CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

General Information

- Ensure the most recent version of the CSHCN Services Program Prior Authorization Request for Prescribed Pediatric Extended Care (PPECC) Services is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form**, according to the instructions. Signatures are required as indicated.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- Submit only the referral and treatment plan form. **Do not submit instruction pages.**
- Submit the PPECC nursing assessment and plan of care along with this completed form. The PPECC services must be ordered as part of the plan of care. The PPECC can submit their plan of care document as well.
- **Refer to:** The Prescribed Pediatric Extended Care Services section of the current *Children with Special Health Care Needs (CSHCN) Services Program Provider Manual*.

Submission Information

- This form can be submitted to TMHP using the TMHP **PA on the Portal** (click "PA on the Portal" and enter your TMHP portal account username and password).
- With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision.
- This form can also be submitted by fax to 1-512-514-4222, or submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727

Prior Authorization Request Submitter Certification Statement

Description
Read the certification statement and select "We Agree."

Section A: Completed By Ordering/Prescribing Physician

Field Description	Guidelines
Client Information	
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.
Gender	Check the appropriate box to identify the client's gender.
Date of birth	Enter the client's date of birth 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.
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP.

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Field Description	Guidelines
Diagnoses and known allergies	Enter the diagnosis code relevant to the client's condition and any known allergies.
Date client last seen by ordering/prescribing physician	The ordering/prescribing physician must be familiar with the client and the client's medical condition(s) and must have examined the client within 30 days prior to initiation of PPECC services. (This date must be within 30 days of the start of care date.)
Ordering/Prescribing Physician Information	
Name	Enter the ordering/prescribing physician's name.
NPI	Enter the ordering/prescribing physician's National Provider Identifier (NPI).
CSHCN TPI	Enter the ordering/prescribing physician's CSHCN Texas provider identifier (TPI).
License number	Enter the ordering/prescribing physician's license number.
Telephone number	Enter the ordering/prescribing physician's telephone number.
Address/City/State/ZIP	Enter the ordering/prescribing physician's address, city, state, and ZIP.
Physician Ordered Services	Check each box that applies for the services that have been ordered by the physician to be rendered in the PPECC. Add additional comments as necessary.
Prior authorization for PT, OT, ST, hospice, and/or respiratory therapy services (if applicable)	If known, include the authorization number of the PT, OT, ST, hospice, and/or respiratory therapy services that have been authorized separately.
Client's current diagnoses and medical condition(s)	Describe the client's current diagnoses and medical condition(s). Include documentation of medical necessity that indicates the client's need for on-going skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services for chronic conditions not expected to resolve in 60 calendar days or less. (Attach additional documents as necessary.)
Ordering or Prescribing Physician Signature	The form must be signed and dated by the ordering or prescribing physician. A valid electronic signature is accepted.
Plan of Care (POC)	A signed and dated copy of the POC must be submitted with the Prior Authorization request. The POC must be signed before the Start of Care (SOC) date by the practitioner who ordered PPECC services
Ordering or Prescribing Physician's signature and date	Verbal orders are not accepted. The form must be signed and dated by the ordering or prescribing physician and the PPECC provider. All signatures must be current, unaltered, original, and handwritten.
Services Client Currently Receives at Home	Check all services the client is currently receiving at home and include the amount, duration, and frequency of the services. Check "unknown" if the information is not available.

Section B: Completed by PPECC Facility

Field Description	Guidelines
Client First Name	Enter the client's first name.
Client Last Name	Enter the client's last name.
Gender	Check the client's gender.
Date of Birth	Enter the client's date of birth.
CSHCN Services Program number	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form.
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

Field Description	Guidelines
Diagnoses	Enter the diagnosis code relevant to the client's condition and any known allergies.
PPECC Facility name	Enter the name of the PPECC Facility
PPECC Facility NPI	Enter the National Provider Identifier (NPI) of the PPECC facility.
PPECC Facility CSHCN TPI	Enter the provider's CSHCN Texas provider identifier (TPI).
Taxonomy code	Enter the provider's taxonomy code.
Benefit code	Benefit code "CSN" is prepopulated in this field.
Contact name	Enter the contact person's name.
Telephone number	Enter the provider's telephone number.
Fax number	Enter the provider's fax number.
Address/City/State/ZIP	Enter the PPECC facility's address, city, state, and ZIP.
Request status:	Check the appropriate type of service being requested: new request, extension of an existing request, update to an existing request.
Requested procedures	Check the type of services requested and include the procedure code that will be billed on the claim. Include a description of the nursing services required and include any necessary additional information.
Start of Care Date (mm/dd/yy)	Indicate the start of care date
End of Care Date (mm/dd/yy)	Indicate the end of care date
Scheduled days	Check the days the client will receive services at the PPECC facility.
Hours of Attendance	Provide the information requested concerning the client's attendance in the PPECC facility. The total number of hours cannot exceed 400 hours.
Original Start of Care Date (mm/dd/yy) (if request is extension or revision)	If this request is for an extension or revision, indicate the original start of care date.
Original End of Care Date (mm/dd/yy) (if request is extension or revision)	If this request is for an extension or revision, indicate the original end of care date.
Reason hours were not used for original request (if revision/extension):	Indicate the reason the hours were not used for original request (if revision/extension).
Date the PPECC nursing assessment was completed	Enter the date the PPECC nursing assessment was completed.
Name of RN who completed the nursing assessment	Enter the name of the RN who completed the nursing assessment.
Title	Enter the title of the RN who completed the nursing assessment.
Credentials	Enter the credentials of the RN who completed the nursing assessment.
Signature/Date	The signature of the RN who completed the nursing assessment.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

Field Description	Guidelines
PPECC Plan of Care (POC)	The PPECC POC must be initiated, signed, and dated by a qualified individual (e.g., registered nurse, advanced practice registered nurse, physician assistant, or physician who is employed by the PPECC in coordination with the interdisciplinary team). The POC must also be signed and dated by the client or the client's responsible adult before the start of care. The POC must be submitted with this prior authorization request and must include the following: • Client information: name, date of birth, gender, and CSHCN Services Program client number • The ordering/prescribing physician's license number • The PPECC provider's CSHCN Services Program Texas Provider Identifier (TPI) • Date the PPECC nursing assessment was completed • The name, title, credentials, and signature of the team member preparing the POC • Date the client was last seen by the ordering/prescribing physician • The Start Of Care (SOC) date for PPECC services, including scheduled days, and hours of attendance • All diagnoses and known allergies • Prognosis • Nursing services requested including amount , duration, and frequency • The client's mental status • The types of therapies requested including amount, duration, and frequency • Equipment and supplies needed • Rehabilitation potential • Prior and current functional limitations • Activities permitted • Nutritional requirements including type, method of administration, and frequency • Mediations including dose, route, and frequency • Treatments including amount and frequency • Wound care orders and measurements • Safety measures to protect against injury • Method of transportation to the PPECC • Discharge Plan • Responsible adult training needs
Name of PPECC team member who prepared the POC	Enter the name of PPECC team member who prepared the POC. This is the team member who prepared the client's POC for PPECC services.
Title	Enter the title of the PPECC team member who prepared the POC.
Credentials	Enter the credentials of the PPECC team member who prepared the POC.
Signature/Date	The signature of the PPECC team member who prepared the POC. The PPECC team member who prepared the PPECC POC must be the person who signs this section of the prior authorization form.
Certification and PPECC Representative Signature	Check the boxes to confirm the attestation statements.
PPECC representative's signature and date	Verbal orders are not accepted. The form must be signed and dated by the ordering/prescribing physician and the PPECC provider. All signatures must meet the requirements listed in Chapter 4, "Authorizations," in the current *CSHCN Services Program Provider Manual*.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

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

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section A: Completed by Ordering/Prescribing Physician	
Client Information	
First Name:	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:
CSHCN Services Program Client Number: 9-__________________________-00	
Address (Street, City, State, ZIP):	
Diagnoses and known allergies:	
Date client last seen by ordering/prescribing physician:	
Ordering or Prescribing Physician Information	
Name:	
NPI:	CSHCN TPI:
License number:	Telephone number:
Address (Street, City, State, ZIP):	

Physician Ordered PPECC Services for this Prior Authorization Request	
Type of PPECC Service	**Additional Comments**
☐ Nursing services	
☐ Medication administration	
☐ Diet and nutritional needs	
☐ Permitted activity level	
☐ Other (e.g., psychosocial, functional/ developmental)	
☐ Transportation provided by:	☐ Responsible adult ☐ PPECC ☐ Other (specify):

Note: *Physical therapy (PT), occupational therapy (OT), speech therapy (ST), hospice and respiratory therapy services will not be prior authorized using this form. Therapy and hospice services must be prior authorized separately using the appropriate CSHCN Services Program prior authorization form.*

Prior authorization number for PT, OT, ST, hospice, and/or respiratory therapy services (if applicable):

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Section A: Completed by Ordering/Prescribing Physician

Statement of Medical Necessity and Provider Signature

Describe the client's current diagnoses and medical condition(s). Include documentation of medical necessity that indicates the client's need for on-going skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services for chronic conditions not expected to resolve in 60 calendar days or less. (Attach additional documents as necessary.)

Current diagnoses and medical condition(s):

Documentation of medical necessity:

Ordering or Prescribing Physician Signature

☐ *I certify that the patient's medical condition is such that the treatment requested above is medically necessary.*

Signature:	Date:

Services Client Currently Receives at Home

Type	Amount	Duration	Frequency	Unknown
☐ Nursing services				☐ Unknown
☐ Physical Therapy				☐ Unknown
☐ Occupational Therapy				☐ Unknown
☐ Speech Therapy				☐ Unknown
☐ Dietary/nutritional				☐ Unknown
☐ Respiratory				☐ Unknown
☐ Hospice				☐ Unknown
☐ Other:				☐ Unknown

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Section B: Completed by PPECC Facility

Client Information

First Name:	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:

CSHCN Services Program Client Number: 9-______________________________ -00

Address (Street, City, State, ZIP):

Diagnoses:

PPECC Provider Information

Facility name:

Facility NPI:	Facility CSHCN TPI:
Taxonomy code:	Benefit code: **CSN**

Contact name:

Telephone number:	Fax number:

Address (Street, City, State, ZIP):

Type of Request

Request status: ☐ New ☐ Revision ☐ Extension – Initial SOC Date (mm/dd/yy):

Requested Procedure(s)

Type of services requested	**Procedure code**	
☐ PPECC services		
☐ Transportation		Method of transportation to PPECC:

Describe the PPECC services required and include any necessary additional information *(Refer to the appropriate manual section for specific prior authorization requirements)*:

Days/Hours Requested

Start of Care Date (mm/dd/yy) this request: ☐ N/A	End of Care Date (mm/dd/yy) this request: ☐ N/A

Scheduled days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Hours of Attendance:

# of Weeks	**# of Days/Wk**	**# of Hrs/Day**	**Total Hrs this request**	**Original # of Hrs Used (if revision/extension)**	**Total # of Hrs per Yr *(*Not to exceed 400 Hrs)***

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Section B: Completed by PPECC Facility	
Original Start of Care Date (mm/dd/yy) if revision/extension: ☐ N/A	Original End of Care Date (mm/dd/yy) if revision/extension: ☐ N/A
Reason hours were not used for original request (if revision/extension):	
Initial Nursing Assessment (*The PPECC nursing assessment must be submitted with this prior authorization request.*)	
Date the PPECC nursing assessment was completed:	
Name of RN who completed the nursing assessment:	
Title:	Credentials:
Signature:	Date:
PPECC Plan of Care (POC) – *The Plan of Care (POC) must be submitted with this prior authorization request and must include all of the information listed below:*	
Last seen by ordering/prescribing physician:	
The client's mental status:	
All diagnoses and known allergies: **Diagnoses:** **Known allergies:**	
Functional limitations: **Prior:** **Current:**	
Rehabilitation potential:	
Permitted activity level:	
Prognosis:	
Responsible adult training needs:	
Equipment and supplies needed:	

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Section B: Completed by PPECC Facility

Nursing, therapy, and other services requested:

Type	Hours/Day	Days/Wk	# of Weeks	Total Hours *(*Not to exceed 400 Hrs/Yr)*
☐ Nursing Services				
☐ Occupational Therapy*				
☐ Physical Therapy*				
☐ Speech Therapy*				
☐ Respiratory Therapy*				
☐ Psychosocial Services				
☐ Nutritional/dietary				
☐ Transportation Services				
☐ Caregiver Training				
☐ Hospice*				
☐ Other				

*** Note:** *PT/OT/ST, hospice, and respiratory therapy services will not be prior authorized using this form. Therapy and hospice services must be prior authorized separately using the appropriate form.*

Treatments:

Type	Amount	Frequency

Wound care orders and measurements:

Orders	Measurements

Nutritional requirements:

Diet	Method of administration	Frequency

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Section B: Completed by PPECC Facility

Medications:

Medication	Dose	Route	Frequency	Medication	Dose	Route	Frequency

Safety measures to protect against injury:

Discharge plan:

PPECC Team Member Who Prepared the POC

Name of PPECC team member who prepared the POC:

Title:

Credentials:

Signature:

Date:

Certification and PPECC Representative Signature

By signing this form:

- ☐ *I certify that the client named above requires care as indicated on this prior authorization request form.*
- ☐ *I certify that the PPECC Nursing Assessment and the Plan of Care for the identified client have been attached to this prior authorization request and include measurable goals and objectives.*

PPECC representative signature:

Date: