CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Augmentative Communication 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.
- This form may be submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** Chapter 10, "Augmentative Communication Devices (ACDs)."

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	Enter the client's address
Diagnoses	Enter the diagnosis code(s) relevant to the need for the ACD

Part 1 – Equipment Information

Field Description	Guidelines
Item information	Check the item information: rented, purchase, modified, or repair
Estimate of repair	Enter the estimate of repair (when applicable)
Age of ACD	Enter the age of the ACD system to be repaired (when applicable)
Manufacturer	Enter the name of the manufacturer of the device or accessories being requested
MSRP	Enter the manufacturer suggested retail price (MSRP) for the device or accessories
Model No.	Enter the model number for the device or accessories
HCPCS Code	Enter the Healthcare Common Procedure Coding System (HCPCS) for the device or accessories
Modifier	Enter the modifier for the device or accessories (when applicable)

Part 2 – Statement of Medical Necessity – Required for all equipment requests

Field Description	Guidelines
Physician name	Enter the prescribing physician's name
Telephone number	Enter the prescribing physician's telephone number
Physician's signature	Physician must sign in this field
Date	Enter the prescribing physician's date of signature

Part 3 – Vendor Information

Field Description	Guidelines
Provider name	Enter the name of the ACD supplier
Contact person	Enter the ACD supplier's contact person name
Telephone number	Enter the ACD supplier's telephone number
Fax number	Enter the ACD supplier's fax number
Address/City/State/ZIP	Enter the ACD supplier's address
CSHCN TPI	Enter the ACD supplier's CSHCN Services Program Texas provider identifier (TPI)
NPI	Enter the ACD supplier's national provider identifier (NPI)
Taxonomy code	Enter the ACD supplier's taxonomy code
Benefit code	Enter the ACD supplier's benefit code
Signature of DME provider	ACD supplier must sign in this field
Date	Enter the date signed

Additional Requirements

ACDs are not prior authorized for purchase unless the client has used the requested ACD for an adequate trial period (at least 30 days and not to exceed 60 days). Prior authorization may be obtained for rental (if feasible) during the trial period. If ACDs are unavailable for rental, a waiver may be granted with adequate supporting documentation. All available components, accessories, and switches, including mounting devices and lap trays necessary for use, must be used during the trial period.

Prior authorization requests must include all of the following information or documentation:

- The medical diagnosis and how it relates to the client's communication needs.
- Any significant medical information pertinent to the use of the ACD.
- The limitations of the client's current communication abilities, system, and devices.
- A statement as to why the prescribed ACD is the most effective with comparison of benefits versus other alternative options.
- A complete description of the ACD with all accessories, components, mounting devices, and modifications necessary for client use (must include the manufacturer's name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating and using the requested ACD.
- A professional assessment must be conducted by a licensed speech-language pathologist in conjunction with other disciplines, such as physical or occupational therapy. This assessment must be completed before the ACD is prescribed by the physician. The prescribing physician should base the prescription on the professional assessment. Professional assessment by a licensed speech-language pathologist must include the following information:
  - Communication status and limitations
  - Speech and language skills assessment, including prognosis for speech or written communication
  - A description of the client's cognitive readiness
  - A description of the client's interactional, behavioral, or social abilities

    - A description of the client's capabilities including intellectual, postural, physical, and sensory (visual and auditory)
    - A description of the client's motivation to communicate
    - A description of the client's residential, vocational, and educational setting
    - A description of how the ACD will be implemented or integrated into environments
    - A description of alternative ACD considered with a comparison of capabilities
    - A description of the ability of the ACD to meet the projected communication needs and growth potential of the client, and how long the ACD will meet the client's needs
    - A detailing of any anticipated changes, modifications, or upgrades with projected time frames (short and long term)
    - A detailed training plan (who, what, when, where)
- Specifications of the ACD, all of the component accessories that are necessary for the proper use of the ACD, and documentation of all necessary therapies and training

It is recommended that the preliminary evaluation for an ACD include involvement of an occupational therapist or physical therapist to address the client's seating/postural needs and motor skills required to utilize the ACD.

Documentation required for modifications of ACDs must include the following:

- Reevaluation by licensed speech-language pathologist
- Prescription from the treating physician
- Documentation of significant changes that have occurred in the client's environment or physical or linguistic abilities; such changes impair or affect the client's ability to benefit from the ACDs currently in use
- Documentation supporting that the prescribed modification provides the client with the potential for an increased level of functional communication with significant reduction of disability

Documentation required for replacements must include the following:

Prior authorization requests must include a joint statement from the prescribing physician and a licensed speech-language pathologist that includes:

- The cause of loss or damage and what measures have been taken to prevent reoccurrences.
- Information stating the client’s abilities or communication needs are unchanged, or no other ACDs currently available are better suited to the client’s needs.
- A new evaluation or assessment if requesting a different ACD from one that has been lost or damaged.

Documentation required for repairs of ACDs must include:

- A prescription from the treating physician.
- A statement that describes the needed repair.
- Justification of medical necessity.
- The estimated cost of repairs.

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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:	

Part 1– Equipment Information

Item is to be: ☐ Rented for 30 days ☐ Purchased (after successful 30-day trial) ☐ Modified

☐ Repaired Cost estimate of repair: _____ Age of ACD: _____

Device or accessories requested:

Manufacturer: _____ MSRP: _____ Model No.: _____

HCPCS Code: _____ Modifier: _____

Part 2 – Statement of Medical Necessity - Requirement for all equipment requests

Attach a copy of the SLP assessment including information about the client's mental, emotional, and physical abilities as to effective use of ACDs. Refer to the *CSHCN Services Program Provider Manual* for specific criteria that must accompany *each* ACD request.

Attach a copy of evaluation of seating, postural control, and motor skills by physical or occupational therapist when appropriate.

Narrative section: (Include a summary of the limitations of the client's current communication abilities, systems, devices, and initial date received. If applicable, describe need for modification or repair of current ACD.)

Describe why prescribed ACD is the best and most cost effective choice for this client.

I certify that the patient's medical condition is such that all equipment requested above is medically necessary.

Physician's name: _____ Telephone number: _____

Physician's signature: _____ Date: _____

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Client Information	
First name:	Last name:
CSHCN Services Program number: 9-_____-00	

Part 3 – Vendor Information		
Provider name:	Contact person:	
Telephone number:	Fax number:	
Address/City/State/ZIP:		
CSHCN TPI:	NPI:	
Taxonomy code:	Benefit code: **CSN**	
Signature of DME provider:		Date: