CONNECTED
SENIOR CARE ADVANTAGE

Utilization Management

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Utilization Management – FAQ's

How do I contact the Utilization Management Department?

Customer Service and Utilization Management are available Monday thru Friday from 8 am – 5 pm CST. We can be contacted at:

Connected Senior Care Advantage

Phone: (737) 236-0999

Toll Free: (833) 282-8883 TTY: 711

Fax: (512) 872-6910

For Peer to Peer call requests, please contact us at the phone number noted above and we will coordinate the call.

How do I submit a request for authorization?

Pre-Service authorization requests are submitted through the secure Provider Portal https://tx.coreportal.com. In the event a provider office is unable to submit a request via provider portal; the request can be faxed to the fax number noted above. Please include **ALL** pertinent clinical information to support the medical necessity of the requested service.

This would include: The most **CURRENT** clinical notes documenting member's current condition, physician's exam and findings, member's pertinent medical history and diagnostic testing results if related to request, and the rationale for the requested service(s).

How do I change a request I've already submitted on the provider portal?

Modifications must be requested in writing. Please submit a written request containing the original request, what change is being requested and the justification of the modification. Fax this request to the fax number noted above.

These modification requests will be evaluated as soon as possible as we monitor our open authorization requests throughout the day to ensure timely completion.

What if I have an urgent authorization request?

Urgent requests are completed within 72 hours.

An 'Urgent' request is defined as: a request that a provider indicates, or the Provider Group / Health Plan determines, that allowing for the standard timeframes could seriously jeopardize the member's life or health, or their ability to attain, maintain or regain maximum function.

Specific to urgent requests:

Determination: An urgent authorization request for any line of business (Medicare, Medicare-Medicaid (Duals), Commercial, or Medicaid) has a mandated turnaround time of no more than 72 hours for determination.

Notification: Medicare requires Medicare members to be notified of the decision made within those 72 hours.

Examples of an inappropriate submission for an urgent authorization request:

- The member has an appointment tomorrow and someone forgot to obtain prior authorization.
- The person responsible for obtaining the prior authorizations in your office is going on vacation and wants to clear all requests before he/she leaves tomorrow.

**We are happy to help- If you need a request processed quickly but it's not a true urgent request, please contact us and ask for assistance once the request has been submitted via provider portal as a routine request. Please do not submit request as an urgent request unless the request clearly and appropriately meets the above noted definition.

How long will it take to get the decision?

Certain requests will process automatically and return as an approval immediately. Requests that require review for medical necessity and benefit verification will be reviewed according to Utilization Management Timeliness Standards as set forth by the Centers for Medicare and Medicaid Services (CMS):

Urgent Medicare Requests:

Notification: Member and Provider – Within 72 hours of receipt of the request.

Standard Medicare Requests:

Notification: Member and Provider- Within 14 calendar days of receipt of the request.

What do I do if I don't agree with a non-coverage determination?

As a requesting provider, you can talk with the Physician Reviewer to better understand how the non-coverage determination was made and request a copy of the reference used to make the decision. In most cases, you will have to submit an appeal to have the decision re-reviewed. Please call (737) 236-0999 and we will assist in coordinating a peer to peer discussion between yourself and our Physician Reviewer.