Section 5: Fee-for-Service Prior Authorizations

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SECTION 5: FEE-FOR-SERVICE PRIOR AUTHORIZATIONS

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5.1 General Information About Prior Authorization

Some fee-for-service Medicaid services require prior authorization as a condition for reimbursement. Information about whether a service requires prior authorization, as well as prior authorization criteria, guidelines, and timelines for the service, is contained in the handbook within Volume 2 that contains the service.

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or the claim is incomplete. Providers must verify client eligibility status before providing services.

In most instances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers' business hours as Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. The documentation of medical necessity must be maintained in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for the TMHP-approved holidays.

Note: *Authorization requests for services administered by a client's managed care organization (MCO) or dental plan must be submitted to the client's MCO or dental plan according to the guidelines that are specific to the plan under which the client is covered.*

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prior authorizations.

5.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

When an authorization request is submitted for a client who has received retroactive Texas Medicaid eligibility, providers should notify TMHP to avoid potential delays. Providers can notify TMHP of the retroactive client eligibility in one of the following ways:

- Add a comment in the additional comments field for authorization requests that are submitted online on the TMHP website at www.tmhp.com.
- Add a comment on the cover sheet or the authorization request form for authorizations that are faxed to TMHP.

If the authorization request is made by telephone, the caller can indicate to the representative at TMHP that the client has retroactive Texas Medicaid eligibility.

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For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying the client's eligibility. Providers are strongly encouraged to verify the client's eligibility frequently. Providers can verify eligibility by:

- Accessing the Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling the Automated Inquiry System (AIS) at 1-800-925-9126.

If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*).

5.1.2 Prior Authorization Requests for Newly Enrolled Providers

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, the provider must contact the appropriate TMHP Authorization Department to request prior approval before providing services that require prior authorization. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations are not issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. Providers should refer to specific handbook sections for details about authorization requirements, claims filing, and timeframe guidelines for authorization request submissions. Retroactive authorizations may be granted according to the timeframe guidelines for the specific service requested, and do not exceed those timeframes.

Note: *All claims must adhere to the claims filing deadlines as outlined in this manual. Retroactive authorizations cannot exceed the claims filing deadline, and are not issued if the date of services is more than 95 days from the date of enrollment as identified by the add date.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

5.1.3 Prior Authorization for Services Rendered Out-of-State

Texas Medicaid covers medical assistance services that are provided to eligible Texas Medicaid clients while they are in a state other than Texas; however, clients are not covered if they leave Texas to receive out-of-state medical care that can be received in Texas. Services that are provided outside of the state are covered by Texas Medicaid to the same extent that medical assistance is furnished and covered in Texas when the service meets one or more requirements of Texas Administrative Code (TAC) Title 1 §352.17.

Note: *Border state providers (providers that render services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Services that are rendered outside of the state must be prior authorized by Texas Medicaid, and TMHP must receive claims from out-of-state providers within 365 days of the date of service. Out-of-state providers that seek reimbursement for services that are rendered outside of the state must submit a Texas Medicaid Provider Enrollment application and be approved for enrollment in Texas Medicaid.

Transplant services that are provided out-of-state but available in Texas will not be reimbursed by Texas Medicaid. When requesting an out-of-state prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation.

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Medical assistance and transplant services that are provided to eligible Texas Medicaid clients must meet the criteria included in subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*). If services are rendered to eligible Texas Medicaid clients that do not meet the criteria, the services are not a benefit of Texas Medicaid and will not be considered for reimbursement.

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.6, "Out-of-State Medicaid Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

5.1.4 Prior Authorization Requests for Clients with Private Insurance

If a client's primary coverage is private insurance and Medicaid is secondary but prior authorization is required for Medicaid reimbursement, providers must follow the guidelines and requirements listed in the handbook for that service.

5.1.5 Prior Authorization Requests for Clients with Medicare/Medicaid

If a client's primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare's final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Note: *Refer to the appropriate handbooks in this manual for additional prior authorization guidelines for clients with dual eligibility.*

5.1.6 Prior Authorizations for Personal Care Services (PCS)

Before sending a prior authorization request for personal care services to TMHP, the Texas Department of State Health Services (DSHS) will fax the communication tool to the provider. The provider must verify that the information listed on the tool is accurate. If any information on the communication tool is inaccurate, the provider must call the DSHS case manager listed on the tool within three business days of receipt to explain the inaccuracy. The DSHS case manager will correct the communication tool and will fax the updated tool to the provider. The provider must review the updated communication tool and call the DSHS case manager if any inaccuracies remain.

If the provider does not contact the DSHS case manager within three business days of receipt of the communication tool, the case manager will send a prior authorization request to TMHP to have the authorization issued with the information provided on the communication tool.

Important: *If a provider fails to notify the DSHS case manager of inaccurate information within three business days of receipt of the communication tool, HHSC will not consider making changes to authorizations for past dates of service.*

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It is the PCS provider's responsibility to know the prior authorization period for each client who has an open authorization and to ensure that, before the authorization expires, a DSHS case manager has conducted a reassessment and extended the authorization through TMHP. If a provider has not received an updated provider notification letter from TMHP within 30 days of the authorization's expiration date, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517 and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, Option 2, and ask for a referral to have DSHS conduct a reassessment.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

Clients can experience a gap in service if an authorization is not updated before it expires. Providers will not be reimbursed for services provided after an authorization has expired and before a new authorization has been issued.

Providers must retain current client information on file.

5.1.6.1 Authorizations for Multiple PCS Clients Within the Same Household

DSHS case managers synchronize PCS authorizations within households that have multiple clients who are receiving PCS.

Synchronization of authorizations within households are made as PCS reassessments come due. When clients are due for reassessment, the DSHS case manager assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same 52-week authorization period. Some authorizations within a household may be shortened or closed and then reinstated to be in alignment with other clients in the same household. DSHS case managers communicate with the provider about the actions that are being taken using the existing Communication Tool.

Note: *There should be no lapse in services to the client.*

5.1.6.2 Verifying the National Provider Identifier (NPI) on PCS Authorizations

When an authorization notification letter is received by a PCS provider, the provider should verify that the correct NPI was used on the prior authorization for the PCS client. Providers must verify that the NPI on the prior authorization is correct for the location at which the client is receiving services.

Providers who provide services through the Agency option or the Consumer Directed Services (CDS) option must ensure that the NPI on the prior authorization is accurate for the option the client is using. If a provider discovers that the NPI used on the prior authorization is incorrect, the provider should contact the DSHS case manager and ask for the correct NPI to be submitted to TMHP.

5.1.7 Prior Authorization for Outpatient Self-Administered Prescription Drugs

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

5.1.8 Prior Authorization for Nonemergency Ambulance Transport

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Refer to: The *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

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According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

HRC states that a provider of nonemergency ambulance transport is entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the ambulance provider submits a copy of the claim for which payment was denied.

Refer to: Subsection 5.1.8.1, "Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number" in this section for more information about appeals.

The *Medical Transportation Program Handbook* (*Vol. 2, Provider Handbooks*) for more information about the Medical Transportation Program.

TMHP responds to nonemergency transport prior authorization requests within 2 business days of receipt of requests for 60 days or less. Providers should submit all requests for a prior authorization number (PAN) in sufficient time to allow TMHP to issue the PAN before the date of the intended transport.

If the client's medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

Medicaid providers who participate in one of the Medicaid Managed Care health maintenance organization (HMO) plans must follow the HMO's prior authorization requirements.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be suspended for additional medical information or be denied.

The following information helps TMHP determine the appropriateness of the transport:

- An explanation of the client's physical condition that establishes the medical necessity for transport. The explanation must clearly state the client's condition requiring transport by ambulance.
- The necessary equipment, treatment, or personnel to be used during the transport.
- The origination and destination points of the client's transport.

Prior authorization is required when an extra attendant is needed for any nonemergency transport.

When a client's condition changes, such as a need for oxygen or additional monitoring during transport, the prior authorization request must be updated.

Refer to: Subsection 2.4.9, "Extra Attendant" in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.1 Appealing Non-Emergent Ambulance Claims Denied for Missing Prior Authorization Number

Medicaid fee-for-service ambulance providers can appeal claims that have been denied for a missing prior authorization number that was not provided by the requesting physician, facility, or hospital for nonemergent transport. The ambulance provider must include proper documentation with the appeal.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

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The Appeals Process

The ambulance provider must submit the appeal as soon as it is realized that the requesting provider did not obtain the prior authorization. The appeal must be submitted according to all filing deadlines.

Refer to: "Section 7: Appeals" (*Vol. 1, General Information*) for information about filing deadlines.

The following documentation must be included with the appeal to support the need for transport:

- Documentation representing the client's medical condition.
- Other clinical information to support medical necessity.
- Level of service given.
- Mode of transportation requested.
- A copy of the run sheet, which must be signed by the emergency medical technician (EMT) in attendance, and which must also include the name and telephone number of the employee requesting the service for the physician, facility, or hospital.

5.1.8.2 Prior Authorization Types, Definitions

One-Time, Nonrepeating

One-time, nonrepeating requests are reserved for those clients who require a one-time transport. The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. Without a signature and date, the form is considered incomplete.

Recurring

Recurring requests, up to 60 days, are reserved for those clients whose transportation needs are not anticipated to last longer than 60 days. The request must be signed and dated by a physician, PA, NP, or CNS. Without a signature and date, the form is considered incomplete. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

5.1.8.3 Nonemergency Prior Authorization Process

To obtain prior authorization, providers must submit a completed Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form by fax to the TMHP Ambulance Unit at 512-514-4205. Prior authorization can also be requested through the TMHP website at www.tmhp.com.

The Nonemergency Ambulance Prior Authorization Form must not be modified. If the form is altered in any way, the request may be denied. The form must be filled out by the facility or the physician's staff that is most familiar with the client's condition. For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request between the requesting provider, which may include a physician, nursing facility, healthcare provider, or other responsible party. Ambulance providers may assist in providing necessary information such as their National Provider Identifier (NPI) number, fax number, and business address to the requesting provider. However, the Non-emergency Ambulance Prior Authorization Request form must be signed, dated, and submitted by the Medicaid-enrolled requesting provider, not the ambulance provider.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

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Medicaid providers may request prior authorization using one of the following methods:

- The client's physician, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www. tmhp.com.
- Hospitals may call TMHP at 1-800-540-0694 to request prior authorization Monday through Friday, 7 a.m. to 7 p.m., Central Time. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur.

A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place. Authorization requests for one day transports submitted beyond the next business day will be denied.

A request for a recurring transport must be submitted before the client is transported by ambulance.

After a prior authorization request has been approved, if the client's condition deteriorates or the need for equipment changes so that additional procedure codes must be submitted for the transport, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request form.

Clients who require a hospital-to-hospital or hospital-to-outpatient medical facility transport are issued a PAN for that transport only.

Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on nonemergency prior authorization for hospitals.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted through the TMHP website is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or the client is not Medicaid-eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. Providers may not appeal prior authorization request denials.

The requesting provider must contact the transporting ambulance provider with the PAN and the dates of service that were approved.

Refer to: Subsection 5.5.1, "Prior Authorization Requests Through the TMHP Website" in this section for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Incomplete online or faxed request forms are not considered a valid authorization request and are denied.

A nonemergency transport will be denied when a claim is submitted with a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered. In addition, a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered will not be accepted on appeal of the denial.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

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Refer to: Subsection 4.2.1, "Prior Authorization Requirements" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

5.1.8.4 Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and who require recurring trips that will extend longer than 60 days may qualify for an exception to the 60-day prior authorization request.

To request an exception, providers must submit all of the following documentation:

- A completed Nonemergency Ambulance Exception form that is signed and dated by a physician. Without a physician's signature and date, the form is considered incomplete.
- Medical records that support the client's debilitating condition, which may include, but is not limited to:
  - Discharge information.
  - Diagnostic images (e.g., MRI, CT, X-rays)
  - Care plan.

Note: *Documentation submitted with statements similar to "client has a debilitating condition" are insufficient.*

5.1.8.5 Documentation of Medical Necessity and Run Sheets

5.1.8.5.1 Documentation of Medical Necessity

Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Documentation to support medical necessity must include one of the following:

- The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client's health (i.e., injury, surgery, or the use of respiratory equipment). The functional, physical, and mental limitations that have rendered the client bed-confined must be documented.

  Note: *Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.*

- The client's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the client's health (e.g., injury, surgery, or the use of respiratory equipment).
- The client is a direct threat to himself or herself or others, which requires the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (e.g., suicidal).

When physical restraints are needed, documentation must include, but is not limited to, the following:

- Type of restraint
- Time frame of the use of the restraint
- Client's condition

Note: *The standard straps used in an ambulance transport are not considered a restraint.*

5.1.8.5.2 Run Sheets

The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care that was provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

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The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a nonemergency ambulance transport, the transport may not be covered by Texas Medicaid.

The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.

It is the responsibility of the ambulance provider to maintain (and furnish to Texas Medicaid upon request) concise and accurate documentation. The run sheet must include the client's physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate means of transport.

Coverage will not be allowed if the trip record does not contain a sufficient description of the client's condition at the time of the transfer for Texas Medicaid to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client's condition is limited to statements or opinions such as the following:

- "Patient is nonambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand or walk."

The run sheet should "paint a picture" of the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request.)

5.1.8.6 Nonemergency Prior Authorization and Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the eligibility "add date," which is the date the client's Medicaid eligibility is added to TMHP's eligibility file.

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services that are provided to fee-for-service Medicaid clients during a client's retroactive eligibility period (i.e., the period from the effective date to the add date), providers must obtain prior authorization within 95 days of the client's add date and before submitting a claim for those services to TMHP.

For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying the client's eligibility. Providers are strongly encouraged to verify the client's eligibility frequently. Providers can verify eligibility by:

- Checking the TMHP electronic data interchange (EDI).
- Accessing the Texas Medicaid Client Portal for Providers.
- Using TexMedConnect.
- Calling the Automated Inquiry System (AIS) at 1-800-925-9126.

If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

If a client's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. Initially this request will be denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date on which the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be considered.

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To inquire about Medicaid eligibility, providers can contact AIS at 1-800-925-9126.

5.1.9 Nonemergency Transport Authorization for Medicare and Medicaid Clients

Providers should simultaneously request prior authorization for the nonemergency transport from TMHP for an Medicaid Qualified Medicare Beneficiary (MQMB) client in the event the service requested is denied by Medicare as a non-covered service.

Note: *Qualified Medicare Beneficiary (QMB) clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.*

5.2 Authorization Requirements for Unlisted Procedure Codes

Providers have the option to obtain prior authorization before rendering the service if all of the required information is available. When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request:

- Client's diagnosis.
- Medical records that show the prior treatment for this diagnosis and the medical necessity of the requested procedure.
- A clear, concise description of the procedure to be performed.
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested.
- Documentation that this procedure is not investigational or experimental.
- Place of service in which the procedure is to be performed.
- The physician's intended fee for this procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation.

If any of this information is unavailable at the time the prior authorization is requested, the request will be returned as incomplete; however, this is not a denial of reimbursement. If the required information becomes available before the service is performed, the prior authorization request can be resubmitted, or the required medical necessity and payment documentation can be submitted with the claim after the service is provided to be considered for reimbursement.

The prior authorization number must appear on the claim when it is submitted to TMHP. Claims submitted without the appropriate prior authorization will be denied.

5.3 Benefit Code

A benefit code is an additional data element that identifies a state program.

Providers that participate in the following programs must use the associated benefit code when they submit prior authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
Texas Health Steps (THSteps) Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

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Program	Benefit Code
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) providers	EC1
Tuberculosis (TB) Clinics	TB1
Intellectual or Developmental Disability (IDD) case management providers	MH2
***Agencies only—Benefit codes should not be used for individual family planning providers.**	

5.4 Submitting Prior Authorization Forms

A physician or health care provider may submit a medical prior authorization recertification request up to 60 days before the expiration of the current authorization of services. Once submitted, the recertification request will be reviewed and a determination will be issued before the existing authorization ends.

For some services, a prior authorization recertification for a course of treatment cannot be issued 60 days before the end of the current authorization period. For example, physical therapy, occupational therapy, speech therapy, and private duty nursing prior authorizations cannot be recertified 60 days before the end of the current authorization period because of requirements for timely documentation. This limitation applies to both fee-for-service and managed care clients.

When a recertification request cannot be reviewed 60 days before the current prior authorization ends, the provider will receive a response from TMHP explaining that the request has been submitted too early, and the provider will need to resubmit at a later time. For managed care clients, providers should contact the client's specific MCO for details.

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If any essential field on a prior authorization request has missing, incorrect, or illegible information, TMHP returns the original request to the provider with the following message:

> "TMHP Prior Authorization could not process this request because the request form submitted has missing, incorrect, or illegible information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP within 14 business days of the request receipt date."

TMHP uses the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned are not considered when determining the start date of service.

Providers that need to update information on a prior authorization request form must strike through the incorrect information with a single line. The original content must remain legible, and the change must be initialed and dated by the original signatory or ordering physician when applicable. Changes that have been made using correction fluid (e.g., Wite-Out) will not be accepted.

Providers must respond to an incomplete prior authorization request within 14 business days of the request receipt date. Incomplete prior authorization requests are requests that are received by TMHP with missing, incomplete, or illegible information.

Prior to denying an incomplete request, TMHP's Prior Authorization department will attempt to get the correct information from the requesting provider. The Prior Authorization department will make a minimum of three attempts to contact the requesting provider before sending a letter to the client about the status of the request and the need for additional information.

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If the information that is necessary to make a prior authorization determination is not received within 14 business days of 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 prior authorization nurse will refer those requests to the CSHCN Services Program for review and determination. The CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

Note: *Providers may resubmit a new, complete request after receiving a denial for an incomplete request; however, the timeliness submission requirements will apply.*

Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client Medicaid number (patient control number [PCN])
- Client date of birth
- Provider name
- National Provider Identifier (NPI)
- *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code
- Quantity of service units requested based on the CPT or HCPCS code requested

5.4.1 Recreating TMHP Prior Authorization and Authorization Forms to Fill Out Electronically

Providers are allowed to recreate a Texas Medicaid or CSHCN Services Program prior authorization or authorization form in order to transfer it to an electronic format only if there are no alterations in the form's content or placement of information (field location).

To ensure that the most current version of the form is utilized, all forms submitted to the prior authorization department for processing must include the form number, effective date and revision date, if applicable, as it appears on the original TMHP form that is published on the TMHP Forms web page.

Important: *Prior authorization and authorization forms recreated and filled out electronically on the provider's computer must continue to be printed and faxed or submitted by mail. To submit prior authorization and authorization requests electronically, providers must use the prior authorization tool available on the TMHP website.*

5.5 Prior Authorization Submission Methods

Prior authorization requests can be submitted by fax, mail, telephone, and online through the TMHP website at www.tmhp.com. The methods to use to request the prior authorization depends on the service being requested.

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5.5.1 Prior Authorization Requests Through the TMHP Website

Online prior authorization requests for some services in the following areas can be submitted through the TMHP website at www.tmhp.com:

- Home Health
- Home Telemonitoring
- Special Medical Prior Authorization (SMPA)
- CCP
- Ambulance
- Substance Use Disorder (SUD) services

The benefits of submitting prior authorization requests through the TMHP website include:

- Online editing to ensure that the required information is being submitted correctly.
- The prior authorization number is issued within seconds of submission and confirms that the prior authorization request was accepted. Before providing services, providers must confirm that the prior authorization was approved.
- Notification of approvals and denials are available more quickly.
- Extension requests and status checks can be performed online for prior authorization requests that were submitted online.

Providers can access online prior authorization requests from the Prior Authorization page located under the Topics tab on the TMHP website at www.tmhp.com.

Instructions for submitting prior authorization requests on the TMHP website are located in the Help section at the bottom of the Prior Authorization page.

Prior authorizations that are submitted online will be processed using the same guidelines as prior authorizations submitted by other methods.

Before providers can submit online prior authorization requests, providers must register on the TMHP website and assign an administrator for each National Provider Identifier (NPI), if one is not already assigned. Users who are configured with administrator rights automatically have permission to submit prior authorization requests.

The NPI administrator can assign submission privileges for nonadministrator accounts. Billing services and clearinghouses must obtain access to protected health-care information through the appropriate administrator of each NPI provider number for which they are contracted to provide services.

5.5.1.1 Duplicate Validation Check

Prior authorizations submitted to TMHP electronically on the TMHP website are subject to a duplicate validation check. Prior authorizations that are duplicates of a previously submitted authorization return an immediate response with an associated duplicate submission error message.

The error message instructs providers to either update or remove details of the prior authorization submission.

If there is a modifier needed for authorization or claims processing, providers should indicate the primary modifier in the field labeled “Modifier 1.”

The appropriate modifier that identifies the type of therapy being requested needs to be used when providers submit requests for physical, occupational, and speech therapy.

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5.5.1.2 Document Requirements and Retention

If information provided in the online request is insufficient to support medical necessity, TMHP Prior Authorization staff may ask the provider to submit additional paper documentation to support the medical necessity for the service being requested.

Submission of prior authorization requests on the secure pages of the TMHP website does not replace adherence to and completion of the paper forms/documentation requirements outlined in this manual and other publications.

Documentation requirements include, but are not limited to, the following:

- Documentation that supports the medical necessity for the service requested.
- Completion and retention in the client's medical record of all required prior authorization forms
- Adherence to signature and date requirements for prior authorization forms and other required forms that are kept in the client record, including the following:
  - All prior authorization forms completed and signed before the online prior authorization request is made
  - Original handwritten or electronic signatures (Stamped signatures and images of wet signatures are not accepted by Texas Medicaid.)
- A printed copy of the Online Request Form, which must be retained in the client's medical record

Any provider, client, or client's responsible adult who is required to sign a prior authorization form or any supporting documentation may do so using a wet or electronic signature. Any electronic signature technologies that are used must comply with all federal and state statutes and administrative rules.

Any required documentation that is missing from the client's medical record subjects the associated payments for services to be recouped.

5.5.1.2.1 Acknowledgment Statement

Before submitting each prior authorization request, providers (and submitters on behalf of providers) must affirm that they have read, understood, and agree to the certification and terms and conditions of the prior authorization request.

Providers and submitters are separately held accountable for their declarations after they have acknowledged their agreement and consent by checking the "We Agree" checkbox after reviewing the certification statement and terms and conditions.

5.5.1.2.2 Certification Statement

"The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

"By checking 'We Agree' you agree and consent to the Certification above and to the TMHP `Terms and Conditions.'"

5.5.1.2.3 Terms and Conditions

"I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by Medicaid for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or

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similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

"Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from federal and state funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law."

Omission of information or failure to provide true and accurate information or notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

5.5.2 Prior Authorization Requests to TMHP by Fax, Telephone, or Mail

When submitting prior authorization requests through fax or mail, providers must submit the requests on the approved form. If necessary, providers may submit attachments with the form. Providers must follow the guidelines and requirements listed in the handbook for the service. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Prior authorization requests must be signed and dated by a physician or dentist who is familiar with the client's medical condition before the request is submitted to TMHP. When allowed, prior authorizations must be signed and dated by an advanced practice registered nurse (APRN) or PA who is familiar with the client's medical condition before the request is submitted to TMHP. Prior authorization requests for services that may be signed by a licensed health-care provider other than a physician, dentist, or when allowed by an APRN and PA, do not require handwritten signatures and dates. Electronic signatures from an RN or therapist are acceptable when submitting therapy requests for CCP.

All signatures must be electronic, digital or handwritten. An electronic or digital signature must be derived using software that creates a digital signature logo with a system-generated date and time stamp or includes the logo of the digital software used. Photocopy or ink stamp of a handwritten signature or a typed signature without a digital stamp are not permitted. TMHP will not authorize any dates of services on the request earlier than the date of the provider's signature. The prior authorization request that contains the original signature must be kept in the client's medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request.

> ***Note:*** *Obstetric (OB) services providers are no longer allowed to initiate prior authorization requests or ultrasound extension requests over the telephone.*

To initiate a new prior authorization request or to request an extension of an existing prior authorization, OB services providers are required to submit the request online using the TMHP secure provider portal or on paper by faxing or mailing the applicable prior authorization form to TMHP.

Providers can continue to use the Prior Authorization telephone line to inquire about the status of the prior authorization requests that have been submitted to TMHP online, by fax, or mail.

5.5.2.1 Prior Authorization Calls

Initial prior authorization calls are handled by the TMHP Contact Center. If the contact center representative determines that a prior authorization inquiry can be better handled by the TMHP Prior Authorization department, the TMHP Contact Center representative will transfer the call to a Prior Authorization Clinician.

> ***Note:*** *This does not impact the timeframes for the resolution of more complex issues.*

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5.5.2.2 TMHP Prior Authorization Requests by Fax

Providers who fax new prior authorization requests, resubmitted requests, or additional information to complete a request must include:

- A working fax number on the prior authorization form, so that they can receive faxed responses and correspondence from TMHP.
- The last four digits of the client's Medicaid identification number on the fax coversheet.

Note: *Prior authorization cover sheets must not contain any protected health information (PHI) per HIPAA. The faxed cover sheet is not meant to replace the appropriate prior authorization form. Providers cannot include information on a cover sheet that is needed to complete the review of a request.*

If a provider is faxing prior authorization requests for more than one client, each client request must be faxed individually with a separate cover sheet. Requests received with multiple clients will be returned to the provider for resubmission to ensure Health Insurance Portability and Accountability Act (HIPAA) compliance.

Contact	Fax Number
Ambulance Authorization Fax (includes out-of-state transfers)	512-514-4205
Home Health Services Fax	512-514-4209
CCP Fax	512-514-4212
Prior Authorization MH/SUD Fax	512-514-4211
Outpatient Psychiatric Fax	512-514-4213
Radiology Fax	833-912-1129
TMHP Special Medical Prior Authorization (SMPA) Fax (including transplants)	512-514-4213

5.5.2.3 TMHP Prior Authorization Requests by Telephone

Contact	Telephone Number
Ambulance Authorization (including out-of-state transfers)	1-800-540-0694

5.5.2.4 TMHP Prior Authorization Requests by Mail

Contact	Address
Ambulance (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations PO Box 200735 Austin, TX 78720-0735
CCP	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) Prior Authorization PO Box 200735 Austin, TX 78720-0735
Dental	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 204206 Austin, TX 78720-4206
Home Health Services	Texas Medicaid & Healthcare Partnership Home Health Services Prior Authorization PO Box 202977 Austin, TX 78720-2977

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Contact	Address
Radiology Services	Texas Medicaid & Healthcare Partnership Radiology Prior Authorization 12365A Riata Trace Parkway Austin, TX 78727
SMPA	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization 12365A Riata Trace Parkway Austin, TX 78727

5.5.3 Home Health Services Prior Authorizations

Home health services providers cannot initiate new prior authorization requests or request extensions over the telephone. The following home health services are affected:

- Skilled nursing and home health aide visits
- Physical and occupational therapy
- Durable medical equipment (DME)
- Expendable medical supplies

Home health services providers must initiate new prior authorization requests or request extension of existing prior authorizations online using the TMHP secure provider portal or on paper by faxing or mailing TMHP the appropriate paper prior authorization form.

Home health services providers can use telephone number 1-800-925-8957 for follow-up and status inquiry of prior authorizations.

5.5.4 Radiology Prior Authorizations

TMHP performs radiology prior authorization services.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) to determine which radiology services require a prior authorization.

5.5.4.1 Retroactive Authorization Requests

Retroactive authorization requests for outpatient diagnostic computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET), and cardiac nuclear imaging services for Texas Medicaid fee-for-service clients must be submitted to TMHP. The retroactive authorizations requests must be submitted to TMHP no later than 14 calendar days after the day on which the study was completed, regardless of the method of submission. If the retroactive authorization request is submitted after the allotted time, the authorization request will not be processed.

5.6 Verifying Prior Authorization Status

Prior authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process.

Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Providers may also check status of prior authorizations that are issued by TMHP by using the following numbers.

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Contact	Telephone Number
Personal Care Services (PCS) Prior Authorization Inquiry Line	1-888-648-1517
CCP and Home Health Status Line	1-800-846-7470
All other authorization requests	1-800-925-9126

5.7 Prior Authorization Notifications

TMHP sends a notification to the provider when the prior authorization is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, TMHP will ask the requesting provider to furnish the additional documentation needed before TMHP can make a decision on the request. If the requesting provider does not respond to the request for additional information, the prior authorization request will be denied. It is the requesting provider's responsibility to contact the appropriate provider, when necessary, to obtain the additional documentation.

5.8 Prior Authorization Denials Appeals Process

Prior authorizations that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department with new or additional information for reconsideration.

If the request is denied a second time, or if the provider has no new or additional information, the provider may file an Administrative Appeal to HHSC. Providers must include a copy of the denial letter.

It is strongly recommended that providers maintain a list that details the prior authorizations, including:

- Client's name
- Client's Medicaid number
- Date of service
- NPI
- Items submitted

This information will be required if a provider needs to file an administrative review.

5.9 Closing a Prior Authorization

When a client decides to change providers or elects to discontinue prior-authorized services before the authorization ends, that prior authorization is updated to reflect the early closure date and the reason for closure.

If a client with an active prior authorization changes providers, TMHP must receive a change of provider letter with the request for a new prior authorization in accordance with submission guidelines for the service. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the previous provider that the client is discontinuing services and the effective date of the change. TMHP also notifies the previous provider by mail when a prior authorization has been closed early. The letter includes the beginning date of service, the revised ending date of the authorization, and the reason for the early closure.

If a provider submits a Change of Provider letter in the middle of an existing authorization period, the current authorization will be end-dated and the original provider will be notified. TMHP will send the new provider an authorization that begins on the next business day after the end date and lasts through the remainder of the authorization period.

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5.10 Submitting Claims for Services That Require Prior Authorization

Claims submitted for services that require prior authorization must indicate the authorization number, NPI, procedure codes, dates of service, required modifiers, number of units, and the amount for manually priced procedure codes as detailed on the authorization letter. If the prior authorization letter shows itemized details and the provider rendered all services listed, the details on the claim must match the details on the prior authorization letter.

Important: *Claims processing and payment may be delayed if the detailed information on the authorization letter and the claim details do not match exactly.*

Claims for prior authorized services must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the applicable electronic fields or in the following blocks for paper claim forms:

Paper Claim Form	Block for Prior Authorization Number
CMS-1500 (professional) claim form	Block 23
UB-04 CMS-1450 (institutional) claim form	Block 63
American Dental Association (ADA) claim form	Block 2
2017 claim form	Block 30

Refer to: Subsection 6.1.3, "TMHP Paper Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

5.10.1 Authorization and Manually Priced Claims

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for them using the MSRP that was submitted with the authorization request and the following information that is listed on the authorization letter:

- Authorization number
- NPI
- Procedure codes
- Dates of service
- Types of service
- Required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter should not be billed on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

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5.11 Guidelines for Procedures Awaiting Rate Hearing

For procedure codes that require prior authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider handbook. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process for the procedure codes is completed to request prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day filing deadline and for ensuring that the prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Claims for procedure codes awaiting a rate hearing are denied. TMHP automatically reprocesses affected claims; providers are not required to appeal the claims unless they are denied for additional reasons after the claims reprocessing is complete. If the required prior authorization number is not on the claim at the time of reprocessing, the claim is denied for lack of prior authorization.

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