House Bill 3459
Preauthorization Exemption Program
Frequently Asked Questions

In response to House Bill 3459, effective October 1, 2022, 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.

Ambetter from Superior HealthPlan recognizes the high level of care providers deliver to our members. In accordance with this bill, participating providers who meet specific criteria will be enrolled in Ambetter's Preauthorization Exemption Program.

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

When does the Preauthorization Exemption Program go into place for Ambetter Health providers?
The Preauthorization Exemption Program went into effect on October 1, 2022 for approved providers.

Does this apply to all Ambetter Health programs?
Yes, provider exemptions will apply to all Ambetter Health programs. This does not apply to Medicare or Medicaid providers.

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

How do I qualify for exemption?
In order to qualify for the exemption providers must have:

- Submitted at least five preauthorization requests within the applicable six-month timeframe; AND
- Received at least 90% preauthorization approval rate for each select health-care service, procedure code or prescription drug.

When was the initial review period?
The initial review period started January 1, 2022 and concluded on June 30, 2022.

How long will the exception be in place?
Providers who quality for the exemption will be exempt for at least six months from the date of exemption notification, at which point the exemption may be extended or rescinded.

How will I be notified if I qualify for the exemption?
For the first notification, providers received a letter notifying them of their exemption status, which included applicable code(s).

Can I request how to receive my notification of exemption?
Providers can select their preferred communication method for future Preauthorization Exemption Program notifications by completing the Ambetter from Superior HealthPlan Preauthorization Exemption Communications Preference Survey.

Are all providers in my group exempt for the same services?
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 preauthorization for all services?
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 preauthorizations for a service during the review period or if they didn't have a high enough approval rate for the requested service. For additional information, please contact your Ambetter Health Account Manager.

Do the exemptions also apply to vendors such as National Imaging Associates (NIA) and TurningPoint?
NIA notified providers of exemptions related to preauthorizations for services they manage. TurningPoint notifications were sent by Ambetter Health.

- If you have questions regarding exemptions from NIA, please contact NIA directly at 1-877-687-1196.
- For questions related to TurningPoint exemptions, please contact your Ambetter Health Account Manager.

Are all services in-scope for the exemption review?
All services are not in-scope for the exemption review. Prescription, outpatient and elective inpatient procedures are subject to review; however, concurring inpatient review services are excluded.

Are transplants considered for exemption review?
Transplants are considered for exemption review. While a provider may meet preauthorization exemption criteria for transplant services, providers must contact the Centene Transplant Unit for notification and arrangement for reimbursement of transplant services by:

- Phone: 1-866-447-8773
- Fax: 1-866-753-5659

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

Are benefit limits waived for Preauthorization Exemption Program?
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 exemption review take place?
The next review period for initial exemptions began on July 1, 2022 and will go 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, the exemption can be rescinded. January and June of each year, Ambetter Health will conduct a review of between five and 20 medical records for claims received. After the clinical review, Ambetter Health will make the determination of whether a provider's exemption should remain in place or be rescinded. Prior authorization exclusion may be rescinded if less than 90% of the sample size does not meet medical necessity criteria.

How and when will I know if my exemption is rescinded?
Ambetter Health will notify providers if they no longer qualify for an exemption beginning June 2023, and each January and June thereafter.

If I am exempt, can I submit an authorization request anyway?
If a provider is exempt, they cannot submit an authorization for the exempt code. If providers submit an authorization request for an exempt code, they will receive a faxback indicating that no authorization is required for that service.

Do I need to do anything different when submitting my claims for payment?
The claim can be submitted as usual if the requesting provider that qualified for the Preauthorization Exemption Program is also the servicing provider submitting the claim.

However, if the servicing provider is **not exempt from preauthorization**, but is utilizing the Preauthorization Exemption Program status of the ordering/requesting provider, then the treating physician or provider must include the name and NPI of the qualifying ordering physician or provider on claims in:

- Fields 17 and 17B of CMS Form 1500.
- Fields 76 - 79 or another appropriate field in Form UB-04.
- Corresponding fields for electronic claims using the ASC X12N 837 format.

Note: If the qualifying provider information is not included in these fields, and the service requires preauthorization, the claim will deny.

Can I appeal Ambetter Health's decision?
Providers may submit their appeal of the initial exemption if they believe they exceeded the minimum threshold to qualify for the Preauthorization Exemption Program.

Note: For rescission of preauthorization exemption, providers may file an appeal with the Ambetter Health Appeals team. Providers may request an independent review from an Independent Review Organization (IRO) if they disagree with Ambetter Health's decision. They can also file a complaint with TDI.

Disclaimer: Notwithstanding the information in this document providers are subject to the terms and conditions of their participating provider agreement or Superior's Usual and Customary Rate process pursuant to Texas Insurance Code Section 1271. Services rendered are subject to member eligibility, benefit limitations, clinical, payment and pharmacy policies. Additionally, the Preauthorization Exemption Program is only considered for Texas Ambetter providers.