CSHCN Services Program Authorization and Prior Authorization Request for Cardiorespiratory Monitor (CRM) Form Instructions

General Information

- Ensure the most recent version of the Authorization and Prior Authorization Request for Cardiorespiratory Monitor form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization and prior authorization*** requests will cause the claim to be 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 authorization form. **Do not submit instruction pages**.
- **Refer to:** The "Respiratory Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.
- ***Please note***: The initial long term device rental is six months with a three month extension for a maximum of nine months.

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

* Essential/Critical field

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Field Description	Guidelines
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 cardiorespiratory device
Date the client was last seen by the ordering physician	Enter the date the client was last seen by the physician ordering the cardiorespiratory device

Equipment Information - Required for all equipment requests.

Field Description	Guidelines
Dates of Service*	Enter the "From" and "To" date(s) of service for the equipment rental or purchase
HCPCS Code*	Enter the procedure code for the requested equipment
Description	Enter the description of the required equipment
Quantity/Frequency*	Enter the quantity and frequency for the equipment
Rental/Purchase	Indicate if this request is an intial request, a request to extend a previously-approved rental, or a request to purchase the equipment

Statement of Medical Necessity

Field Description	Guidelines
After the two-month rental for infants birth through 4 months of age, continuation may be considered with prior authorization which must include all the following	Indicate by checkmarks that the documentation includes both criteria. Submit this request form with the documentation of the 2 month rental for central apnea (Respiratory control disorders) or cardiac rhythm issues. Describe the client's on-going, documented cardiorespiratory episodes in the Comments section of the request form.
A CRM with or without recording feature (procedure code E0618 or E0619) may be considered with prior authorization for rental or purchase for clients 5 months of age or older with one of the following conditions	Indicate by checkmark(s) the conditions applicable to the client
Provider Comments	Add additional comments as necessary and appropriate.

Requesting Physician Information and Required Signature

Field Description	Guidelines
Type or print physician's name*	Enter the requesting physician's name
NPI*	Enter the requesting physician's National Provider Identifier (NPI)
Taxonomy code	Enter the requesting physician's taxonomy code

* Essential/Critical field

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Field Description	Guidelines
Benefit code	CSN is automatically populated in this field
Telephone number	Enter the requesting physician's telephone number
Fax number	Enter the requesting physician's fax number
Provider Signature	The requesting physician must sign in this field
Date Signed	Enter the date the form is signed

Rendering Provider / Supplier Information and Required Signature

Field Description	Guidelines
Rendering Provider / Supplier's Name*	Enter the rendering provider / supplier's name
Supplier Representative's Name	Enter the rendering provider / supplier's contact person's name
Tax ID*	Enter the rendering provider / supplier's Tax Identificaiton Number (TIN)
NPI*	Enter the rendering provider / supplier's National Provider Identifier (NPI)
Taxonomy code*	Enter the rendering provider / supplier's taxonomy code
Benefit code*	CSN is automatically populated in this field
Telephone number	Enter the rendering provider / supplier's telephone number
Fax number	Enter the rendering provider / supplier's fax number
Address/City/State/ZIP*	Enter the rendering provider / supplier's address, city, state, and ZIP + 4 code
Rendering Provider Representative's Signature	The rendering provider / supplier must sign in this field
Date Signed	Enter the date the form is signed

Additional Requirement

Leads and electrodes for use with an apnea monitor owned by the client must be prior authorized.

* Essential/Critical field

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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 username 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 *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.*

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 ordering physician:	

Equipment Information *(required for all equipment requests)*

Dates of Service and HCPCS Code(s) Requested

Dates of Service From*: To*:

HCPCS Code*	Description	Quantity*/Frequency*	Rental or Purchase **		
			☐ Initial	☐ Extension	☐ Purchase
			☐ Initial	☐ Extension	☐ Purchase
			☐ Initial	☐ Extension	☐ Purchase
			☐ Initial	☐ Extension	☐ Purchase

** Initial rentals are for 6 months. Extentions are for an additional 3 months of a previously-approved rental.

Statement of Medical Necessity

Prior authorization of rental is *not* required for infants birth through 4 months of age for a maximum of two months *with documentation* of central apnea (respiratory control disorders) or cardiac rhythm issues. After the two-month rental for infants birth through 4 months of age, continuation may be considered with prior authorization, which must include all of the following *(submit this request form with documentation of the two-month rental for central apnea [respiratory control disorders] or cardiac rhythm issues):*

☐ The client has on-going, documented cardiorespiratory episodes (describe in the comments section)

☐ A physician interpretation, signed and dated by the physician, of the most recent two-month's CRM downloads

A CRM with or without recording feature (procedure code E0618 or E0619) may be considered with prior authorization for rental or purchase for clients 5 months of age or older with one of the following conditions:

☐ An episode of Apparent Life-Threatening Event in an infant

☐ Symptomatic central apnea

☐ Technology dependence - Mechanical ventilation

☐ Technology dependence - Tracheostomy with a critical airway obstruction

☐ Technology dependence - Assisted ventilation dependence

☐ Technology dependence - Cardiac dysrhythmia with significant risk of morbidity or mortality

* Essential/Critical field

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Requesting Physician Information and Required Signature

If ordering only wires and leads, I certify that the client owns their apnea monitor.
I certify that the client's medical condition is such that all equipment requested above is medically necessary.

Type or print physician's name*:		
NPI*:		
Taxonomy code:	Benefit Code: **CSN**	
Telephone:	Fax:	
Physician's Signature:		Date Signed:

Rendering Provider / Supplier Information and Required Signature

Rendering Provider / Supplier's Name*:		
Rendering Provider / Supplier Representative's Name:		
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code: **CSN**	
Telephone:	Fax:	
Street address*:		
City:	State:	ZIP + 4*:
Supplier Representative's Signature:		Date Signed:

* Essential/Critical field