CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Oxygen Therapy 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
12365-A Riata Trace Pkwy., Ste. 100
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 (Completed by Oxygen Provider)

Field Description	Guidelines
Client Information	
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 as indicated on the CSHCN Services Program eligibility form
Address/City/State/ZIP + 4	Enter the client's address, city, and ZIP + 4
Date the client was last seen by the prescribing physician	Enter the date the client was last seen by the physician prescribing the oxygen therapy
Requesting Physician Information	
Name*	Enter the first and last name of the requesting physician
Telephone	Enter the physician's telephone number
License Number	Enter the physician's license number
NPI*	Enter the physician's NPI
Rendering Provider / Supplier Information	
Provider / Supplier's Name*	Enter the supplier's name
Supplier Representative's Name	Enter the name of the supplier's contact person

CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form and Instructions

Field Description	Guidelines
Address/City/State/ZIP + 4*	Enter the client's address, city, and ZIP + 4
Telephone	Enter the telephone number of the supplier's contact person
Fax number	Enter the supplier's fax number
Tax ID*	Enter the supplier's Tax ID
NPI*	Enter the supplier's NPI
Taxonomy*	Enter the appropriate taxonomy code
Benefit Code*	CSN is automatically populated in this field
Supplier Representative's Signature	The supplier's signature and date of signature must be included here

Section B: Procedure and Service Information

Field Description	Guidelines
Dates of Service*	Enter the "From" and "To" dates of service for the equipment rental
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 initial request or a renewal request

Section C: Initial Oxygen Therapy Request (Completed By Physician)

Field Description	Guidelines
Documentation of Medical Necessity (required for all categories)	Enter the client's diagnosis and other information as indicated
O2 category	Select one of the categories indicated and complete the appropriate information as requested
Hypoxemia	Complete the information as requested
Cluster Headaches	Complete the information as requested

Section D: Coverage Categories

Guidelines
Determine the coverage category by selecting the appropriate check boxes. Submit additional documentation supporting the categories selected.

Section E: Renewal of Oxygen Therapy Request

Field Description	Guidelines
Documentation of Medical Necessity	Enter the client's diagnosis and medical need for continuation of oxygen therapy as indicated.
Requesting Physician Signature	Provider must sign in this field.
Date Signed	Enter the date the form is signed.

Section F: Requesting Physician Signature and Certification

Field Description	Guidelines
Requesting Physician Signature	Provider must sign in this field.
Date Signed	Enter the date the form is signed.

CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form

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 user name 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 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 Oxygen Therapy Form

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.*

Section A: Client, Provider, and Supplier Information (Completed by Oxygen Provider)		
Client Information		
First Name*:	Last Name*:	
CSHCN Services Program Number*: 9-____________________-00	Date of birth*:	
Address/City/State/ZIP:		
Date the client was last seen by prescribing physician:		
Prescribing Physician Information		
Name*:	Telephone:	Fax number:
License Number:	NPI*:	
Provider / Supplier Information		
Provider / Supplier's Name*:		
Supplier Representative's Name:		
Street Address*:		
City:	State:	ZIP + 4*:
Telephone:	Fax:	
Tax ID*:	NPI*:	
Taxonomy*:	Benefit Code*: **CSN**	
Supplier Representative's Signature:		Date Signed:

Section B: Procedure and Service Information				
Dates of Service:	From*:	To*:		
HCPCS Code*	Description	Quantity*/Frequency*	Initial or Renewal Request	
			☐ Initial	☐ Renewal
			☐ Initial	☐ Renewal
			☐ Initial	☐ Renewal
			☐ Initial	☐ Renewal

Section C: Initial Oxygen Therapy Request (Completed by Physician)		
Documentation of Medical Necessity *(required for all coverage categories)*		
Diagnoses:		
Date of test:	Arterial pO2 (mmHg):	Oxygen Saturation (%)
O_2 flow rate:	Estimated frequency of use:	
Duration of Use:	Duration of need:	
Oxygen required for home use: ☐ Yes ☐ No	Oxygen required outside of home: ☐ Yes ☐ No	
O2 category (select one and complete the appropriate information on the following page)	☐ Hypoxemia ☐ Arterial PO2 56 – 59 ☐ Clients < 20 yrs of age ☐ Cluster Headaches	☐ Other *(Clarify in the Comments section)*

CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form

Section C: Medical Necessity Information (cont.)			
Hypoxemia:		**Arterial PO2 56 - 59 or Arterial O2 Saturation 89%:**	
Arterial pO2 at rest on room air:	Date of Test:	Arterial pO2:	Date of Test:
Arterial pO2 at sleep (> 5 min):	Date of Test:	Arterial O2 saturation:	Date of Test:
Symptoms of hypoxia during sleep:		**And one of the following:**	
		Dependent edema ☐ Yes ☐ No	
		COR pulmonale ☐ Yes ☐ No	
		Erythrocythemia ☐ Yes ☐ No	
Arterial pO2 during Exercise:	Date of Test:	Hematocrit (result):	Date of Test:
Hypoxemia (clients 20 years of age and younger):		**Cluster Headaches:**	
Gestational age:		Date of neurological evaluation:	
☐ Arterial pO2___________or ☐ Arterial O2 saturation (%) _________	Date of Test:	Result of evaluation:	
Chronic neonatal lung disease (specify):		Therapies tried:	
Other medical condition(s):		Outcome of therapies:	

Section D: Coverage Categories
Coverage for clients with significant hypoxemia with documentation of any of the following *(select all that apply and submit documentation):*
☐ Arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation equal to or less than 88%, taken at rest, breathing room air.
☐ Arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88% taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake.
☐ A decrease in arterial pO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5% for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia e.g., impairment of cognitive processes and nocturnal restlessness or insomnia.
☐ Arterial pO2 at or below equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a client who demonstrates a pO2 at or above 56 mm Hg or an arterial O2 saturation at or above 89% during the day while at rest. In this case supplemental oxygen may be provided during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form

Section D: Coverage Categories (cont.)
Coverage for clients under the age of 20 - Infants and Children (*select all that apply and submit documentation*):
☐ Oxygen therapy for neonates and premature infants who have not reached 40 weeks gestational maturity with a arterial pO2 of less than 60 mm Hg or an arterial oxygen saturation level is less than 92%.
☐ Oxygen therapy for infants with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92%
☐ Other medical conditions, may be considered on a case by case basis with supporting documentation from the treating physician supporting the need for oxygen therapy. These requests will be reviewed by the CSHCN Services Program Medical Director or designee.
Coverage for clients of any age whose arterial pO2 is 56 – 59 mm Hg or whose arterial blood oxygen saturation is 89% with documentation of any of the following *(select all that apply and submit documentation):*
☐ Dependent edema suggesting congestive heart failure (CHF)
☐ Cor Pulmonale (pulmonary hypertension)
☐ Erythrocythemia with a hematocrit greater than 56%
Coverage for clients with a diagnosis of cluster headaches with documentation of all of the following *(select all that apply and submit documentation):*
☐ Neurological evaluation with diagnosis of cluster headache
☐ Documentation of failed medical therapy

Section E: Renewal of Oxygen Therapy Request (Completed by Physician)			
Documentation of Medical Necessity			
Document client diagnosis and medical need of continued oxygen therapy (may attach separately):			
Client compliance with treatment plan: ☐ Yes ☐ No			
(New) Arterial pO2 (mmHg):	Oxygen Saturation (%):	Date of Test:	
Attach documentation client meets one of the following:		☐ Hypoxemia	☐ Clients < 20 yrs of age
☐ Cluster Headaches	☐ Arterial PO2 56-59	☐ O2 saturation of 89% and 1 diagnosis from above	
Result:		Date of test:	
Additional Comments:			

Section D: Prescribing Physician Signature and Certification	
I certify that the client's medical condition is such that all equipment requested above is medically necessary.	
Requesting Physician Signature:	Date: