CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Inpatient Rehabilitation Admission 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
  12365-A Riata Trace Pkwy., Ste. 100
  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:** The "Hospital" chapter in the current *CSHCN Services Program Provider Manual*.

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
Diagnoses	Enter the diagnosis code(s) relevant to the need for the inpatient rehabilitation admission.
Other insurance information (check each that applies)	Indicate whether the client has other insurance, and enter the client's other insurance type (private, Medicare, or Medicaid).
Insurance Type/Carrier	Enter the insurance type/carrier
Insurance ID	Enter the insurance ID

Admission Information

Field Description	Guidelines
Number of initial rehabilitation days requested*	Enter the number of days being requested
Date of admission*	Enter the date of admission
Anticipated date of discharge*	Enter the anticipated date of discharge
Requesting physician's name*	Enter the requesting physician's name.
NPI*	Enter the requesting physician's NPI
Taxonomy code	Enter the requesting physician's taxonomy code
Benefit code	Enter the CSN benefit code
Signature	Requesting physician must sign in this field
Date	Enter the date the form was signed

Information Required for Initial Rehabilitation Admission Authorization

Field Description	Guidelines
Name of team physician	Enter the name of the team physician
Date of onset of condition	Enter the date of onset condition
Is the patient sufficiently alert to participate with the rehabilitation team: • In setting own treatment goals (n/a for patients less than 5 years old) • In therapeutic activities (must complete for patient of all ages)	Check the appropriate box
Has the patient received inpatient rehabilitation at an earlier date?	Check the appropriate box
If yes, explain why needed now	Explain why additional inpatient rehabilitation is necessary now
Has the patient lost previous level of attained functional independence through complications or recurrent illness, and re-attainment of functional independence is feasible?	Check the appropriate box
If child is under 5 years of age, will parent/caregiver be present during inpatient rehabilitation stay and participate in setting treatment goals?	Check the appropriate box
If the patient has a congenital condition, what recent change in medical and functional status warrants inpatient rehabilitation? (If there has been no recent change, justification for inpatient rehabilitation must be sent in addition to this request form)	Document what recent change in medical and functional status warrants inpatient rehabilitation
An initial authorization of up to 14 days is requested to determine the patient's ability to progress toward treatment goals as a result of inpatient rehabilitation.	Check the appropriate box

Information Required for Authorization Extension

Field Description	Guidelines
Date of initial admission:	Enter the date of the initial admission
Initial anticipated discharge date:	Enter the initial anticipated date of discharge
Extension Number of days requested:	Enter the number of requested days
New anticipated date of discharge:	Enter the new anticipated date of discharge
Functional activity	Enter the client's functional activity
Functional level of initial evaluation (give dates)	Enter the appropriate letter to describe the client's functional level and progress (provide dates)
Anticipated functional level (give projected dates)	Enter the appropriate letter to describe the client's anticipated functional level and progress (provide projected dates)
Present functional level (give current dates)	Enter the appropriate letter to describe the client's present functional level and progress (provide current dates)

Facility Information and Authorized Signature (Required for all authorizations)

Field Description	Guidelines
Rendering facility name*	Enter the rendering facility's name
Facility contact name	Enter the facility's contact name
Tax ID*	Enter the facility's Tax Identification Number (TIN)
NPI*	Enter the facility's NPI
Taxonomy code*	Enter the facility's taxonomy code
Benefit code*	Enter the CSN benefit code

Field Description	Guidelines
Telephone	Enter the facility's telephone number
Fax	Enter the facility's fax number
Address/City/State/ZIP*	Enter the facility's address, city, state, and ZIP + 4
Authorized signature	Authorized person must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for inpatient rehabilitation admissions:

- An inpatient rehabilitation provider must be approved by the CSHCN Services Program as an inpatient rehabilitation facility or unit before a prior authorization may be approved.
- Prior authorization may be approved in 14-day increments, not to exceed a maximum of 90 days of inpatient rehabilitation, and may be prior authorized per calendar year. Requests must be submitted in writing with documentation of medical necessity, including the diagnosis and/or condition of the client and progress toward goals (request for additional days) along with a copy of the treatment plan. The "CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission" must be submitted for the initial request and each extension. Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.
- A statement explaining the medical necessity of inpatient versus outpatient rehabilitation services must be included with the documentation submitted for prior authorization. The justification must state the client's current condition and why inpatient rehabilitation, as opposed to outpatient therapy, is required for optimal care. The client's need for daily, intense, focused, team-directed therapy must be substantiated by the circumstances of the case.
- The inpatient rehabilitation program must include medical management, two or more therapies (e.g., respiratory therapy, speech-language pathology services, physical therapy, or occupational therapy), and rehabilitation nursing.
- If the prior authorization request for additional days documents that the client has made progress toward treatment goals, an additional 14 days may be approved up to a maximum of 90 days per calendar year.
- Requests for additional days must be received for prior authorization before the last inpatient rehabilitation day previously prior authorized.
- Requests for extensions are not approved if one of the following conditions applies:
    - The client has met treatment goals, as determined by the rehabilitation team and/or the CSHCN Services Program medical director or designee.
    - The client has failed to make progress toward remaining treatment goals during the currently authorized period.
    - The client no longer requires inpatient rehabilitation, and therapeutic goals can be met on an outpatient basis.
    - The request was received after the last prior authorized inpatient day.
    - The 90-day calendar maximum is exhausted.

CSHCN Services Program Prior Authorization
Request for Inpatient Rehabilitation Admission (page 1 of 3)

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

CSHCN Services Program Prior Authorization
Request for Inpatient Rehabilitation Admission (page 2 of 3)

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:		
Other insurance information (check each that applies) ☐ None ☐ Yes	If Yes: ☐ Private ☐ Medicare ☐ Medicaid	
Insurance ID:	Insurance Type:	
Insurance carrier:		

Initial Admission Information:		
Number of initial rehabilitation days requested*:		
Date of admission*:	Anticipated date of discharge*:	
Requesting physician's name*:		
NPI*:	Taxonomy:	Benefit code: **CSN**
Signature:	Date:	

Information Required for *Initial* Rehabilitation Admission Authorization:		
Name of team physician:	Date of onset of condition:	
Is the patient sufficiently alert to participate with the rehabilitation team?		
☐ In setting own treatment goals (n/a for patients less than 5 years old)	☐ Yes	☐ No
☐ In therapeutic activities (must complete for patient of all ages)	☐ Yes	☐ No
Has the patient received inpatient rehabilitation at an earlier date?	☐ Yes	☐ No
If Yes, explain why needed now?		
Therapies requested:		
Has the patient lost previous level of attained functional independence through complications or recurrent illness, and re-attainment of functional independence is feasible?	☐ Yes	☐ No
If child is under 5 years of age, will parent/caregiver be present during inpatient rehabilitation stay and participate in setting treatment goals?	☐ Yes	☐ No
If the patient has a congenital condition, what recent change in medical and functional status warrants inpatient rehabilitation? (If there has been no recent change, justification for inpatient rehabilitation must be sent in addition to this request form)		
An initial authorization of up to 14 days is requested to determine the patient's ability to progress toward treatment goals as a result of inpatient rehabilitation.	☐ Yes	☐ No

CSHCN Services Program Prior Authorization
Request for Inpatient Rehabilitation Admission (page 3 of 3)

Client Information:

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

Information Required for Authorization Extension:

Date of initial admission:	Initial anticipated discharge date:
Extension Number of days requested:	New anticipated date of discharge:
Extension Number of days requested:	New anticipated date of discharge:
Extension Number of days requested:	New anticipated date of discharge:

This request is for an extension *after* a 14-day authorization. Using the key provided, describe the patient's Functional Level and Progress in the chart below.

Key for Functional Levels

A. Needs *no assistance* to independently perform activity.	**D.** Needs *moderate assistance* to independently perform activity.
B. Needs *only standby assistance* to independently perform activity.	**E.** Needs *maximum assistance* to independently perform activity.
C. Needs *minimal assistance* to independently perform activity.	**F.** Needs *total care*–unable to perform activity independently.

Functional Level and Progress

Functional Activity	Functional Level on Initial Evaluation (Give Dates)		Anticipated Functional Level (Give Projected Dates)		Present Functional Level (Give Current Date)	
e.g. w/c mobility	D	01/06/2006	A	02/15/06	C	01/29/06

Facility Information and Authorized Signature (Required for ALL Authorizations):

I certify the treatment goals cannot be net through outpatient rehabilitation services and significant progress can be attained in cognitive and/or mobility and self care activities:

Rendering facility name*:	Facility contact name:
Tax ID*:	NPI*:
Taxonomy code*:	Benefit code*: **CSN**
Telephone:	Fax:
Street address*:	

City:	State:	ZIP + 4*:
Authorized signature:		Date: