CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services Form and Instructions

General Information

- Ensure the most recent version of the Authorization Request for Non-Face-to-Face Clinician-Directed Coordinated Care form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization*** requests will cause the claim to be denied.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 800-568-2413, Monday through Friday, from 7 a.m. to 7p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

- This form may be submitted by fax to 512-514-4222.
- Submit only the authorization form. Do not submit instruction pages.
- **Refer to:** The "Physician" chapter in the current *CSHCN Services Program Provider Manual.*

Prior Authorization Request Submitter Certification Statement

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

ClientInformation

FieldDescription	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 asindicated 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.
Diagnosis	Enter the diagnosis code relevant to the client's condition.

Certification

Field Description	Guidelines
Date of my last face-to-face inpatient or outpatient evaluation and management visit with the client	Indicate the date of the last face-to-face inpatient or outpatient evaluation and management visit with the client.
Six-month authorization period	Indicate the to and from date of the 6-month authorization period.
Types of service	Check the appropriate type of service being requested.

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Documentation

Field Description	Guidelines
One of the following must be submitted with this authorization form in order to obtain a six-month authorization for non-face-to-face care coordination services:	
Formal and written care plan	Submit a formal written care plan.
A progress note detailing care coordination planning and activities	Submit a progress note detailing care and coordination planning and activities.
A letter stating medical necessity for care coordination and including information on the care plan and care coordination services	Submit a letter stating medical necessity for care coordination and including information on the care plan and care coordination services.

Requesting Provider Information and Required Signature

Field Description	Guidelines
Clinician provider name*	Enter the clinician provider's name.
TIN*	Enter the clinician provider's Tax Identification Number (TIN).
NPI*	Enter the clinician provider's national provider identifier (NPI).
Taxonomy code*	Enter the clinician provider's taxonomy code.
Benefit code*	Enter CSN.
Telephone number	Enter the clinician provider's telephone number.
Fax number	Enter the clinician provider's fax number.
Address/City/State/ZIP+4*	Enter the clinician provider's address, city, state, and ZIP+4.
Clinician provider signature	Clinician provider must sign in this field.
Date	Enter the date the form is signed.

Additional Requirements

Documentation of the following components must be submitted with the authorization form to obtain an initial authorization or renewal:

- A current medical summary, containing key information about the client's health (e.g. conditions, complexity, medications, allergies, past surgical procedures, etc.).
- A current list of the main concerns as well as key strengths and assets, and the related current clinical information.
- Planned action steps or interventions to address the concerns and to sustain or build strengths, with the expected outcomes.
- Persons responsible.
- Timeframes or due dates.

* Essential/Critical field

The supporting documentation can be in the form of:

- Formal written care plan.
- Progress note detailing the care coordination planning.
- Letter of medical necessity detailing the care plan oversight and care coordination.

Authorization is limited to a maximum of six months. Subsequent periods of authorization require submission of a new request with documentation supporting medical necessity for ongoing services.

* Essential/Critical field

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Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account username and password. To submit by fax, send to **512-514-4222.**

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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 relevant *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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Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Client Information

First name*:	Last name*:
CSHCN Services Program number*: 9-_____-00	Date of birth*:
Address/City/State/ZIP:	
Diagnoses:	

Certification

Complete all fields

☐ *I attest that this client's health care is medically complex and multidisciplinary.*

☐ *Medically complex health care is health care provided by a clinician that requires coordination of various treatment modalities or a multidisciplinary approach due to the client's moderate or severe health condition, physical or functional limitations, or health risk factors.*

☐ *Multidisciplinary health care is the coordination of clinician-ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental, or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For CSHCN Services Program coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by non-clinical providers as required to address the overall health needs of a client.*

Date of my last face-to-face inpatient or outpatient evaluation and management visit with the client:

I request a six-month authorization from _____ to _____ for non-face-to-face care coordination services for the client named on this form. I attest that these services are essential to provide quality health care for the identified client. I request authorization for the following types of services in the stated six-month period (check all that apply):

☐ *Non-face-to-face prolonged services (authorization and reimbursement are limited to a maximum of 90 minutes once per client per provider.**)*

** *I understand that I may submit a statement of medical necessity or progress note with a claim or with this authorization form for consideration of authorization of services that exceed the CSHCN Services Program limits indicated above. Documentation must support a significant change in the client's clinical condition.*

☐ *Care plan oversight:* ☐ *Home or other* ☐ *Home health**** ☐ *Hospice****

(Authorization and reimbursement are limited to one service monthly per six-month authorization period without exception.)

*** *I attest that I am the clinician who signed the plan of care for the home health agency or hospice; I do not have a significant financial or contractual relationship with the home health agency or hospice. I am not the medical director or employee of the hospice; and I do not furnish services under any arrangement with the hospice (including volunteering). Team conferences (authorization and reimbursement are limited to a maximum of one service per six-month authorization period. Authorization of additional team conferences may be considered for a client when there is documentation on this form of a change in the client's medical home provider.)*

* Essential/Critical field

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Certification

Complete all fields

I attest that I am the medical home provider for the client and, as such, in coordination with the family and client, I have generated/ updated within the prior 12 months, a comprehensive care plan for the client which is documented in the client's medical record, has been shared with the family or client, and includes the following components, at a minimum:

- *A current medical summary of the client's health status and health care requirements or needs (encompassing prevention, primary health care, specialist, and ancillary health-care requirements or needs).*
- *Main concerns or issues and key strengths or assets.*
- *Planned action steps to improve or enhance health outcomes.*
- *Persons responsible.*
- *Timeframes for action.*

Documentation

One of the following documentation must be submitted with this authorization form in order to obtain a six-month authorization for non-face-to-face care coordination services:

- Formal and written care plan.
- A progress note detailing care coordination planning and activities.
- A letter stating medical necessity for care coordination and including information on the care plan and care coordination services.

Requesting Provider Information and Required Signature

Requesting provider name*:		
Tax ID*:		NPI*:
Taxonomy code*:		Benefit code*: **CSN**
Telephone:		Fax:
Street address*:		
City:	State:	ZIP+4*:
Clinician provider signature:		Date:

* Essential/Critical field