Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP)

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 **512-514-4209**.

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**

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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.*

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

Client Information

Client Name*:	Medicaid Number*:	Date of Birth*:

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 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 Representative's Printed Name:	
Rendering Provider Representative's Signature:	Date Signed:

Section B: Initial Request (Must be completed by physician or allowed practitioner)

Continuous Positive Airway Pressure (CPAP) Device

Diagnosis code(s):	Brief diagnosis description:		
HCPCS code*:	Description:	Price:	☐ Rental ☐ Purchase

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:

Date of polysomnogram:	AHI/RDI: events/hr	O_2 sat:	Sleep time (hours):	Total apneas:

Obstructive apneas:	Lowest oxygen saturation (percent):

Client's blood pressure supporting a diagnosis of hypertension:
Number of episodes of oxygen desaturation to less than 85 percent during a full night sleep study:
Excessive daytime sleepiness documented by either: Epworth Sleepiness Scale (ESS) score of: _____, or multiple sleep latency test (MSLT) score of: _____
Impaired cognition, mood disorders, or insomnia as supported by:

* Essential/Critical field ** Attach additional documentation as necessary.

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Ischemic heart disease or previous myocardial infarction as supported by:
Documented history of stroke, include when and level of involvement:
Any one episode of oxygen desaturation to less than 70 percent, include date and situation:
Pulmonary hypertension as supported by:

Respiratory Assist Device (RAD / Bi-level CPAP) *Without* Set Backup Respiratory Rate

Diagnosis code(s):		Brief diagnosis description:	
HCPCS code*:	Description:	Price:	☐ Rental ☐ Purchase

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:
Rationale for ruling out CPAP:	

☐ **Obstructive sleep apnea**	Include documentation of ineffective therapeutic response with CPAP**:
Restrictive thoracic medical conditions: ☐ **Severe thoracic cage abnormality****	FI0₂ _____ % PaCO₂ _____ Sleep oximetry PaO₂ _____for _____ mins.
☐ **Neuromuscular disorder****	FI0₂ _____ % PaCO₂ _____ Sleep oximetry PaO₂ _____for _____ mins. Maximal inspiratory pressure _____cm H₂O FVC_____% predicted
☐ **Severe COPD**	FIO₂_____% O₂ Flow rate_____L/min PaCO₂_____ Sleep oximetry O₂ sat____ & FIO₂ _____% Rationale if CPAP was ruled out**: _____
☐ **Central sleep apnea** ☐ **Complex sleep apnea**	*Attach* sleep study results with the following: • Titration • Central hypopneas & apneas • Central hypopnea/apnea rate index • FIO₂ used during study • CPAP ruled out with rationale
☐ **Hypoventilation**	FiO₂ _____% PaCO₂ _____ Sleep study O₂ sat _____ Spirometry w/FEVI _____ or Spirometry w/FVC _____

* Essential/Critical field ** Attach additional documentation as necessary.

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RAD / Bi-Level CPAP *With* Set Backup Respiratory Rate			
Diagnosis code(s):		Brief diagnosis description:	
HCPCS code*:	Description:	Price:	*Rental 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:		
Documentation of ineffective therapeutic response with RAD *without* backup:			
Restrictive thoracic medical conditions ☐ **Severe thoracic cage abnormality** **	$FI0_2$ _____ % $PaCO_2$ _____ Sleep oximetry PaO_2_____for ____ mins.		
☐ **Neuromuscular disorder** **	$FI0_2$ _____ % $PaCO_2$ _____ Sleep oximetry PaO_2_____for ____ mins. Maximal inspiratory pressure _____cm H_2O FVC_____% predicted		
☐ **Severe COPD**	FIO_2_____% O_2 Flow rate_____L/min $PaCO_2$_____ Sleep oximetry O_2 sat____ & FIO_2 _____% Rationale if CPAP was ruled out**: _____ RAD without backup used for _____ hours per 24 hr. period for _____ days		
☐ **Central sleep apnea** ☐ **Complex sleep apnea**	*Attach* sleep study results with the following: • Titration • Central hypopneas & apneas • Central hypopnea/apnea rate index	• FiO_2 used during study • CPAP ruled out with rationale	
☐ **Hypoventilation**	FiO_2 _____% $PaCO_2$ _____ Sleep study O_2 sat _____ Spirometry w/FEVI _____ or Spirometry w/FVC _____ Document ineffective therapeutic response to RAD without backup:		

Section C: Renewal Request (Must be completed by physician or allowed practitioner)

Renewal Request for Continuous Positive Airway Pressure (CPAP) Device			
Diagnosis code(s):		Brief diagnosis description:	
HCPCS code*:	Description:	Price:	☐ Rental ☐ Purchase
Client is compliant with the orders and use of the device initially authorized.			☐ Yes ☐ No
Documentation of effectiveness:			

* Essential/Critical field ** Attach additional documentation as necessary.

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Renewal Request for RAD / Bi-Level CPAP *Without* Set Backup Respiratory Rate			
Diagnosis code(s):	Brief diagnosis description:		
HCPCS code*:	Description:	Price:	☐ Rental ☐ Purchase
RAD / Bi-Level CPAP used for _____ hours per 24 hr. period for _____ days		O_2 sat when using RAD / Bi-Level CPAP:	
Client is compliant with the orders and use of the device initially authorized.			☐ Yes ☐ No
Documentation of effectiveness:			

Renewal Request for RAD / Bi-Level CPAP *With* Set Backup Respiratory Rate			
Diagnosis code(s):	Brief diagnosis description:		
HCPCS code*:	Description:	Price:	*Rental Only*
RAD / Bi-Level CPAP used for _____ hours per 24 hr. period for _____ days		O_2 sat when using RAD / Bi-Level CPAP:	
Client is compliant with the orders and use of the device initially authorized.			☐ Yes ☐ No
Documentation of effectiveness:			
Physician or allowed practitioner's signature:			Date signed:

* Essential/Critical field ** Attach additional documentation as necessary.