Texas Children's	Coordination of Benefits for Utilization Management Decisions Procedure	
Procedure # 6221	***Categories*** Clinical →Utilization Management UM	***This Procedure Applies To:*** Texas Children's Health Plan ***Document Owner*** Christi Hicks

PROCEDURE STATEMENT: Texas Children's (TCHP) guides processing authorization requests when TCHP is a secondary payor. Texas Children's Health Plan requires written proof of denial of benefits from TPR prior to issuing authorization.

DEFINITIONS:

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through a third party resource (TPR) that is liable to pay for health care services.

TPR may include payments from any of the following sources:

- Other health insurance including assignable indemnity contracts
- Non Medicaid Health maintenance organization (HMO)
- Public health programs available to clients with Medicaid such as Medicare and Tricare
- Profit and nonprofit health plans
- Self-insured plans
- No-fault automobile insurance such as personal injury protection (PIP) and automobile medical • insurance
- Liability insurance
- Life insurance policies, trust funds, cancer policies, or other supplemental policies • Workers' Compensation
- Other liable third parties

Secondary Payor: An insurance policy, plan, or program that pays second on a claim for medical care.

PROCEDURE

1. All requests for prior authorization are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.
2. If a member has exhausted a benefit limit from their third party resource or their third party resource does not provide coverage of a benefit provided by TCHP, TCHP then becomes the authorizing and responsible payor.

3. TCHP requires written notification from the third party resource that a benefit has been denied.

4. TCHP Utilization Management will require written notification of denial for a particular benefit once per calendar year. Subsequent requests for the same benefit will be able to reference the previously provided written denial in writing or verbally.

5. Prior authorization for non-emergent out-of-network services. If a request for authorization indicates that TCHP is a secondary payor the following is required for authorization of out of network services:
    5.1. Proof of TPR authorization of the services
    5.2. TCHP authorization for the service will not exceed the TPR authorization with the same amount, duration, and scope of services.
        5.2.1. The applicable TCHP guidelines and TMPPM authorization limitations apply to the requested service (e.g monthly, 3 month, 6 month, 12 months).

6. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:

Government Agency, Medical Society, and Other Publications:

Texas Insurance Code Section 843.349 (e) and (f) Accessed June 17, 2020

https://texas.public.law/statutes/tex._ins._code_section_843.349

Centers for Medicare and Medicaid Services Glossary Accessed June 17, 2020

https://www.cms.gov/apps/glossary/

Texas Medicaid Provider Procedures Manual Accessed June 17, 2020
http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf

RELATED DOCUMENTS:

Coordination of Benefits for Utilization Management Decisions Policy

REFERENCES:

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