CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) 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 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 form. **Do not submit instruction pages.**
- **Refer to:** The "Respiratory Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.

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."

Section A: Client, Provider, and Supplier Information

Field Description	Guidelines
Client name*	Enter the client's first and 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
Address/City/State/ZIP:	Enter the client's address
Physician Name*	Enter the physician's first and last name
Physician Telephone	Enter the physician's telephone number
Physician License Number	Enter the physician's license number
Physician NPI*	Enter the physician's NPI
Rendering Supplier Name*	Enter the rendering supplier's name
Supplier Representative's Name	Enter the name of the supplier's contact person
Supplier Telephone	Enter the supplier's telephone number
Supplier Fax Number	Enter the supplier's fax number
Address/City/State/ZIP + 4*	Enter the supplier's address
Supplier Tax ID*	Enter the supplier's Tax ID
Supplier NPI*	Enter the supplier's NPI
Supplier Taxonomy*	Enter the supplier's taxonomy code
Supplier Benefit Code*	Benefit code CSN has been automatically populated in this field
Supplier Representative's Signature	Supplier must sign and date the form in this field

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Section B: Procedure and Service Information

Field Description	Guidelines
Dates of service*	Enter the "From" and "To" dates of service
Choose the procedures being requested and indicate quantity/frequency and rental or purchase*	Enter the procedure code, diagnosis, and Quantity in the top three fields. Enter the Description, condition, and frequency in the bottom three fields. Choose "Initial rental" and enter the # of months to be rented, or choose "Purchase" by checking the appropriate box.

Section C: Medical Necessity for CPAP or RAD

Field Description	Guidelines
Client age	Enter the client's age
Physician's expected length of treatment	Enter the expected duration of treatment
Diagnosis	Enter the applicable diagnosis code(s)
Medical necessity information	Enter the information as requested
Subsection C1: Medical Necessity for CPAP System	Complete the information as requested for the initial request
Subsection C2: Respiratory Assist Devices (RADs)	Complete the information as requested for the initial request for RADs, including BiPAP

Section D: Rental Extension or Purchase (after 3-month rental) (Must be completed by physician)

Field Description	Guidelines
Choose one (as appropriate for this extension/purchase request	Choose the most appropriate option.
For continued rental of RAD with or without set backup rate	Enter the information as requested.
For purchase or continued rental, choose all that apply	Choose all that apply and enter the information as requested.

Section E: Requesting Physician Signature

Field Description	Guidelines
Requesting Physician specialist's signature	The prescribing physician specialist must sign this form
Date	Enter the date the form was signed

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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

CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form

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, Physician, and Supplier Information

Client Information			
First Name*:	Last Name*:		
CSHCN Services Program Number*: 9-_____-00	Date of Birth*:		
Address/City/State/ZIP:			
Requesting Physician Information			
Name*:	Telephone:	Fax Number:	
License Number:	NPI*:		
Rendering Supplier Information			
Supplier Name*:	Supplier Representative's Name:		
Telephone:	Fax:	Street Address*:	
City:	State:	ZIP + 4*:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*: **CSN**
Supplier Representative's Signature:		Date:	

Section B: Procedure and Service Information

Dates of Service From*: To*:

Choose the procedures being requested and indicate quantity/frequency and rental or purchase:

	Procedure Code* / **Description**	**Diagnosis** / **Condition**	**Quantity*** / **Frequency***	**Rental / Purchase** / **Initial / Extension**
CPAP device (for obstructive sleep apnea or other with medical necessity)				☐ Initial rental:_____months (3 month max allowed) ☐ Purchase
RADs including Bi-Level PAP *without* set backup respiratory rate				☐ Initial rental:_____ months (3 month max allowed) ☐ Extension ☐ Purchase
RADs including Bi-Level PAP *with* set backup respiratory rate				☐ Initial rental:_____months (3 month max allowed) ☐ Extension ☐ Purchase
Humidification device used with CPAP device or RAD				☐ Initial rental:_____ months (3 month max allowed) ☐ Extension ☐ Purchase

Note: *Tubing, filters, headgear, masks, and other client interfaces are included in the CPAP/RAD rental and will not be prior authorized or reimbursed separately.*

Section C: Medical Necessity for CPAP or RAD

Client age:	Physician's expected length of treatment:
Diagnosis:	
Date of Polysomnogram:	AHI/RDI:_____events per hour
Sleep Time (hours):	Total Apneas:
Obstructive apneas:	Lowest Oxygen Saturation (percent):

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Section C: Medical Necessity for CPAP or RAD (cont.)

Excessive daytime sleepiness (documented by either Epworth Sleepiness Scale [ESS]_____, or multiple sleep latency test [MSLT]_____)		
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:		
Any one episode of oxygen desaturation to less than 70 percent	☐ Yes	☐ No
Documented symptoms of impaired cognition, mood disorders, or insomnia	☐ Yes	☐ No
Documented ischemic heart disease or previous myocardial infarction	☐ Yes	☐ No
Documented history of stroke	☐ Yes	☐ No
Documented pulmonary hypertension	☐ Yes	☐ No
Adenoidectomy or Tonsilectomy is ☐ contraindicated ☐ delayed ☐ unsuccessful (*attach explanation*)		
If request is for **Bi-level CPAP without set back-up respiratory rate**, explanation of the inability to tolerate CPAP:		
Comments:		

Subsection C1: Medical Necessity for CPAP System *(Complete the following information for the initial request.)*

Diagnosis: ☐ Obstructive sleep apnea ☐ Other *(specify and attach documentation)*:

Client's condition: *(Attach documentation for these conditions)*

- ☐ Excessive daytime sleepiness (documented by either Epworth Sleepiness Scale (ESS) 10 or greater, or multiple sleep latency test (MSLT) less than 6
- ☐ Documented symptoms of impaired cognition, mood disorders, or insomnia
- ☐ Documented hypertension (Systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
- ☐ Documented ischemic heart disease or previous myocardial infarction
- ☐ Documented history of stroke
- ☐ Greater than 20 episodes of oxygen desaturation to less than 85 percent during a full night sleep study
- ☐ Any one episode of oxygen desaturation to less than 70 percent
- ☐ Documented pulmonary hypertension
- ☐ Adenoidectomy or tonsillectomy is contraindicated
- ☐ Adenoidectomy or tonsillectomy is delayed
- ☐ Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

For purchase only: CPAP used for_____hours per 24 hr period for:_____ days

Comments:

Subsection C2: Respiratory Assist Devices (RADs) *(Complete the following information for the initial request for RADs, including BiPAP.)*

Diagnosis: *(Include sleep study documenting this diagnosis.)*

- ☐ Obstructive Sleep Apnea (OSA)
- ☐ Restrictive Thoracic disorders i.e., neuromuscular diseases or severe thoracic cage abnormalities
- ☐ Severe chronic obstructive pulmonary disease (COPD)
- ☐ Central Sleep Apnea (CSA)
- ☐ Complex Sleep Apnea (CompSA)
- ☐ Hypoventilation syndrome
- ☐ Other *(specify and attach documentation)*:

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Section C: Medical Necessity for CPAP or RAD (cont.)

Condition	Medical Necessity Information for RAD *without* set back-up rate	Medical Necessity Information for RAD *with* set back-up rate
Obstructive Sleep Apnea	***Complete the CPAP section (Subsection C1) and submit all required documentation as indicated in the CPAP section.*** **Choose one:** ☐ The CPAP trial failed to be effective in treating the client's OSA *(Include documentation from the treating physician)* ☐ CPAP was found to be ineffective during the initial facility based on sleep laboratory titration trial *(Include the sleep study results from the facility. A new face to face clinical evaluation or a new sleep test is not required.)*	N/A
Restrictive Thoracic Medical Conditions – Severe Thoracic Cage Abnormality	***Complete the following for RAD without set back-up rate:*** **Client diagnosis:** ☐ Severe thoracic cage abnormality (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort. Specify:_____ **Oxygen Information:** ABG PaCO2:_____mm Hg Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2: O2 Sat.:_____% For:_____min Nocturnal recording time:_____ hrs (breathing routinely prescribed FIO2)	***Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:*** Client has tried a RAD without a back-up rate for: _____ days Client was compliant in use of the device using on average:_____hrs in a 24 hr period ☐ The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate *(attach documentation)*
Restrictive Thoracic Medical Conditions – Neuromuscular Disorder	***Complete the following for RAD without set back-up rate:*** **Client diagnosis:** ☐ Neuromuscular disorder (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) negatively impacting the client's respiratory effort *(Provide documentation that supports maximal inspiratory pressure is < 60 cm H2O, or forced vital capacity is < 50% of predicted.)* Specify: _____ **Oxygen Information:** ABG PaCO2:_____mm Hg Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2: O2 Sat.:_____% For:_____min Nocturnal recording time:_____ hrs (breathing routinely prescribed FIO2) Maximal inspiratory pressure:_____cm H2O Forced vital capacity:_____%	***Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:*** Client has tried a RAD without a back-up rate for: _____ days Client was compliant in use of the device using on average:_____hrs in a 24 hr period The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate *(attach documentation)*

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Section C: Medical Necessity for CPAP or RAD (cont.)

Condition	Medical Necessity Information for RAD *without* set back-up rate	Medical Necessity Information for RAD *with* set back-up rate
Severe COPD	***Complete the following for RAD without set back-up rate:*** ☐ Client has a diagnosis of sleep apnea *(Include documentation of sleep apnea and that treatment with a CPAP has been considered and ruled out. Include an explanation of why CPAP has been ruled out.)* ABG PaCO2:_____mm Hg Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2LPM or the client's prescribed FIO2 (whichever is higher). O2 Sat.:_____% For:_____ min ***Choose one:*** FIO2:_____O2:_____LPM Nocturnal recording time:_hrs (breathing routinely prescribed_____FIO2 or_____oxygen) ***Complete the following:*** ☐ If CPAP was tried and found ineffective, complete the CPAP section (Subsection C1) and submit all required documentation as indicated in the CPAP section. Indicate why CPAP was found to be ineffective (*attach explanation*) ☐ To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the client's medical record submitted with the request that demonstrates the client does not have some form of OSA, CSA, or CompSA as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation (*attach explanation*)	***Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:*** Client has tried a RAD without a back-up rate for: _____ days Client was compliant in use of the device using on average:_____ hrs in a 24 hr period The desired therapeutic respiratory response was not achieved with the RAD without a set back-up rate *(attach documentation)*
Central or Complex Sleep Apnea	***Complete the following for RAD without set back-up rate:*** **Client Diagnosis:** *(Choose one)* ☐ Central Sleep Apnea ☐ Complex Sleep Apnea Indicate which of the following is documented by the sleep study: ☐ The sum total of central hypopneas plus central apneas is greater than 50% of the total apneas and hypopneas rate:_____% ☐ A central hypopnea/apnea rate index _____ events per hour and significant improvement of the sleep associated Hypoventilation while breathing the client's prescribed FiO2 ☐ Attach documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated Hypoventilation	***Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:*** Client has tried a RAD without a backup rate for: _____ days Client was compliant in use of the device using on average:_____ _ hrs in a 24 hr period ☐ The desired therapeutic respiratory response was not achieved with the RAD without a set back up rate *(attach documentation)*

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Section C: Medical Necessity for CPAP or RAD (cont.)

Condition	Medical Necessity Information for RAD *without* set back-up rate	Medical Necessity Information for RAD *with* set back-up rate
Hypoventilation Syndrome	***Complete the following for RAD without set back-up rate:*** ABG PaCO2:_____mm Hg *(Obtained while awake breathing routinely prescribed FIO2.)* ☐ A spirometry shows a forced expired volume in 1 sec (FEV1)_____% or the forced vital; capacity (FVC):_____% Oxygen saturation for a number of minutes of continuous nocturnal recording time (minimum recording time of 2 hours) not caused by obstructive upper airway events. O2 Sat.:_____% For:_____ min: nocturnal recording time_____hrs	***Complete the required information for RAD without set back-up rate (at left), and complete the following additional information for RAD with set back-up rate:*** ☐ The client meets the criteria for RAD without a back-up rate for hypoventilation syndrome, and desired respiratory therapeutic effects were not achieved with the RAD without a backup rate (*attach documentation*) ☐ The polysomnogram provides documentation of Hypoventilation syndrome, and the physician documents that the desired respiratory therapeutic effects were not achieved with the RAD without a back-up rate *(attach relevant documentation)*

Comments:

Section D: Rental Extension or Purchase (after 3-month rental) (*must be completed by physician*)

Choose one (as appropriate for this extension/purchase request):

Purchase of RAD: ☐ Without set back-up rate

Continued rental of RAD: ☐ Without set back-up rate ☐ With set back-up rate

For continued rental of RAD with or without set back-up rate:

PaCO2:_____mm Hg OR CBG:_____

For purchase or continued rental, choose all that apply:

☐ The client has completed an initial 3-month rental period. Dates of rental:_____through _____

☐ Client is compliant in use of the device using on average:_____hrs in a 24 hr period for_____days.

☐ Medical necessity documentation attached indicating that the client's symptoms are improved with use.

Documentation of effectiveness:

Comments:

Section E: Requesting Physician Signature

I certify that the client's medical condition is such that all equipment requested above is medically necessary.

Requesting Physician's Signature:	Date: