Aetna Better Health® of Texas

Provider Notification: Prior Auth RFI Changes

Notification of Incomplete Prior Authorization Requests

Effective immediately, we will require all essential information when reviewing prior authorization requests. An incomplete prior authorization (PA) request is a request for a service that is missing information needed to decide medical necessity. Aetna Better Health of Texas will notify the requesting provider and Member, in writing, of missing information no later than 3 business days after the prior authorization receive date.

Incomplete Prior Authorization Request

If any of the information is missing, illegible or incomplete, Aetna Better Health of Texas will contact the provider in writing to obtain the information necessary to resolve the Incomplete PA Request. Our plan's written request for additional information will include:

- A statement that Aetna Better Health of Texas has reviewed the PA 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 missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
- An applicable timeline for the provider to submit the missing information.
- Information on how the provider may contact Aetna Better Health of Texas.

Essential Information Required by HHSC UMCM 3.22

☐Member Name
☐Member number or Medicaid number
☐Member date of birth
☐Requesting provider name
☐Requesting provider's 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
☐Rendering/servicing provider
☐Rendering/servicing provider National Provider Identifier (NPI)

Aetna Better Health of Texas uses the date that the complete request form is received to determine the start date for services. Previous submission dates with missing or incomplete information are not considered when determining the start date of service.

If the information requested is not received within 3 business days from the date that the plan sent the notice to the provider and the PA request will result in an Adverse Benefit Determination-- Aetna Better Health will refer the Incomplete PA Request to the Medical Director with all information received in the initial PA request. The determination should be completed within 3 business days of the referral to the Medical Director.

Coverage Determination
Prior to issuing an Adverse Determination, a medical director will offer a peer-to-peer review to discuss the member's plan of treatment and the clinical basis for the medical necessity determination. Aetna Better Health of Texas will allow one business day or a reasonable timeframe before an Adverse Determination is issued. Final determination will be made within 3 Business Days after the date missing information is provided to Aetna Better Health of Texas.

If services are not approved based on medical necessity, Aetna Better Health of Texas will send the appropriate notice of action to the member, and the requesting/ordering provider. The notice will include an explanation of the determination and the member's internal appeal rights and state fair hearing/external independent review rights and process.

For additional information on the prior authorization process, please review our Provider Manual and Prior Authorization tools:
Provider Manual
https://www.aetnabetterhealth.com/texas/assets/pdf/provider/TX%20ABH%20Medicaid%20and%20CHIP%20Manual%2011921.pdf
Prior Authorization webpage
https://medicaidportal.aetna.com/propat/Default.aspx