Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial 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. 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. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4209**.

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**

Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request

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.*

A. Client and Provider Information (May be completed by provider)

Client Information		
Client Name*:	Medicaid Number*:	Date of Birth*:
Treating Physician or Allowed Practitioner Information		
Name*:	Telephone:	Fax:
License Number:	NPI*:	
Rendering Provider information		
Name*:	Telephone:	Fax:
Street Address:*		
City:	State:	ZIP + 4*:
Tax ID*: / NPI*:	Taxonomy*:	Benefit Code*:
I certify that the services being supplied under this order are consistent with the treating physician or allowed practitioner'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.		
Rendering Provider's Printed Name:		
Rendering Provider's Signature:		Date Signed:

B. Devices Requested (Must be completed by the treating physician or allowed practitioner)

HCPCS and Diagnosis Codes

HCPCS Code*	Description of DME Requested	Qty.*	Price	Diagnosis Code	Brief Diagnosis Descriptor

Indicate if the devices listed above will be rented or purchased. 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.

Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request

B. Devices Requested (Must be completed by the treating physician or allowed practitioner)	
☐ Electrical percussors	☐ Rental ☐ Purchase
☐ High-frequency chest wall oscillation (HFCWO) system	☐ Rental ☐ Purchase
☐ Intermittent positive-pressure breathing (IPPB) devices	☐ Rental ☐ Purchase
☐ Cough augmentation devices (e.g., mechanical insufflation-exsufflation or cough assist machine)	Rental Only
☐ Percussion cup	Purchase Only
Note: ***The "Duration of need for DME" and "Date client last seen by physician or allowed practitioner" below must be filled in.***	
Duration of need for DME: _____ month(s)	Date client last seen by physician or allowed practitioner:

C. Documentation of Medical Necessity

Electrical percussors	
Have other devices for airway mucus clearance been tried and failed?	☐ Yes ☐ No
Describe below all previous courses of therapy and why they did not adequately clear airway mucus:	

HFCWO system	
Does the client have bronchiectasis confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy? (Provide type and dates of infections in narrative section, below)	☐ Yes ☐ No
Does the client have cystic fibrosis or other documented chronic supperative endobronchitis?	☐ Yes ☐ No
Does the client have a chronic neuromuscular disorder affecting client's ability to cough or clear respiratory secretions?	☐ Yes ☐ No
Has the client used other percussion and postural drainage therapy for a minimum of three months and this therapy has been ineffective? (Describe in narrative section, below)	☐ Yes ☐ No
Have other devices for airway mucus clearance been tried and failed? (Describe in narrative section below all previous courses of therapy and why they did not adequately clear airway mucus)	☐ Yes ☐ No
Has the device used resulted in, or exacerbated any gastrointestinal manifestations, aspiration, pulmonary manifestation, or seizure activity?	☐ Yes ☐ No
Client or family unable to do manual or other secretion and mucus clearance device or is it contraindicated ? (provide medical reasons in narrative section, below)	☐ Yes ☐ No
Client has a chronic pulmonary disease or neuromuscular disorder that affects the respiratory musculature, causing a weak, ineffectual or absent cough?	☐ Yes ☐ No
Has client had a chronic respiratory illness with exacerbation or change in baseline respiratory condition in the past 6 months?	☐ Yes ☐ No

Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request

C. Documentation of Medical Necessity

Narrative:

Intermittent positive-pressure breathing (IPPB) devices	
Have other devices for improving lung function been tried and failed?	☐ Yes ☐ No

Describe below the medical necessity for the device requested, all previous courses of therapy tried, and why those therapies did not adequately improve lung function:

Mechanical insufflation-exsufflation or cough assist machine devices	
Client has a weak ineffectual or absent cough caused by chronic pulmonary disease or a neuromuscular disorder?	☐ Yes ☐ No
Client had respiratory illness or complication in the past 6 months? (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations)	☐ Yes ☐ No
Client had pulmonary function studies in last 6 months, if applicable? (provide results in narrative section, below)	☐ Yes ☐ No
Client has a history of school, work, or extracurricular activity absences due to diagnosis related symptoms? (provide history in narrative section, below)	☐ Yes ☐ No
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 in narrative section, below)	☐ Yes ☐ No

Narrative:

Texas Medicaid Prior Authorization Request for Secretion and Mucus Clearance Devices - Initial Request

C. Documentation of Medical Necessity

Percussion cup

Describe below the medical necessity for the percussion cup, including the need to loosen thick secretions, assist respiration, or prevent infection:

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. Provide a complete narrative addressing why both mucus clearing devices are medically necessary to treat the client's respiratory condition.

Treating Physician or Allowed Practitioner Signature

I am a pulmonologist	☐ Yes ☐ No

Requesting physician or allowed practitioner signature:	Date: