

CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form and Instructions

General Information

- Ensure the most recent version of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance 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.
- Submit only the prior authorization form. **Do not submit instruction pages.**
- **Refer to:** The "Respiratory Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.

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
12365-A Riata Trace Pkwy., Ste. 100
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, city, state, and ZIP Code.
Diagnoses	Enter the diagnosis code(s) relevant to the need for a chest physiotherapy device.

Equipment Information (required for all equipment requests)

Field Description	Guidelines
Dates of Service*	Enter the beginning and end dates for the dates of service the equipment is requested.
HCPCS code(s) Requested*	Indicate the Healthcare Common Procedure Coding System (HCPCS) Code(s).
Description	Enter the description of the product including the brand name.
Quantity*/Frequency*	Indicate the quantity requested, and how long the equipment will be needed in days, weeks, months, or years.
Rental/Purchase	Indicate if the item is to be a rented or a purchased by checking the appropriate box.

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Statement of Medical Necessity for Initial Requests *(must be completed by requesting physician)*

Field Description	Guidelines
Percussion Cups	Fill out this section if requesting percussion cups.
Electrical percussors	Fill out this section if requesting electrical percussors.
Cough augmentation devices	Fill out this section if requesting cough augmentation devices
High Frequency Chest Wall Oscillation (HFCWO) system	Fill out this section if requesting HFCWO system
High Frequency Chest Wall Oscillation (HFCWO) vest (purchase)	Fill out this section if requesting HFCWO vest
I am a pulmonologist	Enter Yes or No
Telephone	Enter the provider's telephone number:
Requesting physician's name*	Type or print the requesting physician's name
NPI*	Enter the requesting physician's National Provider Identifier (NPI)
Physician's signature	The physician can e-sign or handwrite the signature
Date signed:	Enter the date the physician signed this form

Statement of Medical Necessity for Renewal Requests *(must be completed by requesting physician)*

Field Description	Guidelines
Electrical percussors	Fill out this section if requesting electrical percussors
Cough augmentation devices	Fill out this section if requesting cough augmentation devices
High Frequency Chest Wall Oscillation (HFCWO) system	Fill out this section if requesting HFCWO system
I am a pulmonologist	Enter Yes or No
Telephone	Enter the provider's telephone number
Requesting physician's name*	Type or print the physician's name
NPI*	Enter the requesting physician's National Provider Identifier (NPI)
Physician's signature	The physician can e-sign or handwrite the signature
Date signed	Enter the date the physician signed this form

Provider / Supplier Information and Required Signature

Field Description	Guidelines
Rendering provider / supplier name*	Enter the rendering provider / supplier's name
Representative's Name	Enter the rendering provider / supplier representative's name
Tax ID*	Enter the rendering provider's Texas provider identifier (TPI)
NPI*	Enter the rendering provider's national provider identifier (NPI)
Taxonomy code*	Enter the rendering provider's taxonomy code
Benefit code*	Benefit code CSN has been autopopulated in this field
Telephone	Enter the rendering provider's telephone number
Fax	Enter the rendering provider's fax number
Address/City/State/ZIP + 4*	Enter the rendering provider's address, city, state, and ZIP + 4
Representative's signature	The rendering provider / supplier must sign in this field
Date signed	Enter the date the form is signed

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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.

Client Information				
First name*:		Last name*:		
CSHCN Services Program number*: 9- _____ -00		Date of birth*:		
Address/City/State/ZIP:				
Diagnoses:				
Date the client was last seen by the prescribing physician:				
Equipment Information (required for <i>all</i> equipment requests) *				
Dates of Service and HCPCS code(s) Requested:				
Dates of Service From*:		To*:		
HCPCS Code*	Item Description	Quantity*/Frequency*	Rental/Purchase	
			<input type="checkbox"/> Rental	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Rental	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Rental	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Rental	<input type="checkbox"/> Purchase
			<input type="checkbox"/> Rental	<input type="checkbox"/> Purchase
** If more than one secretion and mucus clearance device is required, the prescribing physician must be a pulmonologist.				
Statement of Medical Necessity for Initial Requests (must be completed by the prescribing physician)				
Percussion Cups				
Include statement of medical necessity:				
Electrical percussors				
Have other devices for airway mucus clearance been tried and failed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe below all previous courses of therapy and why they did not adequately clear airway mucus:				
Cough augmentation devices				
Client has a weak, ineffectual, or absent cough caused by chronic pulmonary disease or a neuromuscular disorder?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client had respiratory illness or complication in the past six months. Provide additional information in comments section below, (i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations.)			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client had pulmonary function studies in last six months, if applicable. Provide results in comments section below.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client has a history of school, work, or extracurricular activity absences due to diagnosis related symptoms. Provide history in comments section below.			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Cough augmentation devices (<i>cont.</i>)		
There are medical reasons why the client, parent, guardian or caregiver cannot do chest physiotherapy, or why the chest physiotherapy is ineffective? Provide medical explanation below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional comments:		
High Frequency Chest Wall Oscillation (HFCWO) System		
Documentation that the client has one of the medical conditions listed above and has used a cough augmentation device for a minimum of three months prior to the request and that this therapy has been ineffective.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client have bronchiectasis confirmed by CT scan and characterized by either a continuous daily productive cough for six months or frequent exacerbations of pulmonary infections (i.e., more than two times per year) requiring antibiotic therapy? Provide type and dates of infections below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client have cystic fibrosis or other documented chronic suppurative endobronchitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client have a chronic neuromuscular disorder affecting client's ability to cough or clear respiratory secretions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have other devices for airway mucus clearance been tried and failed? Describe all previous courses of therapy and why they did not adequately clear airway mucus in the comments section below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has client had a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Device use has not resulted in aspiration, exacerbation of any gastrointestinal or pulmonary manifestations, nor caused an exacerbation of seizure activity.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional comments:		
<i>Pulmonologist must complete this section if requesting more than one mucus clearance device or when adding an additional mucus clearance device. Provide a complete narrative addressing why both mucus clearing devices are medically necessary to treat the client's respiratory condition.</i>		
Additional comments:		
High Frequency Chest Wall Oscillation (HFCWO) Vest (purchase)		
Include Statement of Medical Necessity:		

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Requesting Physician Certification and Required Signature for Initial Requests			
<i>I certify that the client's medical condition is such that all equipment requested above is medically necessary.</i>			
I am a pulmonologist <input type="checkbox"/> Yes <input type="checkbox"/> No		Telephone:	
Type or print physician's name*:			
NPI*:	Taxonomy:	Benefit Code: CSN	
Physician's signature:		Date signed:	
Statement of Medical Necessity for Renewal Request <i>(must be completed by requesting physician)</i>			
Electrical percussors <i>(Rental period cannot exceed a maximum of nine months)</i>			
Length of time requested:			
Is the client compliant with the use of the equipment and is the treatment effective?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments:			
Cough augmentation devices			
Is the client compliant with the use of the equipment and is the treatment effective?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments:			
HFCWO system			
Client had respiratory illness or complications since initial authorization, (i.e., nebs for respiratory secretions, I.V. antibiotics, and hospitalizations. Include additional information in comments section below.			<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 below.			<input type="checkbox"/> Yes <input type="checkbox"/> No
The use of the HFCWO device has not 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.			<input type="checkbox"/> Yes <input type="checkbox"/> No
The frequency and compliance graphs from the device for the 6-month period showing use of the system at least 50 percent or 3 months of the maximum time prescribed by the physician for each day.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Note: <i>The device is available for purchase after the initial rental period with additional documentation.</i>			
Additional comments:			

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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.

Additional comments:

Requesting Physician Certification and Required Signature for Renewal Requests

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

I am a pulmonologist Yes No Telephone:

Type or print physician's name*:

NPI*: Taxonomy: Benefit Code: **CSN**

Physician's signature: Date signed:

Rendering Provider / Supplier Information and Required Signature

This section is required for all equipment requests.

Rendering provider / supplier's name*:

Representative's name:

Tax ID*: NPI*:

Taxonomy code*: Benefit code*: **CSN**

Telephone: Fax:

Street address*:

City: State: ZIP + 4*:

Rendering provider / supplier representative's signature: Date signed: