

Authorization Tips

<p>Choose the Submission Method that works best for you.</p>	<p>Providers have multiple submission options:</p> <p>Direct Data Entry:</p> <p>All providers are encouraged to submit authorization requests via Direct Data Entry. Utilizing this method of submission will notify the provider immediately if authorization is not required. If authorization is required, the request will immediately route to the appropriate approver. <u>Utilizing Direct Data Entry allows the request to be received more quickly and will begin the authorization review process immediately.</u></p> <p>Fax:</p> <p>When submitting authorization requests via fax, it could take up to 24 hours for the fax to upload into the WCMBP System. The fax could be returned to the provider if mandatory information is missing on the template. Notification of missing mandatory information is mailed via USPS. Once you receive the return, you will have to make necessary corrections and resubmit the authorization request.</p> <p>NOTE: All faxes must be on the appropriate template to be ingested into the system. If the correct template isn't received, you will receive a fax alerting you that the faxed authorization was submitted on the incorrect template and must be re-sent using the correct authorizations template.</p> <p>Paper:</p> <p>When submitting authorization request via paper, it could take up to 24 hours for the request to upload into the WCMBP System once it is received in the mailroom.</p> <p>NOTE: All paper submissions must be on the appropriate template to be ingested into the system. If the correct template isn't received, you will receive a Return to Provider (RTP) letter. informing you that the authorization was submitted on the incorrect template and must be re-sent using the correct authorizations template.</p>
<p>Ensure your 9-digit OWCP Provider ID is active</p> <p>Active means that you can submit bills and authorizations for approval and payment consideration.</p>	<p>Things to know...</p> <ul style="list-style-type: none">• Providers must be actively enrolled into the program where they are submitting authorization. For example, if you are enrolled as a DFEC provider you would not be able to submit an authorization for the DEEOIC program until you enroll with the DEEOIC program.• If your provider number is inactive, visit the WCMBP Portal and refer to the "Tutorial" section where you will find instructions to help you enroll. Once you submit the enrollment via the portal, it can take up to five (5) business days to process.• Providers can track the status of their enrollment application by visiting the WCMBP Portal. Click 'Resume or Track an Enrollment Application' to view the status.
<p>Confirm that the Claimant is eligible for the service.</p>	<p>Before submitting an authorization request:</p> <ul style="list-style-type: none">✓ Confirm the claimant is eligible✓ Confirm if authorization is required for the services you are rendering.

	<ul style="list-style-type: none"> ❖ You can inquire on eligibility within the WCMBP Portal. NOTE: You must be logged into the WCMBP Portal to perform an eligibility inquiry. ❖ Refer to the Claimant Eligibility Tutorial for instructions on how to check claimant eligibility.
<p>Submit Authorization Requests with all mandatory information.</p>	<p>When submitting an authorization request form via fax or mail, be certain to fill the authorization request template out in its entirety. If any mandatory fields are left blank, the request will be returned to the submitter for correction.</p> <p>The following are examples of some fields providers commonly forget to populate:</p> <ul style="list-style-type: none"> • Code Type. • Is this an implant? If you answer yes, you must provide Implant Cost. • Is the requested therapy related to post-operative treatment within 60 days of surgery? • Providing care for a family member? If you answer yes, you must provide the relationship. • Specific Body Part to be treated. • Is this a second surgery on the same body part? • Applicable to Surgical Package Authorization requests only. <ul style="list-style-type: none"> ○ Where will the surgery be performed? (Section D2) ○ All locations/professions requiring authorization for the surgery (Section D3) ○ Has this surgery been performed previously on the same anatomical site? (Section E3) ○ Will this claimant require Home Health Services after surgery? (Section E4) ○ Will this claimant require Physical/Occupation Therapy Services after surgery? (Section E5)
<p>What action to take after receiving a Return to Provider (RTP) letter concerning the submitted authorization request.</p>	<p>Why RTP?</p> <p>Any “required” information missing on the authorization form will be RTP’d back to the provider listing all the reasons the authorization request could not be processed. This means that the provider will have to re-submit the authorization request once changes/updates have been made.</p> <p>Please refer to the instructions page on the authorization template to see all required fields for each section of the template. You can also refer to the example provided in the next section.</p> <p>Remember: Authorizations can be submitted via Direct Data Entry, Fax, or Paper.</p>

<p>Is supporting documentation mandatory for all authorization requests?</p>	<p>Choose the appropriate authorization type/template based on the type of services you wish to perform. Ensure you submit the authorization to the correct program as each program has unique requirements.</p> <p>DEEOIC Authorizations:</p> <ul style="list-style-type: none"> • Durable Medical Equipment (Include the prescription from the prescribing doctor as well as a letter of medical necessity) • General Medical (Supporting documentation is not required) • Rehabilitative Therapies (Supporting documentation is not required) • Medical Transportation (Include receipts/invoices to confirm estimated total charge) • Home Health (Include a letter of medical necessity, plan of care and evidence of in person exam) • Transplant (Include letter of medical necessity, recent clinical evaluation, and a copy of the treatment protocol) • Limiting the number of attachments will prevent receiving an error message due to file size limitation. <p>DFEC Authorizations:</p> <ul style="list-style-type: none"> • Durable Medical Equipment (Include the prescription from the prescribing doctor) • General Medical (Supporting documentation is not required) • Physical Therapy/Occupational Therapy (Include the prescription from the prescribing doctor. The prescription must be signed by a MD, DO, PhD, DPM, PA or NP.) • Transportation and Travel (Include receipts/invoices to confirm the estimated total charge) • HCPCS J-Code Unspecified/Unclassified (Include the prescription from the prescribing doctor) • Surgical Package (Supporting documentation is not required) • Home Health (Supporting documentation is not required)
<p>How to know exactly why an authorization request has been denied and by whom.</p>	<p>When an authorization request is denied by the claimants Case Examiner (CE), the CE will also send a denial letter to the claimant that details the reason(s) for the denial. Providers are encouraged to communicate with the claimant to obtain information on the denial.</p> <p>NOTE: CNSI does not deny authorization request nor send denial letters.</p>
<p>The importance of using appropriate diagnosis.</p>	<p>It is important to submit the diagnosis code(s) on the authorization template that is related to the claimant treatment.</p> <p>Why is it important?</p> <ul style="list-style-type: none"> ○ Submitting the appropriate diagnosis code(s) can ensure the treatment is directly-related to the claimant accepted condition. <p>You can view claimant's accepted conditions on the provider portal, WCMBP Portal. NOTE: You must be logged into the WCMBP Portal to perform an eligibility inquiry.</p> <p>Along with the diagnosis codes, ensure the appropriate diagnosis code pointer is used for each line item on the authorization request to correlate the injury/condition with the service being requested.</p>