Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Renewal Request

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. 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. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4209**.

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 *Texas Medicaid Provider Procedures Manual* (TMPPM).

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 Medicaid enrollment and/or personal exclusion from Texas Medicaid.

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 *Texas Medicaid Provider Procedures 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.*

A. Client and Provider Information (May be completed by provider)

Client Information			
Client Name*:		Medicaid Number*:	Date of Birth*:
Physician or Pulmonologist Information			
Name*:		Telephone:	Fax:
License Number:		NPI*:	
Rendering Provider information			
Name*:		Telephone:	Fax:
Street Address*:			
City:		State:	ZIP + 4*:
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed			
Rendering Provider's Printed Name:			
Rendering Provider's Signature:			Date Signed:

B. Devices Requested (Must be completed by the treating physician or pulmonologist)

HCPCS and Diagnosis Codes					
HCPCS Code*	Description of DME Requested	Qty.*	Price	Diagnosis Code	Brief Diagnosis Descriptor

Indicate if the devices listed above are to be rented or purchased (items marked with double asterisks [**] are available for purchase after the initial rental period with additional documentation). If more than one secretion and mucus clearance device is required, the prescribing physician must be a pulmonologist. Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

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B. Devices Requested (Must be completed by the treating physician or pulmonologist)	
☐ Electrical percussors	☐ Rental ☐ Purchase**
☐ High-frequency chest wall oscillation (HFCWO) system	☐ Rental ☐ Purchase**
☐ Intermittent positive-pressure breathing (IPPB) devices	☐ Rental ☐ Purchase**
☐ Cough augmentation devices (e.g., mechanical insufflation-exsufflation or cough assist machine)	*Rental Only*

Note: ***The "Duration of need for DME" and "Date client last seen by physician," below must be filled in.***

Duration of need for DME: _____ month(s)	Date client last seen by physician:

Documentation of Outcomes Initial Request	
Client had respiratory illness or complications since initial authorization? Include additional information in Section C: Narrative (i.e., nebs for respiratory secretions, I.V., antibiotics, and hospitalizations)	☐ Yes ☐ No
Client had decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications? (describe in Section C: Narrative)	☐ Yes ☐ No
Has using the HFCWO device resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity?	☐ Yes ☐ No
Client has been compliant in use of device? (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period in Section C: Narrative)	☐ Yes ☐ No
Client has achieved the desired health outcome with device?	☐ Yes ☐ No

C. Narrative

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D. Medical Necessity for Multiple Devices

Pulmonologist must complete this section if requesting more than one mucus clearance device or when adding an additional mucus clearance device to the client's medical regimen. Provide a complete narrative addressing why both mucus clearing devices continue to be medically necessary to treat the client's respiratory condition.:

Physician Signature		
I am a pulmonologist	☐ Yes ☐ No	
Requesting physician or pulmonologist signature:		Date: