

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. Fax requests have to be scanned and data entered before the PA Department receives them, which takes up to 24 hours. To access PA on the Portal, go to www.tmhp.com, click on "Providers," then "Prior Authorization" from the left hand menu. Then click "PA on the Portal" from the left hand menu and enter your TMHP Portal account user name and password. To submit by fax, send to 1-512-514-4212.

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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Section A: Client and Provider Information (May be completed by provider)			
Client Information			
Client Name:	Medicaid Number:	Date of Birth:	
Treating Physician or Pulmonologist Information			
Name:	Telephone:	Fax Number:	
License Number:	TPI:	NPI:	
Supplier Information			
Name:	Telephone:	Fax Number:	
Address (Street, City, State, ZIP):			
TPI:	NPI:	Taxonomy:	Benefit Code:
<i>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.</i>			
Supplier Representative's Printed Name:			
Supplier Representative's Signature:			Date Signed:

Section B: Devices Requested (Must be completed by the treating physician or pulmonologist)					
HCPCS and Diagnosis Code(s)					
HCPCS Code	Description of DME Requested	Qty.	Price	Diagnosis	Brief Diagnosis Descriptor
<i>Indicate if the devices listed above are to be rented or purchased (items marked with an asterisk [*] 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.</i>					
<input type="checkbox"/> Electrical percussors				<input type="checkbox"/> Rental <input type="checkbox"/> Purchase *	
<input type="checkbox"/> Intermittent positive-pressure breathing (IPPB) devices				<input type="checkbox"/> Rental <input type="checkbox"/> Purchase *	
<input type="checkbox"/> High-frequency chest wall oscillation (HFCWO) system				<input type="checkbox"/> Rental <input type="checkbox"/> Purchase *	
<input type="checkbox"/> Cough augmentation devices (e.g., mechanical insufflation-exsufflation or cough assist machine)				<i>Rental Only</i>	
Note: The "Duration of need for DME" and "Date client last seen by physician," below <u>must</u> be filled in.					
Duration of need for DME: _____ month(s)			Date client last seen by physician:		
Documentation of Outcomes of 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).				<input type="checkbox"/> Yes	<input type="checkbox"/> 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).				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has using the HFCWO device resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity?				<input type="checkbox"/> Yes	<input type="checkbox"/> 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).				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client has achieved the desired health outcome with device.				<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Section C: Narrative

The physician or pulmonologist prescribing a secretion and mucus clearance device must complete this section with narrative information regarding the medical necessity of the devices requested above, or attach a letter with this information.

Section 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

Physician or Pulmonologist Signature:

Date Signed: