Texas Children's® Health Plan

Utilization Management Overview

Summer 2024

Prior Authorization Resources

All of the authorization resources are available here, https://www.texaschildrenshealthplan.org/for-providers/provider-resources/prior-authorization-information.

Most out of network services must receive a prior authorization from the health plan before the out of network service can occur. The exception is out of network emergency services, for these an authorization is not required.

Providers are responsible for initiating the prior authorization process when a Member requires medical services that require prior authorization, including inpatient admission.

Prior Authorization Guidelines

Providers should reference the guidelines listed on the webpage above for a specific service. Each guideline lists the required documentation and forms that must accompany an authorization request.

Prior Authorization Processing Times

The Utilization Management department processes service requests in accordance with the clinical immediacy of the requested services.

Authorization | Turnaround Time

- Routine | Within 3 business days after receipt of request
- Urgent | Within 1 business day after receipt of request
- Inpatient | Within 1 business day after receipt of request
- Post hospital discharge services* | Within one business day

TCHP does not require prior authorization for Emergency Medical Conditions or Emergency Behavioral Health Conditions

*For members who are hospitalized at the time of the request and services or equipment that are necessary for care of the member immediately after discharge.

Essential Information on Authorization Request

Texas Children's Health Plan requires the following information when an authorization request is made:

- Member Name
- Member Date of Birth
- Member Medicaid/CHIP Identification Number
- Requesting Provider Name and National Provider Identifier (NPI)
- Requested Service
- Current Procedures Terminology (CPT) Codes Requested
- Number of Units Requested
- Dates of Service
- Adequate Supporting Clinical Documentation

Essential Information on Authorization Request cont.

Texas Children's Health Plan (TCHP) supports the guidance from Texas Health and Human Services Commission (HHSC) on rejecting the Prior Authorization (PA) received with incomplete or insufficient documentation per Uniform Managed Care Manual (UMCM), Chapter 3.22.

Closer look at Prior Authorization Resources

- Texas Standard Prior Authorization Form-image below
- Prior authorization requirements- First image on right
- Prior authorization reference information- second image on right

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115

Texas Department of Insurance

Please read all instructions below before completing this form.

*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

Effective Date: 01/02/2024

Texas Children's Health Plan

Prior Authorization Requirements

Below is a list of updated changes to the prior authorization list found in your provider manual and on the Texas Children's Health Plan website. These medical services require prior authorization. A check mark indicates the medical service is a covered benefit if medical necessity criteria are met and with prior authorization. All services will be subject to benefit limitations.

Please be sure to update your material by printing this memo and placing it in the appropriate section.

Medical Services	CHIP	CHIP Perinate	STAR	STAR Kids	STAR Kids MDCP
Augmentative Communication Device and Accessories	✓		✓	✓	✓
Autism Services			✓	✓	✓
Bariatric Surgery			✓	✓	✓
Case by Case Added Services (Codes not listed in the TMHP Fee Schedule)	✓		✓	✓	✓

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Disclaimer: It is the responsibility of the Provider to verify that a service is a benefit of Texas Medicaid for service codes that TCHP does not require prior authorization. Services rendered by out-of-network providers will require prior authorization.

***Effective Dates and Last Review Date listed as 'N/A' indicates that the date was prior to 9/1/2019**

BENEFIT CATEGORIES

(Clicking on the individual benefit category will allow you to jump to detailed information about that benefit)

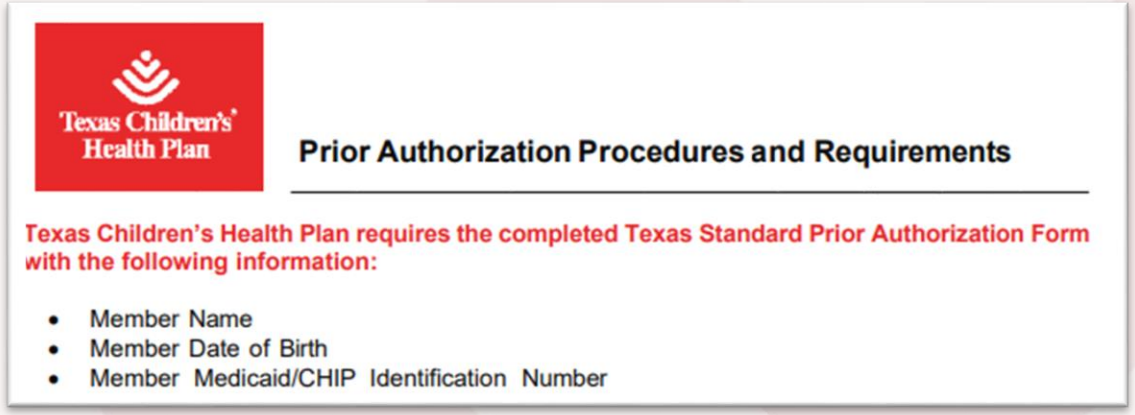
Medical Services

Augmentative Communication Device and accessories

Autism Services (ABA Therapy)

Closer look at Prior Authorization Resources cont.

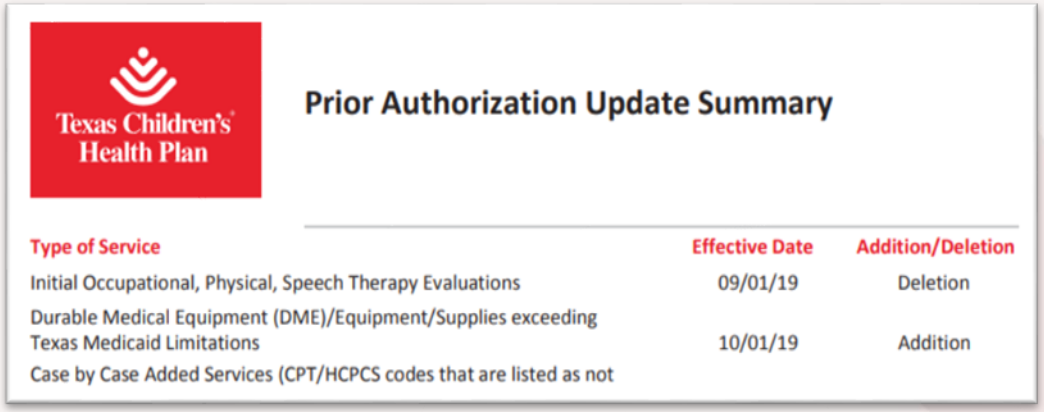
- Prior Authorization Update Summary
- Prior Authorization Procedures and Requirements
- Prior Authorization Dates of Service Calculator from TMHP


Texas Children's Health Plan

Prior Authorization Procedures and Requirements

Texas Children's Health Plan requires the completed Texas Standard Prior Authorization Form with the following information:

- Member Name
- Member Date of Birth
- Member Medicaid/CHIP Identification Number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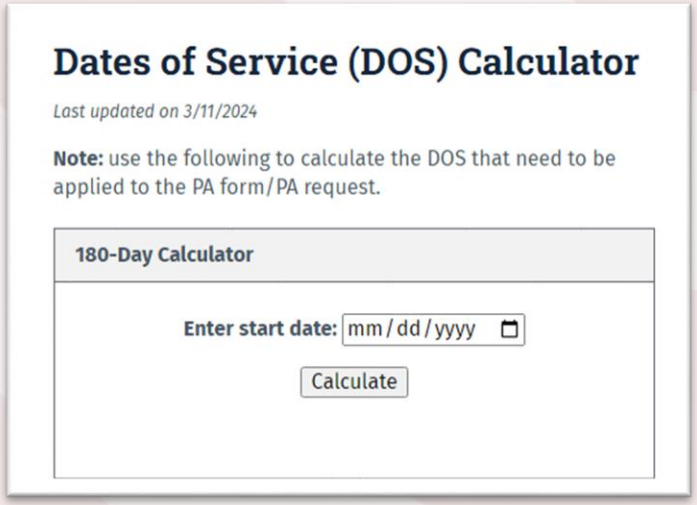
Prior Authorization Update Summary

Type of Service	Effective Date	Addition/Deletion
Initial Occupational, Physical, Speech Therapy Evaluations	09/01/19	Deletion
Durable Medical Equipment (DME)/Equipment/Supplies exceeding Texas Medicaid Limitations	10/01/19	Addition
Case by Case Added Services (CPT/HCPCS codes that are listed as not		


Dates of Service (DOS) Calculator

Last updated on 3/11/2024

Note: use the following to calculate the DOS that need to be applied to the PA form/PA request.

180-Day Calculator

Enter start date: mm/dd/yyyy

Calculate

Closer look at Prior Authorization Resources cont.

Prior Authorization Reference Information
Review Criteria and Documentation

This information can be found on this webpage,
https://www.texaschildrenshealthplan.org/for-providers/prior-authorization-information

If you click on each medical service the corresponding procedure codes are listed along with each line if business and the check marks indicate that an authorization is required.

To search this document for a specific code, click CTRL+F on your keyboard (For Mac, use CMD +F)

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Texas Children's® Link for Authorization Requests

Important benefits of using the provider portal, Texas Children's® Link to submit authorizations include:

- **Real time access to authorization status information** – Authorization status update and status history are immediately available and determinations can be reviewed on the portal in real time.
- **Auto authorizations for certain services** – Certain services and supplies such as medically necessary nutritional supplements, general anesthesia for dental procedures and targeted case management can be submitted for auto authorizations.
- **Easy access for providers and staff** – In addition to providers, both clinical staff and non-clinical staff may submit and review authorization requests and supporting documentation on the portal on behalf of a requesting provider.
- **Access to determination letters** – Authorization determination letters can be accessed on the portal in real time.

Learning tool available – To help providers learn more about submitting prior authorizations, there are some helpful 'How-To Videos' accessible on the provider portal under Quick Links.

Prior Authorization fax lines

Prior authorization may be requested online through Texas Children's® Link or by fax:

Medical Services Fax Line - 832-825-8760 or Toll-Free 1-844-473-6860

Medical Inpatient Admissions and Discharge Notifications - 832-825-8462 or Toll-Free 844-663-7071

Behavioral Health Services Fax Line - 832-825-8767 or Toll-Free 1-844-291-7505

LTSS and Private duty Nursing Fax Line - 346-232-4757 or Toll-Free 1-844-248-1567

Hospital Discharge Authorizations Fax Line* - Toll-Free 866-839-9879

It is recommended to send authorization requests online through the provider portal, Texas Children's® Link.

Denials and Appeals

- Medicaid (STAR) Adverse Benefit Determination (Denials)
  - Texas Children's Health Plan notifies both members and providers when this decision is reached.
  - This outcome may include the denial or limited authorization of a requested service, including the type or level of service, the reduction, suspension or termination of a previously authorized service.
  - A denial for lack of medical necessity (adverse determination) can only be rendered by Texas Children's Health Plan Medical Director, an Associate Medical Director or Physician Reviewer.

- CHIP Adverse Benefit Determinations
  - A denial is issued when medical necessity cannot be determined for a requested service or if the requested service is determined to be experimental or investigational.
  - Only the Texas Children's Health Plan Medical Director, an Associate Medical Director or Physician Reviewer may render an adverse determination.
    - Prior to issuing an adverse determination, providers will be notified by telephone and/or fax of the pending denial and offered the opportunity to submit additional clinical information or to discuss the member's case with the Medical Director or Physician Designee.

Peer-To-Peer Discussion

- Available to the clinical provider ordering the service or supply at any time during the prior authorization, denial or appeal process.
- A denial or reduction of services, or adverse determination for STAR and CHIP, is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
- For CHIP members, the opportunity for a peer-to- peer discussion will be offered prior to issuing an adverse determination.
- For STAR members, a peer-to- peer discussion will be offered before an adverse benefit determination is rendered.
- To schedule a peer-to-peer discussion of the denial, the referring physician may contact Texas Children's Health Plan at 1-877-213-5508, option 3.

Member’s Appeal Process

- Should the member or the member’s representative disagree with a Utilization Management decision, they have the right to access Texas Children’s Health Plan Medical Necessity Appeal Process.
- If Texas Children’s Health Plan denies some but not all of the services requested, the member may ask for an appeal for those services being denied in whole or in part.
  - A member may ask for an appeal by phone or in writing.
  - The member or his or her authorized representative may file an appeal within 60 days from receipt of the adverse benefit determination letter.
- The member appeal process is very similar for both programs, STAR and CHIP. The main difference for CHIP is the specialty review.

Member’s Appeal Process cont.

- Within five (5) business days of receipt of the appeal request, Texas Children’s Health Plan will send a letter acknowledging receipt of the appeal request.
- The Standard Appeal Process must be completed within thirty (30) calendar days after receipt of the initial request for appeal. There are exceptions. See notes section.

- Member Expedited Appeal
  - Members or their authorized representatives may request an expedited within thirty (30) days (or within ten (10) business days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed.

State Fair Hearing

- If a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing.
- State Fair Hearing must be requested within 120 days of the date on the health plan's letter that tells of the decision being challenged.
- If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing.
- Members Access to Expedited State Fair Hearing
  - Members may request an expedited state fair hearing if they believe that waiting for a standard state fair hearing could seriously jeopardize the member's life or health.
  - In order to qualify for an expedited state fair hearing, the member must first complete Texas Children's Health Plan's expedited appeal process.

CHIP Medical Necessity Appeals

- First Level Appeal
  - Appeals are reviewed by a physician not involved in the original adverse determination.
  - Texas Children's Health Plan informs the member, the provider requesting the service and the service provider of appeal rights, including how to access expedited and External Review appeals processes at the time a service is denied.
  - Within five (5) business days of receipt of the appeal request, Texas Children's Health Plan will send a letter acknowledging receipt of the appeal request.
  - Standard appeals resolutions are resolved and communicated to the appealing member no later than thirty (30) calendar days from receipt of the appeal.
- CHIP Specialty Review – Second Level Appeal
  - A second level of appeal is available to the physician requesting the denied service. The provider may request a specialty review in writing. This is unique for CHIP Members and not available with Medicaid.

Member Expedited & External Appeal Process

- Expedited Appeal
  - A member, representative, or health care provider may request an expedited appeal of an adverse determination if waiting thirty (30) calendar days for a standard resolution could seriously jeopardize the member's life or health.
  - Investigation and resolution of expedited appeals are completed based on the medical immediacy of the condition, procedure or treatment but do not exceed one (1) business day from the date all information necessary to complete the appeal is received.
  - The appeal resolution is communicated to the appellant via telephone and in writing.
- External Medical Review (EMR) Information- **Medicaid only**
  - Members will need to request a EMR with the state fair hearing.
  - If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review.
  - The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision.
  - To ask for an External Medical Review, the Member or the Member's representative should either:
    - Complete the State Fair Hearing and External Medical Review Request Form
    - Contact Texas Children's Health Plan at 832-828-1001 or toll-free at 1-866-959-2555; email TCHPUM@texaschildrens.org.
  - Member should not submit additional information during an external medical review.

External Appeal Process cont.

Timing is important:

- If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made.
- If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

Withdraw

- The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request.

Emergency External Medical Review

- If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Texas Children's Health Plan.

External Medical Review contact information:

STAR Members at 832-828-1001 or toll free at 1-866-959-2555
STAR Kids Members toll free at 1-800-659-5764.

For written requests:

Email TCHPUM@TEXASCHILDRENS.ORG
Fax 832-825-8796

Texas Children's Health Plan
Attention: Utilization Management Department
WLS 8390
P.O. Box 301011
Houston, TX 77230-1011

Resources:

- Member Notice of Internal Appeal Decision /State Fair Hearing and External Medical Review Request Form
- Member Notice of Adverse Benefit Determination Form/Health Plan Appeal Request Form

Member Self-Referrals

Texas Children's Health Plan's STAR members do not need a referral from their PCP for the following services.

- Family planning
- Texas Healthy Steps medical and dental checkups
- Well-child annual exams
- Case management for children and pregnant women
- Vision
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope)
- True emergency services- out of network facilities
- Well-woman annual examinations
- OB/GYN care for those who do not qualify for Medicaid
- Observation stays are for hospital short stays of less than 48 hours

Thank you!