House Bill 3459
Preauthorization Exemption Program

Frequently Asked Questions

In response to House Bill 3459, issuers have the right to grant, deny or rescind qualifying preferred providers from obtaining a preauthorization exemption for select health care services, procedure codes and/or prescription drugs.

For additional information, please review the Frequently Asked Questions below.

When did the Prior Authorization exemptions go into place for Ambetter providers?

The effective exemption date would be dependent on the evaluation period.

Evaluation Period:	Effective Date:
01/01/2022-06/30/2022	10/01/2022
07/01/2022-12/31/2022	01/01/2022
01/01/2023-06/2023	09/01/2023

Per TDI, initial exemptions were required to be operationalized October 1, 2022.

How do I qualify for exemption?

Providers who receive 90% medical necessity approval, with a minimum of 5 requests per service/procedure code/prescription during the review period to qualify for exemption.

Does this apply to all Ambetter programs?

Yes, provider exemptions apply to all Ambetter programs; however, exemptions may vary from health benefit plans (i.e., Providers can be exempt for Core and not Value or vice versa). This does not apply to Medicare or Medicaid providers.

Please note: Providers are still required to check a member's eligibility and plan benefits.

If I am not in network with Ambetter but I do see some Ambetter members, can I still qualify for exemption?

Yes, out of network providers can qualify for exemption status.

When was the initial review period?

January – June 2022

How long will I be exempt for?

The exemption will remain in effect for a minimum of 6 months from the date of the notification letter you received and may continue after the initial 6-month period unless you are notified of recission.

How will I be notified if I qualify for the exemption?

Providers can choose how they receive their exemption notification – via mail or email – by completing Ambetter's online communication preference survey.

Are all providers in my group exempt for the same services?

No, the exemption occurs at the National Provider Identifier (NPI) level, not the Tax Identification Number (TIN)/Group level. The approval letter will include the provider NPI that qualified for the exemption.

Am I exempt from prior authorization for all services?

No, the exemption occurs at the service/procedure code/prescription level detailed on your notification letter.

Why didn't I qualify for an exemption?

Providers do not qualify for an exemption if they requested fewer than five prior authorizations for a service during the review period or if the provider did not meet the required 90% approval rate for the requested service. For additional information, please contact your local Account Manager.

Do the exemptions also apply to vendors such as National Imaging Associates (NIA) and TurningPoint?
Yes, NIA was responsible for notifying providers of exemptions related to prior authorizations for services they manage. TurningPoint notifications were sent by Ambetter. For questions, please contact your local Account Manager.

Are all services in-scope for the exemption review?
No, current inpatient services are not eligible for exemption.

Do Value/Virtual Providers still need referrals?
Yes, Value/Virtual providers still need to file a referral for specialists, Durable Medical Equipment (DME), or home health care. Referrals are considered separate from the Preauthorization Exemption Program.

Are benefit limits waived for prior authorization exemption?
No, benefit limits are not waived for the Preauthorization Exemption Program. Providers are still subject to benefit limitations, as well as member eligibility.

When will the next evaluation period take place?
The review period for initial exemptions was July 1, 2022, through December 31, 2022. The review periods for subsequent years are listed below:

- January 1 through June 30
- July 1 through December 31

Can the exemption ever be rescinded?
Yes, January and June of each year we review between 5 and 20 medical records for claims received. After the clinical review, we will make the determination of whether a provider's exemption should remain in place or be removed (rescinded). Prior authorization exclusion may be rescinded if 90% of the sample size do not meet medical necessity criteria.

How and when will I know if my exemption is rescinded?
Beginning in June 2023, and each January and June thereafter, we will send you a notice if you no longer qualify for an exemption.

If I am exempt, what happens if I submit an authorization request anyway?
If providers submit an authorization request for an exempt code, they will receive a faxback indicating that no authorization is required for that service.

Can I appeal Ambetter's decision?
Yes, providers may appeal the initial exemption if they believe they exceeded the minimum threshold. They must submit documentation to support their appeal as well as the letter that stated they did not meet exemption to the Ambetter Appeals department via fax or mail. They can also file a complaint.

For rescission of prior authorization exemption, providers may file an appeal with the Ambetter Appeals department. Providers may request an independent review from an IRO if they disagree with Ambetter's decision. They can also file a complaint with TDI.

Do I need to do anything different when submitting my claims for payment?

Ambetter's claims system has been configured to waive prior authorization requirements for the applicable exempted procedural/service codes. As a result, no new or additional coding or billing requirements must be adopted to adjudicate a clean claim received for payment for an exempted procedural/service code.

However, if you are the ordering physician for an exempted procedural/service code, and another non-exempt provider is delivering the service, the rendering physician or provider's claim must include your name and NPI on submitted claims:

- In fields 17 and 17B of the CMS Form 1500 and in fields 76-79 of the CMS Form 1450 (UB-04); OR
- In the corresponding fields for electronic claims using the ASC X12N 837 format.

If the information listed above is not included on the treating/rendering provider's claim, the claim will be subject to applicable prior authorization requirements.

Disclaimer: *Notwithstanding the information in this notice, providers are subject to the terms and conditions of their participating provider agreement or Ambetter's Usual and Customary Rate process pursuant to Texas Insurance Code Section 1271 and 1301. Services rendered are subject to member eligibility, benefit limitations, referral requirements (if applicable), clinical, payment, pharmacy policies and Texas and Federal law. Additionally, the Preauthorization Exemption is only considered for Texas Ambetter Health providers.*