

## CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) Form and Instructions

### General Information

- Ensure the most recent version of the Prior Authorization Request for Augmentative Communication Devices form is submitted. The form is available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).
- **Complete all sections of this form.**
- Incomplete **prior authorization** requests are denied. Requests are considered only when completed and received before the service is provided.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000, option 2, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:  

TMHP-CSHCN Services Program Authorization Department  
 12357-B Riata Trace Parkway Ste #150 MC-A11  
 Austin, TX 78727
- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- Refer to: Chapter 10, "Augmentative Communication Devices (ACDs)."

### Client Information

Field Description	Guidelines
First name	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Address	Enter the client's address
Diagnoses	Enter the diagnosis code relevant to the need for the ACD

### Part 1 – Equipment Information

Field Description	Guidelines
Item information	Check the item information: rented, purchase, modified, or repair
Estimate of repair	Enter the estimate of repair (when applicable)
Age of ACD	Enter the age of the ACD system (when applicable)
Manufacturer	Enter the name of the manufacturer of the device or accessories being requested
MSRP	Enter the manufacturer suggested retail price (MSRP) for the device or accessories
Model No.	Enter the model number for the device or accessories
HCPCS Code	Enter the Healthcare Common Procedure Coding System (HCPCS) for the device or accessories
Modifier	Enter the modifier for the device or accessories (when applicable)

### Part 2 – Statement of Medical Necessity – Required for all equipment requests

Field Description	Guidelines
Physician name	Enter the prescribing physician's name
Telephone number	Enter the prescribing physician's telephone number
Physician's signature	Physician must sign in this field
Date	Enter the prescribing physician's date of signature

### Part 3 – Vendor Information

Field Description	Guidelines
Provider name	Enter the name of the ACD supplier

Field Description	Guidelines
Contact person	Enter the ACD supplier's contact person name
Telephone number	Enter the ACD supplier's telephone number
Fax number	Enter the ACD supplier's fax number
Address/City/ZIP	Enter the ACD supplier's address
CSHCN TPI	Enter the ACD supplier's CSHCN Services Program Texas provider identifier (TPI)
NPI	Enter the ACD supplier's national provider identifier (NPI)
Taxonomy code	Enter the ACD supplier's taxonomy code
Benefit code	Enter the ACD supplier's benefit code
Current member of CAMA	Indicate whether or not the ACD supplier is a member of Communication Aid Manufacturers Association (CAMA)
Membership expires	Enter ACD supplier's CAMA membership expiration
Signature of DME provider	ACD supplier must sign in this field
Date	Enter the date signed

### Additional Requirements

Prior authorization requests must include all of the following information or documentation:

- The medical diagnosis and how it relates to the client's communication needs.
- Any significant medical information pertinent to the use of the ACD.
- The limitations of the client's current communication abilities, system, and devices.
- A statement as to why the prescribed ACD is the most effective with comparison of benefits versus other alternative options.
- A complete description of the ACD with all accessories, components, mounting devices, and/or modifications necessary for client use (must include the manufacturer's name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating and using the requested ACD.
- A professional assessment must be conducted by a licensed speech-language pathologist in conjunction with other disciplines, such as physical or occupational therapies. This assessment must be completed before the ACD is prescribed by the physician. The prescribing physician should base the prescription on the professional assessment. Professional assessment by a licensed speech-language pathologist must include the following information:
  - Communication status and limitations
  - Speech and language skills assessment, including prognosis for speech and/or written communication
  - A description of the client's cognitive readiness
  - A description of the client's interactional, behavioral, or social abilities
  - A description of the client's capabilities including intellectual, postural, physical, and sensory (visual and auditory)
  - A description of the client's motivation to communicate
  - A description of the client's residential, vocational, and educational setting
  - A description of how the ACD will be implemented or integrated into environments
  - A description of alternative ACD considered with a comparison of capabilities
  - A description of the ability of the ACD to meet the projected communication needs and growth potential of the client, and how long the ACD will meet the client's needs
  - A detailing of any anticipated changes, modifications, or upgrades with projected time frames (short and long term)
  - A detailed training plan (who, what, when, where)

It is recommended that the preliminary evaluation for an ACD include involvement of an occupational therapist and/or physical therapist to address the client's seating/postural needs and motor skills required to utilize the ACD.

# CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) (page 1 of 2)



Client Information	
First name:	Last name:
CSHCN Services Program number: 9- _____ -00	Date of birth:
Address/City/ZIP:	
Diagnoses (ICD-9-CM relevant to need for ACD):	
Part 1– Equipment Information	
Item is to be: <input type="checkbox"/> Rented for 30 days <input type="checkbox"/> Purchased (after successful 30-day trial) <input type="checkbox"/> Modified <input type="checkbox"/> Repaired      Cost estimate of repair: _____      Age of ACD: _____	
Device or accessories requested: Manufacturer: _____ MSRP: _____ Model No.: _____ HCPCS Code: _____ Modifier: _____	
Part 2– Statement of Medical Necessity - Requirement for all equipment requests	
Attach a copy of the SLP assessment including information about the client’s mental, emotional, and mental abilities as to effective use of ACDs. Refer to the <i>CSHCN Services Program Provider Manual</i> for specific criteria that must accompany <i>each</i> ACD request.	
Attach a copy of evaluation of seating, postural control, and motor skills by physical or occupational therapist when appropriate.	
Narrative section: (Include a summary of the limitations of the client’s current communication abilities, systems, devices, and initial date received. If applicable, describe need for modification or repair of current ACD.)	
Describe why prescribed ACD is the best and most cost effective choice for this client.	
I certify that the patient’s medical condition is such that all equipment requested above is medically necessary. Physician’s name: _____ Telephone number: _____ Physician’s signature: _____ Date: _____	

# CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) (page 2 of 2)



Client Information	
First name:	Last name:
CSHCN Services Program number: 9- _____ -00	
Part 3 – Vendor Information	
Provider name:	Contact person:
Telephone number:	Fax number:
Address/City/ZIP:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: <b>CSN</b>
Current member of CAMA <input type="checkbox"/> Yes <input type="checkbox"/> No	Membership expires: _____(mm/dd/yy)
Signature of DME provider:	Date: