



PRIOR AUTHORIZATION ON THE PORTAL

A SUBMISSION GUIDE FOR ONLINE PRIOR
AUTHORIZATION REQUESTS



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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Provider Training Manual

Document Purpose

This document sets forth the procedures for online prior authorization requests, using the Texas Medicaid & Healthcare Partnership's (TMHP's) Prior Authorization (PA) on the Portal system.

This document does not replace the [Texas Medicaid Provider Procedures Manual \(TMPPM\)](#) or the [Children with Special Health Care Needs \(CSHCN\) Services Program Provider Manual](#). It is your responsibility to regularly review these resources and any relevant web articles published on the TMHP website at tmhp.com.

PA on the Portal Request Flow

Preparing Your Prior Authorization Request Submission

Before submitting a PA on the Portal request, ensure that you have the necessary information to fill out all essential fields on the prior authorization forms.

Examples of essential fields include but are not limited to the following:

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

If any essential field on a prior authorization request has missing, incorrect, or illegible information, TMHP will return the original request to you.

For some prior authorizations, clinical documentation is required. Be prepared to give a brief narrative of medical necessity in the Documentation field or in an attached document if more room is needed. Attach supporting clinical documentation such as medical records, progress notes, lab reports, etc., as needed.

Because Medicaid and the CSHCN Services Program are payers of last resort, you must confirm whether the client has primary coverage with private insurance or Medicare. If Medicare denies a service, then a Medicaid or CSHCN Services Program authorization is required. The Medicare final denial letter and Medicare Remittance Advice and Notification (MRAN) will need to be attached to the prior authorization request.

TMHP accepts electronic signatures, using approved software, and original handwritten signatures. Electronic attachments must be signed before they are uploaded to the PA on the Portal.

Submitting Your Request

Select the **SUBMIT** button to check the prior authorization request against a series of validation edits, which confirm that all required fields have been populated. After all fields pass the validation edits, the prior authorization request is sent to the TMHP system. Further validations, such as procedure codes and diagnosis codes, occur to ensure that certain data elements are valid for the service requested.

If the system identifies invalid data, an error message will be displayed at the top of the screen. To proceed, update the appropriate field and resubmit the request.

When a request is complete and passes all validation edits, a confirmation message will be displayed at the top of the screen, and the following will occur:

- The prior authorization request is saved.
- The user is given a prior authorization number.
- The current status of the prior authorization request appears. It is recommended that you allow one hour before checking the detailed status of the request.

If there are errors that have not been corrected, you will not be able to submit the prior authorization request. Errors will be indicated with small yellow triangles, and fields will be outlined with red. An error message will also display at the top of the page listing the required actions to correct the errors.

Statuses and Final Determinations

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

You can check the status of prior authorization requests that are submitted online by signing into the My Account Portal on the TMHP website at tmhp.com.

Additional Information Requests

TMHP will send a notification to you when a prior authorization request is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, you are required to provide the additional information and necessary documentation before TMHP can process the request. If you do not respond, the prior authorization request will be denied. It is your responsibility to contact the appropriate provider, when necessary, to obtain the additional information.

Denied Requests

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

Medicaid Fee-for-Service Appeal Process

If the request is denied a second time, or you have no new or additional information to provide, you may submit an administrative appeal to the Texas Health and Human Services Commission (HHSC). You must include a copy of the denial letter.

It is strongly recommended that you maintain details of the prior authorization requests, including the following:

- Client's name
- Client's Medicaid number
- Date of service (DOS)

- NPI
- Items submitted

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

Appeal requests can be mailed to the following:

Texas Health and Human Services Commission
HHSC Claims Administrator Operations Management
Mail Code-91X, P.O. Box 204077
Austin, Texas 78720-4077

Providers may request the status of an administrative appeal by sending an email to HHSC at mcd_administrative_appeals@hhsc.state.tx.us. The email must include the NPI/API number, client name, Medicaid number, DOS, and, if available, the case review number.

CSHCN Services Program Appeal Process

Providers and clients who have received a denied authorization or prior authorization request from TMHP may submit a request for an administrative appeal to the CSHCN Services Program if they are dissatisfied with TMHP's decision.

All CSHCN clients and providers must submit requests for an administrative review within 30 calendar days of the date that TMHP denied the authorization or prior authorization request. Requests for an administrative review and all supporting documentation must be submitted by mail or fax. Appeal requests can be mailed to the following:

CSHCN Services Program—Administrative Review
MC-1938, P.O. Box 149347
Austin, TX 78714-9347

Appeal requests can be faxed to the following:

CSHCN Services Program—Administrative Review
Fax: 512-776-7238

Additional information requested by the CSHCN Services Program must be submitted within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case will be closed.

Getting Started

TMHP PA on the Portal is available through the [TMHP secure portal](#), which requires each provider to set up a user account and obtain a user ID and password. Providers are encouraged to take advantage of the PA on the Portal features.

For specific information on how to create and manage your account, refer to the [TMHP Portal Security Training Manual](#).

Additional information about the following topics is available in the *TMHP Portal Security Training Manual*:

- Provider administrator responsibilities
- Account activation
- Managing user accounts and permissions
- Requesting a forgotten user ID and resetting a password

System Requirements

When submitting a prior authorization request through PA on the Portal, you are subject to the same policies, procedures, and guidelines for submitting prior authorization requests by paper, phone, or fax. Prior authorization policies are available in the [Texas Medicaid Provider Procedures Manual](#) and the [CSHCN Services Program Provider Manual](#).

The minimum system requirements to use PA on the Portal are as follows:

- Cookies must be enabled.
- Chrome® and Microsoft Edge® are recommended browsers. (Internet Explorer® is no longer supported.)
- Providers should use Adobe Reader Version® 11.0 or higher to ensure full functionality of electronic forms.

Review TMHP Account Permissions

Providers that currently have a user ID and password and are able to log on to the TMHP secure portal are encouraged to review their permissions. The account administrator will need to grant the PA Submitter and the Eligibility Verification (EV) Performer access, as necessary, for each provider NPI/API that will be used to submit prior authorization requests through PA on the Portal.

Please select the permissions to grant **GHI789** to **NPI/API 1234567890, 193200000X, CSN, 111 MAIN ST STE A, 79936-7601**.

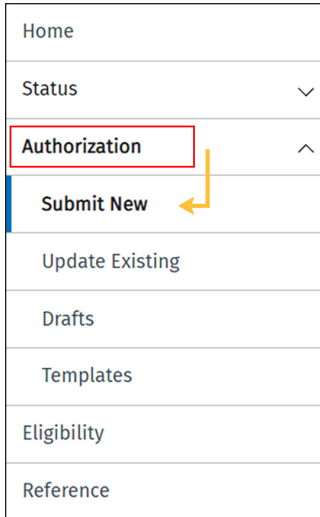
Permissions(s) for: NPI/API 1234567890, 193200000X, CSN, 111 MAIN ST STE A, 79936-7601												
View 835 Reports <small>More Info</small>	PA Submitter <small>More Info</small>	View Payment Amounts <small>More Info</small>	View MET Provider Reports <small>More Info</small>	View ACA PCP Supplemental Payment Reports <small>More Info</small>	CSI Performer <small>More Info</small>	EV Performer <small>More Info</small>	Claim Submitter <small>More Info</small>	Appeal Submitter <small>More Info</small>	Provider Credentialing <small>More Info</small>	Provider Administrator <small>More Info</small>	EW Portal Provider Profile <small>More Info</small>	OIG UR: Provider Upload <small>More Info</small>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Link User

Submit New Requests

Providers can use PA on the Portal to create new prior authorization requests and search for, edit, and update existing prior authorization requests when applicable. For information on how to update an existing request, refer to the [“Updating Existing Prior Authorization Requests”](#) section. To submit a new request, click the **Authorization** button on the navigation menu. The menu will expand to reveal the Submit New, Update Existing, Drafts, and Templates subsections.

Click **Submit New** to begin a new request.



Note: TMHP will not forward prior authorization requests to managed care organizations (MCOs).

Client Eligibility Pre-check

A screenshot of a web form titled "Client Eligibility Pre-check". At the top, there is a note: "Please Note: This is a client eligibility pre-check. For a more comprehensive eligibility check you may use [TexMedConnect](#). These verifications do not guarantee approval of the prior authorization request." The form contains several input fields: "NPI/API" with a dropdown menu and a blue double-right arrow button; "Client Id" with a text input field containing "123456789"; "Authorization Area" with a dropdown menu; "Submission Type" with a dropdown menu; "Requested Authorization From" with a date picker; and "Requested Authorization Through" with a date picker. At the bottom, there are two buttons: "Check Eligibility" (in blue) and "Continue" (in light gray).

Client Eligibility Pre-check provides a preliminary indication of a client’s eligibility for the specified service and is the first screen displayed when beginning a new prior authorization request. This does not guarantee prior authorization request approval or client eligibility at the time of service.

It is each provider's responsibility to verify the client's eligibility at the time that each service is provided. TMHP will not reimburse services provided to ineligible clients. Verify the information you provide in the eligibility pre-check before proceeding.

This information will be autofilled on future screens and cannot be updated without starting a new request.

TexMedConnect Interactivity

A more comprehensive eligibility check is available through the TexMedConnect tool in your [TMHP secure portal account](#) on tmhp.com. A link is provided to TexMedConnect within PA on the Portal. Portal users can have multiple browser windows open, allowing access to both TexMedConnect and PA on the Portal simultaneously. For more information on TexMedConnect, refer to the [TexMedConnect Acute Care Manual](#).

Error Messages

Error messages will display on the screen if incorrect information is entered or required information is missing. All required fields are indicated with a red dot. If you receive an error message on the Client Eligibility Pre-check screen, you will need to correct the error before continuing.

Examples of error messages on the Client Eligibility Pre-check screen include the following:

- "Client ID not found. Please verify and try your entry again."
- "Client is not eligible for dates of service entered. Please verify and try your entry again."
- "Client is not eligible for the requested service."
- "The Client ID you have entered is Medicaid eligible. The CSHCN Services Program does not pay for services provided to children who are also eligible for Medicaid. Please select the appropriate Authorization Area indicated for Medicaid."
- "The Client ID you have entered is CSHCN eligible. Please select the Authorization Area All CSHCN Services Program to continue with this request."

▲ CSHCN is unable to process your request. The NPI/API you selected is not associated to an address registered to the CSHCN Program on file. Please verify NPI/API and try again. For assistance with the application process or to obtain enrollment forms, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time

If you receive an error message, verify the information you keyed in and try submitting the request again. If any information has been updated on the screen, you must click **Check Eligibility** again. If the information entered is correct and you are still receiving an error message, call the TMHP Contact Center at 800-925-9126.

Examples of error messages on the Service Details tab include the following:

- "Procedure code is required."

- “Type of Service is required.”
- “Place of Service is required.”

You are able to continue completing the prior authorization request if errors are present on the Service Details tab. However, the errors need to be corrected before submission. The [“Service Details Tab”](#) is discussed later in this document.

Fields with errors will be indicated with small yellow triangles and outlined with red. Hover your mouse over the yellow triangle for more information about the error. An error message will also display at the top of the page listing the required information necessary to correct the errors.

▲ Error message alert with details below:

- First Diagnosis Code is required.
- Procedure code is required.
- Place of Service is required.

Service Details

	FROM DOS *	TO DOS *	HCPCS/ PROCEDURE CODE *	MODIFIER	TYPE OF SERVICE	PLACE OF SERVICE *	REQUESTED QUANTITY	REQUESTED FREQUENCY	
1	09/23/2022	09/28/2022	<div style="border: 2px solid red; background-color: yellow; padding: 2px;"> </div>	<input type="text"/>	Medical Services	<div style="border: 2px solid red; background-color: yellow; padding: 2px;">Please select a Va </div>	<input type="text"/>	Please sel	<input type="button" value="Remove"/>

Showing 1 to 1 of 1 entries

To add more service details please enter the number of rows and hit enter.

Tool Tips are helpful hints that will display by hovering the cursor over an icon, image, or hyperlink.

Examples of Tool Tips include the following:

Diagnosis

Code: * **Description:**

Diagnosis code must be entered without the decimal

[Add additional Diagnosis Code+](#)

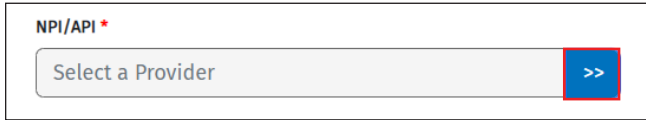
Requested Authorization From *

Click to select date

NPI/API, Client ID, Authorization Area, and Submission Type

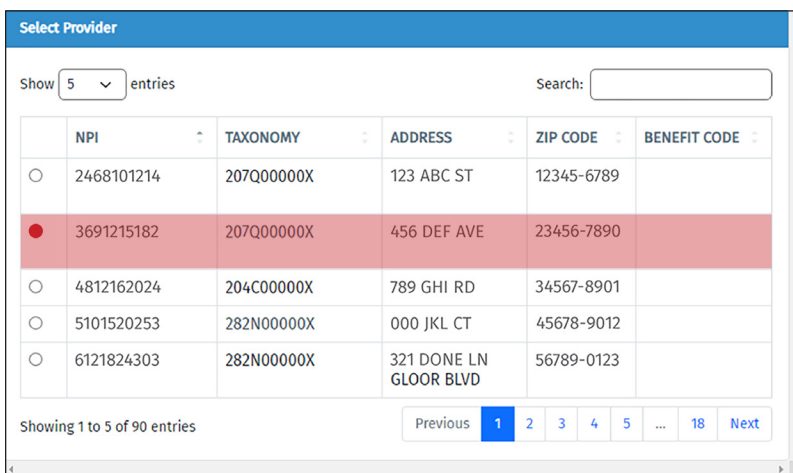
Note: All fields in this section are required as indicated by the red dots to select the NPI/API, Client ID, Authorization Area, and Submission Type.

- 1) Click the double arrow icon to select the provider NPI/API.



- 2) A window will display with all NPIs/APIs associated with the user login. A drop-down menu is available if you would like to adjust the number of NPIs/APIs displayed, and a search field is available for fast access to a specific NPI/API number. Additionally, columns can be sorted in ascending or descending order by clicking the down and up arrows in the column headings. This functionality is present throughout the PA on the Portal tool.

Select the radio button next to the NPI/API that you would like to open.




	NPI	TAXONOMY	ADDRESS	ZIP CODE	BENEFIT CODE
<input type="radio"/>	2468101214	207Q00000X	123 ABC ST	12345-6789	
<input checked="" type="radio"/>	3691215182	207Q00000X	456 DEF AVE	23456-7890	
<input type="radio"/>	4812162024	204C00000X	789 GHI RD	34567-8901	
<input type="radio"/>	5101520253	282N00000X	000 JKL CT	45678-9012	
<input type="radio"/>	6121824303	282N00000X	321 DONE LN GLOOR BLVD	56789-0123	

Note: Verify that you are selecting the correct NPI/API when submitting a request for the CSHCN Services Program. The benefit code is CSN or DM3.

Note: If the NPI/API is not present, the Account Administrator will need to associate the NPI/API with the user login. For instructions on how to administer a provider identifier, refer to the [TMHP Portal Security Training Manual](#), section titled “Activate an Existing Provider Identifier with an Existing TMHP User Account.”

- 3) Enter the Medicaid ID or the CSHCN Services Program client ID in the Client ID field. CSHCN Services Program prior authorization requests must use a CSHCN Services Program client ID and be part of the CSHCN Services Program. This does not apply to ambulance providers. To learn more about the CSHCN Services Program, refer to the [CSHCN Services Program](#) page on the TMHP website.



4) Select an Authorization Area and Submission Type from the available drop-down menus.

Authorization Area *

Please select a value
▼

Submission Type *

Please select a value
▼

Refer to the table below for Authorization Areas and corresponding Submission Types:

Authorization Area	Submission Type
All CSHCN Services Program	<ul style="list-style-type: none"> Ambulance Prior Authorization Dental or Orthodontia Services Durable Medical Equipment (DME) and Supplies Home Health, Hospice, and/or Telemonitoring Hospital, Surgery, and/or Medical Services Outpatient Therapy (Physical Therapy [PT], Occupational Therapy [OT], Speech Therapy [ST])
Ambulance (Medicaid)	<ul style="list-style-type: none"> Ambulance Prior Authorization
Comprehensive Care Program (CCP) (Medicaid)	<ul style="list-style-type: none"> CCP Prior Authorization Request Request for CCP Outpatient Therapy (PT, OT, ST) Psychiatric Hospital Inpatient Extension (20 years of age or younger)
Case Management for Children and Pregnant Women (CPW) (Medicaid)	<ul style="list-style-type: none"> CPW
Dental (Medicaid)	<ul style="list-style-type: none"> Dental or Orthodontia Services
Home Health (Medicaid)	<ul style="list-style-type: none"> Plan of Care Title XIX Request for Acute Home Therapy (PT or OT)
Obstetric (OB) Ultrasound (Medicaid)	<ul style="list-style-type: none"> OB Ultrasound
Special Medical Prior Authorization (SMPA) (Medicaid)	<ul style="list-style-type: none"> Electrocardiogram Medical Services Outpatient Psychotherapy/Counseling Request for Acute Outpatient Therapy (PT, OT, ST) Psychiatric Hospital Inpatient Extension (65 years of age or older)
Substance Use Disorder (Medicaid)	<ul style="list-style-type: none"> Outpatient Counseling Extension Outpatient Withdrawal Management Residential Withdrawal Management Residential Treatment

Note: If you select CCP or SMPA with Psychiatric Hospital Inpatient Extension, a statement will appear that reads as follows: “Requests for initial psychiatric hospital inpatient admission do not require prior authorization. To submit a request for an extended stay beyond the initial five days of the treatment episode, please provide the initial hospital admission date.” This is a required field when populated.

Authorization Dates

The Requested Authorization Dates fields allow the user to define the date range that the prior authorization is requested for.

- 1) Select a date range by either clicking the calendar icon next to each field, or enter the dates manually using the MM/DD/YYYY format.




- 2) Click **Check Eligibility**. If you receive an error message, verify the information and resubmit the entry.



- 3) Click **Check Eligibility** again if any information has been updated on the screen after clicking **Check Eligibility**.

When successful, a confirmation message will appear. Click **Continue** to proceed.



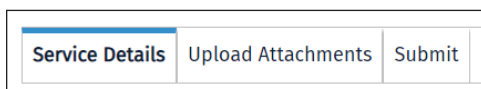
Authorization Request

When the Client Eligibility Pre-check is successful, and you have clicked the **Continue** button, the Authorization Request screen displays. The Authorization Request screen contains the following three tabs that need to be completed:

- Service Details
- Upload Attachments
- Submit



Service Details Tab

The Service Details tab is located at the top of the Authorization Request screen, along with the Upload Attachments and Submit tabs.



Autofilled Content

The top section of the Service Details tab includes provider and client information that is autofilled by the system. This information is not editable. The requesting provider’s information is autofilled with the information associated with the NPI/API that is selected on the Client Eligibility Pre-check screen and includes the provider’s name, NPI/API, taxonomy, benefit code, and address. The client information that is autofilled is based on the Client ID provided on the Client Eligibility Pre-check screen. The information includes the client’s name, Client ID, date of birth (DOB), Social Security number (SSN), and address.

Provider Information		Client Information	
	Name: JOHN DOE MD PA NPI/API: 7142128354 Taxonomy: 193400000X Benefit Code: Address: 365 CIRCLE DR AUSTIN, TX 12345		Name: BILLY BOB Client ID: 987654321 DOB: 1/23/2000 SSN: 987654321 Address: 411 CONGRESS AVE AUSTIN, TX 12345

If the information in this section is not correct, you must cancel and delete the prior authorization request and return to the Client Eligibility Pre-check page. If the **Cancel and Delete** button is selected, two warning messages will display asking you to confirm the permanent deletion of the request. You will need to select **Yes** to both messages to permanently delete the prior authorization request and return to the Client Eligibility Pre-check screen. If the system continues to autofill provider or client information incorrectly after making corrections, call the TMHP Contact Center at 800-925-9126 or the CSHCN Services Program provider line at 800-568-2413.

Below are the provider and client information sections for additional information and authorization dates. These fields are also autofilled from the previous screen.

Additional Information	Authorization Dates
Authorization Area: CCP (Medicaid) Submission Type: Request for CCP Outpatient Therapy (PT, OT, ST)	From: 09/23/2022 Through: 09/28/2022

Provider Contact Information

Each new prior authorization request requires contact information specific to the person submitting the request, including name, preferred method (phone or fax), phone, and fax. Optional fields for entering alternate phone, Additional Provider Name, and Additional Provider NPI/API are available if needed. You may use the additional fields if there is additional provider data that you would like to supply that may not be on the form.

Provider Contact Information
Name: *
Preferred Method: *
Phone: *
Fax: *
Alternate Phone:

Additional Provider Name:
Additional Provider NPI/API:

Requested Services and Specific Item Being Requested

Next, you will need to select the requested services by clicking the checkboxes next to the applicable services in the Select Requested Services section. The services listed in this section are associated with the Authorization Area and Submission Type that were selected on the Client Eligibility Pre-check screen for consistency. Check all services that apply.

Note: The Specific Item Being Requested section contains checkboxes populated based on the selections made in the Select Requested Services section. Fields in this section only display after selecting from the checkboxes in the Select Requested Services section.

Select Requested Services
 Applied Behavior Analysis (ABA) DME External Insulin Pump Inpatient Rehabilitation
 PPECC Private Duty Nursing Supplies Vitamin or Mineral
 Other

Specific Item Being Requested
Supplies *
 Apnea Monitor Bed or Crib Formula Human Milk
 Respiratory Device Specialized/Custom Wheeled Mobility System-Includes Scooters and Strollers Standard Wheelchair Total Parenteral Nutrition
 Other/ None Apply

Refer to the table below for information about how the Authorization Area, Submission Type, Requested Services, and Specific Item being requested correspond.

All CSHCN Services Program

Submission Type	Requested Services
Ambulance Prior Authorization	<ul style="list-style-type: none"> • One-Time/Non-Repeating • Recurring (2-60 Days) • Exception (61-180 Days)
Dental or Orthodontia Services	<ul style="list-style-type: none"> • General Anesthesia • Dental, Orthodontia
Durable Medical Equipment and Supplies	<ul style="list-style-type: none"> • Apnea Monitor • Augmentative Device • Chest Physiotherapy • DME, Expendable Medical Supplies (Diapers, Pull-ups, Briefs, Liners, Other) • External Insulin Pump • Medical Foods Nutritional Counseling • Pulse Oximeter • Specialized/Custom Wheeled Mobility System - Includes Strollers • Standard Wheelchair
Home Health, Hospice, and/or Telemonitoring	<ul style="list-style-type: none"> • Home Telemonitoring • Hospice Services • Oxygen Therapy • Prescribed Pediatric Extended Care (PPEC) • Respiratory Care • Skilled Nursing
Hospital, Surgery, and/or Medical Services	<ul style="list-style-type: none"> • Blood Factor Products • Genetic Testing for Colorectal Cancer • Genetic Testing for Hereditary Breast and/or Ovarian Cancer • Inpatient Hospital Admission - Facility • Inpatient Psychiatric Care • Inpatient Rehabilitation Admission • Inpatient Surgery - Surgeon • Non Face-to-face Clinician Directed Coordinated Care • Omalizumab • Outpatient Surgery - Facility/Surgeon • Renal Dialysis Treatment • Stem Cell or Renal Transplant • Other
Outpatient Therapy (PT, OT, ST)	<ul style="list-style-type: none"> • Extended Outpatient Therapy • Initial Outpatient Therapy

Ambulance (Medicaid)

Submission Type	Requested Services
Ambulance Prior Authorization	<ul style="list-style-type: none"> • One-Time/Non-Repeating • Reoccurring (2-60 Days) • Exception (61-180 Days)

CCP (Medicaid)

Submission Type	Requested Services
CCP Prior Authorization Request	<ul style="list-style-type: none"> • Private Duty Nursing • DME • External Insulin Pump • Inpatient Rehabilitation • PPEC • Supplies (Apnea Monitor, Bed or Crib, Formula, Human Milk, Pulse Oximeter, Respiratory Device, Specialized/Custom Wheeled Mobility System - Includes Strollers, Standard Wheelchair, Total Parenteral Nutrition, Other/None Apply) • Vitamin or Mineral • Other
Request for CCP Outpatient Therapy (PT, OT, ST)	<ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Speech Therapy
Psychiatric Hospital Inpatient Extension (20 years of age or younger)	<ul style="list-style-type: none"> • Is This Service Court Ordered?

CPW (Medicaid)

Submission Type	Requested Services
CPW	<ul style="list-style-type: none"> • Case Management Initial • Case Management Additional Visit

Dental (Medicaid)

Submission Type	Requested Services
Dental or Orthodontia Services	<ul style="list-style-type: none"> • General Anesthesia • Dental • Orthodontia

Home Health (Medicaid)

Submission Type	Requested Services
Plan of Care	<ul style="list-style-type: none"> • Skilled Nursing Visit • Home Health Aid • Physical Therapy Evaluation • Occupational Therapy Evaluation
Title XIX	<ul style="list-style-type: none"> • Chest Physiotherapy Devices • CPAP/BiPAP or Oxygen Therapy • External Insulin Pump • Specialized/Custom Wheeled Mobility System- Includes Scooters or Strollers • Standard Wheelchair • Wound Therapy • None Apply
Request for Acute Home Therapy (PT or OT)	<ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy

OB Ultrasound (Medicaid)

Submission Type	Requested Services
OB Ultrasound	<ul style="list-style-type: none"> • OB Ultrasound

SMPA (Medicaid)

Submission Type	Requested Services
Electrocardiogram	<ul style="list-style-type: none"> • Electrocardiogram
Medical Services	<ul style="list-style-type: none"> • DME • Hereditary Cancer Genetic Testing • Omalizumab • Surgery • Telemonitoring • Transplant • Other
Outpatient Psychotherapy/ Counseling	<ul style="list-style-type: none"> • Psychological Testing • Neuropsychological Testing
Request for Acute Outpatient Therapy (PT, OT, ST)	<ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Speech Therapy
Psychiatric Hospital Inpatient Extension (65 years of age or older)	<ul style="list-style-type: none"> • Is This Service Court Ordered?

Substance Use Disorder (Medicaid)

Submission Type	Requested Services
Outpatient Counseling Extension	• Outpatient Counseling Extension
Outpatient Withdrawal Management	• Outpatient Withdrawal Management
Residential Withdrawal Management	• Residential Withdrawal Management
Residential Treatment	• Residential Treatment

Diagnosis Code, Diagnosis Description, and Service Details

Diagnosis codes are required and can be located under the Requested Services field in the Diagnosis section.

- 1) Enter the diagnosis code in the Code field.
- 2) Click the **magnifying glass** to search for your code. This is a required field for most authorizations.
- 3) The *International Classification of Diseases Tenth Revision* (ICD-10) description of the diagnosis code will populate in the Description field. There is no system validation that the diagnosis code is appropriate for the selected authorization area.
- 4) To add additional diagnosis codes, click the **Add additional Diagnosis Code+** link under the Code and Description fields. Up to four diagnosis codes can be listed for each requested service.
- 5) If a diagnosis code has been added, a Remove button will appear. Unused additional diagnosis codes must be removed before submission. Click **Remove** to delete unwanted diagnosis codes.

Diagnosis

Code: *

Description:

[Add additional Diagnosis Code+](#)

The Service Details table is located under the Diagnosis section. Enter the specific procedure detail information related to the request in this table. A drop-down menu is available to change the number of entries displayed in the table.

Service Details									
	1	2	3	4	5	6	7	8	
	FROM DOS *	TO DOS *	HCPCS/ PROCEDURE CODE *	MODIFIER	TYPE OF SERVICE	PLACE OF SERVICE *	REQUESTED QUANTITY	REQUESTED FREQUENCY	
1	09/23/2022	09/28/2022	<input type="text"/>	<input type="text"/>	Medical Services	Please select a Val	<input type="text"/>	Please sel	<input type="button" value="Remove"/>

Showing 1 to 1 of 1 entries

To add more service details please enter the number of rows and hit enter.

Columns in the Service Details table include the following:

- 1 From DOS: The date of service that the provider would like the prior authorization to start. The field is required but is autofilled with the dates entered on the Client Eligibility Pre-check page. You can edit the DOS by either entering a date manually in MM/DD/YYYY format or by clicking the **calendar** icon and selecting a date.
- 2 To DOS: The date of service that the provider would like the prior authorization to end. The field is required but is autofilled with the dates entered on the Client Eligibility Pre-check page. This is, however, editable and can be altered by either entering a date manually in MM/DD/YYYY format or by clicking the **calendar** icon and selecting a date.
- 3 HCPCS/Procedure Code: This field is required and must be entered manually. When you click on the **magnifying glass** icon, the description of the procedure code will display as a tool tip when the user hovers over the HCPCS/Procedure code.
- 4 Modifier: This describes and qualifies the service provided.
- 5 Type of Service: Select from the options listed in the drop-down menu.
- 6 Place of Service: You will identify where the requested service will take place. You are required to select from the options listed in the drop-down menu.
- 7 Requested Quantity: This indicates the number of units, hours, the quantity to be dispensed, or the number of times the services will be performed. PA on the Portal does not accept decimals in this field.
- 8 Requested Frequency: This indicates how often the service will be performed. You can select the frequency from a drop-down menu.

Note: Requested Frequency is an optional field, but depending on the requested procedure, TMHP may require the data from this field to complete or approve the authorization request.

Note: The Modifier, Requested Quantity, and Requested Frequency fields are optional and should be used only when applicable. Additionally, the Requested Quantity and Requested Frequency fields are not visible to ambulance providers.

To add additional detail lines, enter the number of lines needed in the available field under the Service Details table and click **Enter** on your keyboard. Up to forty detail lines can be listed here.

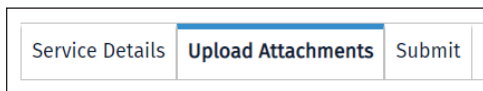
You must remove unused service detail lines before submitting your prior authorization request. To remove a line, click the **Remove** button located in the last column of the Service Details table.

The following options are located under the Service Details table:

- 9** Back: Click to return to the previous screen. To avoid losing any progress, the **Back** button should be used instead of the browser back arrow. If the **Back** button is selected on the Service Details tab, two warning messages will display asking the user to confirm that they are aware that information and attachments will be deleted upon returning to the Client Eligibility Pre-check page. The user will need to select **Yes** for both messages to return to the previous page.
- 10** Next: Click to proceed to the Upload Attachments tab.
- 11** Cancel and Delete: Click to permanently delete the authorization request. If the **Cancel and Delete** button is selected, two warning messages will display asking the user to confirm that they want to permanently delete the request. The user will need to select **Yes** for both messages to permanently delete the authorization request.
- 12** Save as Draft: Click to save the progress of the authorization request. Refer to the [“Drafts and Templates”](#) section for more information on saving a request as a draft.

Note: The prior authorization request will not be saved unless the **Save as Draft** button is selected.

Upload Attachments Tab

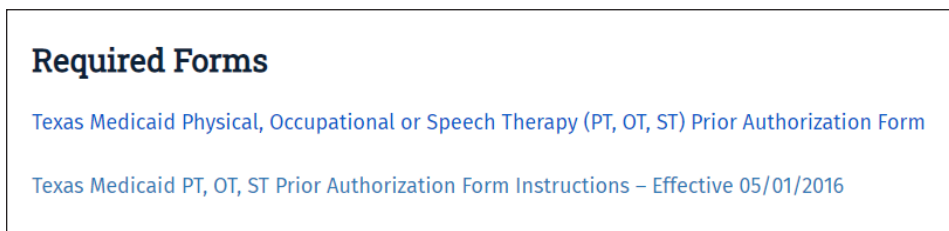


The Upload Attachments tab allows providers to upload supporting documentation as attachments. This tab is presented once the user has completed the Service Details tab.

Required Form URLs and Additional Documentation

The Required Forms section lists all the forms that are required for the provider’s prior authorization request based on the Authorization Area, Submission Type, Requested Services, and Specific Items identified on the Service Details and Client Eligibility Pre-check screens.

Click any of the required fillable form links under the Required Forms section to download the form as a pdf file.



Adobe Reader® Version 11.0 or higher is recommended to electronically complete the forms.

An example of the request form is found in the image below. Read the Certification Statement, and click the **We Agree** checkbox. The Certification Statement must be submitted with the Authorization form. Be sure that you are selecting the correct **We Agree** checkbox. If the request is for the CSHCN Services Program, the form will have the CSHCN Services Program logo.

Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to 512-514-4212.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide 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.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

We Agree

All required Texas Medicaid and CSHCN Services Program Prior Authorization forms are available on the TMHP website at tmhp.com as fillable pdf forms. For a list of prior authorization forms, visit the [TMHP Prior Authorization web page](#).

The forms in this section contain fillable fields that will allow the user to type information into each field. To minimize keying, some fields autofill with information entered on the Service Details tab.

For CSHCN Services Program prior authorization requests for dental or orthodontia services, the form or subsequent documentation cannot be submitted by fax. It is highly recommended that you use PA on the Portal to submit these forms and documentation. A library of forms can be found on [Forms](#) on tmhp.com. You will be required to:

- Download the prior authorization form and save the downloaded form to your computer.
- Complete the form using the fillable fields. Sign the form electronically using the software of your choice or print, complete, and sign the form manually. Electronic attachments must be signed before they are uploaded to PA on the Portal.

Click **Upload Attachments**, locate the necessary forms or documentation, and upload your files to the PA on the Portal request.

You will not be able to modify or sign required forms after they are uploaded.

You can continue to download, print, and manually complete forms if you prefer or if the applicable version of Adobe Reader is not available.

A list of other required documentation, such as proof of medical necessity, is displayed under the Additional Documentation Required section of the Upload Attachments tab.

Signature Options

TMHP accepts electronic or digital signatures on prior authorization forms and supporting documentation from:

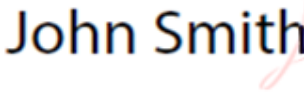
- Prescribing, ordering, or requesting providers
- Dispensing providers
- Clients responsible for adults
- Clients

TMHP will accept an electronic or digital signature if the signature is 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. Refer to the [PA on the Portal Frequently Asked Questions \(FAQ\)](#) for more information on e-signatures.

For example, you can download a fillable form, acquire the necessary signatures electronically, or print and complete the form manually and then upload the completed form to the portal.

Examples of Acceptable Electronic Signatures


Example 1: Software that provides a date stamp, time stamp, and product logo


Provider Signature	
Provider printed name: John Smith	Date: 04/01/2016
 <div style="border: 1px solid red; padding: 2px; display: inline-block; margin-left: 10px;"> Digitally signed by John Smith DN: cn=John Smith, o=Nurses 123, ou, email=johnsmith@nurses123.com, c=US Date: 2016.04.01 21:14:51 -06'00' </div>	
Provider Signature (stamped signatures not accepted)	

Example 2: Software that provides an electronic signature certificate on a separate page (not added to the prior authorization form itself)


<input type="checkbox"/> Is the client in compliance with the hours of oxygen therapy ordered?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	License number:
Must be submitted with a THSteps-CCP Prior Authorization Request Form		
F00077		Effective Date_03162016/Revised Date_04012016

Signature Certificate


 Document Reference: ENYRB8I3SIEHUHPI97VEY3




Easy Online Document Signing



John Smith
 Party ID: H37DLYJVEI96D8PNINDC4R
 IP Address: 67.67.201.117
 VERIFIED EMAIL: johnsmith@gmail.com

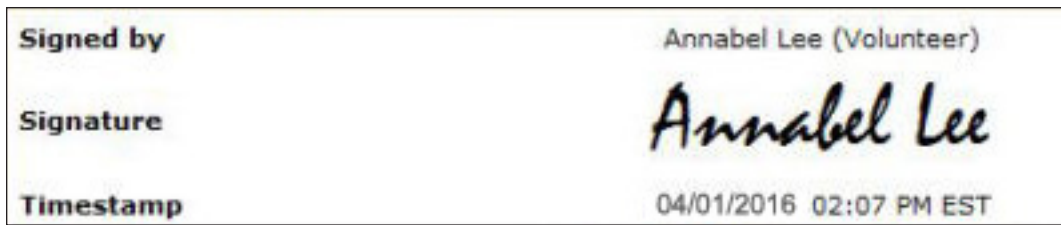
Electronic Signature:


Multi-Factor Digital Fingerprint Checksum
 648b24a1b76e75add03e999d610c6bda031fc209

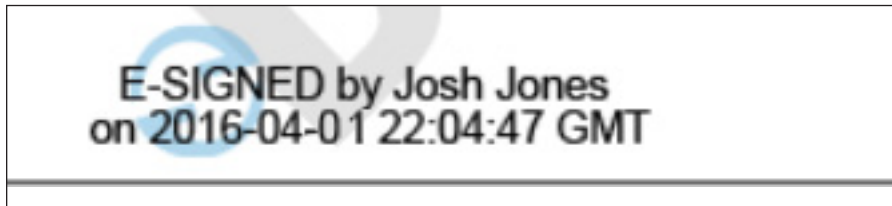


Timestamp	Audit
2016-04-01 14:19:02 -0800	All parties have signed document. Signed copies sent to: John Smith and jsmith.
2016-04-01 14:19:02 -0800	Document signed by John Smith (johnsmith@gmail.com) with drawn signature. - 67.67.201.117

Example 3: Valid signature with date and time stamp



Example 4: Valid signature with date and time stamp and software logo



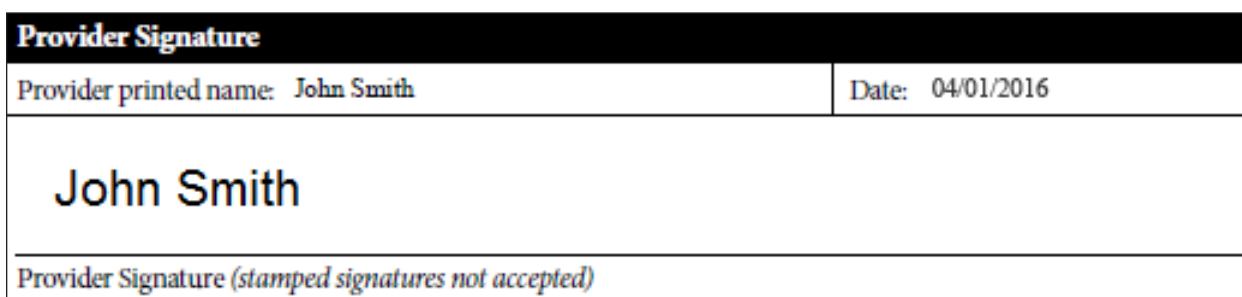
The following types of signatures will not be accepted:

- Ink stamped signatures
- Images of wet signatures (i.e., photocopies of handwritten signatures)
- Digitized signatures (i.e., scanned images of handwritten signatures or signatures on a signature pad)


Note: “Handwritten” signatures include those that are written using an ink pen on a paper form. Signatures written with a stylus on an electronic document are considered e-signatures, not handwritten signatures. You can use a stylus as long as the image of the e-signature complies with policy. Handwritten signatures on faxed documents are not digitized signatures.

Examples of Unacceptable Electronic Signatures

Example 1: Typed signatures without a digital time stamp or software logo



Example 2: Images of wet signatures (i.e., photocopies of handwritten signatures)

Provider Signature	
Provider printed name: John Smith	Date: 04/01/2016
	
Provider Signature (<i>stamped signatures not accepted</i>)	

Example 3: Invalid signature with no time stamp or software logo



Handwritten Signature Requirements

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. An advanced practice registered nurse (APRN) or physician assistant (PA) who is familiar with the client's medical condition may also be allowed to sign and date prior authorization requests. All signatures and dates must be current and unaltered. 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 or PA, do not require handwritten signatures and dates.

Third-Party Software Requirements

You can use the software of your choice to generate your electronic or digital signature and submit the prior authorization request and supporting documentation according to current practice as directed in the [Texas Medicaid Provider Procedures Manual](#) and the [CSHCN Services Program Provider Manual](#).

Some electronic signature software may not insert the signature on the form. The signature may appear on a separate page. If the electronic signature is valid, TMHP will accept the signature on a separate page.

Uploading Attachments

Once the required forms have been completed and additional documentation has been collected, you will need to upload the forms and documentation as attachments. To upload an attachment, click **Upload Documents**.

[Upload Documents](#)

Up to 10 files can be uploaded. Files cannot exceed 50mb per file
Supported file types: PDF, Image (JPG, TIF, PNG), MS Word, MS Excel, and RTF

Once an attachment has been successfully uploaded to the portal that attachment cannot be modified.
All uploaded documents are subject to virus scan and if virus is found document will quarantined and removed.

Successful uploads will display in the Successful Attachments section. The files will be linked, so you can click on any file to view the uploaded document and verify a successful upload. The attached files cannot be changed once they have been uploaded. If changes are required, click **Remove** next to the affected attachment and upload the document again.

[Upload Documents](#)

Up to 10 files can be uploaded. Files cannot exceed 50mb per file
Supported file types: PDF, Image (JPG, TIF, PNG), MS Word, MS Excel, and RTF

✓	F00139_Texas_Medicaid_PT_OT_ST_Prior_Authorization_Form_Complete.pdf	Remove
✓	Spine X-Ray.pdf	Remove

Once an attachment has been successfully uploaded to the portal that attachment cannot be modified.
All uploaded documents are subject to virus scan and if virus is found document will quarantined and removed.

File Size, Type, and Number Limits

Up to 10 files can be uploaded, and each file cannot exceed 50 megabytes. Supported file types include:

- Portable Document Format (pdf)
- Image files in jpg, tif, and png format (for example, an X-ray)
- Microsoft Word® documents
- Microsoft Excel® spreadsheets
- Rich Text Format (rtf)

Additional Notes

Additional information can be added in the Additional Notes section, if necessary. This section can contain up to 1,500 characters.

Additional Notes

1500 characters left

Submit

Service Details	Upload Attachments	Submit
-----------------	--------------------	---------------

The Submit tab provides an opportunity to review and submit the prior authorization request. Once all the attachments and additional documentation have been uploaded successfully, you have the option to click **Next** to proceed to the Submit tab. Other options at the bottom of the screen include a **Back** button to return to the previous screen, a **Cancel and Delete** button to delete the authorization request, or a **Save as Draft** button to save the authorization request as a draft. Refer to the [“Drafts and Templates”](#) section for more information on saving a request as a draft.

Note: The authorization will not be saved unless the **Save as Draft** button is clicked.

You must review the information on the screen. If it is accurate, read the Certification and Terms and Conditions statement by clicking the link labeled **here**.

Certification Statement

Before submitting each prior authorization request, the Provider and Authorization Request Submitter must read, understand, and agree to the Certification and Terms and Conditions. The Provider and Authorization Request Submitter will both be held accountable for their declarations when they acknowledge their agreement and consent. They acknowledge consent by checking the **We Agree** checkbox after reviewing the Certification and Terms and Conditions, which reads as follows:

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter “Prior Authorization Request Submitter”) to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the

original or an exact duplicate of the original; and is maintained in the individual patient’s medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM) or the *CSHCN Services Program Provider Manual*, as appropriate.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal laws, state laws, or both. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider’s Medicaid or CSHCN enrollment or personal exclusion from Texas Medicaid or the CSHCN Program.

The Provider and Prior Authorization Request Submitter certify, affirm, and agree that by checking “We Agree” that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant [Texas Medicaid Provider Procedures Manual](#) or [CSHCN Services Program Provider Manual](#), as appropriate, and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.”

Click the **We Agree** checkbox to attest that you have both read and agree to abide by the Certification and Terms and Conditions. Remember, if the **Cancel and Delete** button is selected, two warning messages will display asking you to confirm that you want to permanently delete the request. You will need to select **Yes** to both messages to permanently delete the authorization request.

⚠ Certification Statement

Please review the certification and Terms and Conditions by clicking [here](#).
By checking 'We Agree' you agree and consent to the [certification](#) and TMHP [Terms and Conditions](#).

WE AGREE

[Back](#) [Cancel and Delete](#) [SUBMIT](#) [Save as Draft](#)

Prior Authorization Request Submission

After the **We Agree** checkbox is checked, the **SUBMIT** button at the bottom of the page becomes enabled. Click **SUBMIT**. After the **SUBMIT** button has been selected, the prior authorization request is checked against a series of validation edits, which confirm that all required fields have been filled in. After all the fields pass the validation edits, the prior authorization request is sent to the TMHP system. Further validation occurs to ensure that certain data elements, such as procedure codes and diagnosis codes, are valid for the service requested.

If the system identifies invalid data, an error message is displayed at the top of the screen. To proceed, update the appropriate field and resubmit the request.

▲ Error message alert with details below:

- Contact Name is required
- Contact Method is required
- Contact Phone is required
- Fax is required
- Please check at least one of the services available for selection.
- First Diagnosis Code is required.
- Procedure code is required.
- Place of Service is required.

When a request is complete and passes all validation edits, a confirmation message will display at the top of the screen and the following occurs:

- The prior authorization request is saved.
- A prior authorization number is issued.
- The current status of the authorization request appears. It is recommended to allow one hour before checking the detailed status of the authorization.
- A **Save as Template** button will display at the bottom of the screen. Refer to [“Saving Templates, Accessing Templates, and Warning Messages”](#) for more information on saving a template.

After submitting the prior authorization request, click **Print** to print the request.

The printed prior authorization request must be maintained in the client’s medical record along with the other prior authorization documentation per policy.

Confirmation: Authorization # 6438625632

Created: 9/23/2022 2:48:26 PM

 Print

Prior to submission, you will also have the option to save the prior authorization request as a draft by clicking the **Save as Draft** button. If you would like to cancel the prior authorization request, click **Cancel and Delete**.

If there are errors that have not been corrected, you will not be able to submit the prior authorization request. Errors will be indicated with small yellow triangles and outlined with red. An error message will also display at the top of the page listing the required information necessary to correct the errors.

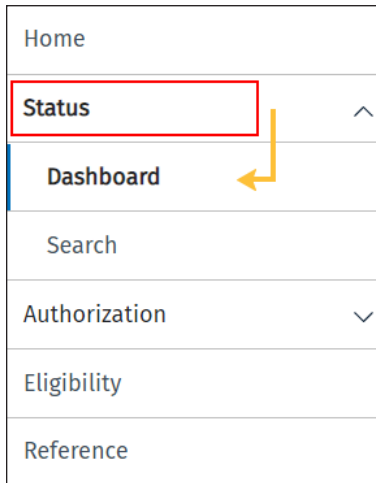
Note: The PA on the Portal system prevents duplicate prior authorization requests. The system analyzes the requesting provider or supplier ID, client ID, and requested prior authorization dates. It then compares the information to existing prior authorization requests in the system. If the fields on the prior authorization request match the client’s ID number, the provider’s API/NPI, and also fall within the requested date range on a prior authorization request that is already in the system, a list of potential duplicates are displayed. After reviewing the potential duplicates, the requester must create a new prior authorization request or choose to extend an existing request.

Status

The Status button on the navigation menu expands to reveal subsections for the Dashboard and Search pages.

Dashboard

Once you have expanded the **Status** button on the PA on the Portal navigation menu, the subsection for Dashboard will be revealed. Click **Dashboard** to display the PA on the Portal Dashboard.



Dashboard Filter Options/Status Tabs

The Status Dashboard screen is a quick, easy way for requesting providers to check the status of a prior authorization request.

Note: Performing providers or facilities should use the search page. Refer to the [“Search by Performing Provider or Facility”](#) section. All required fields in this section are indicated by red dots.

To check the status of a prior authorization request, perform the following steps from the navigation menu:

- 1) Click **Status** to expand the Status menu.
- 2) Click **Dashboard**.

- 3) Select the applicable NPI/API from the Requesting Provider NPI/API drop-down list, which contains all NPIs/APIs associated with the current user login.

Status Dashboard

Search Criteria

Please Note: For Performing Providers or Facilities, please use the [Search Page](#) to locate your Prior Authorization. Prior Authorizations that have been completed more than 30 days ago will NOT appear in the Determination Complete tab of the Status Dashboard. Please refer to the [Search Page](#) for the status of any submitted request.

Requesting Provider NPI/API *

Select a Provider >>

Search
Clear Filter

- 4) A drop-down menu is available for you to adjust the number of NPIs/APIs displayed, and a quick search field is available for fast access to a specific NPI/API number.
- 5) Select the radio button next to the applicable NPI/API.

Select Provider

Show 5 entries Search:

	NPI	TAXONOMY	ADDRESS	ZIP CODE	BENEFIT CODE
<input type="radio"/>	2468101214	207Q00000X	123 ABC ST	12345-6789	
<input checked="" type="radio"/>	3691215182	207Q00000X	456 DEF AVE	23456-7890	
<input type="radio"/>	4812162024	204C00000X	789 GHI RD	34567-8901	
<input type="radio"/>	5101520253	282N00000X	000 JKL CT	45678-9012	
<input type="radio"/>	6121824303	282N00000X	321 DONE LN GLOOR BLVD	56789-0123	

Showing 1 to 5 of 90 entries

Previous
1
2
3
4
5
...
18
Next

- 6) Click **Search** once the applicable NPI/API has been selected.

A list of prior authorization requests associated with the selected NPI/API will display. A drop-down menu is available to adjust the number of requests displayed per page, and a quick search field is available for fast access to a specific prior authorization. Several tabs categorizing the status of the prior authorizations are featured on this screen. The Pending Provider Response will be the default tab.

Pending Provider Response ¹ Received - Awaiting Review ² Review In Progress ³ Determination Complete ⁴							
Show <input type="text" value="10"/> entries						Search: <input type="text"/>	
REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE	DUE DATE FOR ADDITIONAL INFO	PENDING RATIONALE
100000000	000000001	Portal - 573937	1234567890	101010100 - EMBER FAX	08/22/2022	09/12/2022	Click for Details/Letters
100000001	100000001	Portal - 573907	1234567890	101010101 - VINCENT RYDER	08/18/2022	09/08/2022	Click for Details/Letters
100000002	200000001	Paper/Fax - 749772600	1234567890	101010102 - CONOR DAVIS	09/22/2021	10/13/2021	Click for Details/Letters
100000003	300000001	Portal - 731895	1234567890	101010103 - ESTHER CHO	10/15/2021	11/05/2021	Click for Details/Letters

Status tabs include:

- 1** Pending Provider Response: This tab shows all the prior authorization requests that have been submitted or placed in Pending Provider Response status by TMHP. Pending requests require a response and include the reason for the pending status. All NPIs/APIs associated with your username will display. You will be able to correct and resubmit the prior authorization and download all letters associated with the request. Select **Click for Details/Letters** to view the pending rationale and any associated letters.
- 2** Received – Awaiting Review: Items under this tab indicate that TMHP has received the prior authorization request but has not yet begun the process of reviewing it and has not determined whether the prior authorization will be approved. Edits can still be made while an authorization is in this stage.
- 3** Review in Progress: This tab displays prior authorization requests that TMHP has received and are currently being reviewed. Items under this tab have not yet been approved or denied. Edits cannot be made to an authorization while it is in this stage.
- 4** Determination Complete: This tab displays prior authorization requests that were reviewed and approved or denied by TMHP.

Pending Provider Response Status

The Pending Provider Response tab shows all prior authorization requests that require action from the provider. Select **Click for Details/Letters** to view the reasons for the pending status and any letters associated with the prior authorization request.

Pending Provider Response Received - Awaiting Review Review In Progress Determination Complete							
Show <input type="text" value="10"/> entries						Search: <input type="text"/>	
REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE	DUE DATE FOR ADDITIONAL INFO	PENDING RATIONALE
400000000	000000004	Portal - 573907	4567890123	404040404 - VALERIE REYES	08/18/2022	09/08/2022	Click for Details/Letters
Showing 1 to 1 of 1 entries						Previous 1 Next	

This will take you to the Letters screen. At the bottom of the screen, you will find all letters that are associated with the prior authorization request. Columns in this section include Reference ID, Letter #, and Letter Date. Click any link under the Letter Number column to download the letter.

REFERENCE ID	LETTER #	LETTER DATE
749934673	L00902	1/17/2023 10:45:31 AM
749934673	L00902	1/18/2023 8:14:25 AM

Showing 1 to 2 of 2 entries

To view a letter, click on the Letter #

Paper or Fax and Portal Submission View

Providers can view the pending rationale from the TMHP clinician, upload additional attachments, and add additional notes.

Performing Provider Versus Requesting Provider

Only the requesting provider can take action on a prior authorization request in Pending Provider Response status. The performing provider does not have access to this view.

Received – Awaiting Review Status

This status indicates that TMHP has received the prior authorization request but has not begun reviewing it. It has not yet been determined whether the request will be approved. Edits can still be made while a request is in this status.

REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE
200000000	000000002	Portal - 574476	2345678901	202020200 - ALLISON EDWARDS	09/22/2022
200000001	100000002	Portal - 574470	2345678901	202020201 - JOSEPH MCKINNEY	09/22/2022
200000002	200000002	Portal - 574468	2345678901	202020202 - TITUS GILBERT	09/21/2022
200000003	300000002	Portal - 574448	2345678901	202020203 - TEAGEN MITCHELL	09/19/2022
200000004	400000002	Portal - 574439	2345678901	202020204 - WINSTON JOHNSON	09/15/2022
200000005	500000002	Portal - 574295	2345678901	202020205 - KAYLEE KIM	09/09/2022
200000006	600000002	Portal - 574296	2345678901	202020206 - ALEXANDRA LEWIS	09/09/2022
200000007	700000002	Portal - 574285	2345678901	202020207 - ANDREA NORMAN	09/08/2022
200000008	800000002	Portal - 574284	2345678901	202020208 - KAILANI POKI	09/08/2022
200000009	900000002	Portal - 574265	2345678901	202020209 - HARPER BROWN	09/07/2022

Showing 1 to 10 of 33 entries

Paper or Fax

If the prior authorization request was submitted by paper or fax, you can upload additional attachments and add additional notes once a prior authorization number is assigned. You cannot update the quantity or frequency of a detail line if the prior authorization request was submitted by paper or fax. The PA View can be accessed by clicking the prior authorization number under the Received – Awaiting Review tab. The view will be read-only. To unlock the view from read-only format, click **Edit**.

Portal Submission View

If the prior authorization request was submitted through the portal, you can update the quantity or frequency of a detail line, upload attachments, and add additional notes. The PA View can be accessed by clicking the prior authorization number under the Received – Awaiting Review tab. The view will be read-only. To unlock the view from read-only format, click **Edit**.

Performing Provider Versus Requesting Provider

Only the requesting provider can take action on a prior authorization request in Received – Awaiting Review status. The performing provider does not have access to this view.

Review in Progress Status

This status indicates that TMHP has received the prior authorization request and is in the process of reviewing it. It has not yet been determined whether the request will be approved. Edits cannot be made to a prior authorization request while in this status.

Pending Provider Response Received - Awaiting Review Review In Progress Determination Complete					
Show <input type="text" value="10"/> entries					Search: <input type="text"/>
REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE
300000000	00000003	Portal - 573966	3456789012	303030300 - MAX DOUGLAS	08/22/2022
300000001	10000003	Portal - 573931	3456789012	303030301 - XANDER LIU	08/22/2022
300000002	20000003	Portal - 573800	3456789012	303030302 - LEXI WRIGHT	08/01/2022
Showing 1 to 3 of 3 entries					<input type="button" value="Previous"/> <input checked="" type="button" value="1"/> <input type="button" value="Next"/>

Paper/Fax and Portal Submission View

No actions can take place while the prior authorization request is in Review in Progress status, as the request is currently under review by TMHP.

Requesting Provider Versus Performing Provider

The prior authorization request can be viewed in read-only format in its entirety by the requesting provider. The performing provider cannot view all of the client information or the requesting provider information and will not be able to see attachments or notes.

Determination Complete Status

This status indicates that TMHP has completed a review of the prior authorization request and made a determination. Requesting providers can request an extension, recertification, or revision for any approved detail line, regardless of whether the authorization was submitted by PA on the Portal, paper, or fax.

Pending Provider Response Received - Awaiting Review Review In Progress Determination Complete					
Show <input type="text" value="10"/> entries					Search: <input type="text"/>
REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE
500000000	000000005	Portal - 574196	5678901234	505050505 - ROWAN JAMES	09/06/2022
Showing 1 to 1 of 1 entries					Previous 1 Next

Dashboard Search Results

Depending on the status of the authorization request, the following columns may be present on the Dashboard:

Pending Provider Response		Received - Awaiting Review		Review In Progress		Determination Complete	
Show 10 entries		Search: <input type="text"/>					
1	2	3	4	5	6	7	8
REFERENCE ID	PRIOR AUTHORIZATION #	SUBMISSION ID	NPI/API	CLIENT ID	RECEIVED DATE	DUE DATE FOR ADDITIONAL INFO	PENDING RATIONALE

- 1 Reference ID: A unique ID specific to a prior authorization request. This is the same ID located on prior authorization letters received by mail.
- 2 Prior Authorization Number: The number assigned to the prior authorization request upon submission
- 3 Submission ID: This is an identifier that specifies the method of submission (paper/fax/portal) and assigns a unique ID to portal submissions. It's important for a split authorization, which is an authorization that includes services from separate authorization types. For example, if a provider submits a request for three services using the Home Health authorization type, they receive one Prior Authorization number. Upon further review, TMHP determines that one of the services is covered under CCP and creates a new request for that service. The provider will now see two records in the PA on the Portal Status Dashboard with the same submission ID, but a different reference ID and authorization number than the numbers that were received during the original submission.
- 4 NPI/API: National Provider Identifier or Atypical Provider Identifier
- 5 Client ID: Medicaid or CSHCN Services Program ID
- 6 Received Date: The date that TMHP received the authorization request
- 7 Due Date for Additional Info: The date that additional information must be received by TMHP. (This column is blank for ambulance providers.)
- 8 Pending Rationale: This states the reason why the prior authorization request has been placed in pending status by TMHP. For example, the authorization requires additional information. This reason matches what will appear on the provider letter, but it will be available on the portal and by fax immediately after TMHP has reviewed the request, eliminating time spent waiting for the response by mail. Select **Click for Details/Letters** to view the pending rationale and any associated letters.

Dashboard Search Results Information

Performing providers or facilities will not be able to view Dashboard page information unless their user account is linked to a requesting provider. Instead, performing providers or facilities should use the search screen to locate prior authorization requests.

Prior authorization requests that have been completed more than 30 days from the current date will not appear in the Determination Complete tab of the Status Dashboard. Refer to the Search Page for the status of any submitted request with a determination older than 30 calendar days from the current date.

Prior Authorization View

This view is accessed by clicking on the prior authorization number link on the screen. This view will vary based on the following three variables:

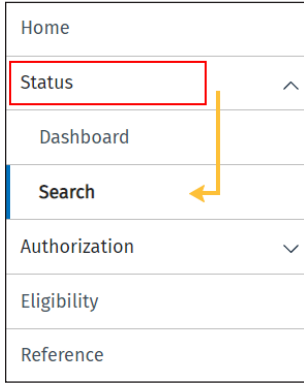
- Whether the user is the requesting provider or performing/facility provider
- Whether the prior authorization request was submitted through the portal or by paper/fax
- The status of the prior authorization request

Only two statuses will display for performing providers or facilities: Review in Progress and Determination Complete. Pending Provider Response and Received – Awaiting Review status will not display because only the requesting provider can make updates to a prior authorization request.

Prior authorization requests submitted by paper or fax can be accessed using PA on the Portal, but limited information is shown here. A message will display at the top of the page alerting users that the data will not be complete.

Search

The Search screen is accessed by selecting the **Search** button under Status in the navigation menu. This screen can also be accessed by selecting the **Update Existing** button under Authorization in the navigation menu.



Select the radio button for the applicable provider type. Options include:

- **Requesting Provider:** The provider who requested the service.
- **Performing Provider or Facility:** The provider who performs the service.
- **Prior Authorization Number:** Search by prior authorization number. This feature is available only to requesting providers.

Search options and results will vary depending on the provider type selected on this screen.

Search by Requesting Provider

To search by Requesting Provider:

- 1) Select the **Requesting Provider** radio button and click the **double arrow** icon next to the NPI/API field.

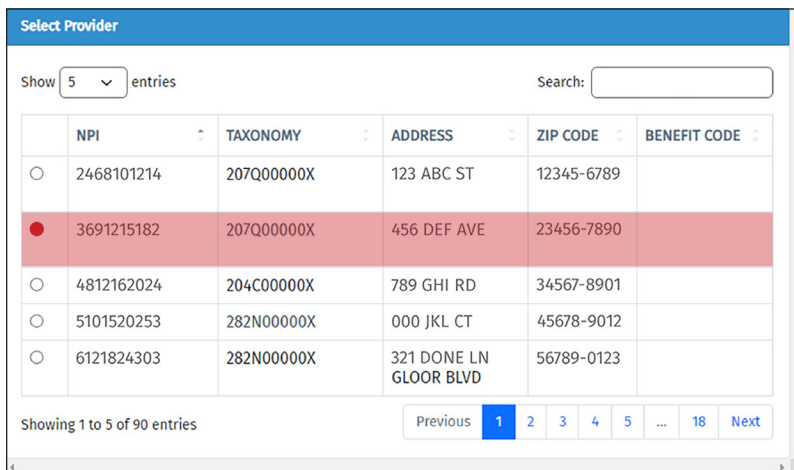
A screenshot of the 'Search' screen. The title 'Search' is underlined in yellow. Below it, the 'SEARCH BY:' section has three radio buttons: 'Requesting Provider' (selected and highlighted with a red box), 'Performing Provider', and 'Prior Authorization Number (for requesting providers only)'. There are four input fields: 'NPI/API *' (containing '1234567890' and a red box with '>>' next to it), 'Prior Authorization Number', 'Reference Id', and 'Client Id'. At the bottom, there are 'Search' and 'Clear Filter' buttons, and a '< Back to Search' link.

2) Additional fields on the Requesting Provider search screen include the following:

- Prior authorization number
- Reference ID
- Client ID

These are not required fields, but they do provide additional details to narrow search results. However, if the returned results are greater than 1,000, you will be required to specify one of the optional fields.

- 3) A window will display with all NPIs/APIs associated with your account. A drop-down menu is available for you to adjust the number of NPIs/APIs displayed per page, and a quick search field is available for fast access to a specific NPI/API number.
- 4) Select the radio button next to the applicable NPI/API. Once the NPI/API has been selected and any additional fields have been completed, click **Search** to continue.



5) The Requesting Provider results screen will display. A drop-down menu is available to adjust the number of prior authorization requests displayed, and a quick search field is available for fast access to a specific request.

REFERENCE ID	PRIOR AUTHORIZATION #	STATUS	NPI/API	CLIENT ID	RECEIVED DATE
000000001	1234567890	Pending Provider Response	7142128354	000000001 - CATHERINE MORRIS	10/07/2021
000000002	2345678901	Determination Complete	7142128354	000000002 - ARTHUR ABDO	10/07/2021
000000003	3456789012	Determination Complete	7142128354	000000003 - CHARLES URBANO	09/22/2021
000000004	4567890123	Determination Complete	7142128354	000000004 - JENNIFER SIMS	08/09/2021
000000005	5678901234	Determination Complete	7142128354	000000005 - HELEN HOGAN	08/09/2021
000000006	6789012345	Determination Complete	7142128354	000000006 - MIRIAH HASHIMOTO	04/21/2021
000000007	7890123456	Determination Complete	7142128354	000000007 - JOSE GREEN	03/24/2021
000000008	8901234567	Determination Complete	7142128354	000000008 - JEAN BAKER	01/11/2021
000000009	9012345678	Determination Complete	7142128354	000000009 - PHILIP CAMERON	01/06/2021
000000010	0123456789	Determination Complete	7142128354	000000010 - JOSE POTTS	01/06/2021
000000011	0123456780	Determination Complete	7142128354	000000011 - JEAN TREVINO	12/30/2020
000000012	0234567890	Determination Complete	7142128354	000000012 - JIMMY BROWN	12/22/2020
000000013	0345678910	Determination Complete	7142128354	000000013 - WAYNE VINCE	12/18/2020
000000014	0456789120	Determination Complete	7142128354	000000014 - JAMES MURPHY	12/10/2020
000000015	0567891230	Determination Complete	7142128354	000000015 - MICHAEL SCOTT	12/04/2020
000000016	0678912340	Determination Complete	7142128354	000000016 - LISA VANLANDINGHAM	12/04/2020
000000017	0789123450	Determination Complete	7142128354	000000017 - BESSIE MCDONALD	12/04/2020
000000018	0891234560	Determination Complete	7142128354	000000018 - MICHELLE TRAN	12/01/2020
000000019	0912345670	Determination Complete	7142128354	000000019 - JASON PEREZ	12/01/2020
000000020	0012345600	Determination Complete	7142128354	000000020 - KIYON KWON	11/30/2020

Showing 1 to 20 of 1,000 entries

Previous 1 2 3 4 5 ... 50 Next

Search by Performing Provider or Facility

To search by Performing Provider or Facility:

- 1) Select the **Performing Provider** radio button and click the **double arrow** icon next to the NPI/API field.

Search

SEARCH BY:

Requesting Provider
 Performing Provider
 Prior Authorization Number (for requesting providers only)

NPI/API * **>>**

Client Id

Requested Authorization From *

Requested Authorization Through *

Note: If "Through" date is left blank, it will automatically default to today's date.

[< Back to Search](#)

A window will display with all NPIs/APIs associated with your account. A drop-down menu is available for you to adjust the number of NPIs/APIs displayed per page, and a quick search field is available for fast access to a specific NPI/API number.

- 2) Select the radio button next to the applicable NPI/API.

The screenshot shows a window titled "Select Provider". At the top left, it says "Show 5 entries" with a dropdown arrow. To the right is a "Search:" field. Below this is a table with the following columns: NPI, TAXONOMY, ADDRESS, ZIP CODE, and BENEFIT CODE. The second row is highlighted in red and has a red radio button selected. Below the table, it says "Showing 1 to 5 of 90 entries" and a pagination bar with buttons for "Previous", "1", "2", "3", "4", "5", "...", "18", and "Next".

NPI	TAXONOMY	ADDRESS	ZIP CODE	BENEFIT CODE
<input type="radio"/> 2468101214	207Q00000X	123 ABC ST	12345-6789	
<input checked="" type="radio"/> 3691215182	207Q00000X	456 DEF AVE	23456-7890	
<input type="radio"/> 4812162024	204C00000X	789 GHI RD	34567-8901	
<input type="radio"/> 5101520253	282N00000X	000 JKL CT	45678-9012	
<input type="radio"/> 6121824303	282N00000X	321 DONE LN GLOOR BLVD	56789-0123	

- 3) In the Requested Authorization Dates field, you will need to input the requested dates the prior authorization request is valid for. The From Date is always required, and if the Through Date is empty, it will default to the current date. Additionally, you may enter the Medicaid or CSHCN Services Program Client ID to help narrow your search.
- 4) Click **Search** to continue after you have selected the applicable NPI/API, filled in the Requested Authorization Date fields, and completed any additional fields.
- 5) The Performing Provider Results screen will display. A drop-down menu is available to adjust the number of prior authorization requests displayed, and a quick search field is available for fast access to a specific request.

The screenshot shows a window titled "Results". At the top left, it says "Show 20 entries" with a dropdown arrow. To the right is a "Search:" field. Below this is a table with the following columns: PRIOR AUTHORIZATION #, STATUS, NPI/API, CLIENT ID, FROM DOS, and TO DOS. The first row contains the following data: 0827202225, Review in Progress, 2468101214, 876543210, 08/04/2022, 08/04/2022. Below the table, it says "Showing 1 to 1 of 1 entries" and a pagination bar with buttons for "Previous", "1", and "Next".

PRIOR AUTHORIZATION #	STATUS	NPI/API	CLIENT ID	FROM DOS	TO DOS
0827202225	Review in Progress	2468101214	876543210	08/04/2022	08/04/2022

Search by Prior Authorization Number

The Search by Prior Authorization Number feature allows requesting providers to search using a specific Prior Authorization Number. Performing providers or facilities should search by **Performing Provider**.

To search by Prior Authorization Number:

- 1) Select the **Prior Authorization Number** radio button and enter the Prior Authorization Number.

Search

SEARCH BY:

- Requesting Provider
- Performing Provider
- Prior Authorization Number (for requesting providers only)

Prior Authorization Number *

[< Back to Search](#)

2) Click **Search** to continue.

The Requesting Provider results screen will display. A drop-down menu is available to adjust the number of prior authorization requests displayed, and a quick search field is available for fast access to a specific request.

Results						
Show 20 entries		Search: <input style="width: 100%;" type="text"/>				
REFERENCE ID	PRIOR AUTHORIZATION #	STATUS	NPI/API	CLIENT ID	RECEIVED DATE	
Processing	5738316481	Received - Awaiting Review	7142128354	987654321 -BILLY BOB	08/11/2022	
Showing 1 to 1 of 1 entries						<input type="button" value="Previous"/> <input checked="" type="button" value="1"/> <input type="button" value="Next"/>

Updating Existing Prior Authorization Requests

If an update to an existing prior authorization request is necessary, you can access the Update Existing screen by clicking the **Authorization** button on the PA on the Portal navigation menu, which will expand to reveal subsections for Submit New, Update Existing, Drafts, and Templates. Click the **Update Existing** button to go to the Search screen. Alternatively, you can locate prior authorization requests in need of updating by navigating to the PA on the Portal Status Dashboard or search functions.

Home
Status ▼
Authorization ▲
Submit New
Update Existing ←
Drafts
Templates
Eligibility
Reference

Edit or Correction of Newly Submitted Authorization

Depending on the status of the prior authorization request and whether it was submitted on the portal or by paper or fax, different actions will be available after you've selected a prior authorization request to update. An advantage of submitting prior authorization requests using PA on the Portal is that you can make certain modifications before it's reviewed by TMHP staff.

For Received – Awaiting Review status:

- If the prior authorization request was submitted through the portal, you can update the quantity or frequency of a detail line, upload attachments, and add additional notes.
- If the prior authorization request was submitted by paper or fax, you can upload additional attachments and add additional notes, but only after a prior authorization number is assigned. You cannot update the quantity or frequency of a detail line if the prior authorization request was submitted by paper or fax.

For authorizations in the Review in Progress status, no actions can take place, as the prior authorization request is currently under review by TMHP staff.

For authorizations in the Pending Provider Response status, you can view the pending rationale from the TMHP clinician, and upload additional attachments as well as add additional notes, regardless of whether the prior authorization request was submitted by the portal, paper, or fax.

For authorizations in the Determination Complete status, you can request an extension/recertification or revision for any approved detail line. A service detail cannot be added under the Service Details tab. The system only provides detail lines eligible for extension. You will be able to choose which lines you want to extend. For example, if there are three approved lines, you could delete two of the lines that were automatically created if you don't want to extend them.

To correct a prior authorization request, navigate to the PA on the Portal Dashboard and click the prior authorization request number to display the PA View for that authorization, which is read only. If the authorization request has allowable edits, an **Edit** button will be available in the top right corner. Clicking the **Edit** button will unlock the authorization, making certain fields editable.



Texas Health Steps Dental Prior Authorizations cannot be updated by fax and all updates and corrections must be made using PA on the Portal.

Revisions

Note: A revision, extension, or recertification will only be allowed if the **Revision**, **Extension**, or **Recertification** buttons are present.



A revision is used when you wish to modify the quantity or frequency of an approved service line. For authorizations in Determination Complete status, you can request an extension/recertification or revision for any approved detail line.

If the status of the prior authorization request is Determination Complete, you will need to click on the prior authorization number to bring up the PA view, where there will be buttons for **Extension** or **Recertification** and **Revision**.

Authorization #: 000000001 Status: Determination Complete Submission ID: Portal - 576245 Create date: 2/14/2023 12:00:00 AM		<input type="button" value="Revision"/> <input type="button" value="Extension"/>
<input type="button" value="Print"/>		
Provider Information		Client Information
 Name: JOHN DOE MD PA NPI/API: 7142128354 Taxonomy: 225X00000X Benefit Code: CCP Address: 365 CIRCLE DR AUSTIN, TX 12345	 Name: JOLENE PARTON Client ID: 987654321 DOB: 02/14/1950 SSN: 987654321 Address: 411 CONGRESS AVE AUSTIN, TX 12345	
Additional Information Authorization Area: CCP (Medicaid) Submission Type: CCP Prior Authorization Request	Authorization Dates From: 02/14/2023 Through: 02/21/2023	Provider Contact Information Name: * John Preferred Method: * Phone Phone: * 123-456-7890 Fax: * 123-456-7890

If the **Revision** button is selected, then you will be able to update the frequency and quantity fields.

Note: When you click **Revision**, you will be directed to the Client Eligibility Pre-check if the authorization request was submitted by paper or fax.



Authorization Request		<input type="button" value="Revision"/>
<input type="button" value="Service Details"/>	<input type="button" value="Upload Attachments/View Letters"/>	<input type="button" value="Submit"/>
Provider Information		Client Information
 Name: JOHN DOE MD PA NPI/API: 7142128354 Taxonomy: 207Q00000X Benefit Code: Address: 365 CIRCLE DR AUSTIN, TX 12345	 Name: JOLENE PARTON Client ID: 987654321 DOB: 02/14/1950 SSN: 987654321 Address: 411 CONGRESS AVE AUSTIN, TX 12345	
Additional Information Authorization Area: CCP (Medicaid) Submission Type: CCP Prior Authorization Request	Authorization Dates From: 02/10/2023 Through: 02/21/2023	Provider Contact Information Name: * John Preferred Method: * Phone Phone: * 123-456-7890 Fax: * 123-456-7890

If additional documentation or notes are needed to complete the authorization request, you can submit that by selecting the Upload Attachments tab. After all necessary documentation has been successfully uploaded, resubmit the request.

After successful resubmission, a confirmation page will display. The prior authorization number will remain the same. However, a new reference ID will be given to the authorization.

Extensions

An extension or recertification is used when you wish to extend an approved service line for a longer amount of time. If the status of the prior authorization request is Determination Complete, then click on the prior authorization number to bring up the PA view, where there will be buttons for **Extension** or **Recertification** and **Revision**.

Authorization #: 000000001 Status: Determination Complete Submission ID: Portal - 576245 Create date: 2/14/2023 12:00:00 AM		Revision	Extension
Print			
Provider Information		Client Information	
	Name: JOHN DOE MD PA NPI/API: 7142128354 Taxonomy: 225X00000X Benefit Code: CCP Address: 365 CIRCLE DR AUSTIN, TX 12345		Name: JOLENE PARTON Client ID: 987654321 DOB: 02/14/1950 SSN: 987654321 Address: 411 CONGRESS AVE AUSTIN, TX 12345
Additional Information	Authorization Dates	Provider Contact Information	
Authorization Area: CCP (Medicaid) Submission Type: CCP Prior Authorization Request	From: 02/14/2023 Through: 02/21/2023	Name: * <input type="text" value="John"/> Preferred Method: * <input type="text" value="Phone"/>	Phone: * <input type="text" value="123-456-7890"/> Fax: * <input type="text" value="123-456-7890"/>

When you click **Extension**, you will be directed to the Client Eligibility Pre-check screen, regardless of the submission method. For an extension or recertification, you will be able to update the To Date of Service field.

Client Eligibility Pre-check

[Extension](#)

Please Note: This is a client eligibility pre-check. For a more comprehensive eligibility check you may use [TexMedConnect](#) . These verifications do not guarantee approval of the prior authorization request.

NPI/API * <input type="text" value="7142128354"/>	Client id * <input type="text" value="987654321"/>
Authorization Area * <input type="text" value="CCP (Medicaid)"/>	Submission Type * <input type="text" value="CCP Prior Authorization Request"/>
Requested Authorization From * <input type="text" value="02/14/2023"/>	Requested Authorization Through * <input style="border: 2px solid red;" type="text" value="02/21/2023"/>



[Check Eligibility](#) [Continue](#)

You will also be able to update the Requested Frequency and Requested Quantity fields. Remember, a service detail cannot be added under the Service Details tab. The system only provides detail lines eligible for extension.

Authorization Request

[Extension](#)

[Service Details](#) [Upload Attachments/View Letters](#) [Submit](#)

Provider Information		Client Information	
	Name: JOHN DOE MD PA NPI/API: 7142128354 Taxonomy: 225X00000X Benefit Code: CCP Address: 365 CIRCLE DR AUSTIN, TX 12345		Name: JOLENE PARTON Client ID: 987654321 DOB: 02/14/1950 SSN: 987654321 Address: 411 CONGRESS AVE AUSTIN, TX 12345
Additional Information	Authorization Dates	Provider Contact Information	
Authorization Area: CCP (Medicaid) Submission Type: CCP Prior Authorization Request	From: 02/14/2023 Through: 02/21/2023	Name: * <input type="text" value="John"/> Preferred Method: * <input type="text" value="Phone"/>	Phone: * <input type="text" value="123-456-7890"/> Fax: * <input type="text" value="123-456-7890"/>

For example, if there are three approved lines, you could delete two of the auto-created lines if you don't want to extend them.

If additional documentation or notes are needed to complete the authorization request, then select the Upload Attachments tab. After all the necessary documentation has been successfully uploaded, you can resubmit the authorization.



After successful resubmission, a confirmation page will display. The prior authorization number will remain the same; however, a new reference ID will be given to the authorization.

Note: Whether or not a revision, extension, or recertification is allowed depends on the Authorization Area and Submission Type. If allowed, the **Revision** and **Extension** buttons will be present. Extensions are allowed for some services of Medicaid, while recertifications are allowed for all CSHCN Services Program services.

Corrections

A correction is used when you need to make an update to a previously submitted prior authorization request due to a data entry error, or when a prior authorization is in Pending Provider Response status due to lack of documentation, physician signature, etc. There is only a 14-day window of time to submit a correction.

You can click on the prior authorization number to display the PA View. An **Edit** button will be present if the prior authorization is in Received – Awaiting Review status or Pending Provider Response status.

Authorization #: 000000002 Status: Received - Awaiting Review Submission ID: Portal - 434522 Create date: 02/28/2023 12:00:00 PM		<input type="button" value="Edit"/> <input type="button" value="Print"/>
Provider Information		Client Information
 Name: JANE DOE MD PA NPI/API: 8162432404 Taxonomy: 225X00000X Benefit Code: CCP Address: 808 SQUARE DR AUSTIN, TX 12345	 Name: JOLLY PARTON Client ID: 123456789 DOB: 06/21/1989 SSN: 123456789 Address: 411 CONGRESS AVE AUSTIN, TX 12345	
Additional Information Authorization Area: CCP (Medicaid) Submission Type: CCP Prior Authorization Request	Authorization Dates From: 02/28/2023 Through: 03/21/2023	Provider Contact Information Name: <input type="text" value="Jane"/> Preferred Method: <input type="text" value="Phone"/> Phone: <input type="text" value="987-654-3210"/> <input type="text" value=""/> Fax: <input type="text" value="987-654-3210"/> Alternate Phone: <input type="text"/>

If the status of the authorization is Pending Provider Response, you can view the pending rationale from the TMHP clinician, upload additional attachments, and add additional notes.

If the status is Received – Awaiting Review and the prior authorization request was submitted through the portal, you can update the quantity and frequency of a detail line, upload additional attachments, and add additional notes. You will not be able to make updates once the status of the authorization request changes from Received – Awaiting Review to Review in Progress. If the prior authorization request was submitted by paper or fax, then no corrections can be made in Received – Awaiting Review status.

Click the **Edit** button to unlock the authorization and make corrections. Once an edit is performed and resubmitted, both the prior authorization number and reference ID will remain the same.

Authorization Request

[Correction](#)

Service Details

Upload Attachments/View Letters

Submit

Provider Information

Name: JANE DOE MD PA

NPI/API: 8162432404

Taxonomy: 225X00000X

Benefit Code: CCP

Address: 808 SQUARE DR
AUSTIN, TX 12345

Client Information

Name: JOLLY PARTON

Client ID: 123456789

DOB: 06/21/1989

SSN: 123456789

Address: 411 CONGRESS AVE
AUSTIN, TX 12345

Additional Information

Authorization Area: CCP (Medicaid)

Submission Type: CCP Prior Authorization Request

Authorization Dates

From: 02/28/2023 **Through:** 03/21/2023

Provider Contact Information

Name:

Preferred Method:

Phone:

Fax:

Alternate Phone:

Things to Remember

A few things to remember about updating an existing prior authorization request:

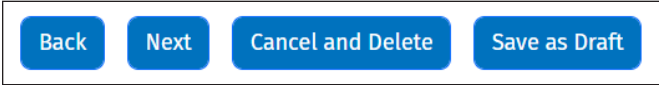
- Whether or not a revision or extension/recertification is allowed is based on the authorization area and submission type. If allowed, the **Revision** and **Extension** buttons will be enabled. If not allowed, the buttons will be disabled.
- Only the requesting provider is allowed to take action (revision/correction/extension/recertification), on a prior authorization request.
- Only one active revision or extension/recertification per prior authorization number can occur.
- Only one correction can occur while a prior authorization is in Received – Awaiting Review status. An indefinite amount of corrections can be performed prior to the due date if the authorization is in Pending Provider Response status.

Drafts and Templates

Prior authorization requests can be saved as drafts, with attachments, if you need to save your progress prior to submission. You will have the option to save a template after a successful prior authorization has been submitted. Up to 200 drafts or templates per NPI/API can be created and saved. Drafts can remain inactive for 90 days before the draft and all attachments are purged from the system. Templates will be retained for a period of 365 calendar days from the last modified date.

Saving Drafts, Accessing Drafts, and Warning Messages

To save a prior authorization as a draft, click the **Save as Draft** button located at the bottom of the Service Details tab or Upload Attachments tab.



A window will display requiring you to name the draft. You also have the option to add any additional notes for up to 100 alphanumeric characters.

Save Draft

Draft Name *

Draft Notes

100 characters remaining

[Cancel](#) [Save](#)

To access saved drafts, click the **Authorization** button on the PA on the Portal navigation menu, and then click the subsection button labeled **Drafts**.

Select the NPI/API associated with the draft from the Requesting NPI/API drop-down menu.

Drafts

Filter Criteria

Requesting NPI/API *

 [>>](#)

Available Drafts

Show entries Search:

1	2	3	4	5	6	
DRAFT NAME	AUTHORIZATION AREA	SUBMISSION TYPE	USER ID	LAST UPDATED DATE	DRAFT NOTE	
Test Doc Removal	CCP (Medicaid)	CCP Prior Authorization Request	user1	09/22/2022	test	Delete

Showing 1 to 1 of 1 entries [Previous](#) [1](#) [Next](#)

Any non-submitted or unmodified draft(s) will be deleted after a period of 90 calendar days.

Results will display with the following columns:

- 1** Draft Name: The title given to the draft
- 2** Authorization Area: Selected in the Client Eligibility Pre-check
- 3** Submission Type: Selected in the Client Eligibility Pre-check
- 4** User ID: This is the user who last updated the draft. The draft can be updated and edited by any user linked to the NPI/API user account.
- 5** Last Updated Date: Last date the draft was updated
- 6** Draft Note: Optional field to document additional information regarding the draft

To select a draft, click on the draft name.

If you wish to delete the draft, click **Delete** at the end of the row. Once you click **Delete**, a warning message will display asking you to confirm the permanent deletion of the draft. You will need to select **Yes** or **No**. Once a draft authorization has been submitted, it will no longer display on the Drafts page.

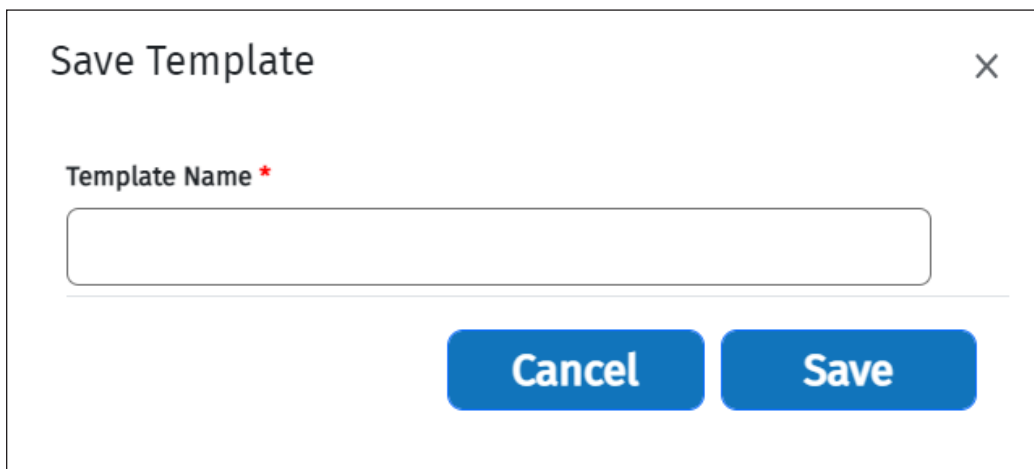
Remember, uploaded attachments will be saved with the draft.

Saving Templates, Accessing Templates, and Warning Messages

Prior authorization requests can also be saved as templates. A template can only be created from a successfully submitted prior authorization. Select the **Save as Template** button at the bottom of the Successful Prior Authorization Submission screen.



A window will display prompting you to name the template. The template name can contain up to 25 alphanumeric characters. To save time, reusable templates can be created for an ongoing service or a specific client. This feature can speed up the authorization process while reducing manual keying.

A dialog box titled "Save Template" with a close button (X) in the top right corner. It contains a text input field labeled "Template Name" with a red asterisk indicating it is required. Below the input field are two blue buttons: "Cancel" and "Save".

Save Template

Template Name *

Cancel Save

To access saved templates, click the **Authorization** button on the PA on the Portal navigation menu, then click the subsection button labeled **Templates**. You must complete the Client Eligibility Pre-check when you access a saved template.

Select the NPI/API that is associated with the template from the Requesting NPI/API drop-down menu.

The screenshot shows the 'Templates' interface. At the top, there is a 'Filter Criteria' section with a 'Requesting NPI/API' dropdown menu containing the value '1003005323'. Below this is the 'Available Templates' section, which includes a 'Show 50 entries' dropdown and a search box. The main content is a table with the following columns: TEMPLATE NAME, AUTHORIZATION AREA, SUBMISSION TYPE, USER ID, LAST UPDATE DATE, and two action columns (Edit and Delete). The table contains three rows of data. Below the table, it says 'Showing 1 to 3 of 3 entries' and has 'Previous', '1', and 'Next' navigation buttons. A light blue banner at the bottom states: 'Any non-submitted or unmodified templates(s) will be deleted after a period of 365 calendar days.'

TEMPLATE NAME	AUTHORIZATION AREA	SUBMISSION TYPE	USER ID	LAST UPDATE DATE		
Test Doc Removal	CCP (Medicaid)	CCP Prior Authorization Request	user1	09/21/2022	Edit	Delete
Home Health	Home Health (Medicaid)	Plan of Care	user1	08/22/2022	Edit	Delete
testreg	CCP (Medicaid)	CCP Prior Authorization Request	user1	08/01/2022	Edit	Delete

Results will display with the following columns:

- 1 Template Name: The title given to the template
- 2 Authorization Area: Selected in the Client Eligibility Pre-check
- 3 Submission Type: Selected in the Client Eligibility Pre-check
- 4 User ID: This is the user who last updated the template. The draft can be updated and edited by any user linked to the NPI/API user account.
- 5 Last Update Date: Last date the template was updated

To open a template, click the template name link.

If you wish to edit a template, click the **Edit** link.

If you wish to delete a template, click the **Delete** link at the end of the row. Once you click **Delete**, a warning message will display asking you to confirm permanent deletion of the template. You will need to select **Yes** or **No**.

Uploaded attachments will not be saved with templates.

Reference

The Reference screen, located on the PA on the Portal navigation menu, contains information and links to supplemental material to help you get the most out of PA on the Portal.

Home	
Operational Workflow	▼
Operational Authorizations	▼
Reference	

Reference Material

The [Electronic Prior Authorization Submission Guide](#) has been developed by TMHP to assist providers with electronic submissions. This document does not replace the [Texas Medicaid Provider Procedures Manual \(TMPPM\)](#) or [CSHCN Services Program Provider Manual](#).

To review Prior Authorization forms and the latest Provider Bulletins and notifications on tmhp.com Prior Authorization page, click [here](#).

[Frequently Asked Questions](#) – PA on the Portal.

For information about TMHP User Account management, please click [here](#).

For PA on the Portal support, please contact the following:

Customer Service at 1-800-925-9126, Option 1
Technical Support (EDI Help Desk) at 1-888-863-3638
For other questions refer to [Contact Us page](#).

Reference Materials

Links include this submission guide, as well as [PA on the Portal](#), the [PA on the Portal Frequently Asked Questions](#), and the [TMHP Portal Security Training Manual](#).

For PA on the Portal support, contact the following:

- Medicaid Customer Service (TMHP Contact Center) at 800-925-9126
- CSHCN Services Program provider line at 800-568-2413
 - Examples of when to contact the Contact Center include prior authorization submission assistance, client and provider autofilled information issues, or eligibility questions.
- Technical Support (EDI Help Desk) at 888-863-3638
 - Examples of when to contact the EDI Help Desk include issues accessing specific NPI information, TMHP portal account questions, or an application error.