CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Stem Cell or Renal Transplant form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all relevant sections of this form.**
- The relevant sections for each service are as follows:
  - Stem cell transplants: Client Information, Facility/Hospital Required Signature and Information, and Stem Cell Transplant Surgeon Information
  - Renal transplants: Client Information, Facility/Hospital Required Signature and Information, and Renal Transplant Surgeon Information.
- 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 "Physician" or "Hospital" chapter in the current *CSHCN Services Program Provider Manual*.
- Inpatient hospital admissions must be also prior authorized by or on behalf of the hospital using the Prior Authorization Request for Inpatient Hospital Admission.

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	Enter the client's address
Diagnoses	Enter the diagnosis code(s) relevant to the need for the transplant

Facility/Hospital Information and Required Signature

Field Description	Guidelines
Rendering provider name*	Enter the rendering transplant facility or hospital's name
Provider contact name (if any)	Enter the transplant facility or hospital's contact name
Tax ID*	Enter the transplant facility or hospital's Tax Identification Number (TIN)
NPI*	Enter the transplant facility or hospital's national provider identifier (NPI)

Field Description	Guidelines
Taxonomy code	Enter the transplant facility or hospital's taxonomy code
Benefit code	Enter the transplant facility or hospital's benefit code
Telephone number	Enter the transplant facility or hospital's telephone number
Address/City/State/ZIP	Enter the transplant facility or hospital's address, including street, city, state, and ZIP + 4
Facility transplant coordinator signature	Facility transplant coordinator must sign in this field [A stem cell transplant facility attests the following by signing in this field: The transplant facility is a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP)]
Date	Enter the date the form is signed

Stem Cell Transplant Surgeon Information

Field Description	Guidelines
Requesting lead surgeon's name*	Enter the lead surgeon's name
Surgeon's Tax ID*	Enter the lead surgeon's TIN
Surgeon's NPI*	Enter the lead surgeon's NPI
Taxonomy code	Enter the lead surgeon's taxonomy code
Benefit Code	Enter the lead surgeon's benefit code
Has this client had a previous stem cell transplant?	Indicate whether the client has had a previous stem cell transplant.
Number of times the client previously has been in remission:	Enter the number of times the client previously has been in remission
Transplant CPT procedure code(s)*	Enter the procedure code for the transplant

Renal Transplant Surgeon Information

Field Description	Guidelines
Requesting lead surgeon's name*	Enter the lead surgeon's name
Surgeon's Tax ID*	Enter the lead surgeon's TIN
Surgeon's NPI*	Enter the lead surgeon's NPI
Taxonomy code	Enter the lead surgeon's taxonomy code
Benefit code	Enter the lead surgeon's benefit code
Type of transplant	Indicate the type of transplant; living-related or cadaveric
Type of dialysis	Indicate the type of dialysis; hemodialysis or peritoneal
Transplant CPT procedure code(s)*	Enter the procedure code for the transplant

Additional requirements for stem cell transplant requests:

Prior authorization requests must include all of the following information or documentation:

- Indicate the client status, statement of medical necessity for transplant and long-term prognosis.
- Indicate status of client:
  - 1st remission
  - 2nd remission
  - Relapse
  - Other (specify)
- Indicate if the client is diagnosed with Chronic Myelogenous Leukemia (CM) in blast crisis.
- Specify the type of transplant to be performed:
  - Allogenic
  - Matched related
  - Matched nonrelated
  - Autologous
  - Other (specify)

Additional requirements for renal transplant requests:

- Indicate the client status, statement of medical necessity for transplant and long-term prognosis
- Documentation supporting the prior authorization request must include the following:
  - A recent and complete history and physical.
  - A statement of the client's status including why a transplant is being recommended at this time.
  - Information indicating the cost effectiveness of the transplant versus continued dialysis.

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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 field. If these fields are not completed, your prior authorization request will be returned.*

The transplant center/coordinator or surgeon must complete this form. Remember that inpatient hospital admissions also must be prior authorized by or on behalf of the hospital using the Prior Authorization Request for Inpatient Hospital Admission.

Please print or type information depending upon the type of transplant requested.

Client Information (complete for both transplant types)

First name*:	Last name*:
CSHCN Services Program number*: 9-_____-00	Date of birth*:
Address/City/State/ZIP:	
Diagnoses:	

Facility/Hospital Information and Required Signature (complete for both transplant types)

Rendering provider name*:	Contact name (*if any*):	
Facility Tax ID*:	NPI*:	
Taxonomy code:	Benefit code: **CSN**	
Telephone number:	Fax number:	
Street address:		
City:	State:	ZIP + 4:
A stem cell facility transplant coordinator signature attests that the transplant facility is a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP)		
Facility transplant coordinator signature:		Date:

Stem Cell Transplant Surgeon Information

Requesting lead surgeon's name*:	Contact name (*if any*):
Surgeon's Tax ID*:	Surgeon's NPI*:
Taxonomy code:	Benefit code: **CSN**
Has this client had a previous stem cell transplant?	☐ No ☐ Yes
Number of times the client previously has been in remission:	
Transplant CPT procedure code(s)*:	
Client status, statement of medical necessity for transplant, and long-term prognosis (*attach additional pages as needed*):	

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Client Information (complete for both transplant types)			
First name*:		Last name*:	
CSHCN Services Program number*: 9-_____-00			
Renal Transplant Surgeon Information			
Requesting lead surgeon's name*:		Contact name (*if any*):	
Surgeon's Tax ID*:		Surgeon's NPI*:	
Taxonomy code:		Benefit code: **CSN**	
Type of transplant:	☐ Living-Related ☐ Cadaveric	Type of dialysis:	☐ Hemodialysis ☐ Peritoneal
Transplant CPT procedure code(s)*:			
Client status, statement of medical necessity for transplant, and long-term prognosis (*attach additional pages as needed*):			