Correction to ‘Prior Authorization Notices with Missing or Incomplete Information Must Be Responded to as Quickly as Possible’

Information posted February 13, 2015

Note: *This article applies to prior authorizations submitted to TMHP for processing. For prior authorizations processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorization, and reimbursement.*

This is a correction to the article titled “Prior Authorization Notices with Missing or Incomplete Information Must Be Responded to as Quickly as Possible,” which was posted on this website on February 6, 2015. The article should have stated that effective February 17, 2015, providers will have 14 business days from the request receipt date to respond to an incomplete prior authorization request.

Incomplete prior authorization requests are requests received by TMHP with missing, incomplete, or illegible information. The following is the complete correct article:

Effective February 17, 2015, providers will have 14 business days from the request receipt date to respond to an incomplete prior authorization request. Incomplete prior authorization requests are requests received by TMHP with missing, incomplete, or illegible information.

Prior to denying an incomplete request, TMHP’s Prior Authorization (PA) department will continue to communicate with the requesting provider in an effort to obtain the required additional information. A minimum of three attempts will be made to contact the requesting provider before a letter is sent to the client regarding the status of the request and the need for additional information.

If the additional information needed to make a prior authorization determination is not received within 14 business days from the request receipt date, the request will be denied as “incomplete.” To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

For fee-for-service (FFS) Medicaid requests that require a physician review before a final determination can be made, TMHP’s Physician Reviewer will complete the review within three business days of receipt of the completed prior authorization request. An additional three business days will be allowed for requests that require a peer-to-peer review with the client’s prescribing physician.

For Children with Special Health Care Needs (CSHCN) Services Program requests that do not appear to meet CSHCN medical policy, the TMHP PA Nurse will refer those requests to CSHCN Services Program for review and determination. CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

Note: *Providers may re-submit a new, complete request after receiving an incomplete denial; however, submission requirements related to timeliness will apply.*

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.