PRIOR AUTHORIZATIONS AND AUTHORIZATIONS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

NOVEMBER 2026

TEXAS
Health and Human
Services

PRIOR AUTHORIZATIONS AND AUTHORIZATIONS

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4.1 General Information

Some services require authorization or prior authorization as a condition for reimbursement. Authorization or prior authorization is not a guarantee of payment.

- Authorization must be obtained no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.
- Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization or prior authorization submission.

TMHP sends a notification to providers and clients when it approves, denies, or modifies an authorization or prior authorization request. It is strongly recommended that providers maintain a list that details the authorizations, including:

- Client name
- CSHCN Services Program client number
- Date of service
- Provider number
- Items submitted

Providers will need this information if they request an administrative review after an authorization or prior authorization is denied. In addition, providers should keep a copy of the request for authorization and the response received from TMHP.

Refer to: Filing Deadline Calendar for 2025

Filing Deadline Calendar for 2026

Providers should allow three business days to receive a response to an authorization or prior authorization request.

4.2 Extension of Filing Deadlines for Holidays

For holidays that extend the filing deadline, please refer to Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

4.2.1 Limitations

Authorization and prior authorization requests will be denied if the provider is not actively enrolled with the CSHCN Services Program. "Actively enrolled" providers are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status.

Refer to: Chapter 2, "Provider Enrollment and Responsibilities" for more information on becoming a CSHCN Services Program provider.

- Providers are responsible for verifying client eligibility before providing services. If the client is not eligible at the time of the authorization or prior authorization request, the request will be denied. If the client becomes eligible at a later date, providers can submit a new authorization or prior authorization request form.
- Any services provided beyond the limitations of the CSHCN Services Program are not reimbursed.

4.2.2 Signature Requirements

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the client's medical provider, dental provider, or medical supplier. If indicated on the form, an authorized representative's signature is acceptable.

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4.2.2.1 Electronic Signatures

4.2.2.1.1 Authority and Definitions

Texas Government Code §531.0055(m) requires the Health and Human Services Commission (HHSC) to establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business and Commerce Code), with respect to any transaction, as defined by Section 322.003, Business and Commerce Code, in connection with the administration of health and human services programs.

The following definitions apply for the policy information outlined in this section:

Term	Definition
Asymmetric cryptosystem	A computer-based system that employs two different but mathematically related keys with the following characteristics: • One key encrypts a given message; • One key decrypts a given message; and • The keys have the property that, knowing one key, it is computationally infeasible to discover the other key.
Certificate	A message, as defined in 1 TAC §203.1(2), which: • Identifies the certification authority issuing it; • Names or identifies its subscriber; • Contains the subscriber's public key; • Identifies its operational period; • Is digitally signed by the certification authority issuing it; and • Conforms to ISO X.509 Version 3 standards.
Certification authority	A person who issues a certificate.
Digital signature	An electronic identifier intended by the person using it to have the same force and effect as the use of a manual signature, and that complies with the requirements of 1 TAC §203.23.
Digitized signature	An image of pen-to-paper.
Electronic record	A record created, generated, sent, communicated, received, or stored by electronic means.
Electronic signature	An electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
Prior authorization	A request submitted to the program, or its designated contractor, to provide a service the program ultimately considers for reimbursement. (Prior authorization must be obtained before the delivery or date of service.)
Program	The Children with Special Health Care Needs Services Program.
Public key	The public part of an asymmetric key pair that is used to verify signatures or encrypt data.
Texas Administrative Code (TAC)	A compilation of all state agency rules in Texas.

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4.2.2.1.2 Electronic Signature Requirements

The CSHCN Services Program complies with 1 TAC, Chapter 203, Guidelines for the Management of Electronic Transactions and Signed Records, which details the requirements for state agencies that send and accept electronic records and electronic signatures or otherwise create, generate, communicate, store, process, use, or rely upon electronic records and electronic signatures.

The program, or its designated contractor, may accept electronic signatures on authorization or prior authorization requests and supporting documentation transmitted by mail, fax, or through the online prior authorization portal, if the electronic signature technology meets all applicable federal and state statutes and administrative rules.

Electronic signatures, also known as digital signatures, that comply with the Texas Department of Information Resources (DIR) rules at 1 TAC §203.24 will be considered to have the same legal effect as a handwritten signature.

Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable.

Electronically-signed documents must have an electronic date on the same page as the signature.

Providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules.

Electronically-signed transactions and electronically-signed documents must be kept in the client's medical record, and a paper copy must be available upon request.

All fax transmissions must reflect the date, time, and fax number of origination, and the original document must be maintained by the provider.

All documentation submitted with a handwritten provider's signature must have a handwritten date next to the signature and must be kept in the client's medical record.

Any signature (electronic or handwritten) on a submitted document certifies, to the best of the provider's knowledge, that the information in the document is true, accurate, and complete.

The provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method have the responsibility for the authenticity of the information being certified for which the authentication is provided.

The provider must exercise reasonable care to retain control of their electronic signature and prevent its disclosure to any person not authorized to create the electronic signature, as described in 1 TAC §203.24(c)(3).

The provider and the provider's representative understand and agree that systems and software products must include protections against modification and bear responsibility for ensuring administrative safeguards are in place.

Stamped signatures and signatures that have been typed in a document without using an electronic identifier will not be accepted.

Digitized signatures will not be accepted. (Examples include scanned images of handwritten signatures or signatures on a signature pad. Handwritten signatures on faxed documents are not digitized signatures.)

4.2.3 Requests for Procedures That Are Pending a Rate Hearing

Some procedure codes that require authorization or prior authorization may be pending a rate hearing. In these cases, providers must follow the established authorization or prior authorization processes for these procedure codes and must not wait until the procedure codes have gone through the rate hearing process to request authorization or prior authorization.

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Providers are responsible for meeting all filing deadlines and for ensuring that the authorization or prior authorization number appears on the claim the first time it is submitted.

TMHP will deny the affected procedure codes as pending a rate hearing until the rates are adopted and implemented. Once the rates are adopted and implemented, TMHP will automatically reprocess the claims. However, if the required authorization or prior authorization number is not on the claim at the time of reprocessing, the claim will be denied as lacking authorization or prior authorization.

Refer to: Section 5.6.2.3, "Determining Reimbursement Rates for New HCPCS Procedure Codes" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for more information.

4.2.4 Requests for Procedures That Are Manually Priced

Certain procedure codes do not have an established fee and must be priced manually by the TMHP-CSHCN Services Program medical staff. The medical staff determines the reimbursement amount by comparing the services to other services that require a similar amount of skill and resources.

If an item requires manual pricing, providers must submit with the prior authorization request or the claim the appropriate procedure codes and documentation of one of the following, as applicable:

- The manufacturers suggested retail price (MSRP) or average wholesale price (AWP)
- The provider's documented invoice cost if a published MSRP or AWP is not available

Note: *The AWP is for nutritional products only.*

For appropriate processing and payment, providers should bill the applicable MSRP or AWP rate instead of the calculated manual pricing rate. The calculated rate or the Pay Price that is indicated on the authorization letter for prior authorized services should not be billed on the claim.

Claims for authorized procedure codes that are manually priced must list the claims detail information in the same order as itemized on the authorization letter.

4.2.5 Clients with Third Party Resources

If a client has other coverage from a third-party resource (TPR), prior authorization and authorization requests will be approved or denied according to the CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment:

- If the TPR does not pay because of co-insurance or deductible amounts.
- When the total amount paid (including all payers) to the provider does not exceed the amount allowed by the program for the covered service.
- If the provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

If clients have dual coverage with the Children's Health Insurance Program (CHIP), prior authorization and authorization requests will be approved or denied according to CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment as follows:

- Dental services and durable medical equipment may be reimbursed after the CHIP cap has been met.
- Orthodontic services not covered under the CHIP medical plan may be reimbursed.
- Other covered program benefits specifically excluded from or capped by the CHIP benefit plan may be reimbursed.
- The provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

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4.3 Authorizations

Providers must submit authorization requests on a CSHCN Services Program-approved form. Requests with insufficient information will be denied and providers will receive notification of the reason for denial. If a form is not available for a specific service, providers must submit the request using the CSHCN Services Program Authorization and Prior Authorization Request form and follow the guidelines and requirements listed in the chapter for that service.

Authorization requests must be submitted and approved no later than 95 days after the date of service and may be submitted before the service is provided. If the service has already been provided, the authorization form may be submitted before the claim, or attached to the paper claim form. Claims for services requiring authorization are denied if the authorization number is not indicated on the claim or if the authorization and all required documentation is not attached to the claim.

The 95-day deadline applies to all services requiring authorization, including extensions and emergency situations. Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization submission. Authorization requests are reconsidered only when resubmitted, received, and approved within 95-days of the date of service.

Important: *No extensions beyond the 95-day initial deadline are given.*

Providers can correct and resubmit requests for authorization. Questions, concerns, or requests for clarification may be included in authorization resubmissions. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail. Corrected requests must meet authorization and prior authorization submission deadlines. Requests that do not meet the deadlines will be denied.

Providers must mail or fax written authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.3.1 Services that Require Authorization

The following is a list of many of the services that require authorization. The list below is not all-inclusive. Information about specific authorization requirements for each of the services that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are available on Forms page of the TMHP website. This form must be used when indicated for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

Blood Pressure Devices, In Specific Instances	
Refer to:	Chapter 11, “Blood Pressure Monitoring and Devices”
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

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Botulinum Toxin (Type A and B)	
Refer to:	Section 31.2.26.9 *, "Botulinum Toxin (Type A and Type B)" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

Clinician-Directed Care Coordination Services	
Refer to:	Section 31.2.12, "Clinician-Directed Care Coordination Services" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form

Durable Medical Equipment (DME)	
Refer to:	Chapter 17, "Durable Medical Equipment (DME)"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)
Exception:	Custom DME and more complex equipment requires prior authorization.

Hemophilia Blood Factor Products	
Refer to:	Section 31.2.9, "Bone Growth Stimulators" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products

Home Health (Skilled Nursing Only) Up to 200 Hours Per Calendar Year	
Refer to:	Chapter 22, "Home Health (Skilled Nursing) Care"
Use:	The CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form

Nebulizers, In Specific Instances	
Refer to:	Section 36.2.5, "Nebulizers" in Chapter 36, "Respiratory Equipment and Supplies"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Outpatient Dental Surgical Procedures	
Refer to:	Section 14.2.7, "Dental Treatment in Hospitals and ASCs" in Chapter 14, "Dental"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services
Use:	The CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia

Telecommunication Services	
Refer to:	Section 38.2.4, "Telemonitoring Services" in Chapter 38, "Telecommunication Services"
Use:	The Home Telemonitoring Services Prior Authorization Request Form

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4.3.2 How To Submit an Authorization Request

Providers must mail or fax written authorization requests and all applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.4 Prior Authorizations

Providers must submit prior authorization requests on a CSHCN Services Program-approved form. If a form is not available for a specific service, providers must submit the request using the CSHCN Services Program Authorization and Prior Authorization Request form and follow the guidelines and requirements listed in the chapter for that service. Only complete prior authorization requests will be considered. Incomplete requests are denied.

Prior authorization requests must be submitted and approved before the service is provided. However, if the service is provided after business hours (business hours are Monday through Friday, from 8 a.m. to 5 p.m., Central Time), on a weekend, or on a holiday then the prior authorization request may be submitted on the next business day.

Refer to: Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

Providers should allow three business days to receive a response to an authorization or prior authorization request.

The TMHP Contact Center receives calls from CSHCN Services Program providers with inquiries related to prior authorization. Contact Center agents make every attempt to answer the provider's questions and/or resolve the provider's concerns. If a provider requires a call back from a Prior Authorization (PA) clinician and the request for call back is not related to urgent/emergent services, the provider should submit a call back request via fax to 1-512-514-4222.

All inpatient admissions must be prior authorized. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied.

Note: *Partial approvals for a hospital stay will not be granted.*

Requests for emergency hospital admissions must be received by the next working day after admission date for the coverage of the entire hospital stay. Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

If the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received by the next business day following the denial of the initial request. If the corrected request is received by the next business day but still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after the next business day following the initial denial will be denied for the entire hospital stay.

Refer to: Section 24.3.1.2, "Emergency Inpatient Hospital Admissions" in Chapter 24, "Hospital" for detailed information on prior authorization requirements.

If a client requires a service that exceeds policy limitations, providers may request prior authorization with documentation of medical necessity.

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If a client requires a service that has diagnosis restrictions, providers may request prior authorization with documentation of medical necessity for diagnoses not listed in the policy.

Claims submissions must include the prior authorization number in the appropriate field.

Refer to: Section 5.7, "Claims Filing Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for claims filing instruction details.

Important: *The Program does not grant extensions to these deadlines to allow providers to complete or correct and resubmit their prior authorization requests.*

4.4.1 Services that Require Prior Authorization

The following is a list of many of the services that require prior authorization. The list below is not all-inclusive. Information about specific prior authorization requirements for each service that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are located on the Forms page of the TMHP website. This form must be used when indicated for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Providers must fill out all sections of the prior authorization form. Providers should refer to the Instructions page for each request form.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

Augmentative Communication Devices (ACDs)	
Refer to:	Chapter 10, "Augmentative Communication Devices (ACDs)"
Use:	The CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs)

Stem Cell Transplants (initial and one subsequent transplant)	
Refer to:	Section 31.2.42.2, "Transplants - Nonsolid Organ" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant

Certified Respiratory Care Practitioner	
Refer to:	Chapter 13, "Certified Respiratory Care Practitioner (CRCP)"
Use:	The CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner (CRCP)

Cleft/Craniofacial Surgical Procedures	
Refer to:	Section 31.2.39.11, "Cleft/Craniofacial Procedures" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

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Cranial Molding Devices (Dynamic Orthotic Cranioplasty [DOC™] only)	
Refer to:	Section 28.2.2, "Orthoses and Prostheses (Not All-Inclusive)" in Chapter 28, "Orthotic and Prosthetic Devices"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Dental Procedures (some), Including Inpatient Admissions for Dental Surgical Procedures	
Refer to:	Chapter 14, "Dental"
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only

Diapers, Liners, and Pull-ups (or any combinations of these supplies)	
Require prior authorization for quantities that exceed 240 per month.	
Refer to:	Chapter 18, "Expendable Medical Supplies"
Use:	The CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners

Home Health (Skilled Nursing) Services Over 200 Hours per Calendar Year	
Refer to:	Chapter 22, "Home Health (Skilled Nursing) Care"
Use:	The CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form

Home Health Services	
Refer to:	Chapter 21, "Home Health Services"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request

Hospice Services	
Refer to:	Chapter 23, "Hospice"
Use:	The CSHCN Services Program Prior Authorization Request for Hospice Services

Inpatient Admissions	
Refer to:	Section 24.3, "Inpatient Services" in Chapter 24, "Hospital"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only

Inpatient Rehabilitation Admissions	
Refer to:	Section 24.3.1.4, "Inpatient Rehabilitation Services" in Chapter 24, "Hospital"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission

Medical Foods, In Specific Instances	
Refer to:	Section 26.3, "Medical Foods" in Chapter 26, "Medical Nutrition Services"
Use:	The CSHCN Services Program Prior Authorization Request for Medical Foods

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More Than One Hour (Four Units) of Nutritional Assessments and Intervention per Rolling Year and More Than Two Nutritional Counseling Visits per Rolling Year	
Refer to:	Section 26.4, "Medical Nutritional Counseling Services" in Chapter 26, "Medical Nutrition Services"
Use:	The CSHCN Services Program Prior Authorization Request for Medical Nutritional Products

Non-Emergency Ambulance Transports	
Refer to:	Section 9.4, "Nonemergency Ambulance Transports" in Chapter 9, "Ambulance"
Use:	The Non-emergency Ambulance Prior Authorization Request The Texas Medicaid and CSHCN Services Program Nonemergency Exception Form and Instructions ***Note:*** *CSHCN Services Program providers must not complete any portion of the Non-emergency Ambulance Prior Authorization Request form to ensure the integrity of the request form. Prior Authorization must be obtained by the facility or the physician's staff for all non-emergency transports. The Non-emergency Ambulance Prior Authorization Request form must be filled out and faxed or mailed to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The CSHCN Services Program ambulance provider must not assist in completing or submitting any portion of this form.*

Orthodontia (except for the initial orthodontic visit)	
Refer to:	Section 14.2.4, "Orthodontia Services" in Chapter 14, "Dental"
Use:	The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services

Orthotics and Prosthetics	
Refer to:	Chapter 28, "Orthotic and Prosthetic Devices"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Outpatient Physical Therapy and Occupational Therapy Services	
Refer to:	Section 30.2.2, "Physical Therapy (PT), and Occupational Therapy (OT)" in Chapter 30, "Physical Medicine and Rehabilitation"
Use:	The CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)

Outpatient Speech-Language Pathology Services (all services except initial evaluations)	
Refer to:	Chapter 37, "Speech-Language Pathology (SLP) Services"
Use:	The CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)
Use:	The CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)

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Pediatric Hospital Cribs and Tops	
Refer to:	Section 17.3.9, "Hospital Beds (Manual and Electric)" in Chapter 17, "Durable Medical Equipment (DME)"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Prescription Shoes	
Refer to:	Section 28.3.7.2, "Prescription Shoes" in Chapter 28, "Orthotic and Prosthetic Devices"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Radiation Therapy Services (some), Including Proton- or Neutron-Beam Treatment Delivery, Intensity Modulated Radiation Therapy, and Stereotactic Radiosurgery	
Refer to:	Chapter 34, "Radiation Therapy Services"
Use:	The CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

Reduction Mammoplasties	
Refer to:	Section 31.2.40, "Diagnostic and Surgical/Reconstructive Breast Therapies " in Chapter 31, "Physician".
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Renal Dialysis	
Refer to:	Chapter 35, "Renal Dialysis"
Use:	The CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment

Renal Transplants	
Refer to:	Section 31.2.42, "Transplants" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant

Rhizotomies	
Refer to:	Section 31.2.40.8, "Rhizotomy" in Chapter 31, "Physician"
Use:	The CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

Total Parental Nutrition (TPN)	
Refer to:	Section 26.6, "Total Parenteral Nutrition (TPN)" in Chapter 26, "Medical Nutrition Services"
Use:	The CSHCN Services Program Authorization and Prior Authorization Request

Ultrasonic Nebulizers, In Specific Instances	
Refer to:	Section 36.2.5, "Nebulizers" in Chapter 36, "Respiratory Equipment and Supplies"

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Ultrasonic Nebulizers, In Specific Instances	
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)

Wheelchair Purchases (custom manual and standard or custom power) and Custom Seating Systems	
Refer to:	Section 17.3.19, "Wheelchairs" in Chapter 17, "Durable Medical Equipment (DME)"
Use:	The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)
Use:	The CSHCN Services Program Wheelchair Seating Evaluation Form

4.4.2 Prior Authorization for Inpatient Admission After Business Hours

Important: *Photocopy these forms and retain the originals for future use.*

For prior authorization of an inpatient admission after business hours in an emergency or when required medical services cannot be delayed, submit requests the next business day by completing the CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only.

Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

Both the facility and the attending physician, surgeon, or supplier must be enrolled in the CSHCN Services Program for inpatient claims to be considered for payment.

Refer to: Section 24.3.1.1, "Initial Inpatient Prior Authorization Requests" in Chapter 24, "Hospital" for additional information.

4.4.3 Specialty Team or Center Services

In addition to requiring prior authorization, the following services have additional requirements for physicians or facilities:

- For stem cell transplant services, the facility must attest on the PA form that it is a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization must be obtained by both the facility and the physician.
- For cleft/craniofacial surgical procedures, the surgeon must be a member of a comprehensive cleft/craniofacial team.

If the specialty team or center requirements are not met, all services related to the procedure are denied.

Note: *Anesthesiologists and assistant surgeons are not required to be enrolled as a specialty team or specialty center. An anesthesiologist may be paid if all enrollment and filing deadlines are met. However, when a procedure or admission is denied by the CSHCN Services Program because the primary surgeon or hospital is not appropriately specialty team- or center-enrolled, the assistant surgeon's claims also are denied.*

Refer to: Section 2.1.7, "Transplant Specialty Centers" in Chapter 2, "Provider Enrollment and Responsibilities" for more information about transplant specialty centers enrollment.

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4.4.4 Retroactive Prior Authorizations

Retroactive prior authorizations will be considered for clients who are eligible for the CSHCN Services Program when all of the following conditions are met:

- The service is a benefit of the CSHCN Services Program.
- A Medicaid prior authorization has been approved and issued for the requested service(s) but the client is no longer eligible for Medicaid on the date of service.
- The CSHCN Services Program prior authorization or authorization requirements have been met.
- All other billing requirements are met.

The retroactive CSHCN Services Program prior authorization request must include documentation that indicates approval of the Medicaid prior authorization request. The provider will be issued a new prior authorization number for the CSHCN Services Program prior authorization.

Note: *The CSHCN Services Program prior authorization request must contain the same information that was submitted to Medicaid.*

After a prior authorization has been approved by the CSHCN Services Program, the provider must resubmit the claim with the CSHCN Services Program client ID number and the approved CSHCN Services Program prior authorization number.

4.4.5 How to Submit a Prior Authorization Request

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If any essential field on a prior authorization request is missing, incomplete, or completed with illegible information, TMHP will return the original request to the provider with the following message:

TMHP Prior Authorization could not process this request because the request form submitted has missing, incorrect, or illegible information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP within 14 business days from the request receipt date.

TMHP will use the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned will not be considered when determining the start date of service.

Providers have 14 business days from the request receipt date to respond to an incomplete prior authorization request. Incomplete prior authorization requests are requests received by TMHP with missing, incomplete, or illegible information.

Providers that need to update information on a prior authorization request form must strike through the incorrect information with a single line. The original content must remain legible, and the change must be initialed and dated by the original signatory or ordering physician when applicable. Changes that have been made using correction fluid (e.g., Wite-Out) will not be accepted.

Prior to denying an incomplete request, TMHP's Prior Authorization (PA) department will continue to communicate with the requesting provider in an effort to obtain the required additional information. A minimum of three attempts will be made to contact the requesting provider before a letter is sent to the client regarding the status of the request and the need for additional information.

If the additional information needed to make a prior authorization determination is not received within 14 business days from the request receipt date, the request will be denied as "incomplete." To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

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CSHCN Services Program requests that do not appear to meet CSHCN medical policy, the TMHP PA Nurse will refer those requests to CSHCN Services Program for review and determination. CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

Note: *Providers may re-submit a new, complete request after receiving an incomplete denial; however, submission requirements related to timeliness will apply.*

TMHP requires information in the essential fields. Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client CSHCN Services Program number
- Client date of birth
- Provider name
- 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

4.4.6 Prior Authorization Electronic Submissions through the TMHP Prior Authorization (PA) on the Portal

The TMHP Prior Authorization on the Portal (PA on the Portal) is available for CSHCN Services Program providers to submit CSHCN Services Program prior authorization requests to TMHP for consideration. The benefits of using the TMHP PA on the Portal are as follows:

- Real-time submissions.
- Robust status information available throughout the processing of the request, including the ability to quickly view and respond to pending action from providers.
- Electronic attachment capability. Providers can upload ALL information related to a request and submit online. Providers will receive immediate confirmation of receipt of information.
- The ability to save requests as a draft and update and submit at a later date.
- The ability to create templates which saves time when requesting similar prior authorizations frequently.
- Greater search capability including additional information provided in the search results and the ability to update existing requests with corrections, revisions or extensions.
- Portal availability using a variety of modern browsers.
- Pre-populated forms using information entered at the start of the request.
- Correct deficiencies or make revisions through the portal. No more mailing or faxing.

Providers can access the TMHP PA on the Portal from the TMHP Prior Authorization web page at www.tmhp.com/topics/prior-authorization, which can also be accessed from a topics page on the TMHP Provider Home Page. Providers will click on PA on the Portal and log on to the TMHP secure portal using their UserID and password obtained when the provider's account was activated.

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Refer to: The Account Management web page of the TMHP website for information about creating an account, obtaining a username and password, and granting permissions.

Important: *To submit CSHCN Services Program prior authorization requests to TMHP, the requesting provider must be enrolled as a CSHCN Services Program provider, and must have registered his or her CSHCN Services Program NPI in an active TMHP portal account. The client ID submitted in the request must be the client's CSHCN Services Program client ID and the client must be currently enrolled in the CSHCN Services Program.*

The following Authorization Areas and Submission Types are available for CSHCN Services Program prior authorizations submitted through the TMHP PA on the Portal:

Authorization Area	Submission Type
All CSHCN Services Program	Ambulance Prior Authorization
	Dental or Orthodontia Services
	Durable Medical Equipment and Supplies
	Home Health, Hospice, and/or Telemonitoring
	Hospital, Surgery, and/or Medical Services
	Outpatient Therapy (PT, OT, ST)

The provider will enter his or her provider, client, and authorization information including service details in the required fields of the Client Eligibility Pre-check screen and the Authorization Request – Service Details screen. All necessary documents, including, but not limited to, the TMHP fillable PDF of the authorization or prior authorization form, can then be electronically attached to the online authorization or prior authorization request.

The required authorization and prior authorization forms are available on the Authorization Request–Attachments screen in PA on the Portal along with a list of additional required documentation that the provider must upload as attachments. For prior authorization forms downloaded from the Authorization Request–Attachments screen in PA on the Portal, certain fields including, but not limited to, client name and client ID, will be automatically populated based on the information entered in the Client Eligibility Pre-Check and Service Details screens.

Note: *Authorization and prior authorization forms are also available on the TMHP Prior Authorization CSHCN PA Forms web page as fillable forms into which providers can type the required information and e-sign the forms using available software. Certain fields will only be pre-populated if the prior authorization form is downloaded from the Authorization Request–Attachments screen in PA on the Portal. Forms that are downloaded from the TMHP Prior Authorization CSHCN PA Forms web page are fillable, but fields will not be pre-populated. Providers can choose to use the pre-populated forms generated from PA on the Portal or the fillable forms available on the new TMHP Prior Authorization web page.*

Providers must submit to TMHP all pages of the prior authorization form, including the Prior Authorization Request Submitter Certification Statement page with "We Agree" checked, and the authorization pages completed and signed as applicable. The only pages that are not required to be submitted to TMHP are the instruction pages. Requests will be pended if the Prior Authorization Request Submitter Certification Statement page with the "We Agree" checked is not included with the submitted documents. Providers will be required to submit the Prior Authorization Request Submitter Certification Statement page, with "We Agree" checked, to TMHP before the request can be processed.

Once a prior authorization request has been submitted through PA on the Portal, providers will be able to submit corrections, revisions, and extensions to applicable prior authorization requests through PA on the Portal.

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Providers can also save drafts and create templates to be used regularly as follows:

- Drafts can be saved with all uploaded attachments. Drafts created in PA on the Portal, but not submitted, will be deleted after 90 calendar days if the draft has not been submitted to TMHP. Up to 200 drafts can be saved per provider NPI and taxonomy combination.
- Attachments will not be saved as part of templates on PA on the Portal. Templates will be retained for up to 365 calendar days from the time the template was last used or modified. Up to 200 templates can be created and saved per provider NPI and taxonomy combination.

Providers can refer to the TMHP Prior Authorization (PA) on the Portal Submission Guide, which is available on the TMHP Prior Authorization web page, for detailed instructions about using the TMHP PA on the Portal.

4.4.7 Browser Compatibility and System Requirements

TMHP's PA on the Portal is compatible with Internet Explorer® (IE) 11.0, Chrome®, and Mozilla Firefox®.

Providers must use Adobe Reader® Version 11.0 or higher to download and complete the authorization and prior authorization forms from PA on the Portal or from the new TMHP Prior Authorization web page.

Reminder: *Providers can continue to download the forms and complete them by hand if the applicable version of Adobe Reader® is not available. (Adobe Reader® is free software that can be downloaded onto the provider's computer.)*

4.4.8 Electronic Attachments

TMHP's PA on the Portal will accept electronic attachments. Providers can submit the authorization or prior authorization forms as well as any other required forms or documentation as electronic attachments.

Up to ten files can be uploaded per authorization or prior authorization request, and each file cannot exceed 50 megabytes. PA on the Portal will accept electronic attachments in the following formats:

- Portable Document Format (PDF)
- Images with the following file extensions: JPG, TIF, PNG, GIF
- Microsoft (MS) Word
- MS Excel
- Rich Text Format (RTF)

Electronic attachments must be completed and electronically signed before they are uploaded to the PA on the Portal. Providers must use their own software to electronically sign forms, and those signatures must be added to the forms before they are uploaded to the PA on the Portal request. Submitters will not be able to electronically sign required forms once they are uploaded to the PA on the Portal request. Providers will be required to:

1) Download the authorization or prior authorization form, and save the downloaded form to their desktop or other folder.
2) Complete the form by typing into the fillable fields, and adding the appropriate signatures (providers can electronically sign the forms using the software of their choice).

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3) Upload the form to the PA on the Portal request.

Important: *The PA on the Portal will always display the most current form that is available on the TMHP Prior Authorization web page to be used for the authorization or prior authorization request. Forms previously downloaded and saved to the providers desktop or folder may not reflect changes made to the form since the last submission. Provider should ensure the submitted form is the most recent.*

4.4.9 Maintaining Complete Documentation

To best maintain accurate client and provider documentation, all forms and documentation completed electronically and e-signed must be kept in the client's medical record, including:

- Prior authorizations submitted to TMHP.
- Documents completed but not submitted to TMHP as a prior authorization request.
- A hard copy of electronic transactions and signed documents must be available upon request.

4.4.10 Sending Prior Authorization Requests via Fax

Providers must include specific information when sending prior authorization requests via fax. The following information is required:

- A working fax number to receive faxed responses or correspondence from TMHP
- The last four digits of the client's CSHCN Services Program Identification number on the fax coversheet

Note: *This requirement applies to submissions of new prior authorization requests, resubmissions, and additional information needed to complete a request.*

Reminder: *Prior authorization cover sheets must not contain any protected health information (PHI) per Health Insurance Portability and Accountability Act (HIPAA). The faxed cover sheet is not meant to replace the appropriate prior authorization form. Providers cannot include information on a cover sheet that is needed to complete the review of a request.*

If a provider is faxing prior authorization requests for more than one client, each client request must be faxed individually with a separate cover sheet. Requests received with multiple clients will be returned to the provider for resubmission to ensure HIPAA compliance.

The fax number listed on the prior authorization form is the fax number used to send faxed responses or correspondences from TMHP.

Providers must mail or fax written prior authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

4.5 Authorization and Prior Authorization Denials

Authorization and prior authorization requests will be denied if they:

- Do not contain all of the information necessary for the Program to make a determination,
- Do not meet medical necessity criteria, or
- Exceed the benefit limitation.

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Some of the most common reasons for the denial of authorizations and prior authorizations are because the request:

- Is incomplete,
- Is submitted on the wrong form,
- Lacks the necessary documentation,
- Contains inaccurate information,
- Fails to meet the submission deadline,
- Is for an ineligible client, benefit, or provider, or
- Is for a client that does not qualify for the health-care benefit requested.

Denied authorization and prior authorization requests may be corrected and resubmitted. Any alterations to the original denied request form must be made by using a single line strike-through so the original content is still legible, and the author of the alteration must initial and date the revision. Corrected requests must meet authorization and prior authorization submission deadlines to be considered.

Providers can also submit questions or requests for clarification of a denied authorization or prior authorization by fax. The TMHP-CSHCN Services Program Authorization Department will respond by phone, fax, or mail. The department will not respond by e-mail in order to comply with *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 requirements.

Providers dissatisfied with TMHP's decision to deny authorization and prior authorization of services may submit a request for an administrative review to the CSHCN Services Program.

Refer to: Section 7.3.5, "Administrative Review for Claims" in Chapter 7, "Appeals and Administrative Review" for information about the administrative review process.

4.5.1 Denied Authorization and Prior Authorization Requests Resubmission

Providers can correct and resubmit requests for authorization and prior authorization, and can include questions, concerns, or requests for clarification. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail.

To correct a denied request, the provider must strike through the error with a single line. The original content and the corrected information must be legible. The provider must initial and date the alteration.

Resubmitted requests must meet submission deadlines to be considered for approval. Requests that do not meet the deadlines will be denied.

Requests for services requiring authorization or prior authorization as a condition for reimbursement must be submitted on a CSHCN Services Program-approved form and contain all of the information that is necessary for the Program to make a decision. Requests submitted with insufficient information will be denied and providers will receive notification of the reason for denial.

4.5.2 Closing a Prior Authorization

When a client decides to change providers or elects to discontinue prior-authorized services before the authorization ends, that prior authorization is updated to reflect the early closure date and the reason for closure.

If a client with an active prior authorization changes providers, TMHP must receive a change of provider letter with the request for a new prior authorization in accordance with submission guidelines for the service. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

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The client is responsible for notifying the previous provider that the client is discontinuing services and the effective date of the change. TMHP also notifies the previous provider by mail when a prior authorization has been closed early. The letter includes the beginning date of service, the revised ending date of the authorization, and the reason for the early closure.

If a provider submits a Change of Provider letter in the middle of an existing authorization period, the current authorization will be end-dated and the original provider will be notified. TMHP will send the new provider an authorization that begins on the next business day after the end date and lasts through the remainder of the authorization period.

4.5.3 Administrative Review for Authorization and Prior Authorization Denials

Clients and providers will receive written notice of denied authorization and prior authorization requests within 30 days of the date of the notification. A provider or a client who has received a denied authorization or prior authorization from TMHP may submit a request for an administrative review to the CSHCN Services Program if they are dissatisfied with TMHP's decision to deny the authorization or prior authorization. A client or provider may not request an administrative review of the program's denial of a prior authorization or authorization request for program services or provider reimbursement amounts that are in accordance with established fee schedules and budget alignment methodologies authorized by the CSHCN Services Program Rules Title 26 Part 1 TAC §351.16.

All clients and providers must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program—Administrative Review
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

4.5.4 Fair Hearing

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C (www.sos.state.tx.us). The fair hearing process is conducted by the Office of General Counsel at the Department of State Health Services (DSHS).

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

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Mail or fax fair hearing requests to:

CSHCN Services Program—Fair Hearing
MC-1938
PO Box 149030
Austin, TX 78714-9947
Fax: 1-512-776-7238

Refer to: Section 7.2.2, "Fair Hearing Requests for Authorizations or Prior Authorizations" in Chapter 7, "Appeals and Administrative Review."

4.6 TMHP-CSHCN Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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