

CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Inpatient Hospital Admission – For Use by Facilities Only form is submitted which is available on the TMHP website at www.tmhp.com.
- **All sections of this form must be completed.**
- Incomplete **prior authorization** requests are denied and are considered only when completed and received before the service is provided.
- Information must be printed or typed.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000, option 2, which is available 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 22, “Hospital.”

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/City/ZIP	Enter the client's address, city, and ZIP
Diagnoses (ICD-9-CM)	Enter the diagnosis code relevant to the need for the inpatient hospital admission
Other insurance information (check each that applies)	Indicate whether the client has other insurance, and enter the client's other insurance type (private, Medicare, or Medicaid).
Insurance Type	Enter the insurance type
Insurance Carrier	Enter the insurance carrier
Insurance ID	Enter the insurance ID

Type of admission and medical necessity

Field Description	Guidelines
Emergent admission from:	Check the appropriate boxes to indicate where the patient was admitted from.
Scheduled Surgery	Check this box for admissions related to a schedule surgery. Enter the surgical procedures codes requested and the surgeon's name, TPI, NPI, taxonomy code and benefit code.
Scheduled chemotherapy or other	Check this box for admissions related to scheduled chemotherapy or other scheduled services. For other services specify the type of service in the space provided.
Document medical necessity	Document medical necessity for each service that pertains to the hospital stay as needed. Attach additional pages as needed.

Initial admission information

Field Description	Guidelines
Number of initial days requested	Enter the number of initial days being requested
Date of initial admission	Enter the date of initial admission
Anticipated date of discharge	Enter the anticipated date of discharge

Field Description	Guidelines
Attending physician's name	Enter the attending physician's name.
CSHCN TPI	Enter the attending physician's CSHCN TPI
NPI	Enter the attending physician's NPI
Taxonomy code	Enter the attending physician's taxonomy code
Benefit code	Enter the CSN benefit code

Extension for inpatient hospital admissions

Note: If more than three extensions are needed, complete a new page 2 and submit with copy of original page 1 submission.

Field Description	Guidelines
Date of initial admission:	Enter the date of the initial admission
Initial anticipated discharge date:	Enter the initial anticipated discharge date
Extension Number of days requested:	Enter the number of days requested
New anticipated date of discharge:	Enter the new anticipated date of discharge

Hospital information and authorized required signature

Field Description	Guidelines
Hospital name	Enter the hospital name
Hospital contact name	Enter the hospital's authorized contact name
CSHCN TPI	Enter the hospital's CSHCN TPI
NPI	Enter the hospital's NPI
Taxonomy code	Enter the hospital's taxonomy code
Benefit code	Enter the CSN benefit code
Telephone number	Enter the hospital's telephone number
Fax number	Enter the hospital's fax number
Address/City/ZIP	Enter the hospital's address, city, and ZIP
Authorized signature	Authorized person must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for inpatient hospital admissions:

- Friday and weekend admissions may be prior authorized on the following Monday (or in the case of a holiday, on the next business day) when an emergency exists or when the required medical services will not be delayed due to the timing of the admission.
- All prior authorization request forms must be complete and must include either the surgeon's and/or the attending physician's name and/or provider identifier on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain authorization.
- If an initial request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if an initial request for prior authorization was not received from an enrolled provider, then the claim(s) cannot be considered for payment and are denied. All providers must be enrolled in order to receive reimbursement.
- If prior authorization for a nonemergency inpatient admission is not requested and approved before the admission, and if a request for authorization is made subsequently and approved, then only the day of the authorization request and subsequent days that were approved may be paid.

Prior Authorization request for emergency inpatient hospital admissions:

- Prior authorization requests for emergency admissions must be completed by the next working day after the admission date for coverage of the entire stay.
- Emergency admissions are defined as those that are medically necessary for same day admission from the emergency room or from a provider's office or clinic. If emergency admissions are not authorized, the CSHCN Services Program covers only emergency care and stabilization services

provided in the first 24 hours. If an authorization request is made later than the next business day and is approved, only the emergency care and stabilization services in the first 24 hours, the day of the authorization request, and subsequent days that are approved may be paid. All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

Prior Authorization request for inpatient hospital extensions:

- Extension of previously prior authorized inpatient dates of service requires prior authorization. Requests for extension of an inpatient stay must be received on or before the next working day following the last authorized day. Except for previously authorized dates of service, any date requested before the date the request is received is denied.
- When requesting an extension that includes a surgical procedure, providers must document the surgical procedure as part of the medical necessity for the extension.
- Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

For bone marrow/stem cell transplants, refer to the CSHCN Services Program Provider Manual for specific criteria that must accompany each request.

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Client Information:		
First name:	Last name:	
CSHCN Services Program number: 9-_____ -00	Date of birth:	
Address/City/ZIP:		
Diagnoses (ICD-9-CM):		
Other insurance information (check each that applies) <input type="checkbox"/> None <input type="checkbox"/> Yes	If Yes: <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	
Insurance ID:	Insurance Type:	
Insurance Carrier:		
Type of admission and medical necessity:		
Emergent admit from:	<input type="checkbox"/> Emergency room <input type="checkbox"/> Dr. Office <input type="checkbox"/> Clinic <input type="checkbox"/> Specialty clinic - Type: _____	
<input type="checkbox"/> Scheduled surgery	Surgical procedures requested (include CPT code[s]):	
	Surgeon's name:	
	Surgeon's CSHCN TPI:	Surgeon's NPI:
	Taxonomy code:	Benefit code: CSN
<input type="checkbox"/> Scheduled Chemotherapy or Other	Specify	
Document medical necessity (attach additional pages as needed):		
Initial Admission Information		
Number of initial days requested:		
Date of initial admission:	Anticipated date of discharge:	
Attending physician's name:		
CSHCN TPI:	NPI:	
Taxonomy code:	Benefit code: CSN	

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Client Information:	
First name:	Last name:
CSHCN Services Program number: 9-_____-00	
Extensions for Inpatient Hospital Admissions	
Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.	
Date of initial admission:	Initial anticipated discharge date:
Extension Number of days requested:	New anticipated date of discharge:
Extension Number of days requested:	New anticipated date of discharge:
Extension Number of days requested:	New anticipated date of discharge:
If more than three extensions are needed, complete a new page 2 and submit with copy of original page 1 submission.	
Hospital Information and Authorized Required Signature:	
Hospital name:	
Hospital contact name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: CSN
Telephone number:	Fax number:
Address/City/ZIP:	
Authorized signature:	Date: