

**Medicaid Managed Care –
Extended Home Health (EHH) and EPSDT-Personal Care Services (PCS)
Prior Authorization Timeframes**

Prior Authorization Timeframes	Aetna Better Health	AmeriHealth Caritas	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections
Regular	60 days	1 month	30 days / 1 month unless the provider requests less	60 days	8 weeks
Chronic Needs	60 days	3 months	30 days / 1 month unless the provider requests less	60 days	8 weeks
Regular	60 days	3 months	180 calendar days or a rolling 6 months	6 months	6 months
Chronic Needs	60 days	6 months	180 calendar days or a rolling 6 months	6 months	6 months
<u>*Renewal Submission Timeline</u>	10 days	10 days	14 calendar days prior to the expiration date of the authorization	14 calendar days prior to the expiration date of the authorization	14 days prior to the end of the approved authorization period

***Number of days prior to the end of a PA that the renewal documents need to be submitted to avoid a lapse in services.** Beneficiaries who have been designated by BHSF as a “Chronic Needs Case” are exempt from the standard prior authorization process. A new request for prior authorization shall still be submitted every 180 days; however, the EPSDT PCS provider shall only be required to submit a PA-14 form accompanied by a statement from the beneficiary’s primary practitioner verifying that the beneficiary’s condition has not improved and the services currently approved must be continued. The provider shall indicate “Chronic Needs Case” on the top of the PA-14 form. This determination only applies to the services approved where requested services remain at the approved level. Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request. NOTE: Only BHSF or its designee will be allowed to grant the designation of a “chronic needs case” to a beneficiary.