



Q&A: SPECIAL CLAIMS PROCESSING

1500 Professional

1. If we switch the claim type to professional for the non-covered Medicare denials, will it deny for Medicare?

The Medicare edits are overridden during this process, when only the denied line item is appealed, using the HCA-17A form.

2. Is there an option for adding more than one other facility ID?

The other facility ID field is only used for school-based IEP-related services. For labs, claims must have the Ordering ID NPI.

3. Is the 6-month timely filing limit calendar days or business days?

Timely filing is 183 calendar days from the date of service.

4. Can the 59 modifier be used without having to special process for secondary claims where Medicare, HMO or TPL has already paid?

The 59 modifier requires review, but typically does not require special processing. Please contact provider services for any specific claim examples.

5. When submitting documentation, do we need to send in the 1500 form along with HCA-17A and other paperwork?

When submitting documents via the provider portal, choose professional as the claim type. This is the 1500. Be sure to upload the HCA-17A and supporting documentation with the claim submission.

6. Soon-to-be-Sooners charges are not covered under Resources Fee schedule. Can those charges be billed to the patient?

OHCA recommends the provider to file a claim. If you receive the denial as non-covered services, then those services can be billed to the member.

7. Do we need to fill out the HCA-28B form to send with Medicare denials that need special processing?



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No, the HCA-28B is only used when Medicare pays, and the claim is submitted as a crossover for special processing via paper.

8. How does the form need to be filled out for manual pricing denials?

Manual pricing denials do not require special processing. Be sure to submit any documentation related to pricing through the normal processing procedures.

9. Will OHCA still accept and process the regular HCA-17 paper form if it is before December 30?

Yes, OHCA will accept paper for the HCA-17 process until Dec. 31, 2020; but we prefer these claims to be filed via the provider portal.

10. We have a patient who has CHAMPVA as a primary payer, but they are about 9-12 months behind in processing their claims and some are out 18 months or longer. Can we file within 6 months, so we'll have timely filing once CHAMPVA pays?

Yes, any time a response is being awaited from primary insurance, please file a claim within the first 6 months to OHCA, as timely filing is crucial to resolving claims. The claim will deny for other insurance, but that denied claim can be used to prove timely filing.

11. Can you submit proof that you were working with primary insurance in a timely manner and use that to bypass timely filing for secondary?

No, OHCA strongly advises you file the claim within the first 6 months from the date of service because the denied claim can be used to prove timely filing. Proof of timely filing is considered a claim from the OHCA provider portal or a remittance advice from OHCA with the claim ID and detail line items.

12. How long does a claim stay in suspended status?

It depends on the level of review the claim needs. Some may need medical review by an OHCA physician or nurse. Paper claim denials are typically processed within 10 business days, and may be quicker for electronic submissions.

13. Will a claim deny as a duplicate if the original claim is not voided when the first line item paid and the second line item didn't?

The duplicate edits are overridden when only the denied line item detail is appealed using the HCA-17A form.



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14. When you click on the blue hyperlink on the HCA-17A form, it gives an option to save. If we save it, can we upload it later?

The option to save the HCA-17A is at the discretion of each practice. OHCA recommends only the provider information section of the form be saved to ensure the accuracy of the data in the claim and contact information sections for each submission.

15. Is the special process used when primary insurance denies and we want to submit the denial to OHCA for adjudication?

Not unless the primary insurance is Medicare. Medicare primary must be special processed when Medicare denies, but other primary commercial insurances would go through regular processing procedures.

16. Do you need to void the partially paid claim before filling out the HCA-17A form?

No. If the criteria for special processing is met, the previously submitted claim does not need to be voided prior to submitting the denied line-item detail with the HCA-17A form.

17. Attachment type used to be OZ for support data. Did this change to the 77?

The 77-attachment type is only for the HCA-17A special claims process. Continue to use the OZ attachment type for regular processed claims.

18. Do we need a 1500 with the special processing?

When submitting via the provider portal, choose professional as the claim type. Upload the HCA-17A form and supporting documentation.

19. Will there be a copy of this presentation available?

The presentation is available on our public website at oklahoma.gov/ohca/providers/provider-training on the right side of the page under Resources and is titled Special Processed Claims – 1500 Professional.

20. We have ABA claims that are suspended every day due to multiple providers in our group seeing the same patient with the same code. Is there a way to avoid completing this form every day?

The option to save the HCA-17A is at the discretion of each practice. OHCA recommends only the provider information section of the form be saved to ensure the accuracy of the data in the claim and contact information sections for each HCA-17A submission.



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21. What if Medicare denied one line item on a claim, but paid the rest and Medicaid covers it. Do we submit it as a crossover or professional?

If it is a non-covered Medicare service, submit as a professional claim because there is no coinsurance or deductible to consider for a crossover.

22. Is the duplicate denial based on the same group NPI/taxonomy or is it based on the tax ID. We have a large multi-specialty group, and all providers have the same tax ID.

The edit that causes duplicate denials checks for same NPI and provider type.

23. OSU files for 150 clinics so there is a huge range of types of claims. Some meet the example you listed where the 25-modifier line didn't pay. We would void that claim and not use the HCA-17A form for them. However, will some meet the other example you listed?

If the criteria for special processing is met, the previously submitted claim does not need to be voided prior to submitting the denied line-item detail with the HCA-17A form.

24. Can we include the HCA-17A form with our documents and upload all in one set under the 77-transaction type?

Yes.

25. If we bill through a vendor, do we use the SoonerCare portal special processing for our appeals? We are an out-of-state provider.

Yes. The SoonerCare portal must be used to submit the special process claim using the HCA-17A.

26. Does OHCA prefer we use Adobe to combine into one set or upload separately?

Submitting as one set is preferred. But uploads can be separate, if the file types are the same.

27. Can you confirm the duplicate denial based on the same group tax ID, but different locations? would this be a special processing since it is different providers?

Different provider IDs would not be subject to duplicate denials.

28. Will there be a training for the new FFS and managed care that OHCA will be selecting in February from the RFP? We are not sure how that will affect claim submissions.

No trainings are scheduled regarding the MCOs. Submission to the MCOs will be based on the MCO's processes and procedures.



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29. If there is a Medicare denial for birth control on younger patient who also has Medicaid secondary, would that qualify for payment under the Medicare non-covered services? Does it need to be submitted as Medicaid primary? Do we need the Medicare denial/EOB to attach with this submitted claim?

That would be considered a Medicare non-covered service, but the remark code for that service on the EOB must be covered by Medicaid. If it is covered by Medicaid, submit as a professional Medicaid primary claim with Medicare EOB attached.

30. Regarding the incidental or mutually exclusive claim, should we file the claim with only the incidental code that denied with Medical records attached?

Yes. Only file the line item that denied as incidental or mutually exclusive on the special processed claim.

31. Do you offer training courses for reasons of denials and what they mean? I have found some of the reason of denials are vague.

In July 2020 a class called Advanced Claim Denials was held via webinar. The recording can be found at oklahoma.gov/ohca/providers/provider-training under Webinar Training Materials. Upcoming trainings can also be found on the provider training webpage. Look for another claim denials class in 2021.

32. If a patient was seen in the hospital and we filed a claim for that and then the patient had a same DOS at the office for the same providers, would that fall under special claims?

Yes, this scenario would require special claims processing utilizing the HCA-17A.

33. What is your recommendation to file a claim on a patient who doesn't have Medicaid at the time of service but a year later coverage is approved? How should a provider file a claim to OHCA for a patient who doesn't have an OHCA ID number or isn't in the OHCA system by name or any other ID to meet the 6-month filing requirement?

The claim can be filed using the patient's SSN. It can be filed on a paper claim or through an EDI clearinghouse. The portal will not allow the claim to be processed with the patient's SSN because the RID field is required and must be a valid ID number in the OHCA system.

34. Will a copy of "print preview" of original claim work as proof of timely filing?

Yes, as long as it includes the claim ID number and line items of service (date of service, procedure codes and billed amounts).



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35. What can you do if primary denied a claim, then it was submitted to OHCA who paid the claim, and then primary came back and paid the claim?

Please contact the adjustments unit at OHCA for further assistance. The claim can be voided, or an adjustment request can be submitted, depending on preference.

36. How do you obtain the DHS approval letter if you are a consultant who saw the patient in the hospital?

Providers may contact the patient for the approval letter or the member's caseworker at DHS.

37. If the HCA-17 submitted online was denied and the provider wants to submit a second inquiry with additional details (or an error was made on the HCA submitted), then how is the provider to submit a second HCA 17 on the same member?

A second HCA-17 inquiry may be submitted with additional information and documentation that was previously submitted. This may include timely filing proof, if the claim is received after 6 months from the date of service.

38. I have a prior authorization that runs from June through December. Recent claims have been denied by OHCA. When I looked up the PA online again to verify the modifier, the authorization end date has been changed from December to October. Why would OHCA have changed the PA authorization dates? Can I resubmit the claims for reconsideration based on my original copy of the authorization? This is for speech therapy.

Please contact the TherapyAdmin@okhca.org with the authorization number for assistance with the authorization end date modification reason.

39. What is HCA-17?

The HCA-17 is used for special processed claims that are submitted on paper. The only paper claims that are still accepted for special processing are those that have denied for crosswalk failed, and proof of timely filing is needed to be attached.

40. Is it acceptable to file an E&M office CPT code with a procedure CPT code and both lines pay out, if documentation is submitted to OHCA?

Yes, it is acceptable for an E&M office code to be billed with a procedure on the same date of service. There have been instances where claims will pay with supporting documentation in this scenario.

41. When submitting Medicare non-covered items for special processing, do we need to submit the claim via the portal like normal to get an ICN number? Then shall we re-submit



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with the HCA-17? Or would we be able to leave the ICN space blank on the HCA17 form in this case?

The related ICN field on the HCA-17A form should contain a claim that was previously submitted for reference of the appeal.

42. You said Soon to be Sooners claims do not require special processing. How about STBS claim denials because the patient miscarried? Can we send these via special processing? Or should it be appealed? We've been told these can get paid, but we don't know how to do it. Our doctors should get paid for these services because the patient sometimes still needs care after miscarriage.

Soon-to-be Sooners eligibility only covers services when there is a viable fetus. Providers are encouraged to contact provider services to verify the overall reason for denial since medical documentation must be attached to support the claim.

43. Can I request a peer-to-peer review for a line-item denial that documentation was submitted for mod 25? The line-item was still denied. If so, what shall I put in the description field of the HCA-17A?

Assistance with specific denials is available by contacting provider services.

44. What type of claims require an ordering provider?

Most services (except for E&M codes) require an ordering. Please refer to Dear provider letter 2016-26 for more information.

45. If the claim rejected as the contract code is missing in an additional field, how can we get proof of timely filing with an ICN?

You may contact OHCA provider services to request the ICN by phone to put the information in the related ICN field.

46. If we submitted a claim and forgot an attachment, do we have to wait until it processes before we can refile with the attachment?

OHCA recommends you wait for the first claim to deny before resubmitting the second claim with the complete supporting documentation. Otherwise, there is a risk the second claim will deny as duplicate to the first claim.

47. Is the only reason to use the HCA-17A for a timely filing is when it's not a Medicaid primary claim?



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Timely filing is not related to whether Medicaid is primary or secondary. The only reason to submit an HCA17-A for timely is if it pertains to one of the four exceptions: administrative agency corrective action or action taken to resolve a dispute; reversal of eligibility determination; investigation for fraud or abuse of the provider; or court order or hearing decision.

48. We have more than 4,000 claims denied due to provider incomplete information or not on file. This was due to error in credentialing. We have instructions in writing to submit with HCA-17 and claim to submit. Are these claims exempt from the 12/31/20 online submission?

Yes. Unless there is other proof of timely of another claim filed within the first six months from the date of service where providers can access that claim on the provider portal and pull that timely as proof. Otherwise, if there is no other claim filed within the first six months from the date of service, the claims that have denied for x-walk failed for billing provider may be appealed on paper by using the HCA-17 form and submitting a red and white HCFA 1500 form to the PO Box address for special processing. The inquiry section on the HCA-17 form must state the claim was denied for crosswalk failed and request OHCA pull timely filing for the claim.

49. A claim originally denied for documentation required because of modifier 25 on claim. Then 6 months timely filing limit expired. In this case, do we need to add HCA-17 form with portal submission?

No. In this case, the claim can be filed for regular processing with the documentation to support the modifier 25 and timely filing proof.

50. If a prior authorization was submitted and denied, but has been approved with the same information in the past, should this be reviewed via HCA-17? It was a Spinraza injection.

No, the HCA-17A process is only for specific claim denials, not authorizations. Please contact the appropriate unit for assistance with the authorization denial.

51. Please explain the professional vs professional crossover selection, with information to include Medicare Advantage plans.

If Medicare denies for non-covered service, then the claim type will be professional. If Medicare pays then the claim type will be crossover professional.



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52. A claim billed after timely filing limit and was denied for timely filing limit expired. It was initially rejected due to crosswalk failure. Do we need to submit with HCA-17 through paper submission?

If there is no other claim filed within the first six months from the date of service for the provider to pull for timely filing proof, then the claims denied for crosswalk failed for billing provider may be appealed on paper. Use the HCA-17 form and submit a red and white HCFA 1500 form to the PO Box address for special processing. The inquiry section on the HCA-17 form must state the claim was denied for crosswalk failed and request OHCA to pull timely filing for the claim.

53. What is the denial code for crosswalk missing?

The denial won't be accessible since the system cannot assign a provider ID number to the claim due to the crosswalk issue.

54. If a rejected claim doesn't have ICN number, then can we leave ICN field blank on the HCA-17A form?

Contact OHCA provider services to request the ICN by phone to put the information in the related ICN field.



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