

	<h2>Case-by-Case Added Services Procedure</h2>	
<p>Procedure # 5467</p>	<p>Categories Clinical → Administrative</p>	<p>This Procedure Applies To: Texas Children's Health Plan</p>
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PROCEDURE STATEMENT: Texas Children's Health Plan (TCHP) evaluates provision of additional benefits on a case-by-case basis. TCHP evaluates whether the requested additional benefit is an EPSDT requirement.

DEFINITIONS:

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. § 1396d(r). The name has been changed to Texas Health Steps in the State of Texas.

Texas Health Steps is the name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. § 1396d(r), and defined and codified at 42 C.F.R. §§ 440.40 and 441.56-62. HHSC's rules are contained in 25 Tex. Admin. Code, Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

PROCEDURE

1. Upon request from Member/LAR/Provider of a case-by-case added service need, the receiving TCHP team member educates the requestor of the Utilization Management process to submit the request.
2. All requests for prior authorization for case-by-case added services are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.
3. The Utilization Management professional receiving the request evaluates the submitted information and submits their assessment and recommendation to the Medical Director for review.
4. A TCHP Medical Director/Physician reviewer evaluates the request and applicable information as it related to medical necessity or cost benefit and potential for health status impact, taking EPSDT medical necessity requirements into account.
5. If the request is determined to be covered under EPSDT requirements, a medical necessity

determination will be made within regulatory timeframes.

6. If the request is not an EPSDT requirement and the Medical Director/ Physician reviewer makes the determination that the requested service will not be covered, a denial will be issued.
7. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

RELATED DOCUMENTS:

[Case-by-Case Added Services Policy](#)

REFERENCES:

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