

Medicaid and CHIP prior authorizations (STAR, STAR+PLUS, STAR Kids, CHIP and CHIP Perinatal)

For services that require prior authorizations, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria. To determine if prior authorization or notification is required, access our Precertification Lookup Tool at:

<https://providers.amerigroup.com/Pages/PLUTO.aspx>.

The following are the prior authorization timelines:

- Nonurgent pre-service: For prior authorization of nonurgent care, a decision will be made within three business days from date of request.
- Urgent/expedited pre-service: For prior authorization of urgent/expedited pre-service care, a decision will be made as expeditiously as a member's condition requires and no later than 72 hours after receipt of the request.
- Urgent concurrent: For urgent concurrent care, a decision will be made within one business day — not to exceed 72 hours of receipt of the request for service or notification of inpatient admission.
- Post-service: For post-service care, a decision and notification is required within a reasonable period but no later than 30 calendar days from the receipt of the request.
- Post-stabilization: Within one hour for post-stabilization or life-threatening conditions, except for emergency medical conditions and emergency behavioral health conditions where prior authorization is not required.
- For a member who is hospitalized at the time of the request, within one business day of receiving the request for services or equipment that will be necessary for the care of the member immediately after discharge, including if the request is submitted by an out-of-network provider, provider of acute care inpatient services or from a member.

In order to process an urgent/expedited/STAT request, the following must occur:

- A member or a physician may request Amerigroup to expedite a determination when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy:
 - The following situations are examples of what do not meet criteria for an expedited/urgent/STAT request and will be managed as nonurgent requests:
 - The date of service (DOS) is greater than one week from the request date
 - Any request for therapy (occupational, speech or physical therapy) greater than two days from the request date

<https://providers.amerigroup.com>

In order to process a prior authorization request, providers must complete the following essential fields on the prior authorization form (please see Section 3 *Prior Authorization Forms* at <https://providers.amerigroup.com/TX> to access all prior authorization forms):

- Member name
- Member Medicaid/CHIP number or assigned identification number
- Member date of birth
- Provider name
- TPI and/or National Provider Identifier (NPI)
- Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) procedure code
- Quantity of service units requested based on the CPT or HCPCS code requested
- Physician signature
- Dates of service (DOS) requested
- Diagnosis

In order to validate member information, the request must have at least two member identifiers (member name, member Medicaid number or assigned identification number, or date of birth).

If any essential field on a prior authorization request has missing, incorrect or illegible information, Amerigroup will attempt one good faith outreach call to contact the provider. If we are unable to obtain the information, the provider will be notified by fax of the required information needed in order to process the request. To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

Amerigroup uses the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms are not considered when determining the start date of service.

Extension process

If the member requests an extension, there is justification for a need for additional information, or an extension is in the best interest of the member, Amerigroup may extend the time frame up to 14 calendar days for standard authorization requests. For expedited extensions, Amerigroup can extend the 72-hour time frame up to 14 calendar days if the member requests an extension or there is a justification for a need for additional information and the extension is in the best interest of the member.

Incomplete *Prior Authorization Request* —Medicaid members (non-CHIP) under 21:

If the prior authorization request does not contain complete documentation and/or information for a medical necessity determination, the reviewer will:

- Return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted.
- When possible, contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process.

If the documentation/information is not provided within 16 business hours of the request to the Medicaid provider, Amerigroup will send a letter to the member explaining that the request cannot be acted upon until the documentation/information that needs to be submitted is provided.

If the documentation/information is not provided to Amerigroup within seven calendar days of the letter to the member, Amerigroup will send a notice to the member informing the member of denial of the requested service due to the incomplete documentation/information, and providing the member an opportunity to request an appeal through the Amerigroup internal appeals process and the Health and Human Services Commission Fair Hearing process.

Prior to issuing an adverse determination, a medical director will offer a peer-to-peer review to discuss the member's plan of treatment and the clinical basis for the medical necessity determination. For a peer-to-peer review discussion with our medical director, call

1-817-861-7768, and for behavioral health cases, please call

1-757-473-2737, ext. 106-128-2008. The peer-to-peer review timeline is as follows:

- No less than one business/working day prior to issuing a prospective utilization review adverse determination
- No less than five business/working days prior to issuing a retrospective utilization review adverse determination
- Prior to issuing a concurrent or post-stabilization review adverse determination

If services are not approved based on medical necessity, the appropriate notice of action will be mailed to the member, the servicing provider, the requesting/ordering provider and the member's primary care physician. The notice includes an explanation of the medical director's determination and the member's internal appeal rights and state fair hearing/external independent review rights and process.

For additional information on the prior authorization process, please review the *Amerigroup Medicaid/CHIP Provider Manual*:

https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_ProviderManual.pdf.