



Appropriate Use of Expedited Authorization Requests

Purpose

This memorandum provides clarification regarding the appropriate use of **expedited authorization requests** for CHIS services.

Recent review trends indicate that some routine CHIS requests are being submitted as expedited. This memo outlines applicable federal standards and clarifies when expedited processing is appropriate.

CMS Definition of Expedited Requests

Under **42 CFR § 438.210(d)(1)**, expedited authorization processing is required when:

"The standard timeframe for making a determination could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function."

Expedited review is reserved for circumstances involving **immediate and serious clinical risk**. It is not intended for routine service requests or ongoing therapy authorizations.

Application to CHIS Services

CHIS services are generally **planned, ongoing therapeutic services**. In most cases, these services do not meet the regulatory threshold for expedited processing.

An expedited request may only be appropriate if clinical documentation clearly demonstrates that waiting the standard review timeframe would:

- Seriously jeopardize the member's life;
- Seriously jeopardize the member's health; or
- Seriously jeopardize the member's ability to attain, maintain, or regain maximum function.

Routine continuation of care, periodic reauthorizations, or anticipated service needs do **not** meet this standard.

Clarification Regarding Delayed Submissions

A delay in provider submission of an authorization request does not constitute grounds for expedited review. Administrative circumstances such as late submission of required documentation, retroactive authorization requests, or scheduling challenges do not meet the CMS definition of an expedited request. The expedited review pathway is reserved exclusively for situations in which the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. It may not be used to offset administrative, operational, or documentation-related delays.

Expectations Moving Forward

Providers should:



- Submit OTI authorization requests under **standard review timeframes** unless clear clinical documentation supports expedited criteria.
 - Telligen's standard review times align with the CMS rule of seven business days.
- Include specific clinical justification when requesting expedited processing.
- Ensure timely submission of continuation requests to avoid service gaps.

Requests submitted as expedited without meeting CMS criteria may be reclassified and processed under standard timeframes.