Prior authorization requirements

Texas | Medicaid

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Utilization management program

Our utilization management (UM) decisions are based on medical necessity of the requested care and services, as well as the member's coverage according to their benefit plan. We do not reward providers or other individuals for issuing denials of coverage, service, or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization.

We will ensure that services for members are sufficient in the amount, duration, or scope to reasonably achieve the purpose for which services are furnished. We will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member (42 CFR §438.210(a)(ii)).

Regarding UM issues, staff are available at least eight hours a day Monday through Friday during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within one business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

For questions about the UM process, including requesting a free copy of our UM criteria/guidelines, call Provider Services at 833-731-2162.

Medical Policies, Clinical UM Guidelines, and medical drug benefit *Clinical Criteria*

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. *Medical Policies*, *Clinical UM Guidelines*, and medical drug benefit *Clinical Criteria* are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting prior authorization and claim decisions through the following websites:

- *Medical Policies & Clinical UM Guidelines*
- Medical Drug Benefit *Clinical Criteria*

In addition, the following criteria/guidelines may be used:

- *Texas Medicaid Provider Procedures Manual* (TMPPM)
- MCG Care Guidelines (based on specific provider contracts, McKesson InterQual® Level of Care criteria) are also used when no specific health plan medical policies exist.
- Carelon Medical Benefits Management, Inc. (formerly known as AIM Specialty Health) guidelines are utilized for the following types of services:
  - Cardiology
  - Genetic testing
  - Radiation oncology
  - Radiology (high-tech)

  - Sleep studies

Please refer to their website, careloninsights.com, for additional information.

- Behavioral Health utilizes the American Society for Addiction Medicine (ASAM) *Patient Placement Criteria* for substance use disorder treatment authorizations, with the exception of detoxification which uses MCG Care Guidelines.
- Superior Vision of Texas utilizes health plan criteria and guidelines for medical/surgical reviews.

The prior authorization catalog is a comprehensive, searchable document containing a list of codes and code descriptions and an effective date for each prior authorization. The catalog can be viewed on our provider website in the Prior Authorization Requirements webpage ("Medicaid and CHIP Precertification Effective dates").

Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, Centers for Medicare & Medicaid Services (CMS) requirements as well as the *Texas Medicaid Provider Procedures Manual (TMPPM)*, tmhp.com/resources/provider-manuals/tmppm, are used when determining eligibility for coverage and supersede any other UM criteria.

Precertification Lookup Tool and submission portal

Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Lookup Tool, which can be found on Availity Essentials through Payer Spaces or the health plan provider website through the following link:

Precertification Lookup Tool: provider.wellpoint.com/tx > Resources > Prior Authorization Requirements > Precertification lookup

Prior authorization requests or notifications can be submitted digitally through Availity Essentials and is the preferred method.

Availity Essentials: Availity.com

Inpatient elective and nonemergent admissions always require prior authorization. All elective services provided by or arranged at a nonparticipating provider or facility require prior authorization, except for emergency medical conditions, emergency behavioral health conditions and minimum required maternity stays where a prior authorization is not required. Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the Texas Medicaid & Healthcare Partnership (TMHP) *Texas Medicaid Provider Procedures Manual (TMPPM)*.

For questions, please contact Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time excluding state-observed holidays. Providers may leave a confidential voicemail after-hours, and messages will be returned within the next business day.

Additional information is available in the Prior Authorization Contact Information section of this document and is also available on the provider website.

Required documentation

A completed prior authorization request is required to eliminate delays in processing, which includes all required essential information, d**ocumentation, current clinical information, and a signed authorization form by the requesting provider.**

The following essential information, per *HHSC Uniform Managed Care Manual Chapter 3.22* is required for all prior authorization request submissions:

- Member name
- Member number or Medicaid/CHIP number
- Member date of birth
- Requesting provider's name and 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

To prevent delays, the health plan requests the following information be included with the request to allow for timely processing:

- Rendering provider's name, NPI, and Tax Identification Number
- Diagnosis code
- Physician signature

These are critical fields we need to build a prior authorization in our system.

Note: Requests that have essential information missing, incorrect, or illegible will be considered incomplete and the following will occur:

- The requesting provider will receive a notification that the submitted request could not be processed due to missing essential information.
- The notification will outline an explanation of why the submitted request was not processed as submitted and will include instructions to resubmit the prior authorization request with complete essential information.
- The request will be processed when the requested information is received.
- The date we receive the fully completed request will be designated as the prior authorization request received date.

To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

Additional information is available in the *Forms and Documentation Required for Prior Authorization Requests* section of this document.

Information needed for a member that is hospitalized

For services or equipment that will be necessary for the care of the hospitalized member

immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the Discharge Planning section of this document.

Submission timelines

Initial requests

For prior authorization with all supporting documentation is recommended to be submitted a minimum of three business days prior to the start of care. Failure to comply with notification rules may result in an administrative denial. Additional information is available in the Administrative Denials section of this document.

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 prior authorization request as the SOC date. SOC date may include prior authorization requests for home health skilled nursing and aide services, private duty nursing (PDN), physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services. These services may require that the provider assess the member and initiate care prior to submitting a prior authorization request within three business days of the SOC date for initial or new PDN services. During the prior authorization process, providers are required to deliver the requested services from the SOC date. Exceptions to the start of care date may include requests for home health skilled nursing, aide services, private duty nursing, physical therapy, occupational therapy, and speech therapy services. Additional information regarding exceptions is discussed below.

Exceptions:

- **Therapy (PT/OT/ST) Services**: Initial prior authorization requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five business day period will be denied for dates of service that occurred before the date that the prior authorization request was received.
- **Home Health Skilled Nursing:** Following the RN's initial assessment or evaluation of the client in the home setting for home health service needs, the agency-employed RN who completed the home evaluation must contact the health plan for prior authorization within three business days of the SOC.
- **Private Duty Nursing:**
  - Initial requests must be submitted within three business days of the SOC date.
  - Initial requests may be prior authorized for a maximum of 90 days.
  - Completed initial requests must be received and dated by the Prior Authorization department within three business days of the SOC. The request must be received by the Prior Authorization department no later than 5 p.m., Central time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Prior authorization recertification process
A physician or health care provider can submit a medical prior authorization recertification request at least every 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exceptions:
The health plan requires that the following prior authorization recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s).

- Physical, Occupational and Speech Therapy:
  - A complete recertification request must be received no earlier than 30 calendar days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.
- Private Duty Nursing (PDN)/Prescribed Pediatric Extended Care Centers (PPECC):
  - A recertification request must be submitted at least seven calendar days before, but no more than 30 calendar days before, a current authorization period will expire.
  - All authorization timelines apply to recertifications.
  - Completed extension requests must be received and dated by the Prior Authorization department at least seven calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by the Prior Authorization department no later than 5 p.m., Central time, on the seventh day, to be considered received within seven calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central time, on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by the Prior Authorization department.

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, the health plan may extend the time frame up to 14 calendar days for standard authorization requests. For expedited extensions, the health plan 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.

Prior authorization review
Upon receipt of a request for prior authorization, an assistant verifies eligibility and benefits prior to forwarding to the nurse or other qualified reviewer. The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures using criteria/guidelines. When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting provider.

Prior authorization not required
If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations and patient eligibility at the time services are rendered.

Incomplete prior authorization requests

If the prior authorization documentation is incomplete or inadequate, the reviewer is unable to process the request. In such instances, we will notify the provider and member in writing no later than three business days after the prior authorization request received date to submit the additional documentation necessary to make a decision, and a notice will be sent to the member based on their preferred method for receiving prior authorization request notices. If the member does not choose a preferred method, a notice will be sent by mail to the member.

The written request for additional information will include the following information:

- A statement that the health plan has reviewed the prior authorization request and is unable to make a decision about the requested services without the submission of additional information.
- A clear and specific list and description of the incomplete documentation/information that must be submitted in order to consider the request complete.
- An applicable timeline for the provider to submit the missing information.
- Information on the manner through which a provider may contact the health plan.

We may also contact the provider by phone to obtain the information necessary to resolve the incomplete request.

Final determination of the prior authorization request will be completed within three business days after the date the missing information is provided. The requested SOC date will be honored when the provider is able to submit a complete request within the timeline detailed in this section and in the Determination Timelines section of this document, and the health plan has determined that the requested services meet medical necessity.

If no additional information is received by the end of the third business day from the date the health plan sent the notice to the provider and the prior authorization request will result in an adverse determination, we will refer the request for medical director review with all information received with the request no later than seven business days after the prior authorization request received date. The medical director will make a determination based on the information previously received within three business days of the referral but no later than the tenth business day after the prior authorization request received date. If a holiday will result in the process exceeding 14 calendar days, we will adjust the timeline accordingly to not exceed 14 calendar days to make a determination for the prior authorization request.

Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial. For information on this process, refer to the Peer-to-Peer Review Process section of this document.

Determination timelines

Utilization review timeliness standards are as follows:

Program	Authorization type	Decision time frame
Medicaid	Routine/non-urgent	3 business days
CHIP	Routine/non-urgent	2 business days (approval)
		3 business days (adverse determination)
Medicaid and CHIP	Urgent/expedited	3 calendar days
Medicaid and CHIP	Concurrent	1 business day
Medicaid and CHIP	Post-service	30 calendar days

- Medicaid Notifications:

  - A written notice of final determination will be provided no later than the next business day following a prior authorization request determination.

- CHIP Notifications:
  - For routine and urgent approvals, written/letter notification is required no later than the second business day after the date of the request.
  - For a member that is not hospitalized at the time of an adverse determination, notification will be provided within three business days in writing to the requesting provider and the member.

Medicaid/CHIP:

- 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 a member.
- Within one hour of receiving the request for post-stabilization or life-threatening conditions, except for emergency medical conditions and emergency behavioral health conditions where a prior authorization is not required.
- Providers can confirm that an authorization is on file by accessing Availity Essentials, Availity.com, or by calling Provider Services at **833-731-2162**. If coverage of an admission has not been approved, the facility should contact Provider Services to resolve the issue.

Expedited requests

A member or physician may request to expedite a determination when the member, or member's physician, believes that waiting for a decision under the standard time frame could cause any of the following:

- Serious jeopardy to the life, health, safety, or the member's ability to regain maximum function, based on a prudent layperson's judgement.
- Serious jeopardy to the life, health or safety of the member or others, due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus.
- In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member.

The following situations are examples that do not meet criteria for an expedited request:

- The date of service is greater than one week from the request date.
- Clinical documentation does not support criteria for an expedited request as defined above
- Any request for therapy (occupational, speech or physical therapy) greater than two days from the request date.

Inpatient admission reviews

For inpatient admissions, our utilization review clinician determines the member's medical status through onsite review and/or communication with the hospital's utilization review department. Appropriateness of stay is documented, and concurrent review is initiated. Cases that do not meet medical necessity or have quality care concerns may be referred to the medical director for review. If a case does not meet medical necessity criteria, the attending provider will be afforded the opportunity to discuss the case with the medical director prior to the determination. For additional information, refer to the Peer-to-Peer Review Process section of this document. When appropriate, members may be referred to a Population Health Program.

Information needed for a member that is hospitalized

For services or equipment that will be necessary for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the Discharge Planning section of this document.

Inpatient concurrent reviews

Each network hospital will have an assigned UM clinician that will conduct a concurrent review of the hospital medical record to determine the authorization of coverage for a continued stay. The review will be performed either at the hospital or by fax, telephone, or through accessing electronic medical records.

The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours, at which time the reviews can be done less frequently than daily.

We will authorize the covered length of stay one day at a time based on the clinical information supporting the continued stay. Exceptions to the one-day length of stay authorization will be made for confinements when the length of stay is predetermined by state law. Examples of confinement and/or treatment include Cesarean section or vaginal deliveries. Exceptions are made by the medical director on a case-by-case basis.

When the clinical information received meets medical necessity criteria, approved days and bed level (if appropriate) coverage will be communicated to the hospital for the continued stay. If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will afford the attending physician the opportunity to discuss the case prior to making a determination. For additional information, refer to the Peer-to-Peer Review Process section of this document.

If the medical director's decision is to deny the request, the appropriate notice of action will be mailed to the hospital, treating or attending practitioner, and member. The notice of action includes an explanation of the member's appeal rights and state fair hearing/Independent Review Organization (IRO) rights and process.

When the UM clinician reviews the medical record at the hospital, he or she also may attempt to meet with the member (and member's family if appropriate) to discuss any discharge planning needs. The UM clinician will also attempt to verify that the member or family is aware of the name, address and telephone number of the member's PCP. The UM clinician will conduct continued stay reviews daily and review discharge plans unless the patient's condition is such that it is unlikely to change within the upcoming 24 hours and discharge planning needs cannot be determined. In that situation, reviews can be done less frequently than daily.

Peer-to-peer review process

Prior to issuing an adverse determination, a medical director will offer a reasonable opportunity to the requesting provider to discuss the member's plan of treatment and the clinical basis for the medical necessity determination. If you receive a notification that a case is under review and would

like to discuss the case with our medical director, please contact the applicable department shown below.

Contact numbers:
- Physical health: **817-861-7768**
- Behavioral health: **844-719-1806**

Staff are available at least eight hours a day, Monday through Friday, during normal business hours.

Be prepared to provide the following information:
- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB, and the health plan ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and their phone number so we can reach out for additional information. The medical director will make every effort to return calls within one business day.

The peer-to-peer review timeline is as follows:
- No less than one business day prior to issuing a prospective utilization review adverse determination
- No less than five business days prior to issuing a retrospective utilization review adverse determination
- Prior to issuing a concurrent or post-stabilization review adverse determination

If the notification received indicates the case was denied, you may contact us within two business days of receipt of the notification to set up a peer-to-peer review for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the copy of the member denial letter received.

If services are not approved based on medical necessity, the appropriate notice of action will be mailed to the member, the servicing provider, and the requesting/ordering provider. 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.

Administrative denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, failure to obtain a prior authorization, or benefit limitations.

If the health plan overturns its administrative decision, the case will be reviewed and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Discharge planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary to ensure a seamless transition from the inpatient setting to outpatient services to improve health outcomes for our members. Our UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's provider(s) regarding follow-up care after discharge and the provider(s) is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending facility is also responsible for ensuring the member has secured an appointment for a follow-up visit with a HEDIS® qualified behavioral health provider. The follow-up visit must occur within seven calendar days of discharge.

When additional or ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

For prior authorization requests for a member who is hospitalized at the time of the request, please clearly document at the top of the request to indicate that the member is hospitalized and has discharge planning needs. To eliminate delays in processing, please ensure all required documentation is submitted with the request along with any required signatures to the applicable department shown below.

Contact numbers (fax):

- Inpatient Discharge Planning — Physical Health: **888-708-2599**
- Inpatient Discharge Planning — Behavioral Health: **844-430-6805**

Staff are available at least eight hours a day Monday through Friday during normal business hours.

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include but are not limited to transportation, home health, durable medical equipment (DME), pharmacy, follow-up visits to practitioners, and outpatient procedures.

Medicaid/CHIP prior authorization contact information

Requests for prior authorization may be submitted for review and approval as indicated below:

- **Digital submission (preferred method):** Availity.com
- **Inpatient/Outpatient surgeries; other general requests:**
  - Fax: 800-964-3627
  - Phone: 833-731-2162
- **Inpatient Discharge Planning (fax only):**
  - Physical Health: **888-708-2599**
  - Behavioral Health: **844-430-6805**
- **Specialized Care Services (fax only):**
  - Back and spine procedures: **800-964-3627**
  - Durable Medical Equipment (DME): **866-249-1271**
  - Home Health Nursing (PDN, SNV, HHA): **866-249-1271**
  - Medical injectable/infusible drugs: **844-512-8995 (**for additional information, refer to the *Pharmacy Prior Authorizations* document on our provider website)
  - Pain management injections and wound care: **866-249-1271**
  - Therapy (physical, occupational and speech): **844-756-4608**
- **Behavioral Health Services:**
  - Digital submission (preferred method): Availity.com
  - Behavioral Health - Inpatient: **844-430-6805** (fax)
  - Behavioral Health - Outpatient: **844-442-8010** (fax)
- **Carelon Medical Benefits Management, Inc. (formerly known as AIM Specialty Health®):**
  - Phone: 833-342-1260
  - Online: careloninsights.com
  - Cardiology
  - Genetic testing
  - Radiation oncology
  - Radiology (high-tech)
  - Sleep studies

- **Superior Vision of Texas (Medical/Surgical):**
  - Fax: 855-313-3106
  - Email: ecs@superiorvision.com

- **Nursing Facility: 844-206-3445** (fax)
- **Ambulance Transportation (nonemergent):**
  - Physical Health — nonurgent: **866-249-1271** (fax)
  - Behavioral Health — nonurgent: **844-442-8010** (fax)
  - Urgent: **833-731-2162** (phone)
  - For additional information, refer to the Ambulance Transportation Services (Nonemergent) section of the Medicaid/CHIP provider manual.
- **STAR Kids** Long-Term Services and Supports (LTSS)/Personal Attendant Services (PAS):
  - Fax: 844-756-4604
- **STAR+PLUS:**
  - LTSS/PAS requests are to be submitted by service area (fax only):
  - Jefferson: **888-220-6828**
  - Lubbock/West RSA: **888-822-5761**
  - Nueces: **888-822-5790**
- **Urgent Services: 833-731-2162 (**phone)

For questions, call Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time excluding state-observed holidays. You may leave a confidential voicemail after-hours and your call will be returned the next business day.

Documentation and forms required for prior authorization requests are available on our provider website at provider.wellpoint.com/tx.

Member assistance with prior authorizations
Members who have questions regarding prior authorizations may contact Member Services. Members can also **live chat** with a representative or send a **secure message** once a member logs into their account:

- CHIP, STAR, STAR+PLUS: **833-731-2160 (TTY 711),** available Monday through Friday from 7 a.m. to 6 p.m. Central time
- STAR Kids: **844-756-4600 (TTY 711),** available Monday through Friday from 8 a.m. to 6 p.m. Central time

If you have any questions regarding pharmacy prior authorizations/preapprovals, contact Pharmacy Member Services, available 24/7, using the information below:

- CHIP, STAR, STAR+PLUS: **833-235-2022 (TTY 711)**
- STAR Kids: **833-370-7463 (TTY 711)**

Forms and documentation required for prior authorization requests

To request a prior authorization, we will accept the following standard forms:

- *The health plan's Medicaid Prior Authorization Request Form*
- *Texas Standard Prior Authorization Request Form for Health Care Services*

The provider website includes links to forms under the *Forms* section.

Other forms available on the provider website include:

- *Therapy Prior Authorization Request Form*
- *Mental Health Targeted Case Management & Rehabilitative Services Form*
- Behavioral health:
  - Initial Review Form
  - Concurrent Review Form
  - Psychological Testing Request Form
  - Neuropsychological Testing Request Form
  - Treatment Plan Request Form for Autism Spectrum Disorders
- Nonemergency ambulance:
  - Nonemergency Ambulance Prior Authorization Request Form
  - Nonemergency Ambulance Exception Form
- Pharmacy:
  - Texas Standard Prior Authorization Request Form for Prescription Drug Benefits
  - Medical Injectables Prior Authorization Form

The following table outlines the required forms and documentation needed for prior authorization requests. Current clinical documentation includes, but not limited to, applicable progress notes, imaging reports, lab or test reports, and consultation reports.

This list does not represent whether the service requires prior authorization or is a covered benefit. Verification that the service/procedure requires prior authorization is recommended prior to submitting the request.

Note: For any specified service with a change in provider, a signed notification by the member will be required.

Forms and documentation required for prior authorization requests

Service	Forms	Documentation
Abortion	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Acupuncture	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Adaptive Equipment/Aids	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation • If applicable, documentation of primary insurance denial of coverage of services • For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Adult Day Care/ Day Health Services	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Adult Foster Care	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Allergy Testing	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Allergy Treatment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Ambulatory Surgical Center services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Ambulance – NEMT	• Completed *Nonemergency Ambulance Prior Authorization Request Form* • If applicable, the *Nonemergency Ambulance Exception Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* • Please note, completed forms may not be submitted by ambulance provider as per *Texas Medicaid Provider Procedures Manual*.
Anesthesia	Dental (6 and under): • Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional Requirements:** • *Criteria for Dental Therapy Under General Anesthesia Form* • *THSteps Dental Mandatory Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*

Service	Forms	Documentation
Applied Behavior Analysis (ABA)	• Completed *Treatment Plan Request Form for Autism Spectrum Disorders*; or • *CCP Prior Authorization Request Form*	• Current signed *Physician ABA Referral* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*
Assisted Living/Residential Care	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Assistive/Augmentative Communication Devices	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*
Attendant Care Services	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Audiology/Hearing Aids, Supplies & Fittings	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*

Service	Forms	Documentation
Bariatric Surgery	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation (Preoperative psychological evaluation) • Surgery must be provided by a facility in Texas that is one of the following: – Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). – A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.
Behavioral Health – Crisis Intervention	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Crisis Stabilization	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Hospital Based Detoxification Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation

Service	Forms	Documentation
Behavioral Health – Hospital Based Services – MD Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Hospital Based Services – Inpatient Professional	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Inpatient – Psychiatric/ Chemical Dependency	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Intensive Outpatient Program (IOP), Psychiatric	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Substance Abuse/Chemical Dependency	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Outpatient/Ambulatory Detoxification Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Outpatient Mental Health – MD Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation

Service	Forms	Documentation
Behavioral Health – Outpatient Substance Abuse	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Partial Hospital, Psychiatric	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Psychological Testing	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Behavioral Health – Respite Care	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• *Current signed Physician Order or designee* • Current clinical documentation
Birthing Center	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Blood Administration and Other Blood Products	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Bone Mass/Density Study – Bone Biopsy/Photon Absorptiometry	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Botox Injections	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Breast Reduction	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Burn Pressure Garments	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Cardiac Rehabilitation Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*.
Chemotherapy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Chiropractic Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Chore Services	• N/A – Not a benefit	• N/A
Circumcisions	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Clinical Trials	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Cochlear Implants	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*.
Colorectal Cancer Screening – • Barium Enema • Flexible Sigmoidoscopy • FOBT (Fecal Occult Blood Test) • Screening Colonoscopy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Corrective Vision Surgery	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Court Ordered Services	• Notification from Courts	• Current signed Court Order • Current clinical documentation (if available)
Deep Brain Stimulators	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Dental – Routine	• Dental MCO to review.	
Dental Services – Medical/Accidental	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*; and	• Health Plan reviews for Level 4 sedation/general anesthesia and facility for 6 years of age and under. • Dental MCO to review for procedure.

Service	Forms	Documentation
	• *Criteria for Dental Therapy Under General Anesthesia Form*	
Waiver Dental Services	• DentaQuest to review.	• For STAR+PLUS members requesting LTSS services, the member/ legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Dermatology services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Diabetic Screening	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Diabetic Supplies	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*. • See pharmacy guidelines for glucometer and glucometer supplies For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change

Service	Forms	Documentation
		– Refer to TMPPM requirements
Diagnostic Testing Laboratory	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Dialysis at Free-Standing Clinic	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Dialysis (ESRD) – Locations Other Than Free-Standing Clinics	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation

DME – Durable Medical Equipment	• Completed *Medicaid Prior Authorization Request Form*; or
	• *TDI Standard Prior Authorization Request Form*
	
	Additional requirements:
	• Home Health Services (Title XIX) DME/ Medical Supplies *Physician Order* Form
	• For Wheelchairs including Power Wheelchairs: *Wheelchair/Scooter/ Stroller Seating Assessment Form* (THSteps-CCP/Home Health Services)
	• Applicable forms as per *Texas Medicaid Provider Procedures Manual*
		• Current signed *Physician Order*
		• Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*.
		
		Miscellaneous codes (for example E1399) either the Title XIX form or a detailed and itemized list of parts with descriptions, quantity and cost must be submitted
		
		Custom Wheelchairs
		• Documentation must include either the Title XIX or a detailed and itemized list of parts, quantity and cost
		• If applicable, documentation of primary insurance denial of coverage of services
		
		For Service Provider changes:
		• *Change of provider letter ("Client Choice Statement")*
		  • Client must sign/date letter, include name of previous and current providers, and effective date for the change
		  • Refer to TMPPM requirements

DME and Supplies Exceptional Circumstances Provision (members 21 years of age or older)	• Completed Home Health Services (Title XIX) DME/Medical Supplies *Physician Order* Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form etc.	To request prior authorization for home health DME and supplies under the Exceptional Circumstances provision, providers must submit a written notice to the health plan. The written notice must include: • Completed copies of all of the necessary forms for the requested home health DME or supplies, such as the Home Health Services (Title XIX)

Service	Forms	Documentation
		DME/Medical Supplies *Physician Order* Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form etc. The forms must be signed and dated by the prescribing physician along with a cover letter indicating the forms are being submitted under the Home Health DME and Supplies Exceptional Circumstances provision. • The client's specific diagnosis, medical needs and the reasons why they can only be met by the requested home health DME or supply. • A clear, concise description of the requested DME or supply. • The manufacturer's suggested retail price (MSRP) for the requested DME or supply or an invoice documenting the provider's cost. • Letters of Medical Necessity (LOMN) from the client's prescribing physician and other clinical professionals, as appropriate, documenting the alternative measures and alternative DME or supplies that have been tried and have failed to meet the client's medical needs, or have been ruled out and an explanation of why they have failed or have been ruled out. For Service Provider changes:

Service	Forms	Documentation
		• *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Donor Human Milk	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *Donor Human Milk Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*
Drugs/Biologicals (Non-Self Administered)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Early Childhood Intervention (ECI) Services	• None	• The health plan will pay for all ECI covered services in the amount, duration, scope and service setting established by the Individual Family Service Plan (IFSP)
Electroconvulsive Therapy (ECT)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Emergency Services	• None	• None
Enteral Nutrition	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional Requirements:** • *CCP Prior Authorization Request Form (if applicable)*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
EPSDT/Texas Health Steps Services performed by a Texas Health Steps Provider	• N/A	• N/A
Erectile Dysfunction Treatment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Experimental and Investigational	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Family Planning Benefit, Consults, Supplies, and Equipment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation • No prior authorization for family planning services available for STAR/STAR Kids/STAR+PLUS nondual (not covered for CHIP)

Service	Forms	Documentation
Financial Management	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Federally Qualified Healthcare Clinic (FQHC) Services	• None	• None
Genetic Testing or DNA Testing	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Glaucoma Screening	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
HIV/AIDS Testing/Treatment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Home Delivered Meals	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Home Environment Evaluation	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Home Infusion/Total Parenteral Nutrition	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* For Service Provider changes: – Change of provider letter ("Client Choice Statement") – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Home Modification	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Hospice Care	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	For STAR, STAR Kids, and STAR+PLUS, hospice care is through Texas Health and Human Services Commission (HHSC). For CHIP members, the following is required for inpatient services: • Current signed *Physician Order* • Current clinical documentation Notification is required for outpatient hospice services.
Hyperbaric Oxygen Therapy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional Requirements:**	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*

Service	Forms	Documentation
	• Special Medical Prior Authorization (SMPA) Request Form	
Hypnosis	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Hysterectomy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional Requirements:** • *Sterilization Consent Form*	• Current signed *Physician Order* • Current clinical documentation
Immunizations	• N/A	• N/A
Incontinence/Ostomy Supplies	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the Texas *Medicaid* Provider Procedures Manual For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements

Service	Forms	Documentation
Infertility Services and Treatment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Injections	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Inpatient Hospital Facility Services (Acute)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Inpatient Rehabilitation – Freestanding (members 20 years of age and younger)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *CCP Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation • Therapy goals related to client individual needs and treatment plan
Intermediate Care Facility Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Lead Blood Screening	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Mammograms (Screening and Diagnostic)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Methadone	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current *Physician Order* signed by MD/DO • Complete current supporting clinical documentation
Nebulizers, Kits and Spacers (Supplies)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Newborn Care Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Nurse Midwife Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Nursing Facility Services (Nursing Home Add-on services)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Nursing Services: See PDN and SNV section	• N/A	• N/A

Service	Forms	Documentation
Nutritional Assessment/Risk Reduction/Education	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed *Physician Order* • Current clinical documentation
OB Ultrasound (Routine and High Risk)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Obesity Surgery (for Bariatric Surgery see Bariatric Surgery section)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Observation	• N/A	• N/A
Obstetrical Care Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Occupational Therapy	• Completed *Therapy Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *THSteps-CCP Prior Authorization Request Form* • *Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Request Form* • *Special Medical Prior Authorization (SMPA) Request Form*	• Signed *Physician Order* or signed *Prior Authorization Form* or signed *Plan of Care* (cannot be older than 60 days from DOS) including frequency and duration **Duration requirements:** • **Under 21 years of age: Request cannot exceed 180 days** • **Over 21 years of age: Request cannot exceed 60 days** Current clinical documentation including: • *Evaluation and Treatment Plan or Plan of Care (POC)* with the required elements

Service	Forms	Documentation
		• Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Oncology Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Ophthalmology Services (Surgical and Non-Surgical)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Optometry (Medical Conditions of the Eye)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Orthopedic Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Orthotics	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* • For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Osteopathic Manipulation (Treatments)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Other Alternative Medical Therapies	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Out of State/ Country	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Outpatient Hospital Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Over-the-Counter (OTC) Drugs	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Oxygen and Related Respiratory Equipment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Pain Management	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation per Carelon Medical Benefits Management Inc. guidelines/ Medical and/or Clinical Policies from the health plan For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Personal Care Services	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Personal Emergency Response	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Pest Control	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Physical Therapy	• *Completed Therapy Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *THSteps-CCP Prior Authorization Request Form* • *Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Request Form* • *Special Medical Prior Authorization (SMPA) Request Form*	• Signed *Physician Order* or signed *Prior Authorization Form or signed Plan of Care* (*cannot be older than 60 days from DOS*) including frequency and duration **Duration requirements:** • **Under 21 years of age: Request cannot exceed 180 days** • **Over 21 years of age: Request cannot exceed 60 days** Current clinical documentation including: • *Evaluation and Treatment Plan or Plan of Care (POC)* with the required elements • Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change

Service	Forms	Documentation
		– Refer to TMPPM requirement
Physician Home Visits	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Podiatry Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Portable X-Ray Service	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Pre-Admission Testing	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Prescription Drugs – Self-Administered Drugs	• Completed *Pharmacy Medicaid Prior Authorization Request Form*; or • TDI Standard Prior Authorization Request Form *for Prescription Drug Benefits*	• Current signed *Physician Order* • Current clinical documentation
Preventative Health Services – Adult	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Private Duty Nursing/Prescribed Pediatric Extended Care Center (PPECC) (age restriction birth-20 years of age)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*

Service	Forms	Documentation
	Additional requirements: • *THSteps- CCP Prior Authorization Request Form* • *Plan of Care Form* • *Nursing Addendum to Plan of Care* for private duty nursing and/or PPECC	For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Prostate-Specific Antigen (PSA) Testing	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Prosthetics	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual* • For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Pulmonary Rehabilitation	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*
Radiation Therapy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Radiology – Diagnostic	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Radiology – Nuclear Medicine	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Reconstructive Procedures	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Respiratory Therapy	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Respite Care Services in Assisted Living Facility (ALF), Nursing Facility (NF), Adult Foster Care (AFC), In Home	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Second Opinions	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Skilled Nursing Facility (SNF)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Skilled Nursing Visits	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *Plan of Care Form* or *Oasis Form* • Special Medical Prior Authorization (SMPA) Request Form	• Current signed *Physician Order* • Current clinical documentation as required per the *Texas Medicaid Provider Procedures Manual*
Sleep Studies and Sleep Therapy (Reviewed by Carelon Medical Benefits Management Inc.)	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Smoking Cessation Programs/Supplies	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Social Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
Speech Therapy	• Completed *Therapy Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *THSteps-CCP Prior Authorization Request Form* • *Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Request Form* • *Special Medical Prior Authorization (SMPA) Request Form*	• Signed *Physician Order* or signed *Prior Authorization Form* or signed *Plan of Care* (cannot be older than 60 days from DOS) including frequency and duration **Duration requirements:** • **Under 21 years of age: Request cannot exceed 180 days** • **Over 21 years of age: Request cannot exceed 60 days** Current clinical documentation including: • *Evaluation and Treatment Plan or Plan of Care (POC)* with the required elements • Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • *Change of provider letter ("Client Choice Statement")* – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Sterilization and Reversal	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form* **Additional requirements:** • *Sterilization Consent Form*	• Current signed *Physician Order* • Current clinical documentation
Take Home Supplies	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request*	• Current signed *Physician Order* • Current clinical documentation

Service	Forms	Documentation
	Form	
Thermography/ Thermograms	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Signed *Physician Order* • Current clinical documentation
TMJ Treatment	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Transplant Donor	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Transplants	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Urgent Care Services	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation
Vision – • Optical Appliances (Lenses & Frames) • Routine Exams	• Reviewed by Superior Vision of Texas	
Weight Reduction Program	• Completed *Medicaid Prior Authorization Request Form*; or • *TDI Standard Prior Authorization Request Form*	• Current signed *Physician Order* • Current clinical documentation