Guidance for MCOs and MMPs regarding New and Initial Prior Authorizations

Background:

HHSC is issuing this guidance to Medicaid and CHIP MCOs and Medicare-Medicaid Plans (MMPs) to help ensure continuity of care during the COVID-19 response.

Key Details:

Effective immediately, Medicaid and CHIP MCOs and MMPs must move forward with processing new and initial prior authorization (PA) requests, including recertification requests, by relaxing document submission timeframes for providers if they are unable to provide certain required documentation during the COVID-19 emergency.

This guidance applies to all state plan services, including acute care and long-term services and supports such as personal assistance services, personal care services, Community First Choice, private duty nursing, day activity and health services, and durable medical equipment and supplies. This guidance **does not** apply to dental services, facility services, and outpatient pharmacy services.

Examples of such documentation include, but are not limited to:

- TMPPM-required timely signatures from physicians and other providers,
- client signatures,
- up to date visit with primary care or ordering physician,
- and certification of timely face-to-face visits

Providers must submit the appropriate PA forms for requesting services, including:

- the procedure and diagnosis codes,
- applicable modifiers,
- dates of service,
- and numerical quantities for services requested

Forms must be submitted in a timely manner, complete to the greatest extent possible, and documentation must note the COVID-19 related issue(s) that prevents the provider from being able to submit required documents. Medical necessity-related documentation of clinical records to demonstrate patient status and progress specific to some services is still required. Such documentation includes, but is not limited to:

- letters of medical necessity,
- progress notes,
- therapy evaluations and re-evaluations,
- nursing plans of care and notes,
- and seating assessments, etc.

Failure to provide this documentation without a COVID-19 related explanation in the PA request is justification for the MCO to deny the requested service due to an inability to determine medical necessity.

Providers are expected to document and ensure the services being delivered are medically necessary. An MCO or MMP may request additional information if deemed necessary but may not deny PA requests if providers are unable to provide certain required documentation in a timely manner as outlined above. It is expected that the provider has obtained the appropriate required documentation for inclusion in the member's file before reimbursement is requested and will make it available to the MCO upon retrospective review. The services delivered may still be subject to retrospective review for medical necessity-related documentation. The MCO or MMP should review exceptions on a provider or member-specific basis.

If MCOs or MMPs implement a retrospective review process that impacts claims for PAs that were approved during the COVID-19 emergency, MCOs may not recoup solely on the basis that the provider did not fulfill all of the documentation requirements normally required for PA requests. However, the provider must be able to provide a documented justification that the service was medically necessary.

In addition, MCOs and MMPs must have a process to ensure network providers are aware of and have timely access to the PA information needed to bill appropriately and enter authorization information into the electronic visit verification (EVV) system prior to service delivery (for EVV-required services).

Additional Information:

A provider notice was also released and is available on the TMHP website.

Contact:

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