CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form and Instructions

General Information

- Ensure the most recent version of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices form is submitted. The form is available on the TMHP website at 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, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- Submit only the prior authorization form. **Do not submit instruction pages.**
- **Refer to:** The "Respiratory Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.

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 Code.
Diagnoses	Enter the diagnosis code(s) relevant to the need for a chest physiotherapy device.

Equipment Information (required for *all* equipment requests)

Field Description	Guidelines
Dates of Service	Enter the beginning and end dates for the dates of service the equipment is requested.
HCPCS code(s) Requested	Indicate the Healthcare Common Procedure Coding System (HCPCS) Code(s).
Description	Enter the description of the product including the brand name.
Quantity/Frequency	Indicate the quantity requested, and how long the equipment will be needed in days, weeks, months, or years.
Rental/Purchase	Indicate if the item is to be a rented or a purchased by checking the appropriate box.

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Statement of Medical Necessity for Intitial Requests (*must be completed by prescribing physician*)

Field Description	Guidelines
Percussion Cups	Fill out this section if requesting percussion cups.
Electrical percussors	Fill out this section if requesting electrical percussors.
Cough augmentation devices	Fill out this section if requesting cough augmentation devices
High Frequency Chest Wall Oscillation (HFCWO) system	Fill out this section if requesting HFCWO system
High Frequency Chest Wall Oscillation (HFCWO) vest (purchase)	Fill out this section if requesting HFCWO vest
I am a pulmonologist	Enter Yes or No
Telephone number	Enter the provider's telephone number:
Physician's name	Type or print the physician's name
Physician's signature	The physician can e-sign or handwrite the signature
Date signed:	Enter the date the physician signed this form

Statement of Medical Necessity for Renewal Requests *(must be completed by prescribing physician)*

Field Description	Guidelines
Electrical percussors	Fill out this section if requesting electrical percussors
Cough augmentation devices	Fill out this section if requesting cough augmentation devices
High Frequency Chest Wall Oscillation (HFCWO) system	Fill out this section if requesting HFCWO system
I am a pulmonologist	Enter Yes or No
Telephone number	Enter the provider's telephone number
Physician's name	Type or print the physician's name
Physician's Signature	The physician can e-sign or handwrite the signature
Date Signed	Enter the date the physician signed this form

Provider / Supplier Information and Required Signature

Field Description	Guidelines
Provider / Supplier Name	Enter the supplier's name
Supplier Representative's Name	Enter the supplier representative's name
CSHCN TPI	Enter the provider's Texas provider identifier (TPI)
NPI	Enter the provider's national provider identifier (NPI)
Taxonomy code	Enter the provider's taxonomy code
Benefit code	Benefit code **CSN** has been autopopulated 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 Code
Supplier Representative's Signature	The supplier must sign in this field
Date Signed	Enter the date the form is signed

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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 prescribing physician:	

Equipment Information (required for *all* equipment requests) *

Dates of Service and HCPCS code(s) Requested:

Dates of Service From: To:

HCPCS Code	Item Description	Quantity/Frequency	Rental/Purchase	
			☐ Rental	☐ Purchase
			☐ Rental	☐ Purchase
			☐ Rental	☐ Purchase
			☐ Rental	☐ Purchase
			☐ Rental	☐ Purchase

* ***If more than one secretion and mucus clearance device is required, the prescribing physician must be a pulmonologist.***

Statement of Medical Necessity for Initial Requests (*must be completed by the prescribing physician*)

Percussion Cups

Include statement of medical necessity:

Electrical percussors

Have other devices for airway mucus clearance been tried and failed?	☐ Yes	☐ No

Describe below all previous courses of therapy and why they did not adequately clear airway mucus:

Cough augmentation devices

Client has a weak, ineffectual, or absent cough caused by chronic pulmonary disease or a neuromuscular disorder?	☐ Yes	☐ No
Client had respiratory illness or complication in the past six months. Provide additional information in comments section below, (i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations.)	☐ Yes	☐ No
Client had pulmonary function studies in last six months, if applicable. Provide results in comments section below.	☐ Yes	☐ No
Client has a history of school, work, or extracurricular activity absences due to diagnosis related symptoms. Provide history in comments section below.	☐ Yes	☐ No

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Cough augmentation devices (*cont.*)		
There are medical reasons why the client, parent, guardian or caregiver cannot do chest physiotherapy, or why the chest physiotherapy is ineffective? Provide medical explanation below.	☐ Yes	☐ No
Additional comments:		

High Frequency Chest Wall Oscillation (HFCWO) System		
Documentation that the client has one of the medical conditions listed above and has used a cough augmentation device for a minimum of three months prior to the request and that this therapy has been ineffective.	☐ Yes	☐ No
Does the client have bronchiectasis confirmed by CT scan and characterized by either a continuous daily productive cough for six months or frequent exacerbations of pulmonary infections (i.e., more than two times per year) requiring antibiotic therapy? Provide type and dates of infections below.	☐ Yes	☐ No
Does the client have cystic fibrosis or other documented chronic supperative endobronchitis?	☐ Yes	☐ No
Does the client have a chronic neuromuscular disorder affecting client's ability to cough or clear respiratory secretions?	☐ Yes	☐ No
Have other devices for airway mucus clearance been tried and failed? Describe all previous courses of therapy and why they did not adequately clear airway mucus in the comments section below.	☐ Yes	☐ No
Has client had a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past six months?	☐ Yes	☐ No
Device use has not resulted in aspiration, exacerbation of any gastrointestinal or pulmonary manifestations, nor caused an exacerbation of seizure activity.	☐ Yes	☐ No
Additional comments:		

Pulmonologist must complete this section if requesting more than one mucus clearance device or when adding an additional mucus clearance device. Provide a complete narrative addressing why both mucus clearing devices are medically necessary to treat the client's respiratory condition.
Additional comments:

High Frequency Chest Wall Oscillation (HFCWO) Vest (purchase)
Include Statement of Medical Necessity:

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Prescribing Physician Certification and Required Signature for Initial Requests			
I certify that the client's medical condition is such that all equipment requested above is medically necessary.			
I am a pulmonologist ☐ Yes ☐ No	Telephone number:		
Type or print physician's name:			
CSHCN TPI:	NPI:	Taxonomy:	Benefit Code: **CSN**
Physician's Signature:	Date signed:		

Statement of Medical Necessity for Renewal Request (*must be completed by prescribing physician*)		
Electrical percussors (*Rental period cannot exceed a maximum of nine months*)		
Length of time requested:		
Is the client compliant with the use of the equipment and is the treatment effective?	☐ Yes	☐ No
Additional comments:		
Cough augmentation devices		
Is the client compliant with the use of the equipment and is the treatment effective?	☐ Yes	☐ No
Additional comments:		
HFCWO system		
Client had respiratory illness or complications since initial authorization, (i.e., nebs for respiratory secretions, I.V. antibiotics, and hospitalizations. Include additional information in comments section below.	☐ Yes	☐ No
Client had decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications. Describe below.	☐ Yes	☐ No
The use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity?	☐ Yes	☐ No
Client has been compliant in use of device. Document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period.	☐ Yes	☐ No
The frequency and compliance graphs from the device for the 6-month period showing use of the system at least 50 percent or 3 months of the maximum time prescribed by the physician for each day.	☐ Yes	☐ No
Note: *The device is available for purchase after the initial rental period with additional documentation.*		
Additional comments:		

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The physician or pulmonologist prescribing a secretion and mucus clearance device must complete this section with narrative information regarding the medical necessity of the devices requested above, or attach a letter with this information.
Additional comments:

Physician Certification and Required Signature for Renewal Requests

I certify that the patient's medical condition is such that all equipment requested above is medically necessary.			
I am a pulmonologist ☐ Yes ☐ No	Telephone number:		
Type or print physician's name:			
CSHCN TPI:	NPI:	Taxonomy:	Benefit Code: **CSN**
Physician's Signature:		Date Signed:	

Provider / Supplier Information and Required Signature (required for *all* equipment requests)

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: