

CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) 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 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 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."

Section A: Client, Provider, and Supplier Information

Field Description	Guidelines
Client name	Enter the client's first and 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
Address/City/State/ZIP:	Enter the client's address
Physician Name	Enter the physician's first and last name
Physician Telephone	Enter the physician's telephone number
Physician License Number	Enter the physician's license number
Physician TPI	Enter the physician's CSHCN Services Program TPI
Physician NPI	Enter the physician's NPI
Supplier Name	Enter the supplier's name
Supplier Representative's Name	Enter the name of the supplier's contact person
Supplier Telephone	Enter the supplier's telephone number
Supplier Fax Number	Enter the supplier's fax number
Address/City/State/ZIP	Enter the supplier's address
Supplier TPI	Enter the supplier's CSHCN Services program TPI
Supplier NPI	Enter the supplier's NPI
Supplier Taxonomy	Enter the supplier's taxonomy code
Supplier Benefit Code	Benefit code CSN has been automatically populated in this field
Supplier Representative's Signature	Supplier must sign and date the form in this field

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Section B: Procedure and Service Information

Field Description	Guidelines
Dates of service	Enter the "From" and "To" dates of service
Choose the procedures being requested and indicate quantity/frequency and rental or purchase	Enter the procedure code, diagnosis, and Quantity in the top three fields. Enter the Description, condition, and frequency in the bottom three fields. Choose "Initial rental" and enter the # of months to be rented, or choose "Purchase" by checking the appropriate box.

Section C: Medical Necessity for CPAP or RAD

Field Description	Guidelines
Client age	Enter the client's age
Physician's expected length of treatment	Enter the expected duration of treatment
Diagnosis	Enter the applicable diagnosis code(s)
Medical necessity information	Enter the information as requested
Subsection C1: Medical Necessity for CPAP System	Complete the information as requested for the initial request
Subsection C2: Respiratory Assist Devices (RADs)	Complete the information as requested for the initial request for RADs, including BiPAP

Section D: Rental Extension or Purchase (after 3 month rental) (Must be completed by physician)

Field Description	Guidelines
Choose one (as appropriate for this extension/purchase request)	Choose the most appropriate option.
For continued rental of RAD with or without set backup rate	Enter the information as requested.
For purchase or continued rental, choose all that apply	Choose all that apply and enter the information as requested.

Section E: Prescribing Physician Signature

Field Description	Guidelines
Prescribing Physician specialist's signature	The prescribing physician specialist must sign this form
Date	Enter the date the form was 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

CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form

Section A: Client, Physician, and Supplier Information

Client Information			
First Name:		Last Name:	
CSHCN Services Program Number: 9- _____ -00		Date of Birth:	
Address/City/State/ZIP:			
Physician Information			
Name:		Telephone:	Fax Number:
License Number:	CSHCN TPI:		NPI:
Supplier Information			
Supplier Name:		Supplier Representative's Name:	
Telephone:		Fax Number:	
Address/City/State/ZIP:			
TPI:	NPI:	Taxonomy:	Benefit Code: CSN
Supplier Representative's Signature:			Date:

Section B: Procedure and Service Information

Dates of Service From: _____		To: _____		
Choose the procedures being requested and indicate quantity/frequency and rental or purchase:				
	Procedure Code	Diagnosis	Quantity	Rental / Purchase
	Description	Condition	Frequency	Initial / Extension
CPAP device (for obstructive sleep apnea or other with medical necessity)				<input type="checkbox"/> Initial rental: _____ months (3 month max allowed)
				<input type="checkbox"/> Purchase
RADs including Bi-Level PAP <i>without</i> set backup respiratory rate				<input type="checkbox"/> Initial rental: _____ months (3 month max allowed)
				<input type="checkbox"/> Extension <input type="checkbox"/> Purchase
RADs including Bi-Level PAP <i>with</i> set backup respiratory rate				<input type="checkbox"/> Initial rental: _____ months (3 month max allowed)
				<input type="checkbox"/> Extension <input type="checkbox"/> Purchase
Humidification device used with CPAP device or RAD				<input type="checkbox"/> Initial rental: _____ months (3 month max allowed)
				<input type="checkbox"/> Extension <input type="checkbox"/> Purchase

Note: Tubing, filters, headgear, masks, and other client interfaces are included in the CPAP/RAD rental and will not be prior authorized or reimbursed separately.

Section C: Medical Necessity for CPAP or RAD

Client age:	Physician's expected length of treatment:
Diagnosis:	
Date of Polysomnogram:	AHI/RDI: _____ events per hour
Sleep Time (hours):	Total Apneas:
Obstructive apneas:	Lowest Oxygen Saturation (percent):

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Section C: Medical Necessity for CPAP or RAD (cont.)

Excessive daytime sleepiness (documented by either Epworth Sleepiness Scale [ESS] _____, or multiple sleep latency test [MSLT] _____)

Client's blood pressure supporting a diagnosis of hypertension:

Number of episodes of oxygen desaturation to less than 85 percent during a full night sleep study:

Any one episode of oxygen desaturation to less than 70 percent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Documented symptoms of impaired cognition, mood disorders, or insomnia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Documented ischemic heart disease or previous myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Documented history of stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Documented pulmonary hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Adenoidectomy or Tonsillectomy is contraindicated delayed unsuccessful (*attach explanation*)

If request is for **Bi-level CPAP without set back-up respiratory rate**, explanation of the inability to tolerate CPAP:

Comments:

Subsection C1: Medical Necessity for CPAP System *(Complete the following information for the initial request.)*

Diagnosis: Obstructive sleep apnea Other (*specify and attach documentation*):

Client's condition: (*Attach documentation for these conditions*)

- | | |
|---|--|
| <input type="checkbox"/> Excessive daytime sleepiness (documented by either Epworth Sleepiness Scale (ESS) 10 or greater, or multiple sleep latency test (MSLT) less than 6
<input type="checkbox"/> Documented symptoms of impaired cognition, mood disorders, or insomnia
<input type="checkbox"/> Documented hypertension (Systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
<input type="checkbox"/> Documented ischemic heart disease or previous myocardial infarction | <input type="checkbox"/> Documented history of stroke
<input type="checkbox"/> Greater than 20 episodes of oxygen desaturation to less than 85 percent during a full night sleep study
<input type="checkbox"/> Any one episode of oxygen desaturation to less than 70 percent
<input type="checkbox"/> Documented pulmonary hypertension
<input type="checkbox"/> Adenoidectomy or tonsillectomy is contraindicated
<input type="checkbox"/> Adenoidectomy or tonsillectomy is delayed
<input type="checkbox"/> Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA |
|---|--|

For purchase only: CPAP used for _____ hours per 24 hr period for: _____ days

Comments:

Subsection C2: Respiratory Assist Devices (RADs) *(Complete the following information for the initial request for RADs, including BiPAP.)*

Diagnosis: (*Include sleep study documenting this diagnosis.*)

- | | |
|--|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (OSA)
<input type="checkbox"/> Restrictive Thoracic disorders i.e., neuromuscular diseases or severe thoracic cage abnormalities
<input type="checkbox"/> Severe chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Central Sleep Apnea (CSA)
<input type="checkbox"/> Complex Sleep Apnea (CompSA)
<input type="checkbox"/> Hypoventilation syndrome
<input type="checkbox"/> Other (<i>specify and attach documentation</i>): |
|--|---|

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Section C: Medical Necessity for CPAP or RAD (cont.)		
Condition	Medical Necessity Information for RAD <i>without</i> set back-up rate	Medical Necessity Information for RAD <i>with</i> set back-up rate
Obstructive Sleep Apnea	<p>Complete the CPAP section (Subsection C1) and submit all required documentation as indicated in the CPAP section.</p> <p>Choose one:</p> <p><input type="checkbox"/> The CPAP trial failed to be effective in treating the client's OSA (Include documentation from the treating physician)</p> <p><input type="checkbox"/> CPAP was found to be ineffective during the initial facility based on sleep laboratory titration trial (Include the sleep study results from the facility. A new face to face clinical evaluation or a new sleep test is not required.)</p>	N/A
Restrictive Thoracic Medical Conditions – Severe Thoracic Cage Abnormality	<p>Complete the following for RAD without set back-up rate:</p> <p>Client diagnosis:</p> <p><input type="checkbox"/> Severe thoracic cage abnormality (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort. Specify: _____</p> <p>Oxygen Information:</p> <p>ABG PaCO2: _____ mm Hg</p> <p>Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2:</p> <p>O2 Sat.: _____ % For: _____ min</p> <p>Nocturnal recording time: _____ hrs (breathing routinely prescribed FIO2)</p>	<p>Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:</p> <p>Client has tried a RAD without a back-up rate for: _____ days</p> <p>Client was compliant in use of the device using on average: _____ hrs in a 24 hr period</p> <p><input type="checkbox"/> The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate (attach documentation)</p>
Restrictive Thoracic Medical Conditions – Neuromuscular Disorder	<p>Complete the following for RAD without set back-up rate:</p> <p>Client diagnosis:</p> <p><input type="checkbox"/> Neuromuscular disorder (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) negatively impacting the client's respiratory effort (Provide documentation that supports maximal inspiratory pressure is < 60 cm H2O, or forced vital capacity is < 50% of predicted.) Specify: _____</p> <p>Oxygen Information:</p> <p>ABG PaCO2: _____ mm Hg</p> <p>Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2:</p> <p>O2 Sat.: _____ % For: _____ min</p> <p>Nocturnal recording time: _____ hrs (breathing routinely prescribed FIO2)</p> <p>Maximal inspiratory pressure: _____ cm H2O</p> <p>Forced vital capacity: _____ %</p>	<p>Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:</p> <p>Client has tried a RAD without a back-up rate for: _____ days</p> <p>Client was compliant in use of the device using on average: _____ hrs in a 24 hr period</p> <p>The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate (attach documentation)</p>

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Section C: Medical Necessity for CPAP or RAD (cont.)		
Condition	Medical Necessity Information for RAD <i>without</i> set back-up rate	Medical Necessity Information for RAD <i>with</i> set back-up rate
Severe COPD	<p>Complete the following for RAD <i>without</i> set back-up rate:</p> <p><input type="checkbox"/> Client has a diagnosis of sleep apnea (<i>Include documentation of sleep apnea and that treatment with a CPAP has been considered and ruled out. Include an explanation of why CPAP has been ruled out.</i>)</p> <p>ABG PaCO₂: _____ mm Hg</p> <p>Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2LPM or the client's prescribed FIO₂ (whichever is higher).</p> <p>O₂ Sat.: _____ % For: _____ min</p> <p>Choose one:</p> <p>FIO₂: _____ O₂: _____ LPM</p> <p>Nocturnal recording time: _____ hrs (breathing routinely prescribed _____ FIO₂ or _____ oxygen)</p> <p>Complete the following:</p> <p><input type="checkbox"/> If CPAP was tried and found ineffective, complete the CPAP section (Subsection C1) and submit all required documentation as indicated in the CPAP section. Indicate why CPAP was found to be ineffective (<i>attach explanation</i>)</p> <p><input type="checkbox"/> To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the client's medical record submitted with the request that demonstrates the client does not have some form of OSA, CSA, or CompSA as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation (<i>attach explanation</i>)</p>	<p>Complete the required information for RAD <i>without</i> set back-up rate (at left), and complete the following additional information for RAD <i>with</i> set back-up rate:</p> <p>Client has tried a RAD without a back-up rate for: _____ days</p> <p>Client was compliant in use of the device using on average: _____ hrs in a 24 hr period</p> <p>The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate (<i>attach documentation</i>)</p>
Central or Complex Sleep Apnea	<p>Complete the following for RAD <i>without</i> set back-up rate:</p> <p>Client Diagnosis: (<i>Choose one</i>)</p> <p><input type="checkbox"/> Central Sleep Apnea</p> <p><input type="checkbox"/> Complex Sleep Apnea</p> <p>Indicate which of the following is documented by the sleep study:</p> <p><input type="checkbox"/> The sum total of central hypopneas plus central apneas is greater than 50% of the total apneas and hypopneas rate: _____ %</p> <p><input type="checkbox"/> A central hypopnea/apnea rate index _____ events per hour and significant improvement of the sleep associated Hypoventilation while breathing the client's prescribed FiO₂</p> <p><input type="checkbox"/> Attach documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated Hypoventilation</p>	<p>Complete the required information for RAD <i>without</i> set back-up rate (at left), and complete the following additional information for RAD <i>with</i> set back-up rate:</p> <p>Client has tried a RAD without a backup rate for: _____ days</p> <p>Client was compliant in use of the device using on average: _____ hrs in a 24 hr period</p> <p><input type="checkbox"/> The desired therapeutic respiratory response was not achieved with the RAD without a set back up rate (<i>attach documentation</i>)</p>

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Section C: Medical Necessity for CPAP or RAD (cont.)		
Condition	Medical Necessity Information for RAD <i>without</i> set back-up rate	Medical Necessity Information for RAD <i>with</i> set back-up rate
Hypoventilation Syndrome	<p>Complete the following for RAD without set back-up rate:</p> <p>ABG PaCO₂: _____ mm Hg (Obtained while awake breathing routinely prescribed FIO₂.)</p> <p><input type="checkbox"/> A spirometry shows a forced expired volume in 1 sec (FEV1) _____% or the forced vital capacity (FVC): _____%</p> <p>Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours) not caused by obstructive upper airway events.</p> <p>O₂ Sat.: _____% For: _____ min: nocturnal recording time _____ hrs</p>	<p>Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:</p> <p><input type="checkbox"/> The client meets the criteria for RAD without a back-up rate for hypoventilation syndrome, and desired respiratory therapeutic effects were not achieved with the RAD without a backup rate (attach documentation)</p> <p><input type="checkbox"/> The polysomnogram provides documentation of Hypoventilation syndrome, and the physician documents that the desired respiratory therapeutic effects were not achieved with the RAD without a back-up rate (attach relevant documentation)</p>
Comments:		
Section D: Rental Extension or Purchase (after 3-month rental) (must be completed by physician)		
<p>Choose one (as appropriate for this extension/purchase request):</p> <p>Purchase of RAD: <input type="checkbox"/> Without set back-up rate</p> <p>Continued rental of RAD: <input type="checkbox"/> Without set back-up rate <input type="checkbox"/> With set back-up rate</p> <p>For continued rental of RAD with or without set back-up rate:</p> <p>PaCO₂: _____ mm Hg OR CBG: _____</p> <p>For purchase or continued rental, choose all that apply:</p> <p><input type="checkbox"/> The client has completed an initial 3-month rental period. Dates of rental: _____ through _____</p> <p><input type="checkbox"/> Client is compliant in use of the device using on average: _____ hrs in a 24 hr period for _____ days.</p> <p><input type="checkbox"/> Medical necessity documentation attached indicating that the client's symptoms are improved with use.</p>		
Documentation of effectiveness:		
Comments:		
Section E: Prescribing Physician Signature		
<i>I certify that the client's medical condition is such that all equipment requested above is medically necessary.</i>		
Prescribing Physician's Signature:	Date:	