DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	N/A	January 15, 2010	Initial version Uniform Managed Care Manual Chapter 13.1, "Notification Process for Incomplete Prior Authorization Requests".
Revision	2.0	November 15, 2014	Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042. Applicability is updated to include Medicaid Dental.
Revision	2.1	April 5, 2016	Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. "Applicability of Chapter 3.22" is modified to add the STAR Kids Program and the Medicare-Medicaid Dual Demonstration. "Notification for Incomplete Prior Authorization Requests" is modified to change Alberto N. v. Suehs to Alberto N. v. Traylor.
Revision	2.2	December 1, 2020	Chapter 3.22 is replaced in its entirety with a new chapter 3.22. The chapter title is modified from "Notification Process for Incomplete Prior Authorization Requests" to "Process for Standard Prior Authorization (PA) Requests received with Incomplete or Insufficient Documentation."
Revision	2.3	September 1, 2022	New Section VI.A adds clarification on PA submission guidelines. Section VI.B adds clarification to Start of Care date policy.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

I. Applicability

This chapter applies to managed care organizations (MCO) participating in the STAR, STAR+PLUS, Medicare-Medicaid Dual Demonstration, STAR Kids, and STAR Health programs, and Dental contractors providing Medicaid dental services to Members through dental health plans. The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, dental contractors, Medicare-Medicaid plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, Dual Demonstration, STAR Kids, and STAR Health programs, and the Medicaid dental contractors. The requirements in this chapter apply to all Medicaid programs, except where noted.

II. Definitions

For purposes of this chapter only, the following terms have the meanings assigned below, unless the context clearly indicates otherwise:

A. Complete PA Request - A request for a service that includes all information/documents required to make and establish a medical necessity determination. The prior authorization (PA) requirements to consider a PA request complete are listed on the MCO's website for the requested service.

B. Essential Information – The information required to initiate the PA review process:

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Service requested - Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)
- Service requested start and end date(s)

- Quantity of service units requested based on the CPT, HCPCS, or CDT requested

C. Incomplete PA Request – A request for a service that is missing information to establish medical necessity as listed in the PA requirements on the MCO's website.

D. Prior Authorization Receive Date - The date the PA request containing complete Essential Information is received by the MCO. This date is considered Business Day zero on the PA timeline.

III. Initiation of the PA Process

If the PA request has Essential Information, the MCO must begin to process the PA request as described in Article V of this chapter. The MCO must not require additional elements to initiate a PA request process other than those elements listed under the definition of Essential Information.

If Essential Information on a PA request is missing, incorrect, or illegible, the MCO should not enter the request into the system ("shell it") and must not approve or deny the request. The MCO must return the request to the requesting provider with an explanation of why the submitted request was not processed as submitted and include instruction to resubmit the PA request with complete Essential Information.

If a PA request is rejected or returned to the provider because of missing, incorrect, or illegible Essential Information, no PA Receive Date is established. Regardless, the MCO must track how many of these PA request rejections occur.

IV. Prior Authorization Process Compliance

The MCO is responsible for evaluating the accuracy and completeness of PA requests. HHSC may enforce Contract remedies for identified instances in which a Complete PA Request is provided but the MCO processes the request as an Incomplete PA Request.

If a PA request is missing documentation to determine medical necessity and it will likely result in an Adverse Benefit Determination, the PA request must be limited to the PA requirements listed on the MCO's website on the date the request is received. The MCO must utilize the PA request process described in this chapter to request additional documentation (including documentation required for THSteps-Comprehensive Care Program and Home Health Durable Medical Equipment and Supplies exceptional circumstances requests) that is identified as missing or insufficient to support complete documentation listed on the MCO's website.

V. Timeframes for Coverage Determinations

A. Complete PA Requests

For Complete PA Requests, a coverage determination must be made within timeframes listed in the applicable managed care contract (e.g., Uniform Managed Care Contract (UMCC) section 8.1.8 Utilization Management).

B. Incomplete PA Requests

The MCO must issue coverage determinations for Incomplete PA Requests according to the following timelines:

i. Notify the requesting provider and Member, in writing, of missing information no later than 3 Business Days after the PA Receive Date. Additionally, the MCO is permitted to contact the provider by telephone and obtain the information necessary to resolve the Incomplete PA Request. The MCO's written request for additional information must include the following:

   a. A statement that the MCO has reviewed the PA request and is unable to make a decision about the requested services without the submission of additional information.
   b. A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
   c. An applicable timeline for the provider to submit the missing information.

d. Information on the manner through which a provider may contact the MCO.

HHSC will permit the MCO's specific list of information to the provider and Member, as identified in this Article, to justify a need for additional time to consider the PA request under two circumstances: (1) if the Member requests an extension, or (2) the MCO shows to the satisfaction of HHSC, and upon HHSC's request, that the additional time for consideration is in the Member's interest. An MCO is not required to preliminarily seek HHSC permission before adopting an extension on an Incomplete PA Request. However, an MCO must document and be able to justify to HHSC, upon request, the need for additional information and how the extension is in the Member's interest.

ii. If the MCO does not receive the information requested under section V.B.i.b by the end of the 3rd Business Day from the date that the MCO sent notice to the provider and the PA request will result in an Adverse Benefit Determination, then the MCO must refer the Incomplete PA Request for MCO physician review with all information received with the PA request. This referral must be no later than the 7th Business Day after the PA Receive Date.

iii. Within 3 Business Days of the referral for MCO physician review, but no later than the 10th Business Day after the PA Receive Date, the MCO must make a final decision on the PA request.

During the PA request process, a peer to peer consultation can occur any time after the MCO physician review. An MCO must offer an opportunity for a peer to peer consultation to the requesting physician no less than one Business day before an Adverse Benefit Determination is issued.

The MCO must make a final determination of medical necessity within 3 Business Days after the date the missing information is provided to the MCO.

If a state-recognized holiday will result in the PA request process exceeding the 14 Day time limit the MCO must adjust the timeline accordingly so that the prior authorization timeline does not exceed the 14 Days.

VI. Other clarifications:

A. MCO Submission Guidelines

MCOs must publish clear PA submission guidelines for all services, including those services that require a provider to assess the member or initiate care prior to submitting a PA request. MCOs must follow UMCM Chapter 3.32 relating to website critical elements.

MCOs must ensure ongoing provider updates on PA processes. Per UMCC 8.1.8.1, the MCO must provide guidance to the provider holding the PA no less than 45 Days prior to effective date of the change. If the change is a result of a service code, procedure code, or benefit change adopted by HHSC, the MCO must issue notice of the change by the later of: (1) 45 Days prior to the effective date of the change, or (2) within 10 Business Days of receiving notice of the change from HHSC. MCOs may choose to reissue PAs or publish guidance to providers on updating current PAs. Information must be sufficient for providers to accurately bill for services. The MCO must establish and document a plan to inform all impacted providers of the changes. The MCO must be able to demonstrate that each impacted provider is notified of the changes within the prescribed timeframe through broadcast messages or individual notifications. The MCO must provide a copy of the plan and any associated notifications to HHSC upon request.

B. Start of Care Date

The "Start of Care" (SOC) date is the date agreed to by the physician, the service provider, and the Member or responsible adult and is indicated on the submitted ~~plan of care (POC)~~ PA request as the SOC date. SOC date may include PA requests for home health skilled nursing and aide services, private duty nursing (PDN), physical therapy, occupational therapy, and speech therapy services. These services may require that the provider assess the Member and initiate care prior to submitting a PA request for services. For example: PDN providers must submit a PA request within three Business Days of the SOC date for initial or new PDN services. During the PA process, providers are required to deliver the requested services from the SOC date. In the case of incomplete requests, the requested SOC date must be honored when the provider is able to submit a complete request within the timeline detailed in Section V of this chapter and the MCO has determined that the requested services meet medical necessity.

C. Peer to Peer Consultations and Reasonable Opportunity

In accordance with Texas Government Code § 533.00284, the MCO must follow the established timeframes set forth in this chapter to provide the requesting physician with a reasonable opportunity to discuss the Member's treatment plan with a physician who is contracted by the MCO and who practices in the same or similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the Member on whose behalf the request is submitted.

A peer to peer consultation is between a MCO Medical Director and the requesting physician for a specified service. An MCO Medical Director is permitted to determine that his/her clinical knowledge or experience is insufficient to accurately render a decision on a PA request. In this case, standard of care indicates that the MCO must seek and document, by an acceptable method of its design, additional information from reference material, from the expertise of another physician associated with the MCO, or by employing an outside organization.

The MCO must document the time, date, name, and credentials of the individual consulted on a PA request and the substance of any verbal communication between the individual consulted and MCO.

A person may not review Health Care Services or make Adverse Benefit Determination or changes to a PA request if he or she, or a member of his or her family –

1. Participated in developing or executing the Member's treatment plan;
2. Is a part of the Member's family;
3. Is a governing body member, officer, partner, 5 percent or more owner, or managing employee in the health care organization where the services were or are to be furnished; or
4. A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

D. Relating to Grievances, Fair Hearing Rights and Appeal Timelines

The process and timelines set forth in Article V of this chapter do not affect: (1) any related timeline, including the timeline for MCO Internal Appeal, a State Fair Hearing, or a review conducted by an External Medical Reviewer; (2) any rights of a Member to appeal a determination made on a PA request.

E. Communication and Notices

i. Provider Notifications:

After the MCO determines that a PA request is incomplete, it must use at least one of the following modes of communication to contact the provider: fax, electronic communication via secure provider portal, or postal mail.

The MCO will not be required to mail notices to the provider if notice is sent by fax or electronic communication via secure provider portal. A date and time stamp must be properly documented by the MCO if notice is sent by fax or electronic communication via secure provider portal. Additionally, the MCO is permitted to contact the provider by telephone. If the MCO obtains the information necessary to complete the PA request during the phone call, the MCO must document the time, date, credentials, and name of the

individual consulted during the phone call, and the substance of their verbal communication. All clinical information must be received from a licensed physician, or other appropriately licensed and credentialed medical personnel.

The MCO must send a written notice of final determination no later than the next Business Day after a determination is made on a PA request. This final notice must be dated the day the notice is sent. HHSC recognizes written notice may be delivered by fax, mail or through an electronic communication via a secure provider portal.

ii. Member Notifications:

The MCO must allow Members to choose a preferred method for receiving PA request notices to the extent practicable using existing resources, and provide Members notice through their preferred methods. If a Member does not choose a preferred method, HHSC requires the MCO send notices via mail.

In addition to the requirements discussed above, the MCO must follow UMCM Chapter 3.21 relating to MCO notices of action requirements.

F. STAR Health Members

If, after all new information is reviewed, the PA request is still missing necessary documentation to process the request, the MCO must follow the process detailed in Section V of this chapter and also request all available and necessary information by contacting the Member or the Member's medical consenter as primary contacts. If the MCO is unable to reach a Member or Member's medical consenter, the MCO must contact the Member's caregiver as a secondary contact or DFPS staff as tertiary contact.

G. Pharmacy Exceptions

The MCO must adopt PA requirements that comply with state and federal laws governing authorization of Health Care Services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Texas Government Code §§531.073 and 533.005(a)(23).

The MCO must adhere to requirements and time frames in UMCC Section 8.1.21.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies.

H. Non-Emergency Ambulance

This chapter is not applicable to non-emergency ambulance PA requests. Non-emergency ambulance PA requirements must follow established rules and timelines set forth in 1 TAC §354.1115, Authorized Ambulance Services.