



COMMISSIONER
Jon Weizenbaum

Fax Cover Sheet
Specialized Services/Durable Medical Equipment Authorization Request

Date: _____

To: DADS Access and Intake PASRR Unit, Attention: Program Specialist

Area Code and Fax No.: 512-438-2180

No. of Pages including cover: _____

Additional questions, email PASRR@dads.state.tx.us

Other DME, please specify: _____

From: _____

Name of Nursing Facility Representative: _____

Title of Nursing Facility Representative: _____

Area Code and Fax No.: _____

Area Code and Telephone No.: _____

Notes/Additional Comments:

Confidential Information: This communication (including any attached documentation) contains privileged and/or confidential information. If you are not an intended recipient of this communication, please be advised that any disclosure, dissemination, distribution, copying or other use of this communication or any attached document is strictly prohibited. If you have received this communication in error, please notify the sender immediately and promptly destroy all copies of this communication and any attached documentation.

Specialized Services Durable Medical Equipment (DME) Authorization Request

Is this submission a request to transfer the authorization of DME to a new facility? Yes No

(If Yes, complete only Sections A, E and F and submit the form.)

- Notes:**
- This form will not be accepted if not complete, including any required additional information.
 - This form is to be used only when requesting prior authorization for specific DME for Medicaid-eligible nursing facility residents.
 - Only nursing facility residents who are Preadmission Screening and Resident Review-eligible for Specialized Services are eligible for this benefit.
 - When completed, fax Form 1017 and the MSRP lists to: DADS Access and Intake Division, PASRR Unit, 512-438-2180.

Section A. Resident and Nursing Facility Identifying Information

| | | | |
|---------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------|------------------------------------|
| Resident's Name | | Date of Birth | |
| Resident's Medicaid No. | Resident's Social Security No. | Is resident age 21 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Resident's Legally Authorized Representative (LAR) Name | | Resident's LAR Area Code and Telephone No. | |
| Resident's LAR Address | | City, State, ZIP Code | |
| Nursing Facility Name | DADS Contract No. | NPI No. | |
| Nursing Facility Address | | City, State, ZIP Code | |
| Primary Contact Name | Position | Area Code/Telephone No. | Nursing Facility Area Code/Fax No. |

Section B. Therapist Identifying Information and DME Assessment

| | | | |
|-----------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------|--|
| Therapist Name and Title | | <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physical Therapist | |
| Is therapist employed by the nursing facility?..... | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Therapist Area Code/Telephone No. | Therapist Area Code/Fax No. | Therapist Employer Name | |
| Mailing Address | | City, State, ZIP Code | |

Assessment (Completed by Therapist)

Which DME item is being requested? (check one)

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> gait trainer | <input type="checkbox"/> prosthetic device |
| <input type="checkbox"/> standing board | <input type="checkbox"/> orthotic device (such as ankle-foot orthotic or knee-foot orthotic) |
| <input type="checkbox"/> positioning wedge | <input type="checkbox"/> special needs car seat or travel chair/restraint (removable – not permanently attached to vehicle) |
| <input type="checkbox"/> specialized/treated pressure reducing support surface/mattress (such as air floatation mattress, air pressure mattress or cushion) | |

Resident Name:

I. Requested DME Item

| |
|-----------------------------------------------------------------------------------------------------------------------------------|
| a. Describe the resident's current DME item (if the item requested is a replacement), including the type and the age of the item: |
| b. Describe why the current DME item does not meet the resident's needs: |
| c. Describe the DME item that is being requested: |
| d. Describe the medical necessity for the requested DME item: |
| e. Describe any anticipated modification/changes to the DME item within the next five years: |

II. Neurological Factors

| | |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| a. Indicate resident's muscle tone: | <input type="checkbox"/> Hypertonic <input type="checkbox"/> Absent <input type="checkbox"/> Fluctuating <input type="checkbox"/> Other |
| b. Describe resident's muscle tone: | |
| c. Describe active movements affected by muscle tone: | |
| d. Describe passive movements affected by muscle tone: | |
| e. Describe reflexes present: | |

Resident Name:

III. Postural Control

| | | | | |
|------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Head Control..... | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> None |
| Trunk Control | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> None |
| Upper Extremities..... | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> None |
| Lower Extremities..... | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> None |

IV. Medical Surgical History and Plans

a. Is there a *history* of decubitus/skin breakdown? Yes No

If Yes, explain:

b. Is there a *current* decubitus/skin breakdown? Yes No

If yes, explain and include the wound stage and wound dimensions of each current site:

c. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

d. Describe other physical limitations or concerns (i.e., respiratory):

e. Describe any recent or expected changes in medical/physical/functional status:

f. If surgery is anticipated, indicate the procedure and expected date:

Resident Name:

V. Functional Assessment

a. Ambulatory Status Nonambulatory With assistance Short distance only Community ambulatory

Indicate the resident's ambulation potential:

Expected within 1 year Not expected Expected in the future within _____ years

b. Is the resident dependent upon a wheelchair or walker for ambulation?..... Yes No

If Yes, describe the level of dependence. If No, describe the resident's ability to ambulate.

c. Is the resident tube fed?..... Yes No

If Yes, explain.

d. Feeding:

Maximum assistance Moderate assistance Minimum assistance Independent

Dressing:

Maximum assistance Moderate assistance Minimum assistance Independent

Describe any equipment the resident must access on a regular basis and the effect, if any, this has on the use of the requested DME item (i.e., augmented communication device, wheelchair, other).

VI. Environmental Assessment

a. Is the resident's living environment accessible and safe for the use of the DME item requested? Yes No

Will the DME item need to be transported?..... Yes No

If Yes, describe how the DME item will be transported.

b. If the resident has a current education/vocational setting, complete Items 1 – 3.

1. Name of education/vocational site: _____

2. Was the requested DME item used at this site? Yes No

3. If Yes, is the site accessible and safe for the use of the DME item?..... Yes No

Additional comments and observations of therapist:

Resident Name:

VII. Certification by Therapist Completing Assessment

| | |
|--------------------------|----------------------------------------|
| Therapist Name (Printed) | Therapist License Type and License No. |
|--------------------------|----------------------------------------|

Signature – Therapist

Date

Section C. Supplier Information and Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

| | |
|-------------------------------------------|-----------------------------|
| Supplier's Business Name | Area Code and Telephone No. |
| Supplier's Representative Completing Form | Area Code and Fax No. |

| | |
|---------|-----------------------|
| Address | City, State, ZIP Code |
|---------|-----------------------|

| Item No. | HCPCS Code | Description of Item | Item Price* | Quantity | Total Price |
|--------------------------------------------|------------|---------------------|-------------|----------|-------------|
| 1 | | | | | \$ |
| 2 | | | | | \$ |
| 3 | | | | | \$ |
| 4 | | | | | \$ |
| 5 | | | | | \$ |
| 6 | | | | | \$ |
| 7 | | | | | \$ |
| 8 | | | | | \$ |
| 9 | | | | | \$ |
| 10 | | | | | \$ |
| 11 | | | | | \$ |
| 12 | | | | | \$ |
| 13 | | | | | \$ |
| 14 | | | | | \$ |
| 15 | | | | | \$ |
| 16 | | | | | \$ |
| 17 | | | | | \$ |
| 18 | | | | | \$ |
| 19 | | | | | \$ |
| 20 | | | | | \$ |
| 21 | | | | | \$ |
| 22 | | | | | \$ |
| Total Amount of All Items Requested | | | | | \$ |

*Item price must be based on MSRP.

Nursing Facility Administrator Certification of Section C

By signing this form, I hereby attest that each item listed in Section C is consistent with provided MSRP documentation to support each item price. By listing each item identified in Section C I certify each listed item has been thoroughly reviewed. Each item listed in Section C is appropriate and can be safely used in the resident's environment when used as prescribed.

Signature – Nursing Facility Administrator

Date

Resident Name:

Physician's Attestation for Requested DME Item (Note: "Date last seen" and "Duration of Need" Items must be provided.)

| | |
|-----------------------------|----------------------------------------------------|
| Date Last Seen by Physician | Duration of Need for DME Item Month(s) or years |
|-----------------------------|----------------------------------------------------|

By signing this form, I hereby attest that the information provided in Section B, Therapist Identifying Information and DME Assessment, is consistent with the determination of the resident's current medical necessity and prescription. By prescribing the identified DME item, I certify the prescribed items are appropriate and can be safely used in the resident's environment when used as prescribed.

| | | |
|-------------------------|-----------------|-----------------|
| Physician's License No. | Physician's TPI | Physician's NPI |
|-------------------------|-----------------|-----------------|

Signature/Attestation – Physician

Signature Date

Section E. Transfer Request and Medical Professional Attestation

I. I am formally requesting that the existing durable medical equipment (DME) authorization for _____ be transferred from his/her previous nursing facility to the facility named in Section A of this form. He/she transferred to this facility as of _____, is currently residing in this facility and will be receiving delivery of his/her DME item at this location.

| | |
|----------------------------------------------|-------------------------------------|
| Name of Facility's Primary Contact (Printed) | Title of Facility's Primary Contact |
|----------------------------------------------|-------------------------------------|

Signature – Facility's Primary Contact

Signature Date

II. DME Medical Professional Certification: The medical professional certifying the statements below must be the resident's physician, an occupational therapist or a physical therapist.

I certify the following:

- The resident's living environment is accessible to the DME item.
- There are ramps (if applicable) available in the resident's living environment.
- The DME item being supplied under this request is consistent with the assessment contained in the original request form submitted for this resident and that the requested item is appropriate and can safely be used in the resident's environment when used as described in the assessment.

| | |
|---------------------------------------|------------------------------------|
| Medical Professional's Name (Printed) | Type of Medical Professional/Title |
|---------------------------------------|------------------------------------|

Signature – Medical Professional

Signature Date

Section F. Acknowledgement and Signature of Nursing Facility Administrator for Initial Submissions and Transfer Requests

I acknowledge that I have been made aware of the resident's DME request. I understand appropriate facility staff or contract therapist provided the resident assessment information included in this request to support the resident's needs specific to the item requested.

| |
|--------------------------------------------------|
| Name of Nursing Facility Administrator (Printed) |
|--------------------------------------------------|

Signature – Nursing Facility Administrator

Date