

Authorization Category	Type	Time Frame	Details and Definitions
Prospective	Routine Requests STAR/STAR Kids with all supporting documentation	3 business days	Within three business days after the receipt of the request for authorization of services (with all supporting documentation) regarding routine / non-urgent cases.
	Non-emergent Ambulance Requests STAR/STAR Kids with or without all supporting documentation	3 business days	Within three business days after the receipt of the request for authorization of services regarding routine / non-urgent cases.
	CHIP Lines of Business with all supporting documentation and request is approved	2 business days	Within two business days after the receipt of the request for authorization of services (with all supporting documentation) regarding routine / non-urgent cases when request is approved.
	CHIP Lines of Business without all supporting documentation and/or request is denied	3 business days	Within three business days after the receipt of the request for authorization of services regarding routine / non-urgent cases.

		Lack of Information for Non-emergent Ambulance Requests and Requests for CHIP Line of Business	If no clinical information is provided with the request, or if the information provided is insufficient to make a medical necessity determination, the provider is contacted via fax, phone, or both specifying the information being requested and the timeframe in which it is due (one business day). If supporting information is not received from the provider within one business day, the Requesting Provider, Attending Provider, and/or facility is provided with a written notification via fax and USPS mail that the authorization request has been administratively denied for lack of information.
	Routine STAR/STAR Kids Lack of Information (LOI) for All Ages (Excluding Non-emergent Ambulance Requests and All Requests for CHIP Line of Business)	If supporting information is lacking, up to 14 calendar days	Concerning requests for ambulatory services (excluding non-emergent ambulance requests for all lines of business and all requests for CHIP line of business) lacking or with incomplete or insufficient information for STAR and STAR Kids members (of all ages), the Lack of Information (LOI) Process shall be applied per state regulatory requirements as follows: • If after completion of pre-authorization screening or initial clinical review, it is determined that supporting, clinical information is lacking or incomplete/insufficient to make a medical necessity determination, the “Referred by” Provider is sent a LOI Clinical Request letter within three business days from receipt of the prior authorization request. The LOI Clinical Request letter will describe specifically what is lacking in order to make a determination and the timeframe in which it is due (three business days). The “Referred to” Provider and the Member receive a copy of the LOI Clinical Request letter. • If the requested information is not received from the provider within three business days, the request is forwarded to a medical director for review of medical necessity, which could result in a medical necessity denial due to incomplete or insufficient documentation. The Medical Director will have two business days from the date the request was forwarded to him/her to make a decision on the request. • After the Medical Director makes a decision on the request, one business day is provided for peer-to-peer reasonable opportunity discussion prior to entering a final determination. Upon his/her request, the Requesting Provider will have the opportunity to discuss the request with another provider of the same or similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the Member on whose behalf the request was submitted.

			Final determination is entered on the referral request within three business days from the date the request was forwarded to the medical director. The “Referred to” and “Referred by” Providers, Attending Provider, and/or facility is provided with a written notification via fax and USPS mail. The Member is provided with a written notification via USPS mail.
	Urgent	ASAP after receipt of the request but no later than 24 hours	DHP processes urgent requests as soon as possible after receipt of the request, but no later than 24 hours, if the application of the time periods for making non-urgent care determinations: - Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or - In the opinion of a physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is being requested. An urgent condition means: - A health condition, including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical evaluation or medical treatment within 24 hours to prevent serious deterioration of the Member’s condition or health. An urgent behavioral health situation means: - A behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.
	Post-Stabilization/ Emergent	1 hour	Within one hour from receipt of authorization request for post-stabilization, care subsequent to emergent treatment of life-threatening conditions. Emergency Medical Conditions and Emergency Behavioral Health Conditions will not require prior authorization. No authorization is required for emergency care.

			“Emergency care” means: - Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Member’s condition, sickness, or injury is of such a nature that failure to get immediate medical care could: - Place the Member’s health in serious jeopardy; - Result in serious impairment to bodily functions; - Result in serious dysfunction of bodily organ or part; - Result in serious disfigurement; or - For a pregnant woman, result in serious jeopardy to the health of the fetus.
Concurrent	Routine Non-Urgent	1 business day 1 business day for DC planning services	DHP reviews and issues determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames: - within one business day after receiving the request (with all supporting documentation) or identifying the need to extend, including if the request is submitted by a provider including an Out of Network provider or Provider of Acute Care Inpatient Services, or the request is submitted by a Member or Provider for services or equipment that will be necessary for the care of the Member immediately upon discharge; or - within one hour of receiving the request if the request is related to transfer and post stabilization care or a life-threatening condition.
		Lack of information	Facilities must submit admission notification to DHP within one business day of admission and clinical documentation supporting medical necessity of the stay within two business days of admission. If additional information is required for continued stay, DHP will contact the facility. The due date for additional clinical is within one business day of the request. If supporting information is not received from the provider by the date due, the Requesting Provider, Attending Provider, and/or facility is provided with a written notification via fax

			and USPS mail that the authorization request has been administratively denied for lack of information.
	Reductions Terminations	1 business day	Reductions or terminations of a previously approved course of treatment: DHP issues the determination early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs, but no longer than one business day of receipt of the request (with all supporting documentation) in accordance with HHSC guidelines and URAC standards.
	Urgent	24 hours if received at least 24 hours before expiration 1 business day/ 72 hours if received less than 24 hours before expiration	Per state regulatory requirements, DHP issues a determination for a request to extend a current course of treatment for cases involving urgent care: - Within 24 hours of receipt if the request for extension was received at least 24 hours before the expiration of the currently certified period or treatment. - Within one business day / 72 hours (whichever is sooner) of receipt if the request for extension was received less than 24 hours in advance of expiration of the currently certified period or treatment.

Retrospective		30 calendar days Lack of Information	DHP will issue a determination within 30 calendar days from the receipt of request for a retrospective UM determination. If no clinical information is provided with the request, or if the information provided is insufficient to make a medical necessity determination, the provider is contacted via fax, phone, or both specifying the information being requested and the timeframe in which it is due (three business days). If supporting information is not received from the provider within three business days, the Requesting Provider, Attending Provider, and/or facility is provided with a written notification via fax and USPS mail that the authorization request has been administratively denied for lack of information.
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Extensions of Prospective and Retrospective Reviews		14 calendar days	In addition to the time frame requirements listed above for prospective and retrospective reviews, DHP may allow a one-time extension not to exceed 14 calendar days if the member requests the extension before the initial time frame requirements listed above have expired or if DHP determines an extension is necessary to obtain more information and is in the best interests of the member. DHP notifies the Member (verbally and in writing) and providers (in writing) of the circumstances requiring the extension and the date when the plan expects to decide prior to the expiration of the initial time frame requirements listed above for prospective or retrospective reviews. The Member has the right to file a grievance within 2 calendar days of receipt of the notification to extend. If the extension is required because the provider or Member fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information and the timeframe in which it is due. The Member must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.
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Pharmacy			Prescriber's office may call the Navitus PA call center and receive the prior authorization determination immediately. All other PA requests, Navitus will notify the prescriber's office of a PA determination no later than 24 hours after receipt. If Navitus cannot provide a response to the PA request within 24 hours after receipt or the prescriber is not available to make a PA request because it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation, Navitus on behalf of DHP must allow the pharmacy to dispense a 72-hour supply of the drug.
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