



COMMISSIONER
Jon Weizenbaum

February 27, 2015

To: Nursing Facilities

Subject: Information Letter 15-22
Processing of Custom Power Wheelchair, Durable Medical Equipment, and
Goal-Directed Therapy (Rehabilitative Services) Prior Authorization Requests

This information letter is provided as a follow-up to the *Claims Forwarding, Dental Billing, and Other Changes Related to the Nursing Facility Transition to Managed Care* Long Term Care news article which was posted to TMHP.com on February 5, 2015. The news article indicated the Department of Aging and Disability Services (DADS) would provide additional information to nursing facility (NF) providers about the processing of Custom Power Wheelchair (CPWC), Durable Medical Equipment (DME), and Goal-Directed Therapy (Rehabilitative Services) prior authorization requests which are in-process after the STAR + PLUS NF transition occurs on March 1, 2015.

Prior Authorization Requests

For the March 1, 2015, transition to managed care and ongoing, STAR+PLUS managed care organizations (MCOs) are responsible for reviewing prior authorization requests for managed care members and making a determination regarding approval or denial. Providers should submit prior authorization requests to a resident's MCO for non-emergency services provided outside of the Unit Rate (i.e. not included in daily care), including CPWC, DME, and Goal-Directed Therapy (Rehabilitative Services).

To do so, providers should utilize the appropriate STAR+PLUS MCO's designated portal, contact the MCO directly, or visit the MCO website for information related to that MCO's prior authorization process at:

- Amerigroup: <https://providers.amerigroup.com/Providerdocuments>
- Cigna-HealthSpring: <https://starplus.hsconnectonline.com>
- Molina: <https://provider.molinahealthcare.com>
- Superior: <https://www.provider.superiorHealthPlan.com/sso/login>
- United Healthcare: <http://www.unitedhealthcareonline.com>

Custom Power Wheelchair Prior Authorization Requests

For the March 1, 2015, transition to managed care and ongoing, providers should contact a resident's MCO concerning pending CPWC prior authorization requests. The Texas Medicaid Healthcare Partnership (TMHP) will provide CPWC prior authorization requests in progress to resident's MCO to ensure continuity of care. NFs should not submit claims for reimbursement to TMHP for a managed care member after March 1, 2015.

For ongoing operations, TMHP will continue to review CPWC prior authorization requests for all Fee for Service (FFS) residents, and NFs should continue following the current DADS CPWC prior authorization request process. If a FFS resident becomes a managed care member during the prior authorization review process, providers should contact the resident's MCO concerning pending CPWC prior authorization requests. TMHP will provide CPWC prior authorization requests in progress to the resident's MCO to ensure continuity of care.

After March 1, 2015, validation of the authorization and reimbursement for CPWC claims for a managed care member should be made by the DME provider with the MCO. No services will be delayed due to the change in process for handling these authorization requests.

Durable Medical Equipment Prior Authorization Requests

DADS will not review prior authorization requests for DME for managed care members. DADS will fax rejection notifications to the submitting provider for all requests made to DADS in error up until April 30, 2015.

For residents enrolled in STAR+PLUS on or after March 1, 2015, DME prior authorization requests must be submitted to the appropriate MCO for determination of approval or denial. Validation of the authorization and reimbursement for DME claims for a managed care member after March 1, 2015, should be made by the DME provider with the MCO.

Goal-Directed Therapy Prior Authorization Requests (Rehabilitative Services)

MCOs may receive open prior service authorizations as of March 1, 2015, for some managed care members. This will continue during the transition period between a resident's enrollment in Medicaid and enrollment in Managed Care.

DADS does not review Goal-Directed Therapy (Service Codes 7, 8, and 9) prior authorization requests for managed care members. For residents enrolled in STAR+PLUS on or after March 1, 2015, these prior authorization requests must be submitted to the appropriate MCO for approval.

Prior authorizations in-progress when a resident is enrolled in managed care will require a new prior authorization request with a member's MCO. Providers should utilize the appropriate MCO's designated portal, contact the associated MCO directly, or visit the MCO website (as noted above) for information related to that MCO's prior authorization process.

Providers should submit claims to TMHP, to be paid as FFS, for dates of service prior to the resident's managed care enrollment date. Providers should submit claims for services incurred after a resident's managed care enrollment date to the associated MCO for payment.

Medicaid Eligibility and Service Authorization Verification (MESAV)

Providers should continue to use the MESAV to monitor the statuses of the Level of Service, and Applied Income for Daily Care services. The MESAV will display utilized units for FFS residents only. As of February 18, 2015, the MESAV began displaying the effective date of the resident's enrollment in Managed Care and their associated MCO.

For questions about this information letter or the prior authorization request process, NF providers should contact Marie Redman, DADS Provider Claims Services, at (512) 438-2200, option 1.

Sincerely,

[signature on file]

David Cook
Chief Financial Officer

DC:sjw