CSHCN Services Program Authorization and Prior Authorization Request for Cardiorespiratory Monitor (CRM) Form and Instructions

General Information

- Ensure the most recent version of the Authorization and Prior Authorization Request for Cardiorespiratory Monitor form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization and prior authorization*** requests will cause the claim to be 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, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- Submit only the authorization form. **Do not submit instruction pages**.
- **Refer to:** The "Respiratory Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.
- ***Please note***: The initial long term device rental is six months with a three month extension for a maximum of nine months.

Submission Instructions:

- 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 #150 MC-A11
Austin, TX 78727

Prior Authorization Request Submitter Certification Statement

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

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/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnoses	Enter the diagnosis code(s) relevant to the need for the cardiorespiratory device
Date the client was last seen by the ordering physician	Enter the date the client was last seen by the physician ordering the cardiorespiratory device

Equipment Information - Required for *all* equipment requests.

Field Description	Guidelines
Dates of Service	Enter the "From" and "To" date(s) of service for the equipment rental or purchase
HCPCS Code	Enter the procedure code for the requested equipment
Description	Enter the description of the required equipment
Quantity/Frequency	Enter the quantity and frequency for the equipment
Rental/Purchase	Indicate if this request is an intial request, a request to extend a previously-approved rental, or a request to purchase the equipment

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Statement of Medical Necessity

Field Description	Guidelines
After the two-month rental for infants birth through 4 months of age, continuation may be considered with prior authorization which must include all the following	Indicate by checkmarks that the documentation includes both criteria. Submit this request form with the documentation of the 2 month rental for central apnea (Respiratory control disorders) or cardiac rhythm issues. Describe the client's on-going, documented cardiorespiratory episodes in the Comments section of the request form.
A CRM with or without recording feature (procedure code E0618 or E0619) may be considered with prior authorization for rental or purchase for clients 5 months of age or older with one of the following conditions	Indicate by checkmark(s) the conditions applicable to the client
Provider Comments	Add additional comments as necessary and appropriate.

Ordering Physician Information and Required Signature

Field Description	Guidelines
Type or print physician's name	Enter the ordering physician's name
CSHCN TPI	Enter the ordering physician's CSHCN Texas Provider Identifier (TPI)
NPI	Enter the ordering physician's National Provider Identifier (NPI)
Taxonomy code	Enter the ordering physician's taxonomy code
Benefit code	CSN is automatically populated in this field
Telephone number	Enter the ordering physician's telephone number
Fax number	Enter the ordering physician's fax number
Provider Signature	The ordering physician must sign in this field
Date Signed	Enter the date the form is signed

Provider / Supplier Information and Required Signature

Field Description	Guidelines
Provider / Supplier's Name	Enter the provider / supplier's name
Supplier Representative's Name	Enter the provider / supplier's contact person's name
CSHCN TPI	Enter the provider's CSHCN Texas Provider Identifier (TPI)
NPI	Enter the provider's National Provider Identifier (NPI)
Taxonomy code	Enter the provider's taxonomy code
Benefit code	CSN is automatically populated in this field
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/State/ZIP	Enter the provider's address, city, state, and ZIP
Suppler Representative's Signature	The supplier must sign in this field
Date Signed	Enter the date the form is signed

Additional Requirement

- Leads and electrodes for use with an apnea monitor owned by the client must be prior authorized.

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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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Client Information					
First name:		Last name:			
CSHCN Services Program number: 9-_____-00		Date of birth:			
Address/City/State/ZIP:					
Diagnoses:					
Date the client was last seen by the ordering physician:					

Equipment Information (*required for all equipment requests*)					
Dates of Service and HCPCS Code(s) Requested					
Dates of Service From: To:					
HCPCS Code	Description	Quantity/Frequency	Rental or Purchase *		
			☐ Initial	☐ Extention	☐ Purchase
			☐ Initial	☐ Extention	☐ Purchase
			☐ Initial	☐ Extention	☐ Purchase
			☐ Initial	☐ Extention	☐ Purchase
* Initial rentals are for 6 months. Extentions are for an additional 3 months of a previously-approved rental.					

Statement of Medical Necessity
Prior authorization of rental is *not* required for infants birth through 4 months of age for a maximum of two months *with documentation of* central apnea (respiratory control disorders) or cardiac rhythm issues. After the two-month rental for infants birth through 4 months of age, continuation may be considered with prior authorization, which must include all of the following *(submit this request form with documentation of the two-month rental for central apnea [respiratory control disorders] or cardiac rhythm issues):*
☐ The client has on-going, documented cardiorespiratory episodes (describe in the comments section)
☐ A physician interpretation, signed and dated by the physician, of the most recent two-month's CRM downloads
A CRM with or without recording feature (procedure code E0618 or E0619) may be considered with prior authorization for rental or purchase for clients 5 months of age or older with one of the following conditions:
☐ An episode of Apparent Life-Threatening Event in an infant
☐ Symptomatic central apnea
☐ Technology dependence - Mechanical ventilation
☐ Technology dependence - Tracheostomy with a critical airway obstruction
☐ Technology dependence - Assisted ventilation dependence
☐ Technology dependence - Cardiac dysrhythmia with significant risk of morbidity or mortality
Provider Comments:

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Ordering Physician Information and Required Signature		
If ordering only wires and leads, I certify that the client owns their apnea monitor. *I certify that the client's medical condition is such that all equipment requested above is medically necessary.*		
Type or print physician's name:		
CSHCN TPI:	NPI:	
Taxonomy code:	Benefit Code: **CSN**	
Telephone number:	Fax number:	
Physician's Signature:		Date Signed:

Provider / Supplier Information and Required Signature		
Provider / Supplier's Name:		
Supplier Representative's Name:		
CSHCN TPI:	NPI:	
Taxonomy code:	Benefit code: **CSN**	
Telephone number:	Fax number:	
Address/City/State/ZIP:		
Supplier Representative's Signature:		Date Signed: