

CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Pulse Oximeter 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.
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** The "Respiratory Equipment and Supplies" chapter of the current *CSHCN Services Program Provider Manual*.
- Pulse oximeters may only be authorized for clients that meet the criteria described in the "Respiratory Equipment and Supplies," chapter of the *CSHCN Services Program Provider Manual*.

Note: *The initial long term device rental is up to a maximum of six months. A three-month extension is considered with medical necessity. Rental cannot exceed a maximum of nine months. Short term rental is up to a maximum of one calendar month.*

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
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727.

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/City/State/ZIP	Enter the client's address, including city, state, and ZIP

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Equipment and Supplies Information (required for *all* equipment requests)

Field Description	Guidelines
Dates of Service:	Enter the "From" and "To" date(s) of service for the equipment rental or purchase
HCPCS Code with modifier	Enter the procedure code for the requested equipment and the appropriate modifier
Description	Enter the description of the required equipment
Qty / Frequency	Enter the quantity and frequency for the equipment
Rental / Purchase	Indicate if this request is for a short-term rental, long-term rental, or purchase for the equipment

Statement of Medical Necessity for Short Term Rental (up to 30 calendar days)

Field Description	Guidelines
Diagnoses	Enter the diagnosis code(s) supporting the need for the short-term rental
Dates of Service requested for Prior Authorization	Enter the dates of service for the short-term rental
Anticipated length of monitor need	Enter the anticipated length of time for the monitoring
Indicate the reason for the short term rental	Indicate by checkbox the statement that defines the reason for the short-term rental
Weaning Plan	Enter the weaning plan
Additional Comments (optional)	Enter additional comments as necessary
Type or print physician's name	Enter the prescribing physician's name
Physician's signature	Physician must sign in this field
Date signed	Enter the date the form is signed

Statement of Medical Necessity for Long Term Rental or Purchase

Field Description	Guidelines
Diagnoses	Enter the diagnosis code(s) supporting the need for the long-term rental
Client is oxygen or ventilator dependent, is not stable, and has frequent need for changes in oxygen or ventilator settings	Check Yes or No
Client frequently experiences respiratory complications and requires equipment that has oxygen saturation monitoring capabilities	Check Yes or No
Has the caregiver or medical health care provider present been trained in the use of the oximeter and how to respond to readings in a medically safe and appropriate manner?	Check Yes or No

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Field Description	Guidelines
What is the medical basis for need of continuous monitoring?	Enter a detailed description of the medical basis for need of continuous monitoring
Additional Comment(optional)	Enter additional comments as necessary
Type or print physician's name	Enter the prescribing physician's name
Physician's Signature	Physician must sign in this field
Date Signed	Enter the date the form is signed

Provider / Supplier Information and Required Signature

Field Description	Guidelines
Provider / Supplier's Name	Enter the provider's name
Supplier Representative's Name	Enter the name of the supplier's contact person
CSHCN TPI	Enter the provider's CSHCN Services Program TPI
NPI	Enter the provider's NPI
Taxonomy code	Enter the appropriate taxonomy code
Benefit code	Benefit code CSN is automatically populated in this field
Telephone number	Enter the contact person's telephone number
Fax number	Enter the provider's fax number
Address/City/State/ZIP	Enter the provider's address including city, state, and ZIP code
Supplier Representative's Signature	The supplier's signature can be an e-signature or a wet/handwritten signature
Date Signed	Enter the date the provider signed the form

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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:					
Equipment and Supplies Information (required for <i>all</i> equipment requests)					
Dates of Service and HCPCS Code(s) Requested					
Dates of Service From:			To:		
HCPCS Code with modifier	Brief Description	Qty / Frequency	Rental (Short or Long term) / Purchase		
			<input type="checkbox"/> Short	<input type="checkbox"/> Long	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Short	<input type="checkbox"/> Long	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Short	<input type="checkbox"/> Long	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Short	<input type="checkbox"/> Long	<input type="checkbox"/> Purchase
Equipment designated for clinical use only is not considered appropriate for use in the home. * Short-term rental is 30 calendar days. **Long-term rental is six months with a three-month extension for a maximum of nine months.					
Statement of Medical Necessity for Short-Term Rental (<i>up to 30 calendar days</i>)					
Diagnoses:					
Dates of service requested for prior authorization		From:		To:	
Anticipated length of monitor need:					
Indicate the reason for the short-term rental: <input type="checkbox"/> Client is clinically stable and able to wean from oxygen or ventilator. <input type="checkbox"/> To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep. <input type="checkbox"/> When a change in the client's condition requires adjustment to the liter flow of home oxygen. <input type="checkbox"/> To determine home oxygen liter flow with diagnosis of neuromuscular disease involving chronic lung disease or severe cardiopulmonary disease.					
Weaning Plan:					
Additional Comments (optional):					
<i>I certify that the patient's medical condition is such that all equipment requested above is medically necessary.</i>					
Type or print Physician's Name:				Date client last seen by physician:	
Physician's Signature:				Date signed:	

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Statement of Medical Necessity for Long-Term Rental or Purchase (<i>rental cannot exceed nine months</i>)		
Diagnoses:		
Dates of service requested for prior authorization	From:	To:
Anticipated length of monitor need:		
Client is oxygen or ventilator dependent, is not stable, and has frequent need for changes in oxygen or ventilator settings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client frequently experiences respiratory complications and requires equipment that has oxygen saturation monitoring capabilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the caregiver or medical health care provider present been trained in the use of the oximeter and how to respond to readings in a medically safe and appropriate manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the medical basis for need of continuous monitoring?		
Additional Comments (optional):		
<i>I certify that the patient's medical condition is such that all equipment requested above is medically necessary.</i>		
Type or print physician's name:	Date client last seen by physician:	
Physician's Signature:	Date signed:	
Provider / Supplier Information and Required Signature		
Provider / Supplier's Name:		
Supplier Representative's Name:		
CSHCN TPI:	NPI:	
Taxonomy code:	Benefit code: CSN	
Telephone number:	Fax number:	
Address/City/State/ZIP:		
Supplier Representative's Signature:	Date signed:	