Home Telemonitoring Services Prior Authorization Request

Children with Special Health Care Needs (CSHCN) Services Program

Fax completed form to 1-512-514-4222.

All sections of the form must be completed unless otherwise stated.

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *CSHCN Services Program Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in *the CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Section A: Client information (completed by home health agency or outpatient hospital)		
Name:	First:	Last:
CSHCN Services Program number:		
Date of birth:		

Section B: Requested telemonitoring service information (completed by home health agency or outpatient hospital)		
Home telemonitoring qualifying diagnosis:	☐ Diabetes	☐ Hypertension
Requested dates of service	From:	To:
A copy of the plan of care, signed and dated by the prescribing physician that includes the frequency of clinical data transmissions must be submitted with this request form.		
Comments (optional):		

Section C: To be completed by home health agency or outpatient hospital		
Provider printed name:		
Contact person:		
Address/City/ZIP:		
Telephone number:	Fax number:	
TPI:	NPI:	Taxonomy:

My signature confirms the following:

- Telemonitoring equipment meets all the following requirements:
  - Capable of monitoring any data parameters included in the plan of care
  - FDA Class II Hospital grade medical device
  - Capable of measuring and transmitting client glucose or blood pressure data
- Staff are qualified to install the needed telemonitoring equipment and to monitor the client data transmitted according to the client's care plan
- Clinical data will be provided to the client's primary care physician or his/her designee
- Services are not duplicated under the disease management programs described in Section 32.057, Human Resources Code
- Monitoring of the client's clinical data is not duplicated by any other provider
- Provider has written policies and procedures on the provision of home telemonitoring services
- Provider has written protocols that address all of the following:
  - Authentication and authorization of users
  - Authentication of the origin of client data transmitted
  - Prevention of unauthorized access to the system or information
  - System security, including the integrity of information that is collected, program integrity, and system integrity
  - Maintenance of documentation about system information usage
  - Information storage, maintenance, and transmission
  - Synchronization and verification of patient profile data.

Provider's Signature:	Date signed:

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Section D: To be completed by requesting physician

Diagnoses:

Client Risk Factors (check all that apply):

- ☐ Two or more hospitalizations in the prior 12-month period
- ☐ Frequent or recurrent emergency department visits
- ☐ Documented history of poor adherence to ordered medication regimens
- ☐ Documented history of falls in the prior six-month period
- ☐ Limited or absent informal support systems
- ☐ Living alone or being home alone for extended periods of time
- ☐ Documented history of care access challenges

Additional information related to above risk factors (optional):

Physician's name:

Address/City/ZIP:

Telephone number:	Fax number:

TPI:	NPI:	Taxonomy:

My signature confirms the following:

- The client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data, unless the equipment does not require active participation from the recipient
- The client is not currently receiving duplicate services via disease management services
- Monitoring of the client's clinical data is not duplicated by any other provider.

Physician's signature:	Date signed: