CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Extension of Outpatient Therapy (TP2) 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.
- 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.
- 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 512-514-4222, or submitted by mail to the following address:

  TMHP-CSHCN Services Program
  Prior Authorization Department
  12365-A Riata Trace Pkwy., Ste. 100
  Austin, TX 78727
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** The "Physical Medicine and Rehabilitation" and "Speech-Language Pathology (SLP) Services" chapters in the current *CSHCN Services Program Provider Manual*.

Prior Authorization Request Submitter Certification Statement

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

Client Information

Field Description	Guidelines
Client name*	Enter the client's 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
Client address	Enter the client's address
Therapy in school district	Check if the client receives therapy through a school district. If "yes," indicate how services requested through CSHCN Services Program will differ.
Diagnosis code(s)	Enter the diagnosis code(s) relevant to the client's condition

Evaluation or Re-Evaluation Summary

Field Description	Guidelines
Date of evaluation or re-evaluation	Enter the date of evaluation or re-evaluation. ***Note:*** *A copy of the evaluation or re-evaluation must be attached.*
Type of evaluation	Check the appropriate type of evaluation
Comments	

Service Request

Field Description	Guidelines
Service request*	Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month. Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.
Requesting physician name, signature, NPI, and date*	Indicate the requesting physician's name, signature, NPI, and date of signature
PT name, signature, and date	Indicate the physical therapist's name, signature, and date of signature
OT name, signature, and date	Indicate the occupational therapist's name, signature, and date of signature
SLP name, signature, and date	Indicate the speech language pathologist's name, signature, and date of signature

Provider Information and Required Signature

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

Functional Status, Goals, and Treatment Summary

Field Description	Guidelines
Current functional status	Enter the current functional status
New treatment goals	Enter the new treatment goals
Prior dates of service	Enter the to and from prior dates of service
Prior functional status	Enter the prior functional status
Prior treatment goals	Enter the prior treatment goals
Prior treatment provided	Enter the prior treatment provided
Additional comments	Indicate additional comments

Additional Requirements

- Prior authorization requests for an extension require documentation of medical necessity.
- Request PT using the GP modifier and OT using the GO modifier.
- Request SLP services using the GN modifier.
- Time-based procedure codes are billed in units (15-minute increments).
- Untimed or encounter-based procedure codes are billed once per day.

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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 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

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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.*

This is a multi-page form. Complete all pages and print or type requested information below.

Client Information

Client name*:

CSHCN Services Program number*: 9-____________________-00 | Date of birth*:

Client Address:

Does the client receive therapy services through a school district?** ☐ Yes ☐ No

** If "yes," please indicate in the evaluation how it is different than the services requested under CSHCN.

Diagnosis Code(s):

Evaluation or Re-Evaluation Summary

Date of evaluation or re-evaluation: (A copy of the evaluation or re-evaluation *must* be attached.)

Type of evaluation: ☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech-Language Pathology (SLP)

Comments:

Service Request

Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month.
Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.

Procedure Code*	Modifier	From Date*	To Date*	Frequency/Week*	Frequency/Month*

Requesting physician name*:	Physician signature:	NPI*: Date:
PT name:	PT signature:	Date:
OT name:	OT signature:	Date:
SLP name:	SLP signature:	Date:

Rendering Provider Information and Required Signature

Rendering provider name*:

Tax ID*:	NPI*:	Taxonomy*:	Benefit code*: **CSN**

Provider contact name:

Telephone: | Fax:

Street address*:

City: | State: | ZIP + 4*:

Signature of provider: | Date:

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Client Information		
Client name*:		
CSHCN Services Program number*: 9-__________________-00		
Functional Status, Goals, and Treatment Summary		
Current functional status:		
New treatment goals:		
Prior dates of service:	From date:	To date:
Prior functional status:		
Prior treatment goals:		
Prior treatment provided:		
Additional comments:		