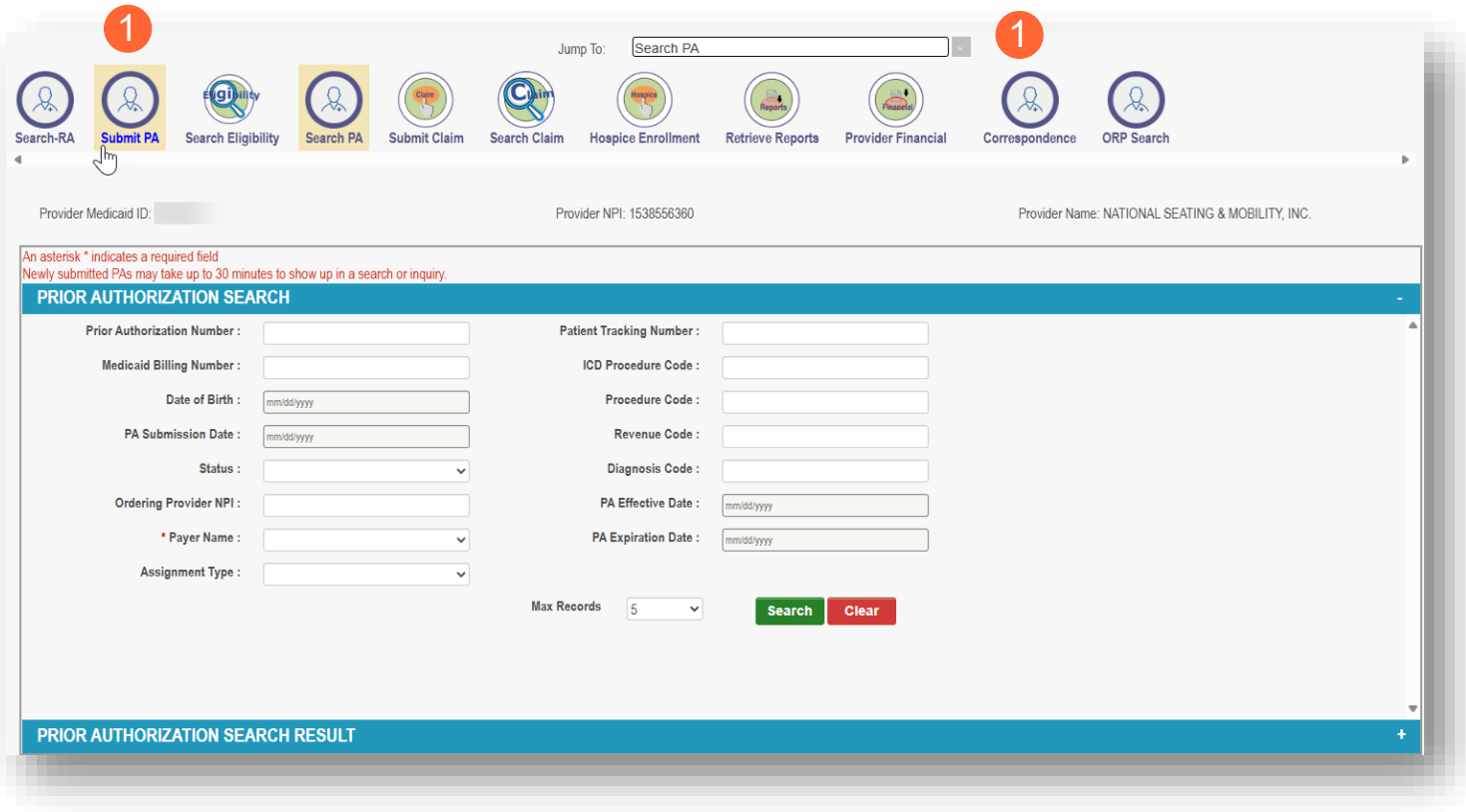
Note: If you are not prepared to submit the prior authorization, you can click **Save** and the prior authorization submission will be saved in the PNM system for up to 72 hours for future retrieval.



# Submit a New Prior Authorization

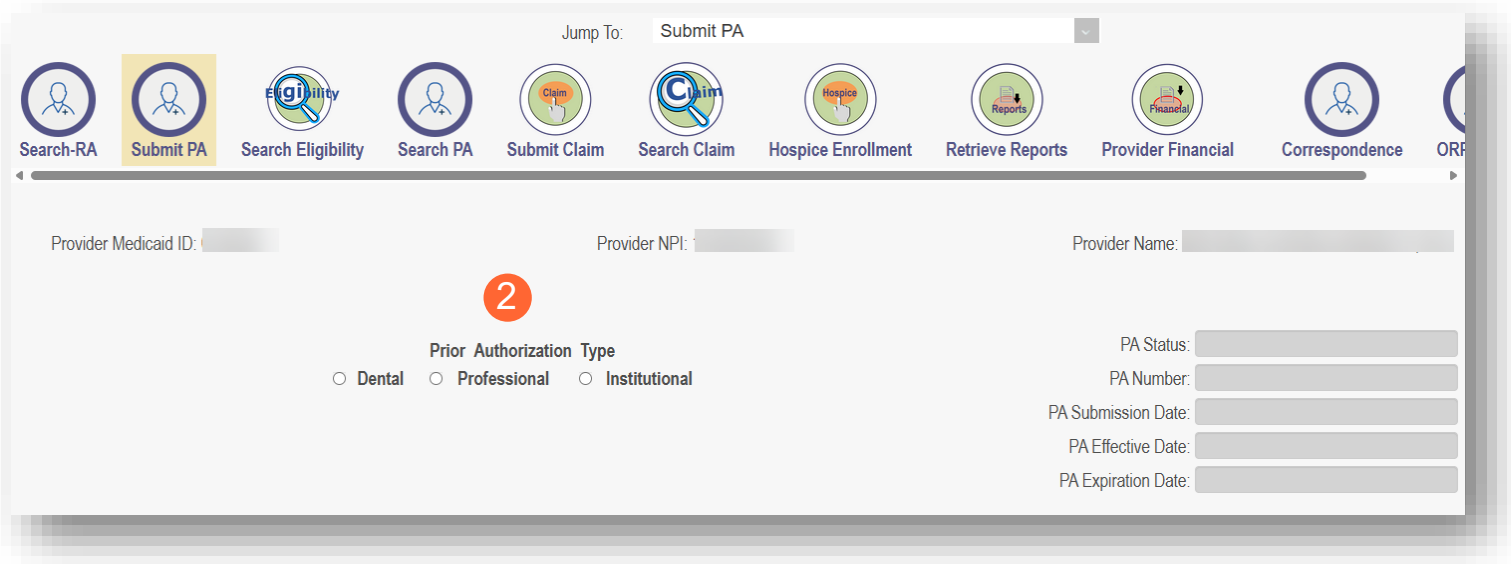
Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 1:** To submit a prior authorization, click the 'Submit PA' icon at the top of the page or select "Submit PA" from the drop-down menu.



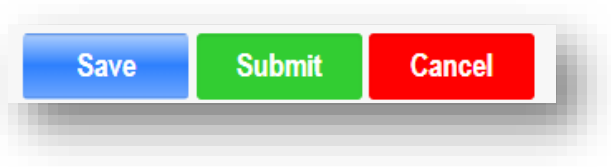
**Step 2:** Select the Prior Authorization Type you are submitting by choosing the appropriate radio button:

- Dental
- Professional
- Institutional




Note: If you select the incorrect prior authorization type, click **Cancel** at the bottom of the page. This will reset the prior authorization submission page and allow for the correct type to be selected

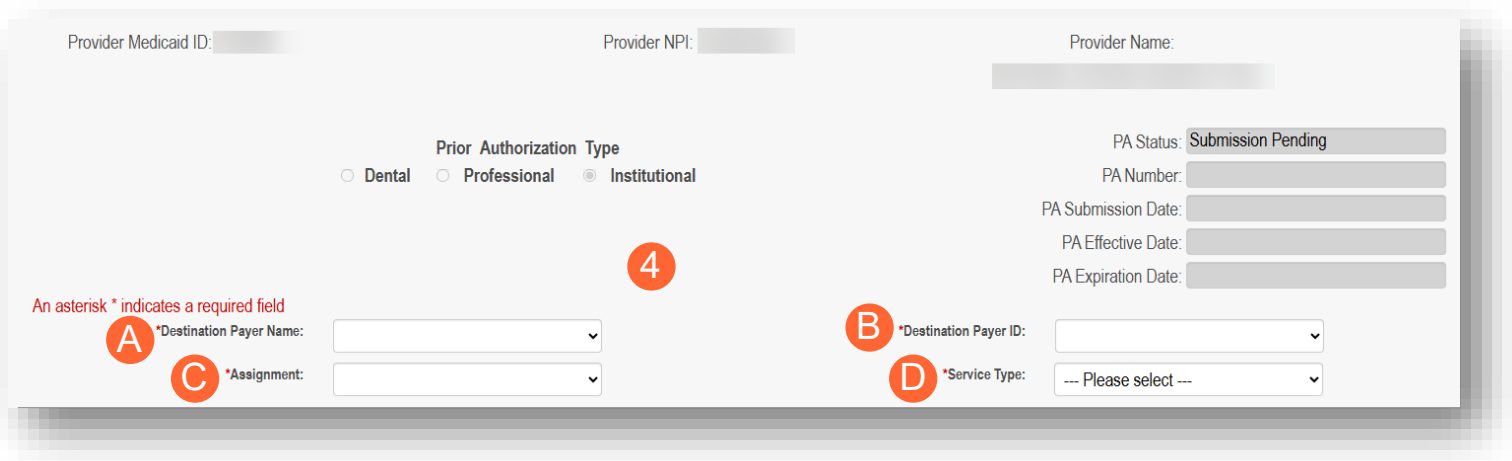
Note: The Save, Submit, and Cancel buttons below appear at the bottom of the prior authorization submission page.




- **Save**: Saves the prior authorization form and data entered
  - Prior authorizations that are in 'Saved' status have not been submitted to the payer and are able to be saved in the PNM system for up to 72 hours for future retrieval.
  - To search for a 'saved' prior authorization, complete the steps under the Search an Existing Prior Authorization section.
- **Submit**: Sends the prior authorization for review.
- **Cancel**: Cancels the prior authorization and erases data entered.

**Step 3:** After selecting a Prior Authorization Type, additional options will appear below.

Note: The same Destination Payer options will appear regardless of what type of Prior Authorization Type is selected.



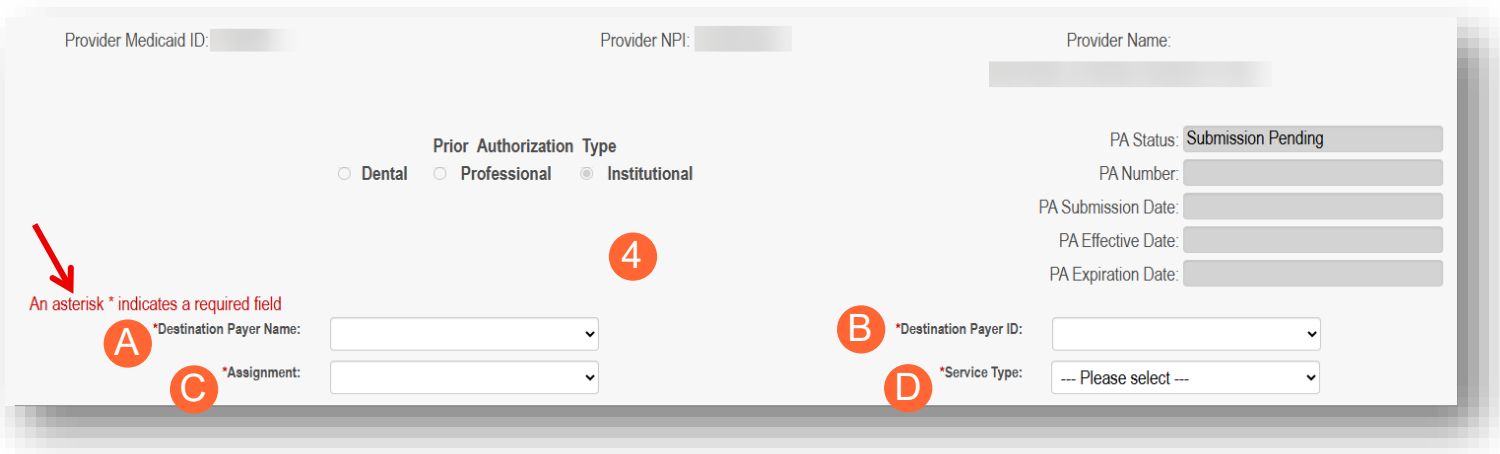

**Step 4:** Select the following from the provided drop-down menus:

- Destination Payer Name **(A)**
  - Ohio Department of Medicaid
- Destination Payer ID **(B)** *(options dependent on what is selected for Destination Payer Name)*
  - *When selecting Ohio Department of Medicaid*
    - MMISODJFS - Ohio Department of Medicaid
- Assignment **(C)**
  - The Assignment options that appear are dependent upon the Prior Authorization Type selected. **Dental (D)**, Professional (P), *Institutional (I)*
  - 01 – Compression Garments (P)
  - 02 – Decubitus Care Equipment (P)
  - **03 – Dental (D)**
  - 04 – Dressings, Surgical (P)
  - 05 – Enteral Nutrition and Supplies (P)
  - 06 – Hearing Aids (P)
  - 07 – Hospital Beds (P)
  - 08 – Incontinence Supplies (P)
  - 09 – Miscellaneous Equipment (P)
  - 10 – Orthotics (MTA) (P)
  - 11 – Orthotics/Prosthetics (Nurses) (P)
  - 12 – Repairs (P)
  - 13 – Respiratory (MTA) (P)
  - 14 – Respiratory (Nurses) (P)
  - 15 – Speech Generating Devices (P)
  - 16 – Supplies (Miscellaneous) (P)
  - 17 – Therapies (P)
  - 18 – Vision (P)
  - 19 – Wheelchairs (P)
  - **20 – Orthodontics (D)**
  - 21 – Transportation (P)
  - 23 – PDN (P)
  - *34 – Hospital Inpatient (I)*
  - *35 – Hospital Outpatient (I)*

- *37 – Psychiatric Inpatient (I)*
- 38 – Increase State Plan Home Health (P)
- 39 – Physician Services (P)
- 40 – Medicaid School Program (P)
- 43 – Medical Nutrition Therapy (P)
- 44 – Chiropractic / Acupuncture (P)
- 45 – Psychotherapy (P)
- 46 – Applied Behavioral Analysis (P)
- 47 – ACT Enrollment (P)
- 48 – IHBT Enrollment (P)
- 49 – Medical Services (P)
- 50 – SUD Partial Hosp Services (P)
- 52 – Services for ACT Enrollees (P)
- 53 – SUD Residential Services (P)
- 54 – Mental Health Services (P)
- *55 – Hospital OP-Behavioral Health (I)*
- 56 – Services for IHBT Enrollees (P)
- 57 – ASC (P)
- 58 – Laboratory Services (P)
- *59 – Hospital High-Cost Carve-Out (I)*
- 60 – Non-Institution High-Cost Drugs (P)

- Service Type **(D)**
  - Select the type of service being requested.
  - Selections populated from the EDI 278 Service Type Code List

Note: A red asterisk (*) anywhere on the page (in a section header/title or next to a field) indicates that field or panel is required to be completed. If required fields are not completed, PNM will display error messages in red text.

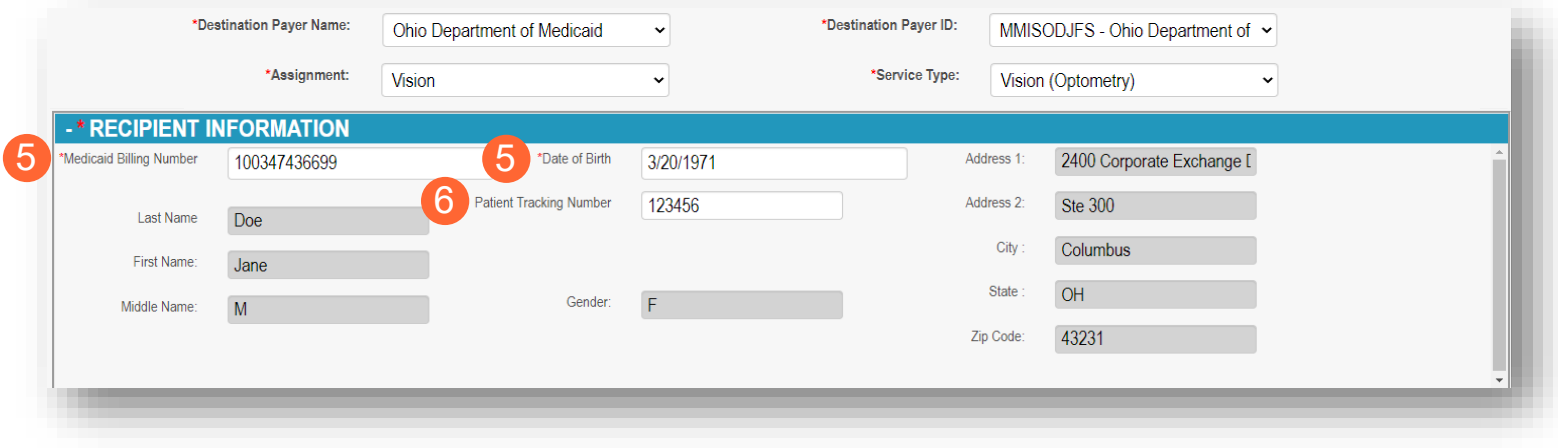


# Recipient Information

**Step 5:** Enter the Medicaid Billing Number and Date of Birth for the recipient.

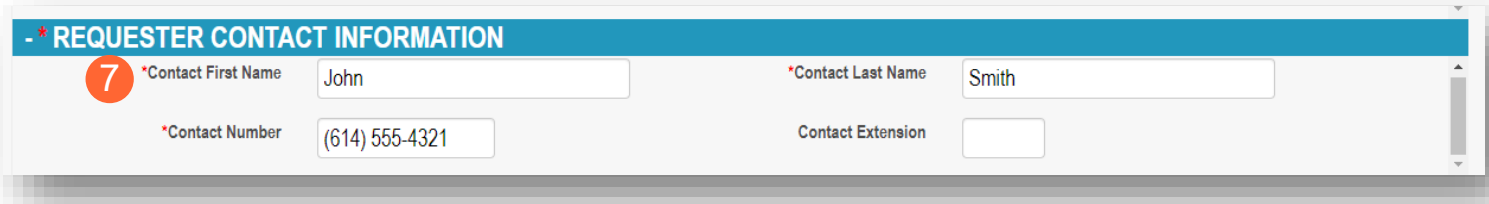
**Step 6:** Create a unique patient tracking number for the recipient to use when reconciling the prior authorization (this is not a required field and is used for any internal tracking number you have for the recipient).

> Note: The information appearing in gray boxes populates after a Medicaid Billing Number and Date of Birth have been entered for the recipient. This information is read-only data and cannot be changed.




# Requester Contact Information

**Step 7:** Enter contact information for the requester. This is the person the Destination Payer will contact if there are any questions regarding the prior authorization. First Name, Last Name, and Contact [Phone] Number are required.




# Service Information

The Service Information section has some minor differences between the Prior Authorization Types (Dental, Professional, Institutional).

The section for Dental and Professional is titled 'Non-Institutional': Jump to Non-Institutional Claim Service for Step 8

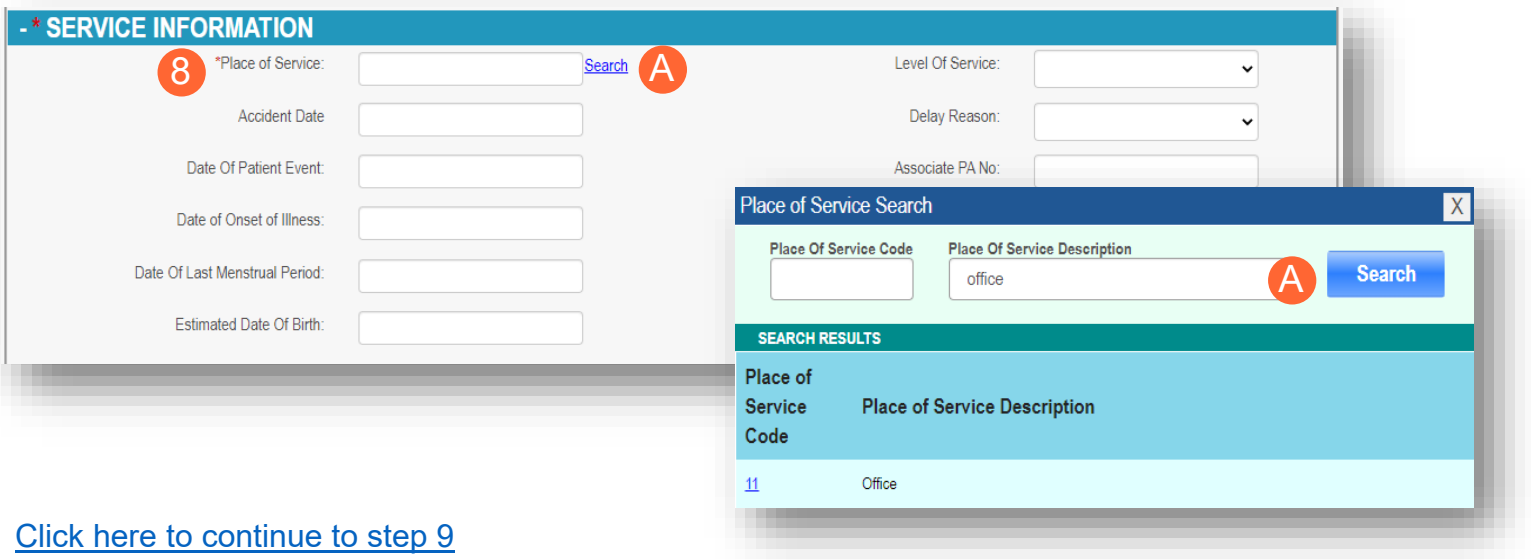
The Institutional Claim service information is outlined within its own section in this document: Jump to Institutional Claim Service for Step 8

## Non-Institutional

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 8:** Enter information related to the service.

- Place of Service is the only required field in this section.
  - If you don't know the place of service, click the 'Search' hyperlink to bring up a search panel to locate the Service Code. Enter a Place of Service Description and click **Search** **(A).** Once the Place of Service code is located, click the code hyperlink.
- Accident Date
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Patient Event
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Onset of Illness
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Date of Last Menstrual Period
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Estimated Date of Birth
  - If entered, date must be in MM/DD/YYYY format.
- Level of Service
  - E – Elective
  - U – Urgent
- Delay Reason
  - 1 – Proof of Eligibility Unknown or Unavailable
  - 2 – Litigation
  - 3 – Authorization Delays
  - 4 – Delay in Certifying Provider
  - 7 – Third Party Processing Delay
  - 8 – Delay in Eligibility Determination
  - 10 – Administration Delay in the Prior Approval Process
  - 11 – Other
  - 15 – Natural Disaster
  - 16 – Lack of Information
  - 17 – No Response to Initial Request
- Associate PA Number
  - A prior authorization number assigned by the payer that is related to this request.
  - This field can be used during a Continued Stay Review to indicate the associated PA.

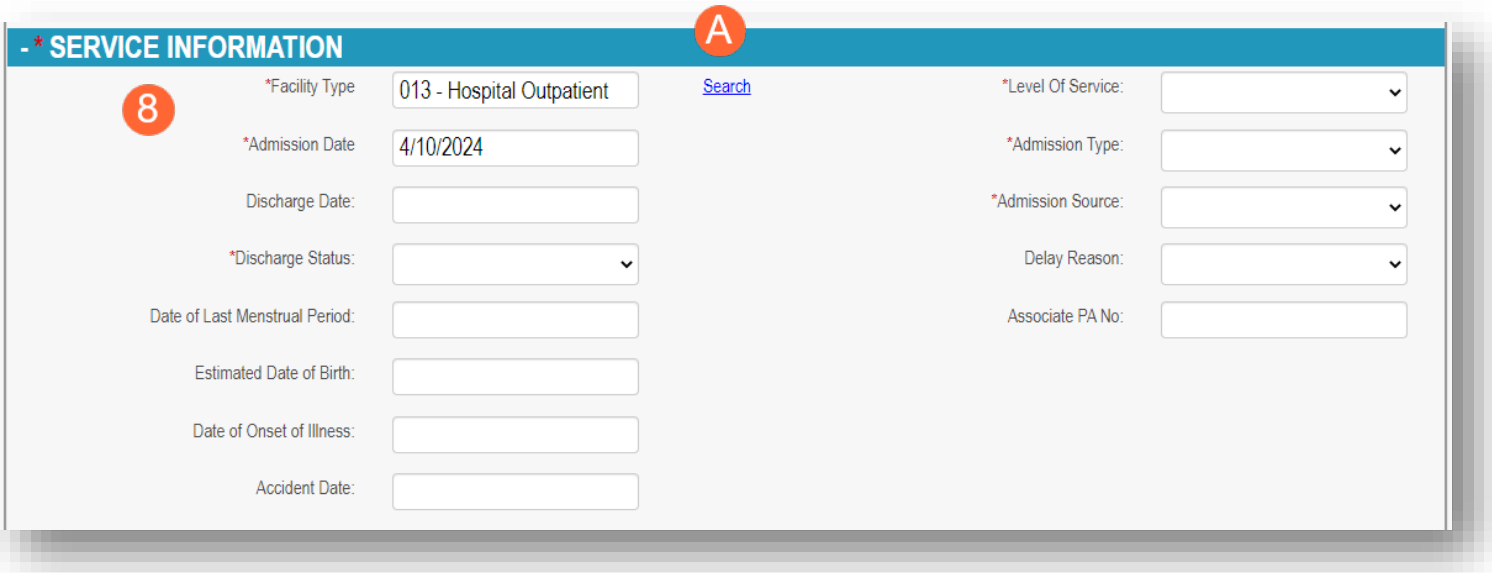



Click here to continue to step 9

## Institutional

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 8:** Enter information related to the service.




- Facility Type *(required)*

  - If you don't know the place of service, click the 'Search' hyperlink to bring up a search panel to locate the Service Code. Enter a Place of Service Description and click **Search** (A). Once the Facility Type code is located, click the code hyperlink.
- Admission Date *(required)*
  - Date of anticipated admission for the recipient
  - Date must be in MM/DD/YYYY format
- Discharge Date
  - If entered, date must be in MM/DD/YYYY
- Discharge Status
  - 1 – Discharged to Home or Self Care (Routine Discharge)
  - 2 – Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
  - 3 – Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
  - 4 – Discharged/Transferred to a Facility That Provides Custodial or Supportive Care
  - 5 – Discharged/Transferred to a Designated Cancer Center or Children's Hospital
  - 6 – Discharged/Transferred to Home under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
  - 7 – Left Against Medical Advice or Discontinued Care
  - 9 – Admitted as an Inpatient to This Hospital
  - 20 – Expired
  - 21 – Discharged/Transferred to Court/Law Enforcement
  - 30 – Still Patient
  - 40 – Expired at Home
  - 41 – Expired in a Medical Facility (E.G. Hospital, SNF, ICF, or Free-Standing Hospice)
  - 42 – Expired - Place Unknown
  - 43 – Discharged/Transferred to a Federal Health Care Facility
  - 50 – Hospice – Home
  - 51 – Hospice - Medical Facility (Certified) Providing Hospice Level of Care
  - 61 – Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
  - 62 – Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
  - 63 – Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
  - 64 – Discharged/Transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare
  - 65 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
  - 66 – Discharged/Transferred to a Critical Access Hospital (CAH)
  - 69 – Discharged/Transferred to a Designated Disaster Alternative Care Site
  - 70 – Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in This Code List
  - 81 – Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
  - 82 – Discharged/Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
  - 83 – Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
  - 84 – Discharged/Transferred to a Facility That Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
  - 85 – Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission

  - 86 – Discharged/Transferred to Home under Care of Organized HH Service Organization in Anticipation of Covered Skilled Care w/ Planned Acute Care Hospital Inpatient Readmission
  - 87 – Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
  - 88 – Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
  - 89 – Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
  - 90 – Discharged/Transferred to Inpatient Rehab Facility (IRF) Include Rehab Distinct Part Units of Hospital W/ Planned Acute Care Hospital Inpatient Readmission
  - 91 – Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
  - 92 – Discharged/Transferred to Nursing Facility Certified under MCAID But not Certified under Medicare W/ Planned Acute Care Hospital Inpatient Readmission
  - 93 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of Hospital W/A Planned Acute Care Hospital Inpatient Readmission
  - 94 – Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
  - 95 – Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in Code List W/ a Planned Acute Care Hospital Inpatient Readmission

- Date of Last Menstrual Period
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Estimated Date of Birth
  - If entered, date must be in MM/DD/YYYY format.
- Date of Onset of Illness
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Accident Date
  - If entered, date must be in MM/DD/YYYY format and future date is not allowed.
- Level of Service
  - E – Elective
  - U – Urgent
- Admission Type
  - 1 – Emergency
  - 2 – Urgent
  - 3 – Elective
  - 4 – Newborn
  - 5 – Trauma
  - 9 – Information Not Available
- Admission Source *(options do not appear unless Admission Type is selected)*
  - 1 – Physician Referral
  - 2 – Clinic Referral
  - 3 – HMO Referral
  - 4 – Transfer from a Hospital
  - 5 – Transfer from a SNF
  - 6 – Transfer from Another Health Care Facility
  - 7 – Emergency Room
  - 8 – Court/Law Enforcement
  - 9 – Information not Available
  - D – Transfer from one Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer

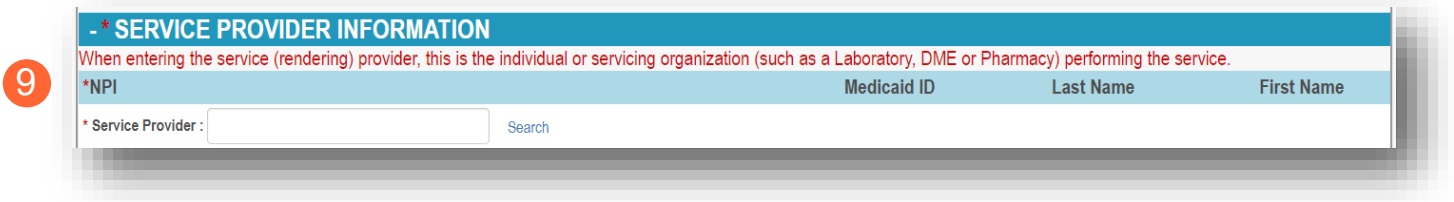
  - E – Transfer from Ambulatory Surgery Center
  - F – Transfer from a Hospice Facility
  - G – Transfer from a Designated Disaster Alternate Care Site

  In the Case of Newborn (Admission type 4), only the below values display for Admission Source:
  - 5 – Born Inside This Hospital
  - 6 – Born Outside of This Hospital
- Delay Reason
  - 1 – Proof of Eligibility Unknown or Unavailable
  - 2 – Litigation
  - 3 – Authorization Delays
  - 4 – Delay in Certifying Provider
  - 7 – Third Party Processing Delay
  - 8 – Delay in Eligibility Determination
  - 10 – Administration Delay in the Prior Approval Process
  - 11 – Other
  - 15 – Natural Disaster
  - 16 – Lack of Information
  - 17 – No Response to Initial Request
- Associate PA Number
  - Previous prior authorization number assigned by the payer that is related to this request.
  - This field can be used in the event of a Continued Stay Review to indicate the associated PA.

## Service Provider Information

**Step 9:** Enter the National Provider Identifier (NPI) for the Service Provider. This is the individual or servicing organization (such as a Laboratory, DME or Pharmacy) performing the service. If you don't know it, you can click 'Search' to search for the Provider by Medicaid ID, Business Name, or First and Last Name. Once the provider is located, click the NPI hyperlink.

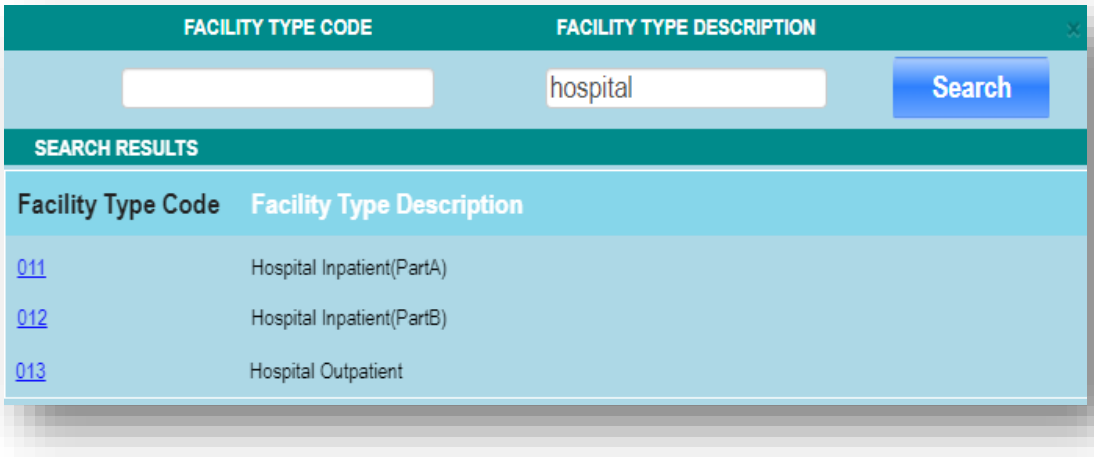
Note: Medicaid ID field will be populated only if NPI is not available.



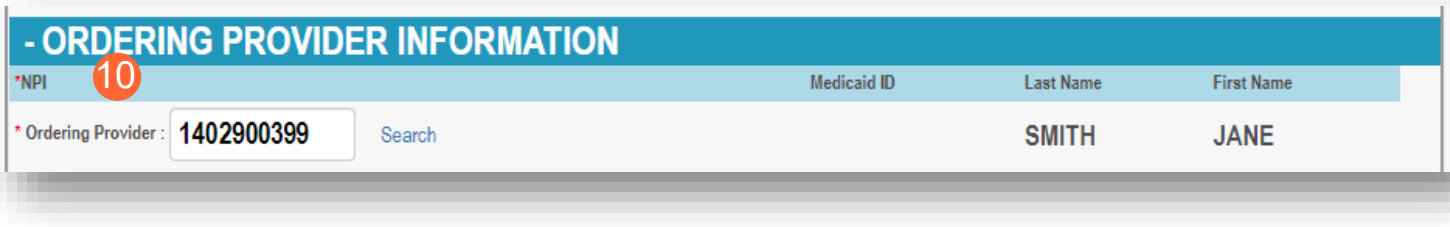

## Ordering Provider Information

Note: This may not be a required section.

'Dressings, Surgical', 'Enteral Nutrition and Supplies', 'Hearing Aids', 'Hospital Beds', 'Incontinence Supplies', 'Miscellaneous Equipment', 'Orthotics (MTA)', 'Orthotics/Prosthetics (Nurses)', 'Repairs', 'Respiratory (MTA)', 'Respiratory (Nurses)', 'Speech Generating Devices', 'Supplies (Miscellaneous)', 'Therapies', 'Wheelchairs', 'PDN', 'Medicaid School Program' or 'Applied Behavioral Analysis.'

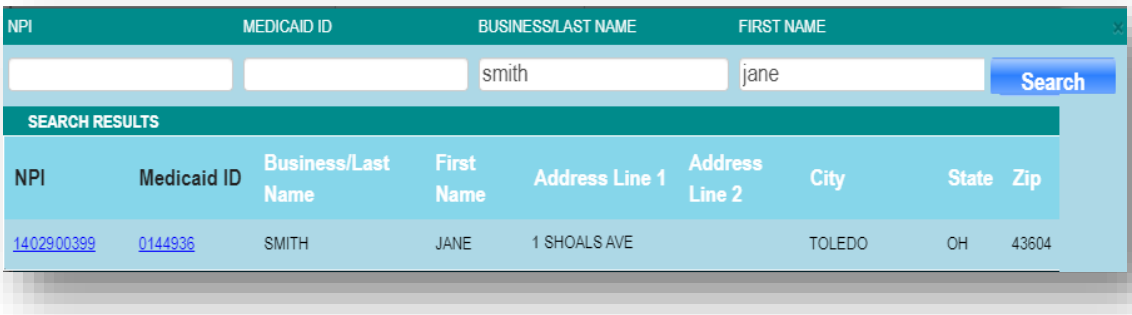



**Step 10:** Enter the NPI for the Ordering Provider if it is different than the provider who is completing the prior authorization information. If the provider completing the information is the same as the ordering provider, the section does not need to be completed.




Enter the National Provider Identifier (NPI) for the Service Provider. If you don't know it, you can click 'Search' to search for the Provider by Medicaid ID, Business Name, or First and Last Name. Once the provider is located, click the NPI hyperlink.

Note: Medicaid ID field will be populated only if NPI is not available.

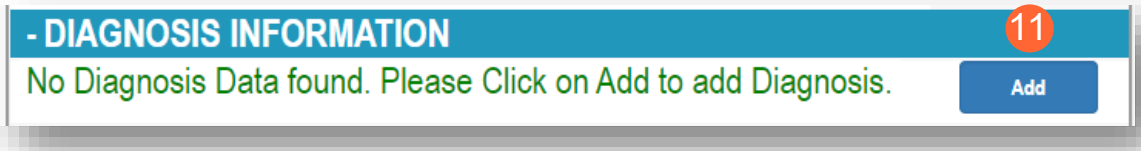


# Diagnosis Information

*Decimals are not allowed on PA submissions. Be sure to enter the diagnosis code without decimals.*

Note: This may not be a required section for the prior authorization being submitted. Diagnosis panel is required when the Assignment *(Step 4 above)* selected is not 'Dental', 'Vision', or 'Orthodontics.'

**Step 11:** Click **Add** to enter diagnosis information.



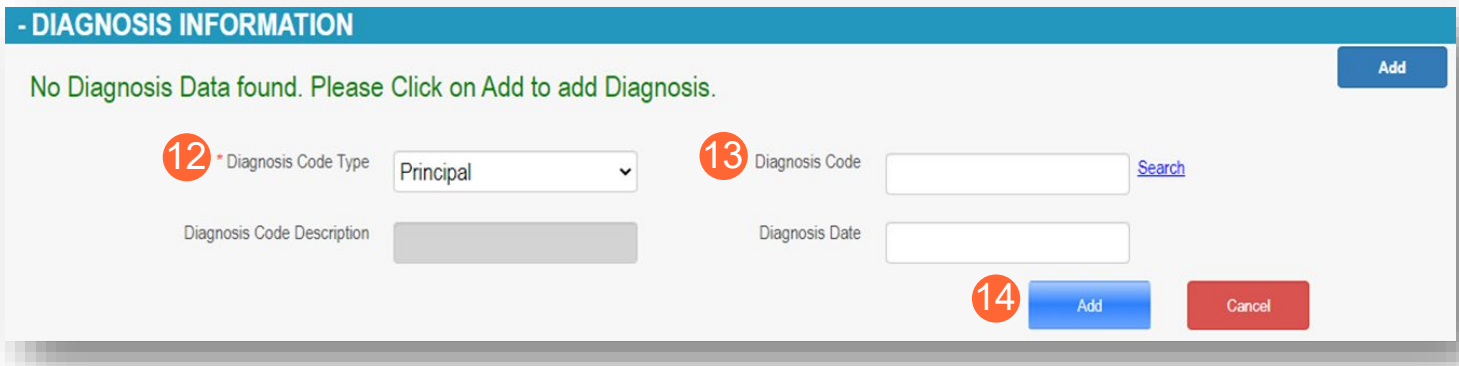

**Step 12:** Select a Diagnosis Code Type *(first line being added defaults to 'Principal').*

- Principal
- Admitting
- Patient Reason for Visit
- Other

**Step 13:** Enter a Diagnosis Code. If you do not know the code, click 'Search' to open a code lookup window.

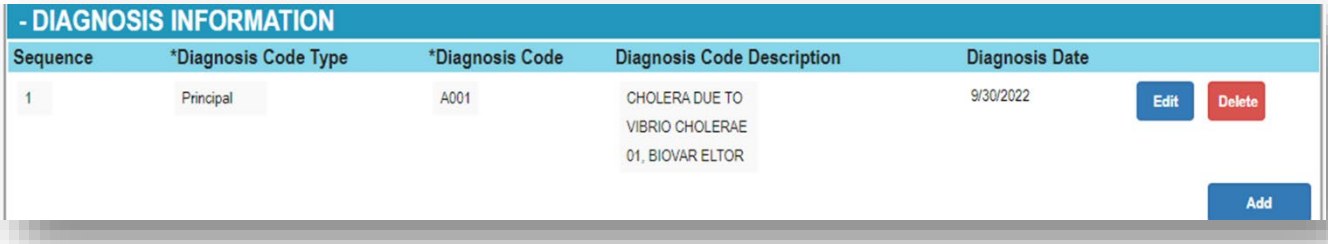
Note: Once the code is entered, the Diagnosis Code Description auto-fills.

**Step 14:** Click **Add** to add the diagnosis.




- The added diagnosis appears on a list. Repeat the process above to add an additional diagnosis.

- 12 Diagnosis Code lines are allowed (*Principal and Admitting Diagnosis Code Types are each allowed just once).*




## Service Details

Information shown in the gray boxes reflects data provided by the Fiscal Intermediary (FI) following the submission and processing of the prior authorization request.

Note: If providers request a prior authorization for procedure code *T1033*, the prior authorization request will be denied.

A prior authorization may be requested for procedure code *T1032* when the maximum units of 48 have been billed direct and/or exceeded. See OAC (Doula Services) 5160-8-43.

Click here to continue to Dental Claim Step 15

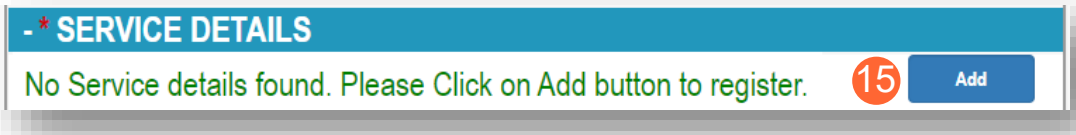
Click here to continue to Institutional Claim Step 15

Click here to continue to Professional Claim Step 15

## Dental

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

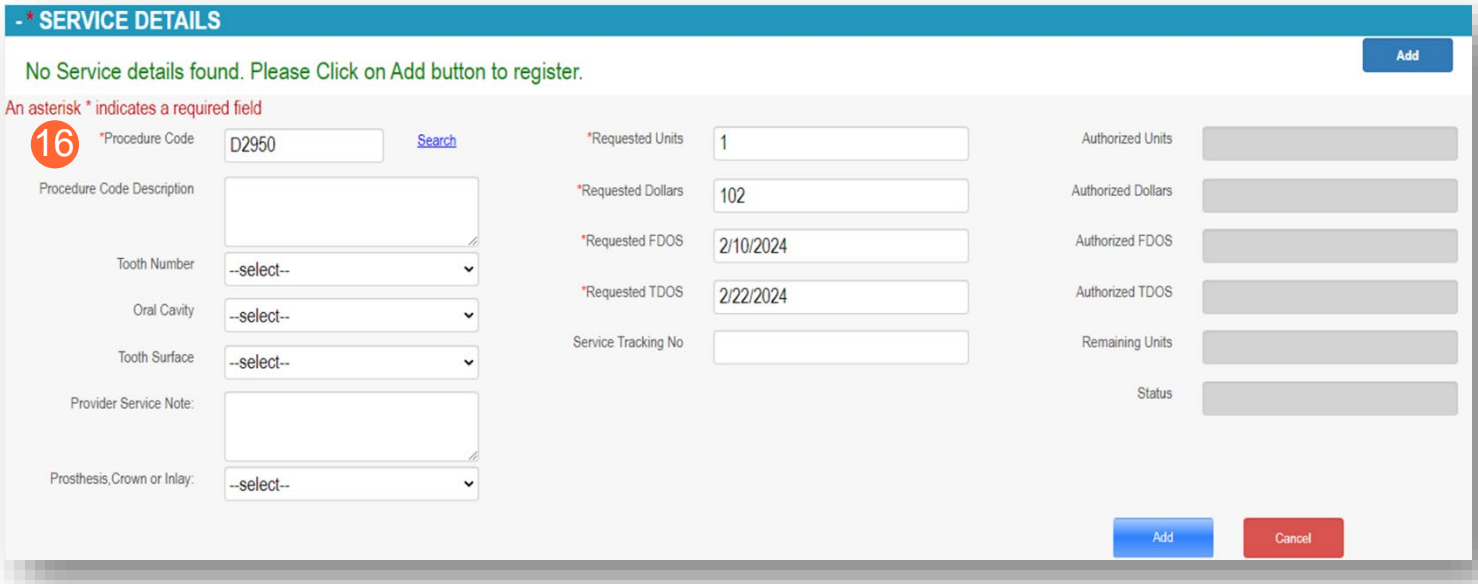
**Step 15:** Click **Add** to enter service details.




**Step 16:** The following information:

- Procedure Code *(required)*
  - If you do not know the code, click 'Search' to open a code lookup window.

- Procedure Code Description *(as needed)*
- Tooth Number *(as needed)*
  - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 32, A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, TS, SS, RS, QS, PS, OS, NS, MS, LS, KS, 30, 31
- Oral Cavity *(as needed)*
  - 00 – Entire Oral Cavity
  - 01 – Maxillary Arch
  - 02 – Mandibular Arch
  - 10 – Upper Right Quadrant
  - 20 – Upper Left Quadrant
  - 30 – Lower Left Quadrant
  - 40 – Lower Right Quadrant
- Tooth Surface *(as needed)*
  - B – Buccal
  - D – Distal
  - F – Facial
  - I – Incisal
  - L – Lingual
  - M – Mesial
  - O – Occlusal
- Provider Service Note *(as needed)*
- Prosthesis, Crown, or Inlay *(as needed)*
  - Initial Placement
  - Replacement
- Requested Units (*required)*
- Requested Dollars (*required)*
- Requested From Date of Service (FDOS) *(required)*
- Requested To Date of Service (TDOS) *(required)*
- Service Tracking No *(as needed)*

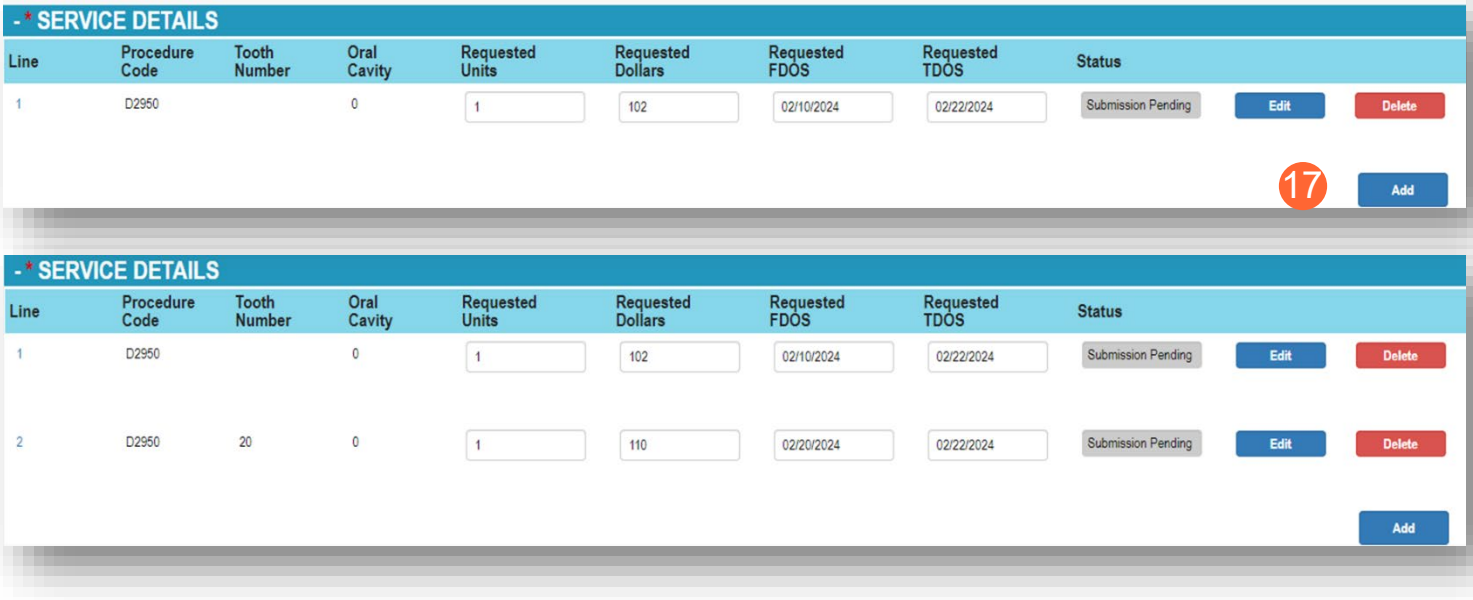


- Allows entry of a service reference number that corresponds to provider's system to reconcile each service requested for the Prior Authorization.

Note: If a Federally Qualitied Health Center (FQHC) is entering a prior authorization for FQHC dental services, the applicable tooth number, oral cavity quadrant, or tooth surface, must be entered under the 'Provider Service Note' field, instead of selecting options from the drop-down menu. A separate note for each tooth/service will be entered for each service line. *Example note: "Crown on #9."*

**Step 17:** Click **Add** to add the service.

- The added service appears on a list. Repeat the process above to add additional services.




- A maximum of 999 service detail lines can be added.

Click here to proceed to Submit Prior Authorization

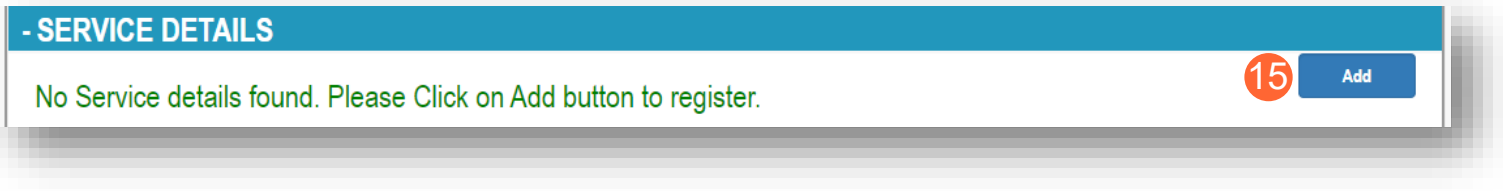
Click here to add Provider Notes (Optional)

Click here to add Attachments (Optional)

# Institutional

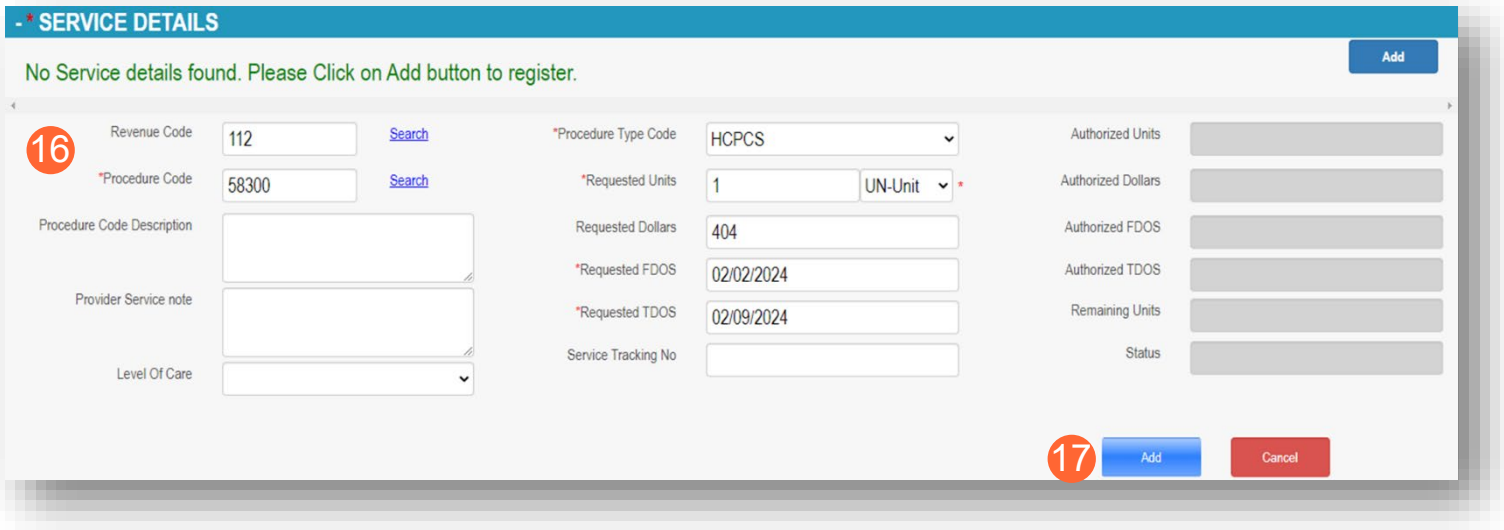
Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

**Step 15:** Click **Add** to enter service details.



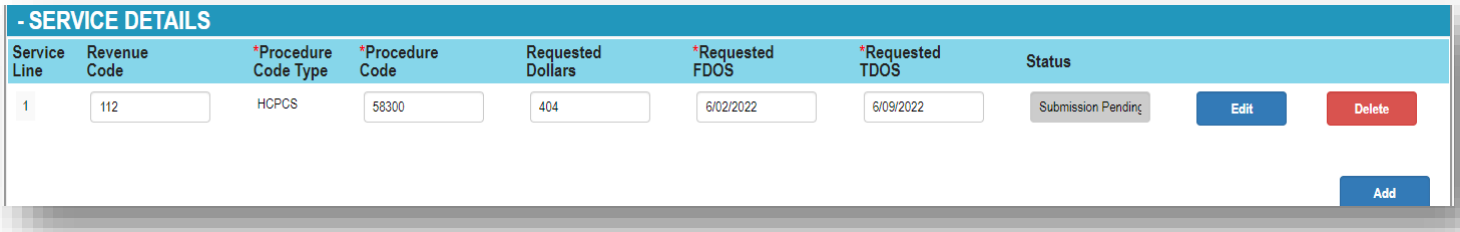

**Step 16:** The following information:

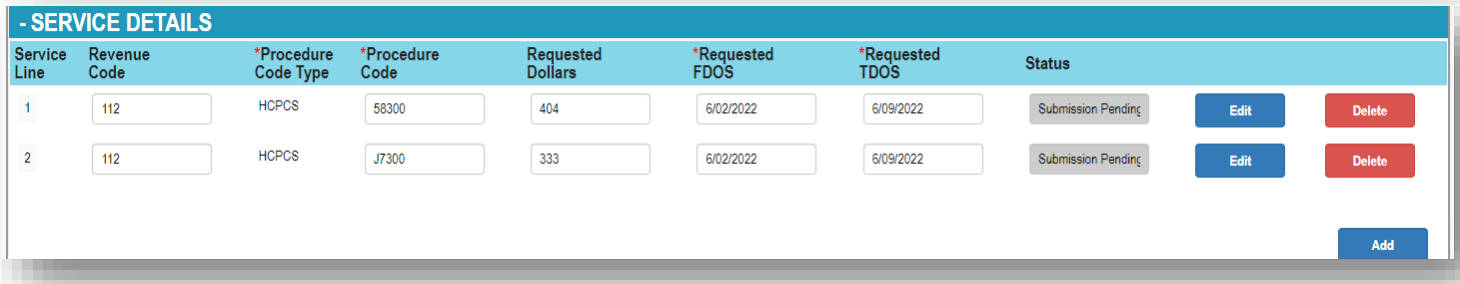
- Revenue Code *(as needed)*
  - If you do not know the code, click 'Search' to open a code lookup window.
- Procedure Code *(required)*
  - If you do not know the code, click 'Search' to open a code lookup window.
- Procedure Code Description *(as needed)*
- Provider Service note *(as needed)*
- Level of Care *(as needed)*
  - 1 – Skilled Nursing Facility (SNF)
  - 2 – Intermediate Care Facility (ICF)
  - 3 – Intermediate Care Facility – Mentally Retarded (ICF-MR)
  - 4 – Chronic Disease Hospital (CD)
  - 5 – Intermediate Care Facility (ICF) Level II
  - 6 – Special Skilled Nursing Facility (SNF)
  - 7 – Nursing Facility (NF)
  - 8 – Hospice
- Procedure Type Code
  - ICD 10 Procedure
  - HCPCS
- Requested Units – (1st field) *(required)*
  - The number of which you are ordering
- Requested Units – (2nd field) *(required)*
  - F2 – International Unit
  - DA – Days
  - UN – Unit
- Requested Dollars *(as needed)*
- Requested From Date of Service (FDOS) *(required)*
- Requested To Date of Service (TDOS) *(required)*
- Service Tracking No *(as needed)*
  - Allows entry of a service reference number that corresponds to provider's system to reconcile each service requested for the Prior Authorization.




**Step 17:** Click **Add** to add the service.

- The added service appears on a list. Repeat the process above to add additional services.
- A maximum of 999 service detail lines can be added.

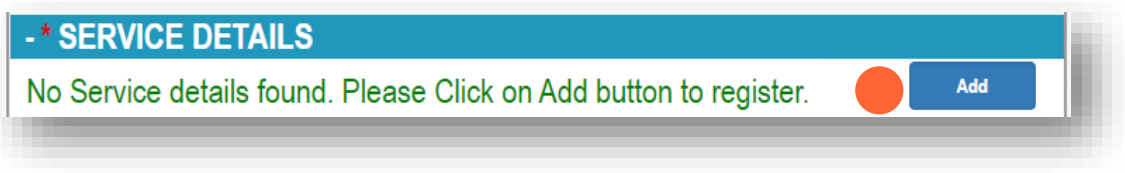


# Professional

Visit the Ohio Department of Medicaid (ODM) website and view the 'Prior Authorization Requirements' page to confirm services that require a prior authorization: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

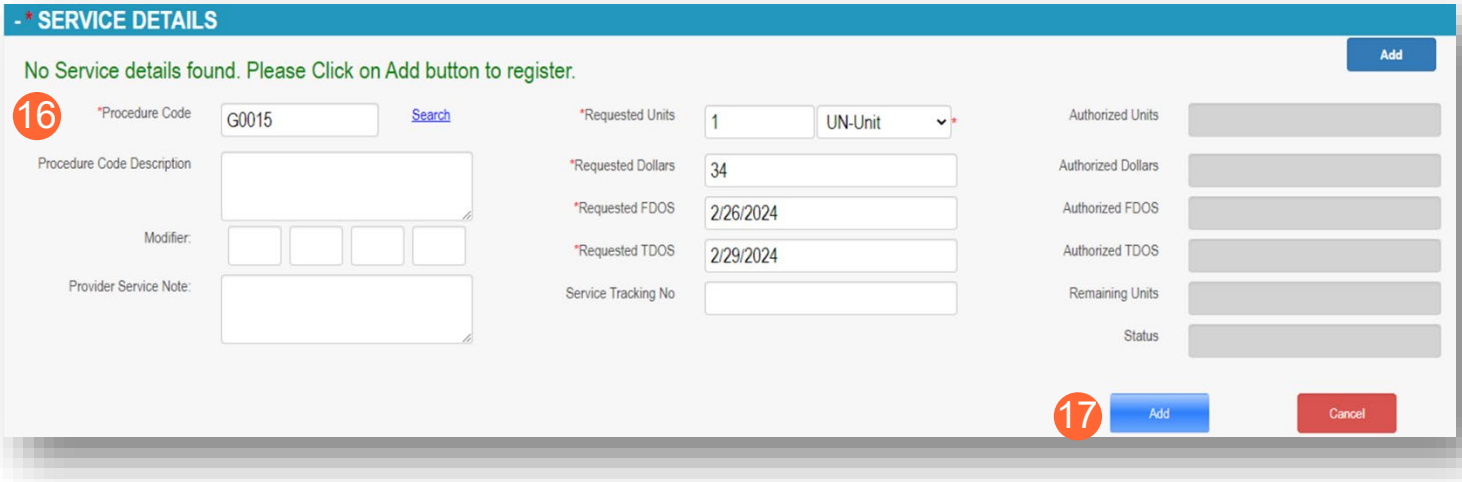
**Step 15:** Click **Add** to enter service details.




**Step 16:** The following information:

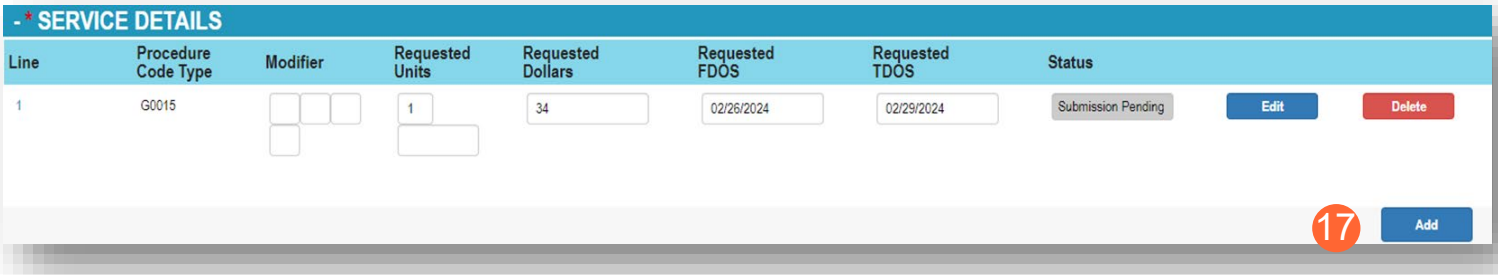
- Procedure Code *(required)*
  - If you do not know the code, click 'Search' to open a code lookup window.
- Procedure Code Description *(as needed)*
- Modifier *(as needed)*
  - Up to 4 values allowed on a prior authorization
- Requested Units (The number of which you are ordering)
- Provider Service Note *(as needed)*
- Requested Units – (1st field) *(required)*
  - The number of which you are ordering
- Requested Units – (2nd field) *(required)*
  - F2 – International Unit
  - DA – Days
  - UN – Unit
- Requested Dollars *(required)*
- Requested From Date of Service (FDOS) *(required)*
- Requested To Date of Service (TDOS) *(required)*
- Service Tracking No *(as needed)*

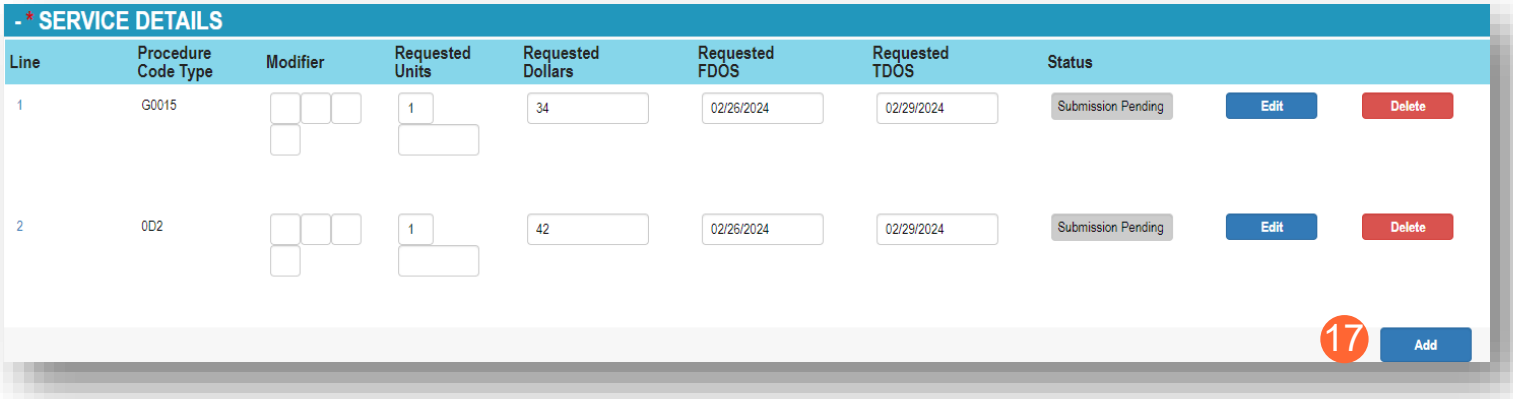
- Allows entry of a service reference number that corresponds to provider's system to reconcile each service requested for the Prior Authorization.




**Step 17:** Click **Add** to add the service.

- The added service appears on a list. Repeat the process above to add additional services.
- A maximum of 999 service detail lines can be added.



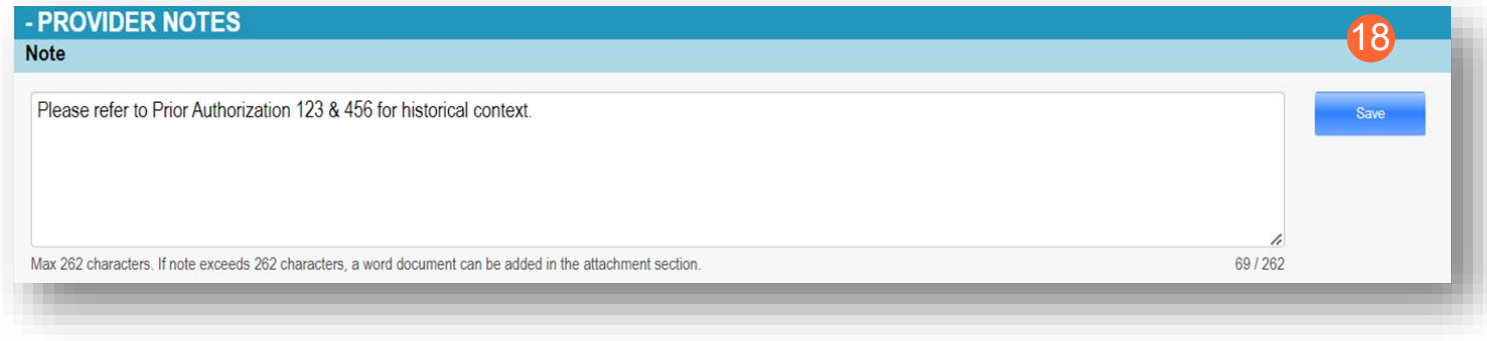




Click here to proceed to Submit Prior Authorization (Step 18)

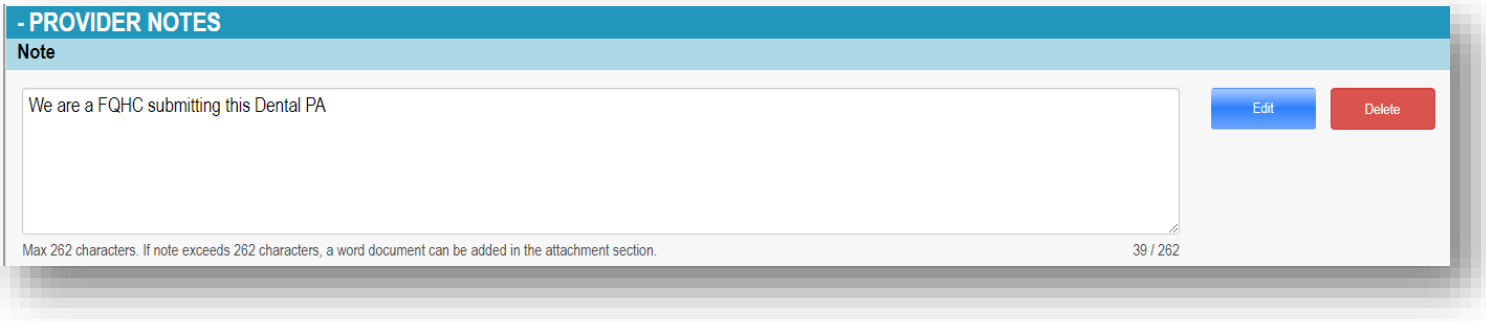
# Provider Notes (Optional)

**Step 1:** Enter any notes related to the Prior Authorization request and click **Save**.

- Save button appears after text in entered in the box.
- A maximum of 262 characters can be entered for a provider note.
- If additional notes need to be provided beyond the 262 characters, these comments can be captured by including an attached document in the submission. *(See Attachment section)*




- Edit and Delete options appear after saving the note.



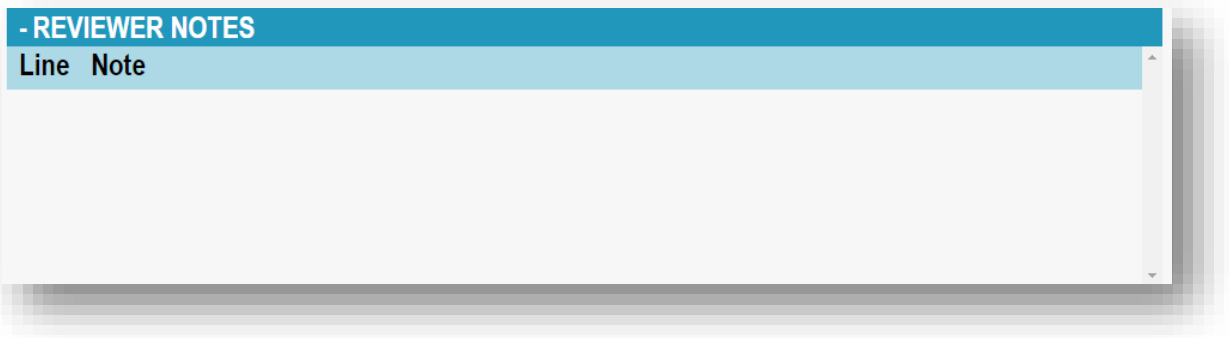

Note: When a Federally Qualified Health Center (FQHC) submits a prior authorization request for dental services, it is required to clearly state that the request pertains to an FQHC dental service submitted using the professional claim format, rather than the American Dental Association dental claim format.

**Click here to proceed to Submit Prior Authorization (Step 18)**

## How to Access Reviewer Notes

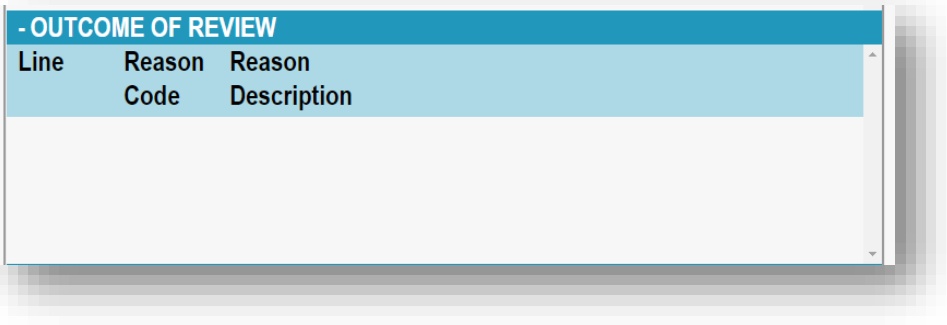
*After the Prior Authorization request is reviewed, notes from the reviewer will display in this section.*

*If the reviewer leaves a note that is longer than 262 characters, a letter with this information will be listed under Provider Correspondence for the Medicaid ID in PNM. Follow the steps for Accessing Prior Authorization Letters.*




## Outcome of Review

*After the Prior Authorization request is reviewed, an outcome for each service requested will display in this section.*



# Attachments (Optional)

This section allows for the uploading of support documentation for the prior authorization.

***IMPORTANT:** A Medicaid Billing Number **must be listed** for the Recipient on the PA submission **before** a document is attached.*

Note: The maximum allowed documents to upload in a prior authorization submission is 10 documents. The maximum upload size for each document is 10 MB.

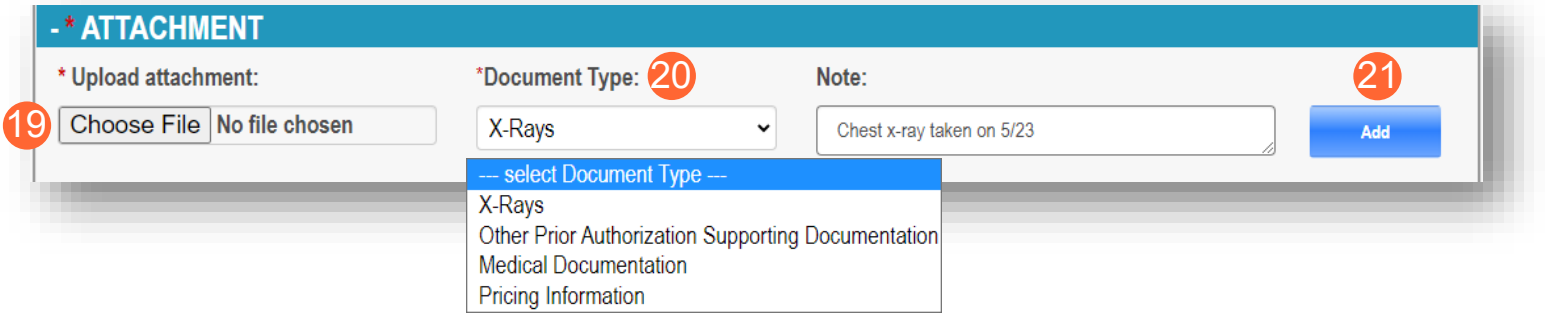
**Step 1:** Click **Choose File** and locate the file you wish to upload on your computer.

**Step 2:** Select a Document Type from the drop-down menu.

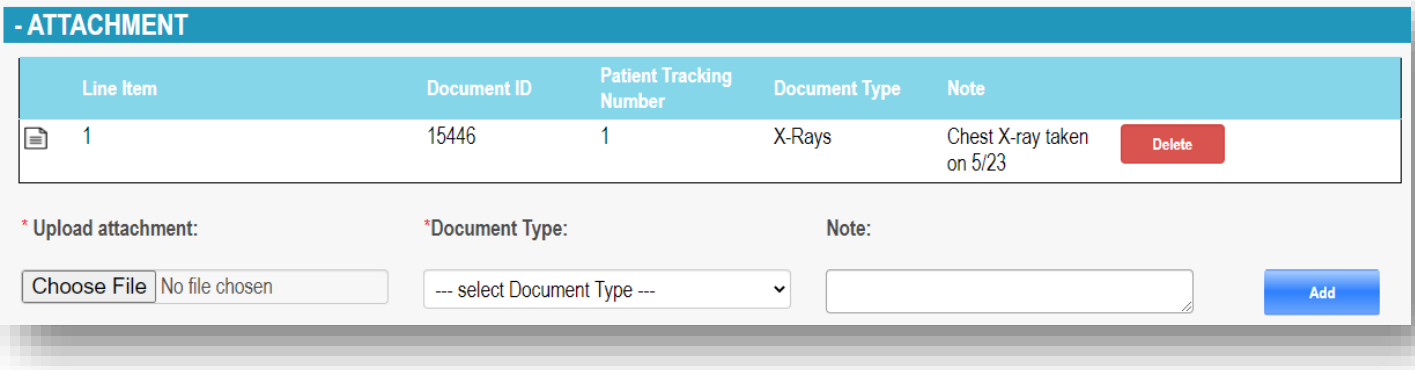
- X-Rays
- Other Prior Authorization Supporting Documentation
- Medical Documentation
- Pricing Information

- Enter any notes related to the uploaded document (maximum of 80 characters).

**Step 3:** Click **Add**.




- The added attachment appears on a list. Repeat the process above to add additional attachments.
- Up to 10 documents are allowed in a single prior authorization submission.



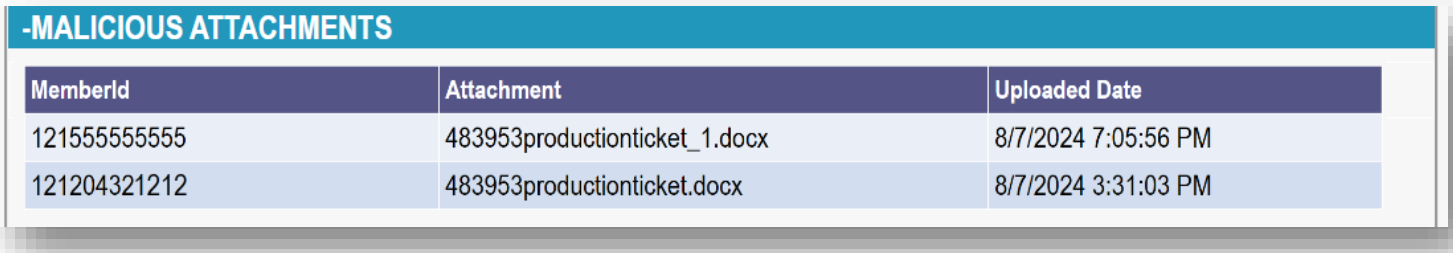

Accepted File Types:

- Word: doc, docx
- Excel: xls, xlsx, xlsm, xlsx
- Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
- PDF: pdf
- Other: pi, ec, zip, csv, acrbak, msg

Click here to proceed to Submit Prior Authorization (Step 18)

## If Malicious Attachments Are Uploaded

*After the Prior Authorization request is reviewed, if an attached document is found to contain damaging macros, it will be flagged as a 'malicious attachment.' Malicious attachments for the prior authorization request will be listed in this section. To replace the malicious attachments, follow the steps for Malicious Attachments.*

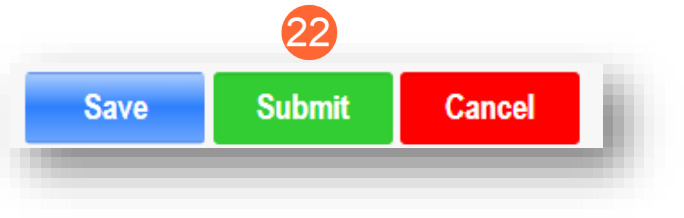


-MALICIOUS ATTACHMENTS

| MemberId | Attachment | Uploaded Date |
|---|---|---|
| 121555555555 | 483953productionticket_1.docx | 8/7/2024 7:05:56 PM |
| 121204321212 | 483953productionticket.docx | 8/7/2024 3:31:03 PM |

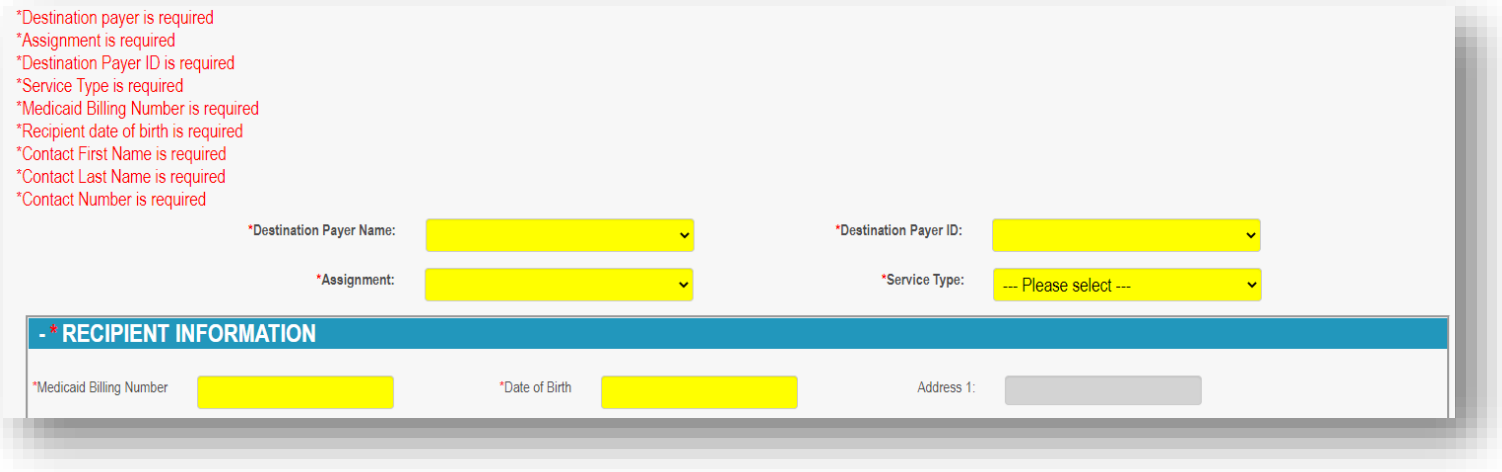
# Submit Prior Authorization

**Step 18:** When all data has been entered, click **Submit** at the bottom of the page.



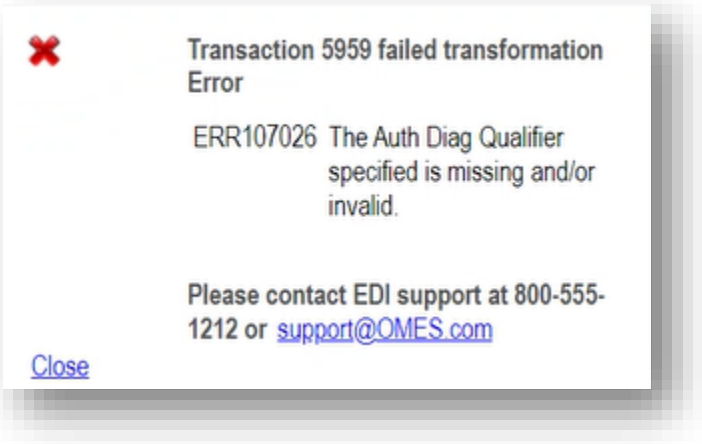

Note: If there are any entry errors in PNM preventing submission, error messages will display at the top of the page in red text.

Click on the PNM error message text and PNM will direct you to the section that needs to be reviewed/corrected. The field that needs attention will be highlighted.

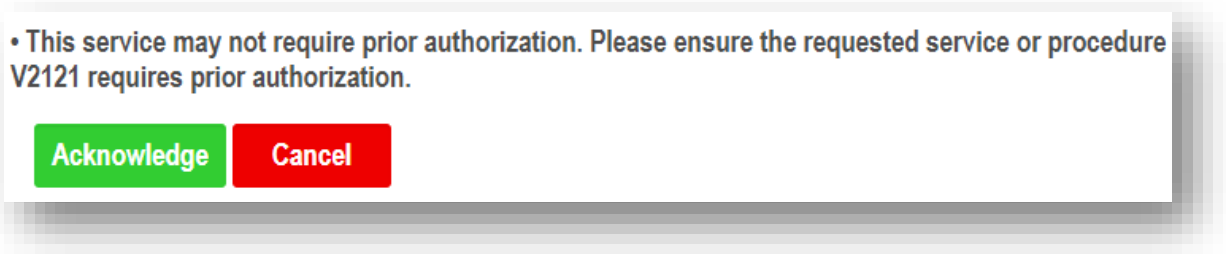



Note: Messages that appear in pop-up windows are from the Fiscal Intermediary (FI). Error messages or informational messages may be received from FI.

If error messages are received, please work to correct, or reach out to the contact information provided for assistance.



If informational messages are received, please review, and either click **Acknowledge** or **Cancel**.

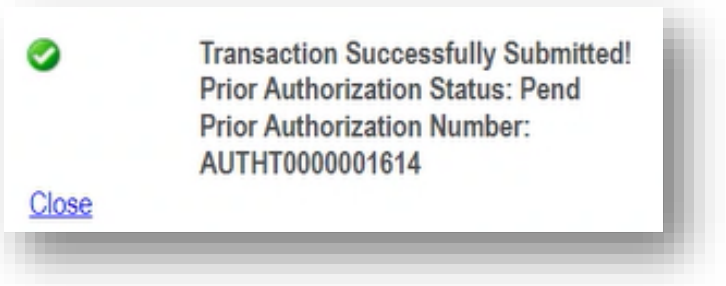



Note: If you wish to proceed with the submission, click **Submit** again.

**Step 19:** If no errors are present, or once they have been resolved, a confirmation message appears informing that the transaction was successfully submitted.

> Note: The submission confirmation message contains the Prior Authorization Number assigned to the submission. This number can be used to search for the prior authorization in PNM.

Click 'Close.'



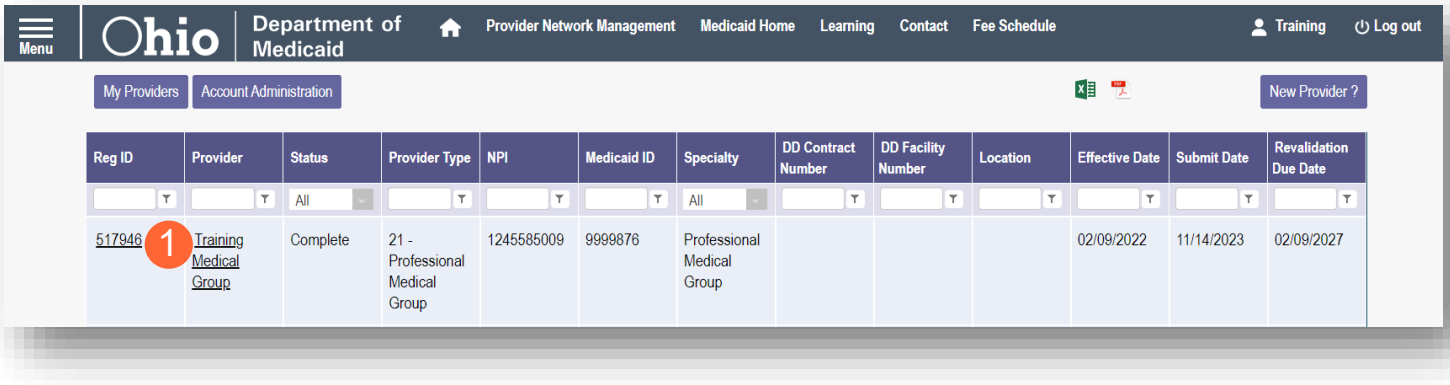

**This completes the submission of Prior Authorization**

# Accessing Prior Authorization Letters

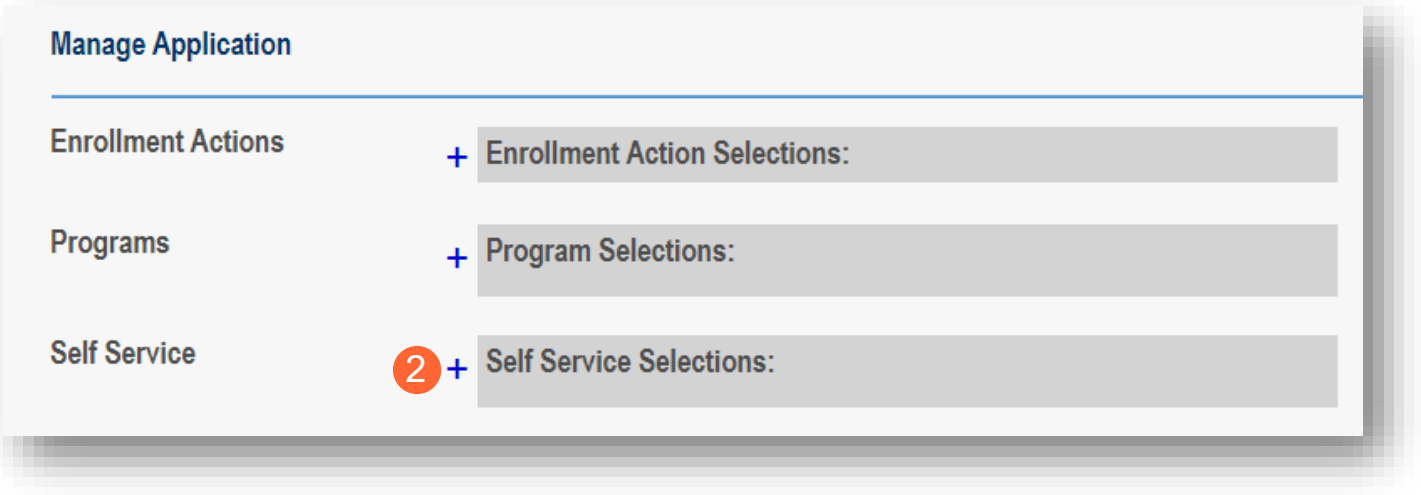
Letters related to prior authorizations are available to access in PNM.

| Definition of Letters | |
|---|---|
| **Prior Authorization Notice** | Used to communicate to service providers the decision that was made on the prior authorization request. This letter is used for denied Prior Authorization or modified Prior Authorizations |
| **Hospital PA Decision Notice** | Used to communicate to service providers the decision that was made on the hospital inpatient or outpatient prior authorization request (special review). |
| **Transplant Approval Notice** | Used to communicate to service providers (the Facility) the approval decision that was made on the transplant request. |
| **Prior Authorization Notice Approval PDN** | Used as the Private Duty Nursing (PDN) approval letter. |
| **Certification of Admission Notice** | Used to communicate to the inpatient facility the approval decision that was made on the psychiatric inpatient admission pre-certification request. |
| **Pre-Certification Denial Notice** | Used to communicate to the inpatient facility the denial decision that was made on the psychiatric inpatient admission pre-certification request. This letter is specific to a “technical denial” which indicates the request has been denied because the provider did not submit the correct information in the 24-hour time frame. |
| **Clinical Appeal Determination Notice** | Used to communicate to the inpatient facility the outcome of a reconsideration review performed on a previous determination for psychiatric inpatient admission certification. The reconsideration review is performed by an Ohio-licensed/board-certified psychiatrist who practices in Ohio. |
| **Retrospective Certification of Need for Inpatient Psychiatric Hospitalization** | Used to communicate to the inpatient facility the approval decision that was made on the retrospective psychiatric inpatient admission pre-certification request. |

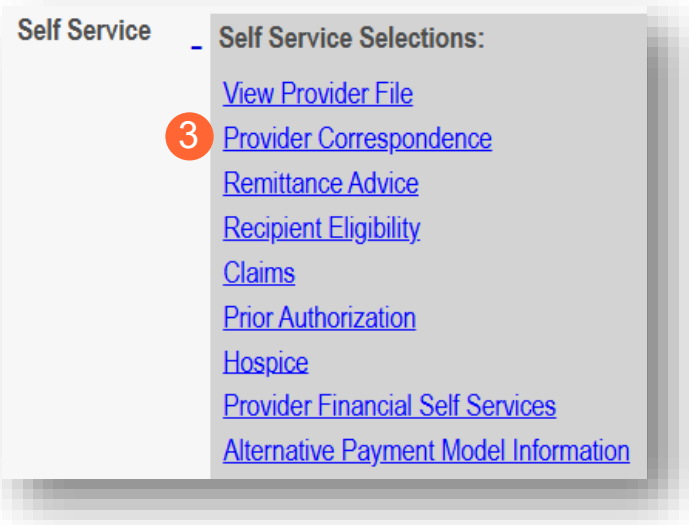
**Step 1:** From the Provider Homepage/Dashboard, click the hyperlink under Reg ID or Provider to manage the file of the Provider you wish to access.




**Step 2:** Under the Manage Application section, click the '+' icon to expand the Self Service Selections.

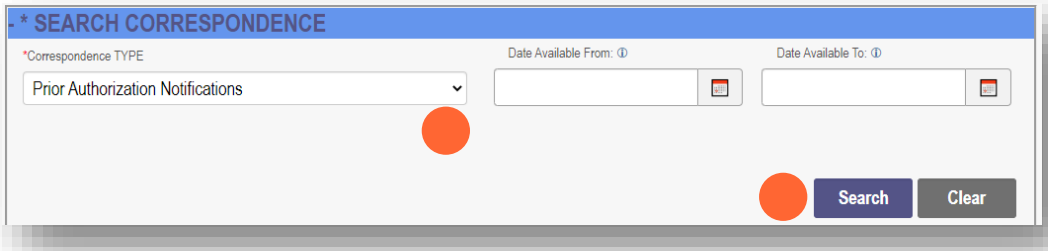



**Step 3:** Click the 'Provider Correspondence' hyperlink.



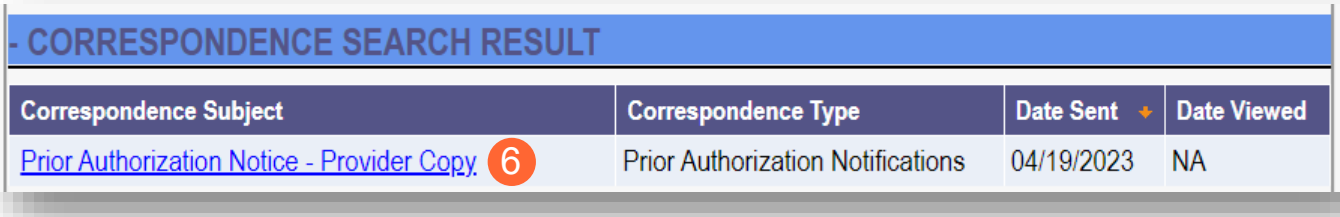
**Step 4:** To locate correspondence, complete the following:

- Select 'Prior Authorization Notifications' from the Correspondence Type drop-down menu.
- Enter a data range for the search.

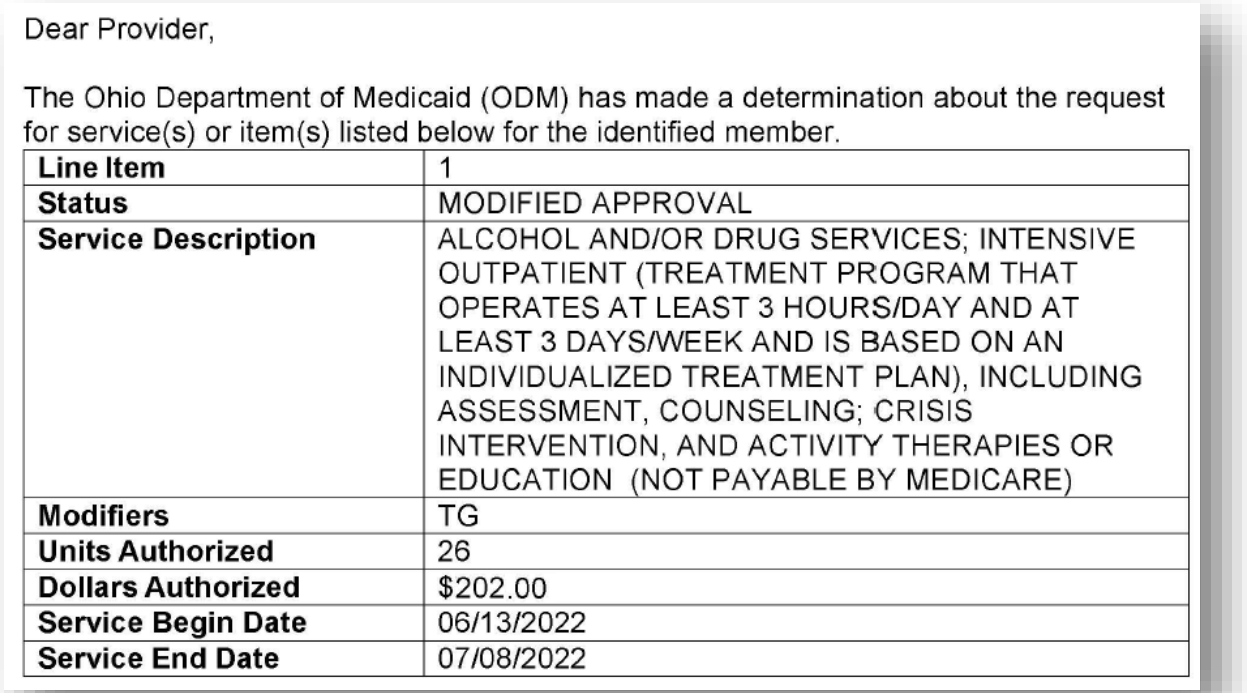



**Step 5:** Click **Search**.

**Step 6:** Locate the search results at the bottom of the page and select the one with the subject related to any of the prior authorization letters listed in the table above. Click the hyperlink for the letter you wish to access.




**Step 7:** Review the correspondence. Once you have viewed, you can click the 'X' in the top-right corner to close.



Dear Provider,

The Ohio Department of Medicaid (ODM) has made a determination about the request for service(s) or item(s) listed below for the identified member.

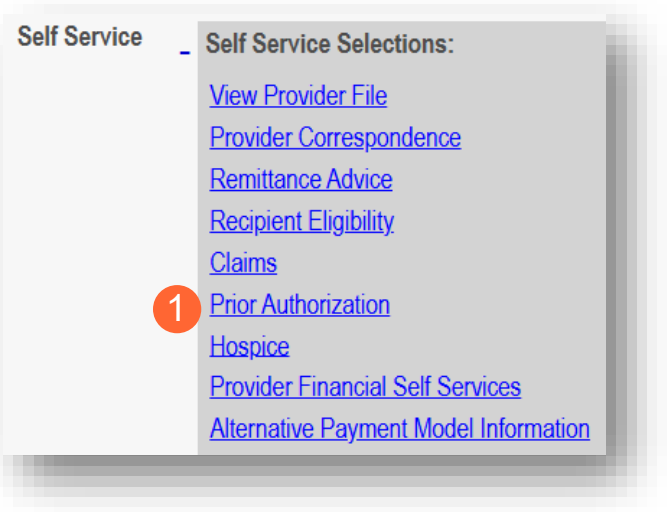
| | |
|---|---|
| **Line Item** | 1 |
| **Status** | MODIFIED APPROVAL |
| **Service Description** | ALCOHOL AND/OR DRUG SERVICES; INTENSIVE OUTPATIENT (TREATMENT PROGRAM THAT OPERATES AT LEAST 3 HOURS/DAY AND AT LEAST 3 DAYS/WEEK AND IS BASED ON AN INDIVIDUALIZED TREATMENT PLAN), INCLUDING ASSESSMENT, COUNSELING; CRISIS INTERVENTION, AND ACTIVITY THERAPIES OR EDUCATION (NOT PAYABLE BY MEDICARE) |
| **Modifiers** | TG |
| **Units Authorized** | 26 |
| **Dollars Authorized** | $202.00 |
| **Service Begin Date** | 06/13/2022 |
| **Service End Date** | 07/08/2022 |

# Attachments to a Prior Authorization in 'Pending Additional Info' Status

If a PA is submitted and the reviewer or approver needs additional supporting information, then the PA will be placed in 'Pending Additional Info' status. Follow this process to upload additional supporting documents.

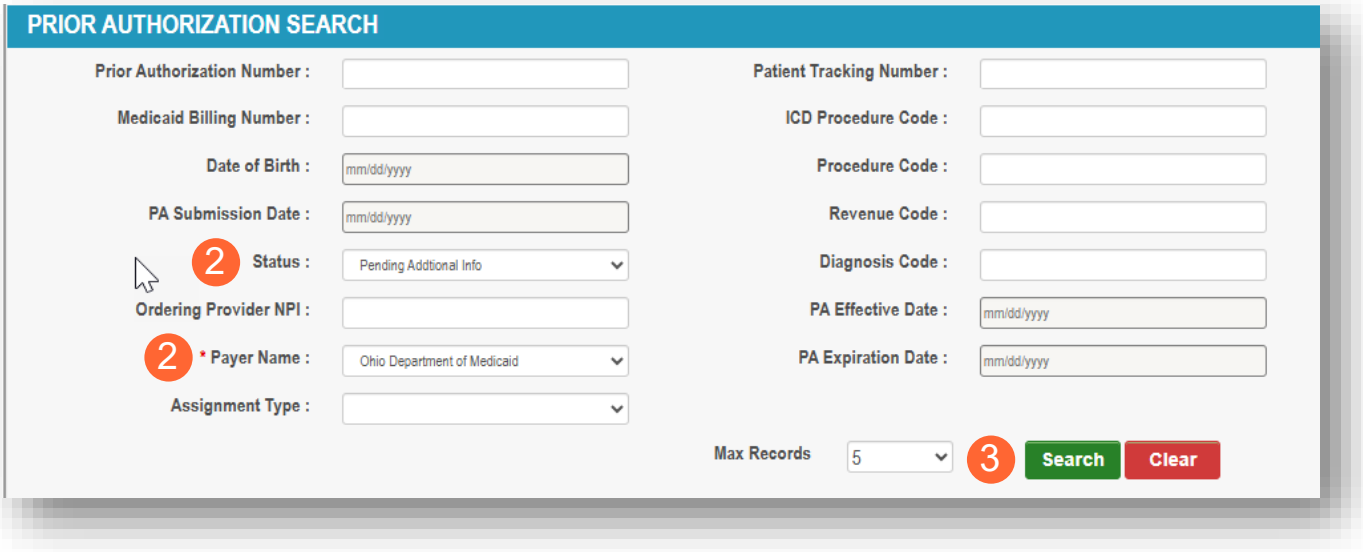
**Step 1:** Click the 'Prior Authorization' hyperlink to begin a prior authorization search.

**IMPORTANT: To perform a search and inquire/view a submitted Prior Authorization, a user is required to be logged into PNM with access to the Requesting Provider (the user is the Provider Administrator or Provider Agent for the Medicaid ID under which the Prior Authorization was submitted).**




**Step 2:** Enter the prior authorization search criteria.

- The 'Payer Name' is a required field. Options to select include:
  - 
- **Use the Status drop-down menu and select 'Pending Additional Info'.**



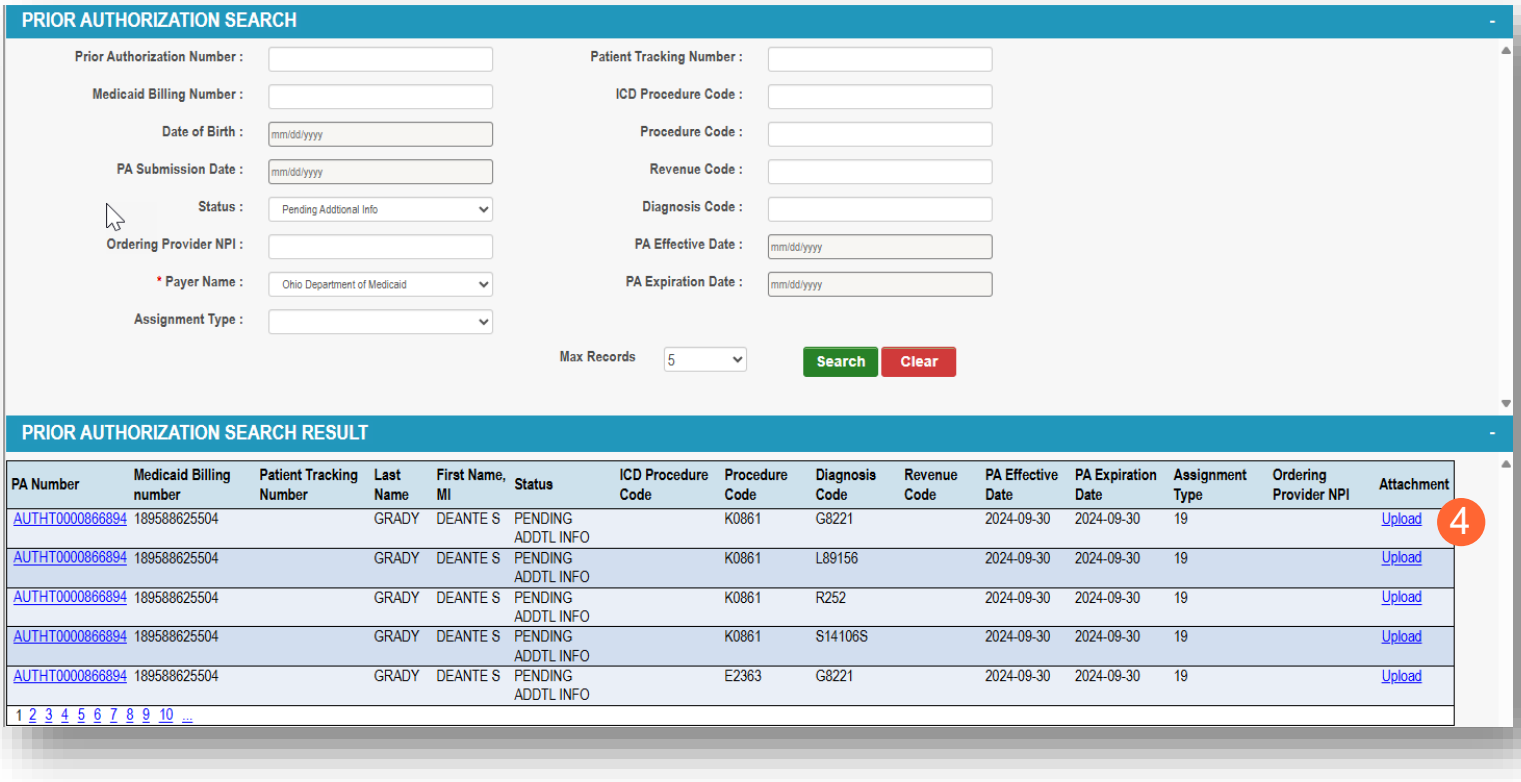

**Step 3:** Click **Search**.

Note: You can adjust the Max Records for the search results to show up to 100 records at a time.

**Step 4:** Identify the prior authorization search result and click the **'Upload'** hyperlink that appears in the Attachments column, located on the far-right side.

Note: On the PA search, a user may see multiple search results with the same AUTH number. This is based on diagnosis codes. For example, if a PA is submitted with 5 diagnosis codes, 5 search results under the same AUTH number will display. (If a PA is submitted with 3 diagnosis codes and each of those have 3 different ICD 10 codes, you will see 9 search results under the same AUTH number). It doesn't matter which search result line/link is chosen to view; it will display the same AUTH information.

Note: To clear search data and begin a new search, click the red **Clear** button.

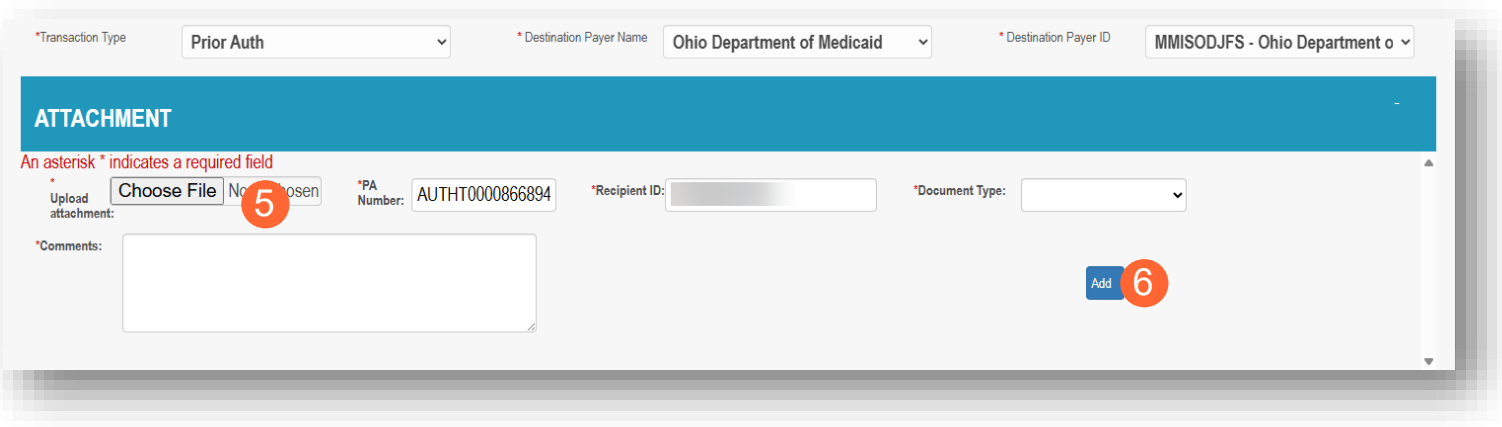



**Step 5:** Click **Choose File** and locate the file on your computer and enter or select the following information:

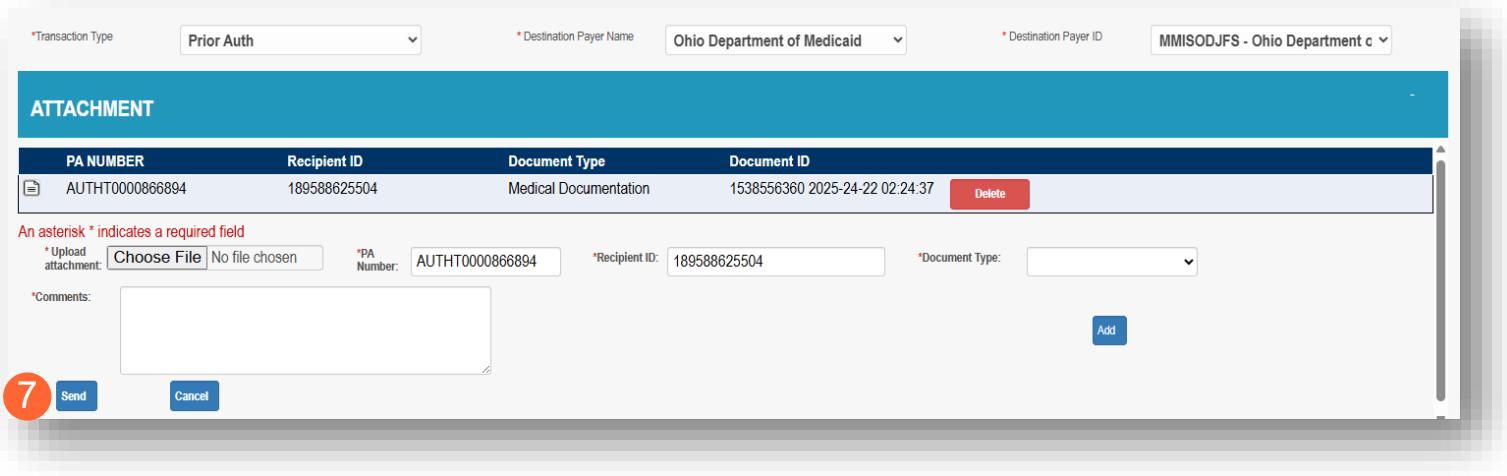
- Prior Authorization Number, Recipient ID, Document Type, and Comment.

Note: Recipient ID is the recipient's Medicaid number.

**Step 6:** Click the **Add** button.




**Step 7:** The added attachment appears on a list. Click the **Send** button to complete the attachment upload. Repeat the process above to add additional attachments.




Note: Below are important details about document attachments/uploads.

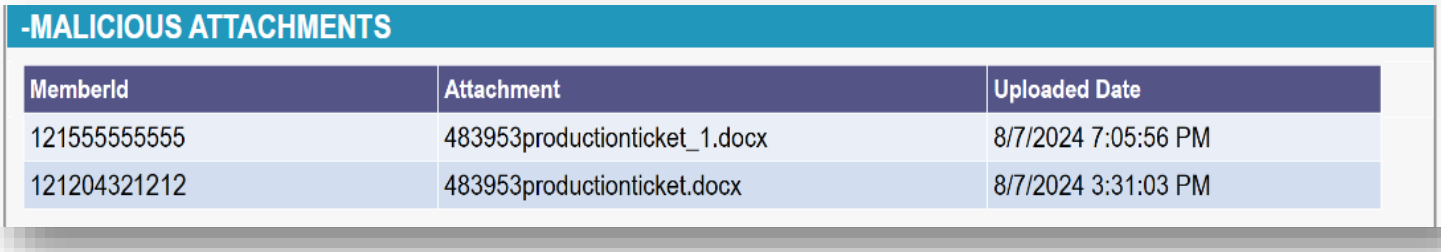
- A maximum of 10 documents can be sent to the Destination Payer at a time.
- The maximum file size per document upload is 10 MB.
- The following document types are acceptable:
  - Word: doc, docx
  - Excel: xls, xlsx, xlsm, xlsx
  - Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
  - PDF: pdf
  - Other: pi, ec, zip, csv, acrbak, msg

# If Submission Contains Malicious Attachments

If a document uploaded during a prior authorization submission is found to contain damaging macros, it will be flagged as a 'malicious attachment'. Any flagged malicious attachments will be listed on the prior authorization submission page in the 'Malicious Attachment' section.

**Step 1:** Review the malicious attachments list on the prior authorization submission page.

Note: Notifications regarding malicious attachments are not sent from PNM.

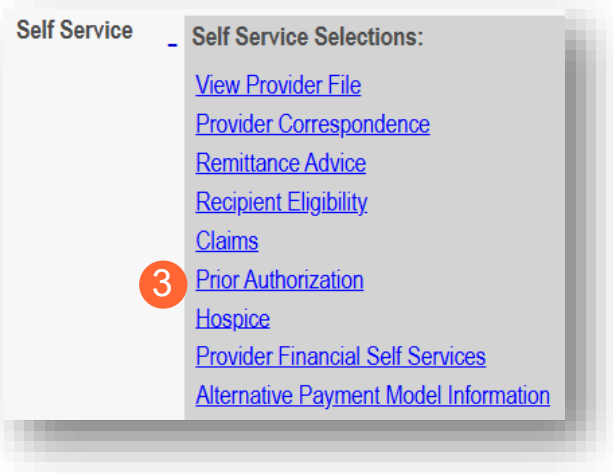


-MALICIOUS ATTACHMENTS

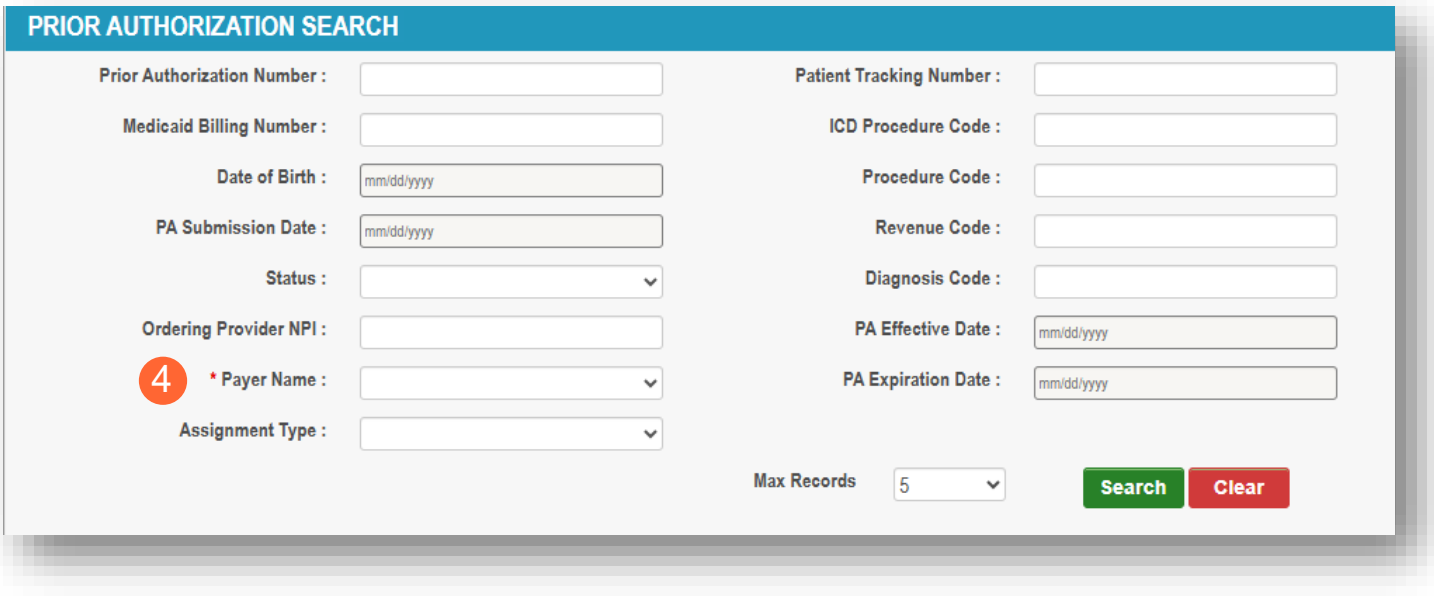
| MemberId | Attachment | Uploaded Date |
|---|---|---|
| 121555555555 | 483953productionticket_1.docx | 8/7/2024 7:05:56 PM |
| 121204321212 | 483953productionticket.docx | 8/7/2024 3:31:03 PM |

**Step 2:** Use virus scanning software on your computer to review the document for any malicious data.

**Step 3:** Upload a 'clean' version of the document by clicking the 'Prior Authorization' hyperlink.



**Step 4:** Enter search criteria in the boxes provided.




Note: Newly submitted prior authorizations may take up to 30 minutes to display in a search inquiry.

- The 'Payer Name' is a required field. Options to select include:
  - 

- Enter the Payer Name, along with any of the other fields. Some examples are below:
  - Payer Name, Prior Authorization Number
  - Payer Name, Medicaid Billing Number, Status
  - Payer Name, Patient Tracking Number
  - Payer Name, Medicaid Billing Number, Submission Date

- If using a Medicaid Billing Number in the search, the full 12-digit number needs to be entered.

- If selecting a Status, the following options display:

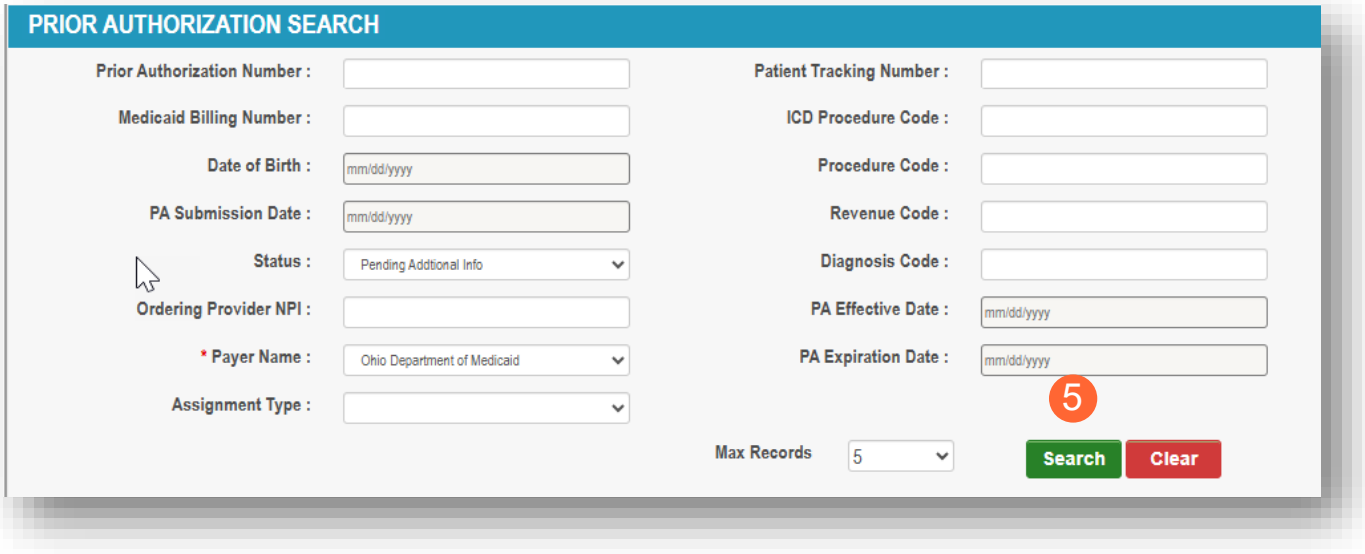
  - Approved
  - Closed
  - Denied
  - InProcess
  - Partially Approved
  - Pend
  - Pending Additional Info
  - Saved

Note: Saved, unsubmitted, prior authorizations can also be searched for by entering the below minimum search criteria. Updates/changes can be made to previously saved records:

- Status of "Saved", Patient Tracking Number, Payer Name

- If selecting an Assignment Type, the following options display:
    - 01-Compression Garments
    - 02-Decubitus Care Equipment
    - 03-Dental
    - 04-Dressings, Surgical
    - 05-Enteral Nutrition and Supplies
    - 06-Hearing Aids
    - 07-Hospital Beds
    - 08-Incontinence Supplies
    - 09-Miscellaneous Equipment
    - 10-Orthotics (MTA)
    - 11-Orthotics/Prosthetics (Nurses)
    - 12-Repairs
    - 13-Respiratory (MTA)
    - 14-Respiratory (Nurses)
    - 15-Speech Generating Devices
    - 16-Supplies (Miscellaneous)
    - 17-Therapies
    - 18-Vision
    - 19-Wheelchairs
    - 20-Orthodontics
    - 21-Transportation
    - 23-PDN
    - 34-Hospital Inpatient
    - 35-Hospital Outpatient
    - 37-Psychiatric Inpatient
    - 38-Increase State Plan Home Health
    - 39-Physician Services
    - 40-Medicaid School Program
    - 43-Medical Nutrition Therapy
    - 44-Chiropractic / Acupuncture
    - 45-Psychotherapy
    - 46-Applied Behavioral Analysis
    - 47-ACT Enrollment
    - 48-IHBT Enrollment
    - 49-Medical Services
    - 50-SUD Partial Hosp Services
    - 52-Services for ACT Enrollees
    - 53-SUD Residential Services
    - 54-Mental Health Services
    - 55-Hospital OP-Behavioral Health
    - 56-Services for IHBT Enrollees
    - 57-ASC
    - 58-Laboratory Services
    - 59-Hospital High-Cost Carve-Out
    - 60-Non-Institution High-Cost Drugs

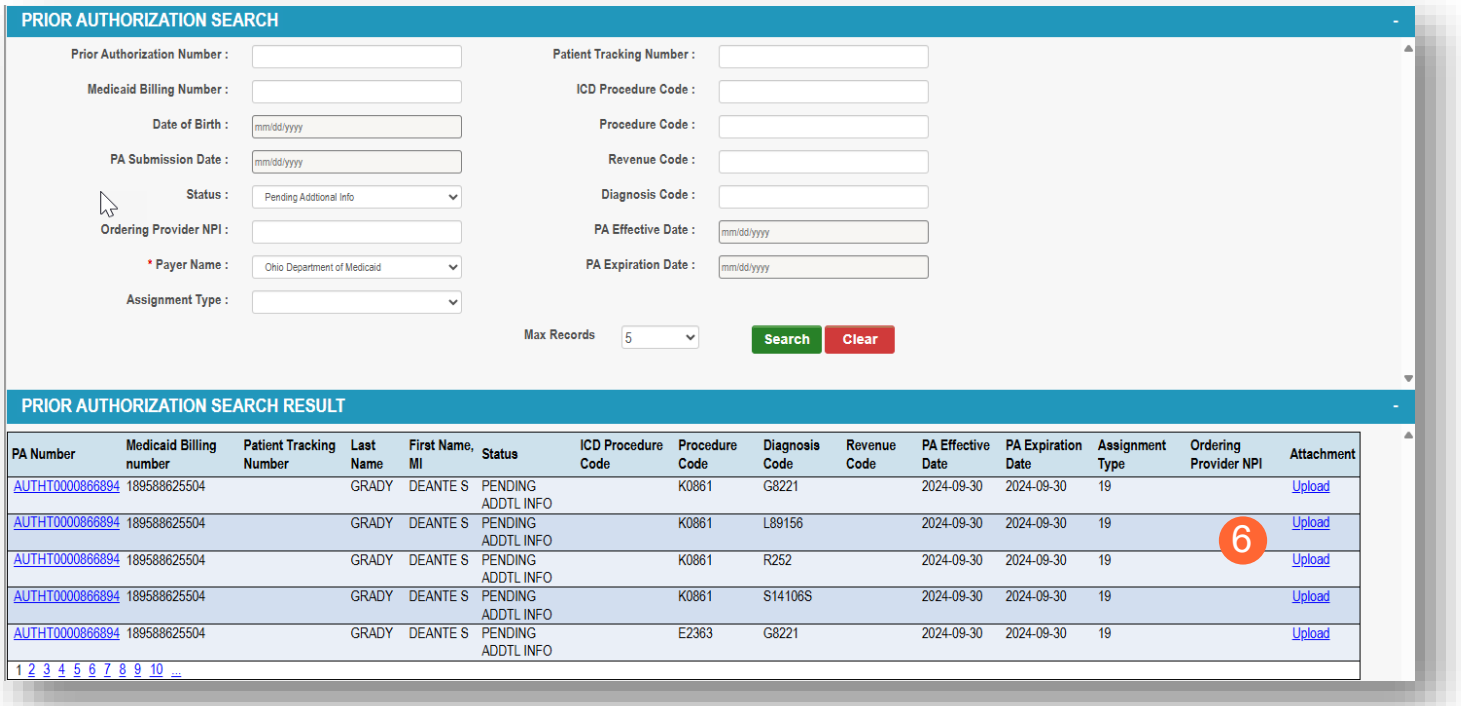
**Step 5:** After criteria is entered, click **Search**.




Note: You can adjust the Max Records for the search results to show up to 100 records at a time.

Note: To clear search data and begin a new search, click the red **Clear** button.

**Step 6:** Identify the prior authorization search result and click the **'Upload'** hyperlink that appears in the Attachments column, located on the far-right side.



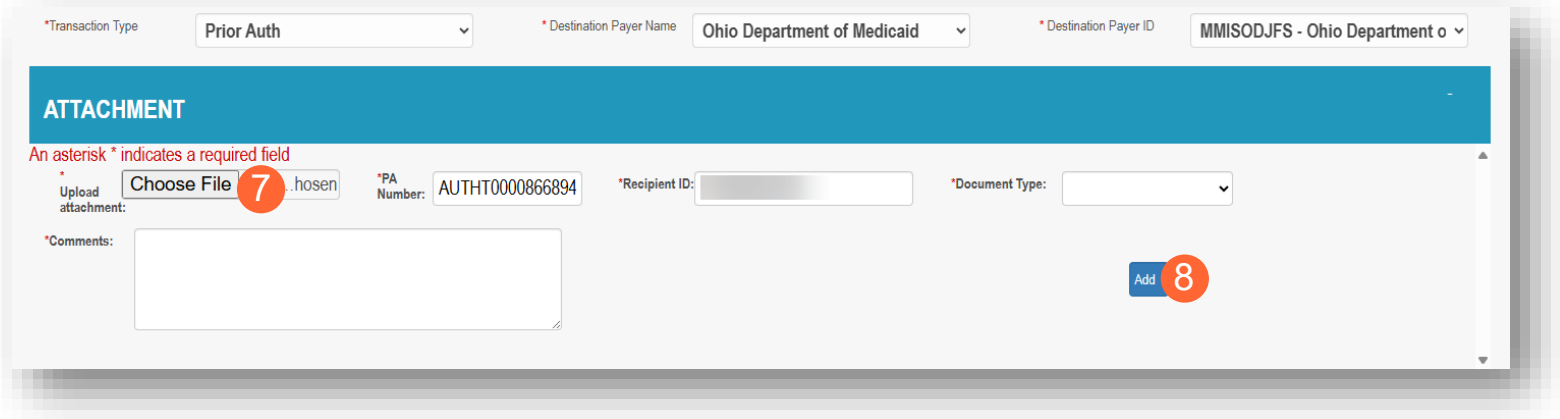
Note: On the PA search, a user may see multiple search results with the same AUTH number. This is based on diagnosis codes. For example, if a PA is submitted with 5 diagnosis codes, 5 search results under the same AUTH number will display. (If a PA is submitted with 3 diagnosis codes and each of those have 3 different ICD 10 codes, you will see 9 search results under the same AUTH number). It doesn't matter which search result line/link is chosen to view; it will display the same AUTH information.

**Step 7:** Click **Choose File** and locate the file on your computer and enter or select the following information:

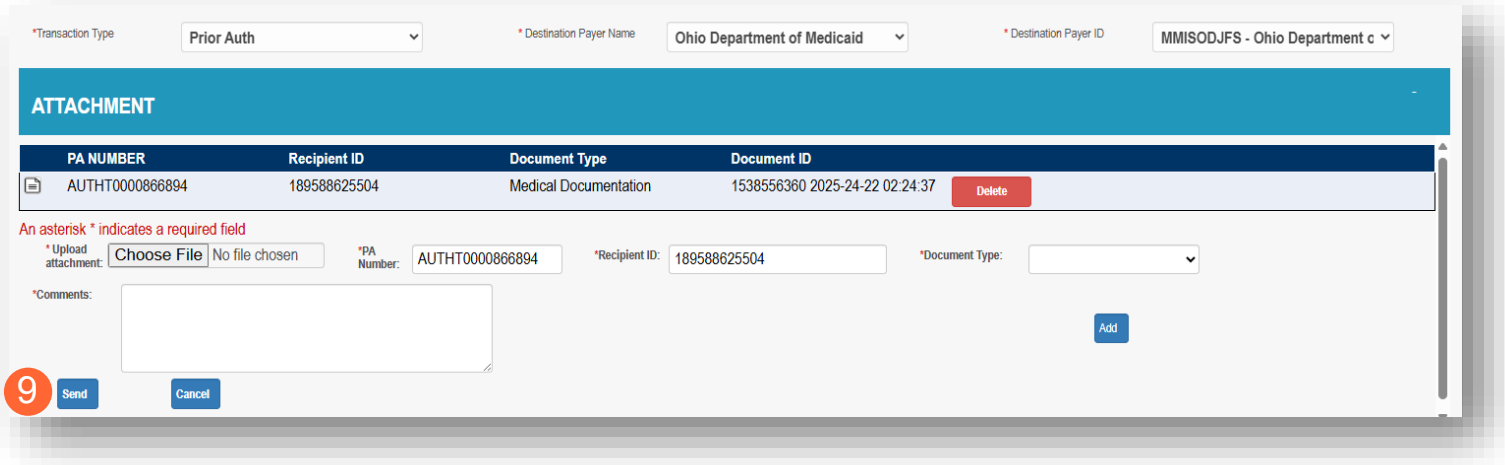
- Prior Authorization Number, Recipient ID, Document Type, and Comment.

  Note: Recipient ID is the recipient's Medicaid number.

**Step 8:** Click the **Add** button.




**Step 9:** The added attachment appears on a list. Click the **Send** button to complete the additional attachment upload. Repeat the process above to add additional attachments.




Note: Below are important details about document attachments/uploads.

- A maximum of 10 documents can be sent to the Destination Payer at a time.
- The maximum file size per document upload is 10 MB.
- The following document types are acceptable:

- Word: doc, docx
- Excel: xls, xlsx, xlsm, xlsx
- Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tif
- PDF: pdf
- Other: pi, ec, zip, csv, acrbak, msg

## Resources

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 additional Prior Authorization Reinstatement Requirements from ODM visit:

  https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

- A Frequently Asked Questions (FAQs) document about Reinstating Prior Authorization (PA) Requirements can be found at: https://ohpnm.omes.maximus.com/OH_PNM_PROD/pages/ShowFiles.aspx?mode=inline&FileName=PA%20Reinstatement%20FAQs.pdf