



**Detailed Item by Item Guide
for Completing the
Authorization Request for
PASRR Nursing Facility
Specialized Services Form**

**Texas Health and Human Services
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TEXAS
Health and Human
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Purpose

This document describes details for completing the Authorization Request for Nursing Facility Specialized Services (NFSS) Portable Document Format (PDF) printable form.

This guide is to be used to complete the Authorization Request for NFSS PDF printable form prior to submitting the information in the Texas Medicaid & Healthcare Partnership (TMHP) Long-Term Care (LTC) Online Portal to request authorization for a specialized service from the Health and Human Services Commission (HHSC).

Overview

To find resources referenced in this document from the TMHP website, users will need to select:

1. “Programs” from the main TMHP website
2. “Long-Term Care (LTC)”
3. Any of the following:
 - a) “Provider Bulletins”
 - b) “Provider Education”
 - c) “Reference Materials”
 - d) “Forms”

The screenshot shows the Texas Medicaid & Healthcare Partnership (TMHP) website. At the top left is the TMHP logo with the text "TEXAS MEDICAID & HEALTHCARE PARTNERSHIP A STATE MEDICAID CONTRACTOR". At the top right are links for "Provider" and "Client/Cliente", and a search bar. The main navigation menu includes "Home", "1. Programs", "Topics", "Resources", "Contact", and "My Account". The "Programs" menu is highlighted with a red box. Below the navigation is a banner for "Long-Term Care" with a description: "HHSC administers programs providing long-term care (LTC) services and institutional care to eligible clients." and a button for "LTC Online Portal". Below the banner is a breadcrumb trail: "Home > Programs > Long Term Care (LTC)".

2. Long-Term Care (LTC)

- Provider Bulletins
- a. Provider Education
- b. Reference Material
- c. Forms
- d.

Long-Term Care (LTC)
Last updated on 5/31/2020

The Texas Health and Human Services Commission (HHSC) administers programs providing long-term care (LTC) services and institutional care to eligible clients.

The Texas Medicaid & Healthcare Partnership (TMHP) supports the provider community through provider education and

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1/27/2021

HCS, TxHmL Quarterly

When an existing assessment instrument is available to the therapist, that assessment tool should be used to perform the required assessment. The word ‘therapist’ is used to represent either a Texas licensed occupational therapist, licensed physical therapist, or licensed speech therapist.

The therapist may choose to complete the assessment section of the printable NFSS PDF form for the specialized service for which authorization is being requested when there is no assessment tool for the particular specialized service.

No matter which assessment instrument is used, all required fields within the NFSS form on the LTC Online Portal must be completed to submit the prior-authorization request.

Once the assessment has been completed the nursing facility must submit the request through the LTC Online Portal no more than 30 calendar days from the date it was completed and signed by the therapist. The original assessment is maintained in the individual's medical record.

The NFSS PDF form is used as an assessment instrument. Once the NFSS PDF is completed, the information is entered into the NFSS form on the LTC Online Portal to request nursing facility specialized services including durable medical equipment (DME), a customized manual wheelchair (CMWC), and habilitative therapies.

For an individual to be eligible for nursing facility specialized services, and before an authorization request is submitted, the standard Preadmission Screening and Resident Review (PASRR) procedures must be followed as described below.

PL1 Screening Form

The PASRR Level I (PL1) Screening Form is designed to identify individuals who are suspected of having mental illness (MI), intellectual disability (ID), or a developmental disability (DD). A developmental disability is also referred to as a related condition (RC).

The referring entity (RE), local intellectual or developmental disability authority (LIDDA), local mental health authority (LMHA), local behavioral health authority (LBHA), or nursing facility (NF) will screen the individual and fill out all fields of the PL1 Screening Form and enter the PL1 Screening Form into the LTC Online Portal.

If documentation entered on the PL1 Screening Form indicates a suspicion of MI/ID/DD, a PASRR Evaluation (PE) must be completed.

PE

The PE is completed by the LIDDA, LMHA, or LBHA, and is designed to confirm or deny the suspicion of MI, ID, or DD/RC, ensure the individual is placed in the most integrated personal setting, and ensure the individual is receiving the specialized services needed to improve and maintain the individual's level of functioning.

IDT

For an individual with a positive PE, the initial interdisciplinary team (IDT) meeting is held within 14 days of an individual's admission into the NF to determine whether the individual is best served in a NF or community setting. In addition, the IDT meeting is used to identify which of the specialized services recommended on the PE, the individual, or legally authorized representative (LAR) on the individual's behalf, wants to receive.

Once the initial IDT meeting is held, an Annual IDT specialized services review meeting is held thereafter to review and update any specialized services the individual or the individual's LAR wants to receive.

The IDT must include the participation of:

- The individual;
- The individual's LAR, if any;
- A registered nurse from the NF with responsibility for the individual;
- A representative of the LIDDA, LMHA, or LBHA; and
- Others as applicable:
 - ▶ Concerned persons whose inclusion is requested by the individual or LAR;
 - ▶ Persons specified by the individual or LAR, NF, or LIDDA, LMHA, or LBHA, as applicable, who are professionally qualified, certified, or licensed with special training and experience in the diagnosis, management, needs, and treatment of people with MI, ID, or DD; and
 - ▶ Representatives of the appropriate school district, if the individual is school eligible, as requested by the individual or LAR.

As a required member of the IDT, a representative of the LIDDA, LMHA, or LBHA will confirm their attendance at the meeting (in person or by phone). They will also confirm that the specialized services documented on the IDT or specialized services review meeting forms were those agreed to during the meeting and documented on the PASRR Comprehensive Service Plan (PCSP) form.

Initiating PASRR nursing facility specialized services

The NF has 20 business days from the date of the initial IDT or a specialized services review meeting to initiate all PASRR nursing facility specialized services (NFSS) for those with a positive PE for ID/DD recommended and agreed to at the meeting. The following NF habilitative specialized services must be requested by completing all required fields in the NFSS form on the LTC Online Portal:

- Occupational therapy (OT)

- Physical therapy (PT)
- Speech therapy (ST)
- A customized manual wheelchair (CMWC)
- Durable medical equipment (DME), which consists only of the following items:
 - ▶ Gait trainer
 - ▶ Standing board
 - ▶ Special needs car seat or travel restraint
 - ▶ Specialized or treated pressure-reducing support surface mattress
 - ▶ Positioning wedge
 - ▶ Prosthetic device
 - ▶ Orthotic device

When to Complete and Submit an NFSS Form

Before providing a PASRR NFSS, a NF must request and receive authorization from HHSC through the LTC Online Portal to deliver the service. Once authorized, a NF must submit a complete and accurate claim within 12 months of the end of the month in which the service was provided. Only NFs can submit an NFSS form on the LTC Online Portal.

Once a PASRR specialized service has been recommended through the IDT or the LIDDA's service planning team (SPT) meeting, the NF should ensure that a Daily Care Service Authorization (NF or hospice) or a Medicare Skilled Nursing Service Authorization (co-insurance) exists for the date intended to complete the assessment. Then initiate the required assessment to verify and confirm the needs of the individual. If the assessment confirms the need for the specialized service, the authorization request for both the assessment and the service should be submitted into the LTC Online Portal together using the NFSS form. Submitting only the assessment authorization will not result in service authorization being created. The NF must also ensure that a Daily Care Service Authorization (NF or hospice) or a Medicare Skilled Nursing Service Authorization (co-insurance) exists for the date the request for the service is submitted.

If the assessment does not confirm the need for a particular service, the NF may still request authorization for payment for performing the assessment.

Performing an Assessment for the NFSS Form

For any part of the PASRR NFSS (a DME, CMWC, Occupational Therapy, Physical Therapy, or Speech Therapy), a licensed therapist must complete, or have recently completed (within the last 30 calendar days), an assessment on the individual to determine whether the service being requested is medically necessary. Depending on the service being requested, the therapist must be an occupational therapist, physical therapist, or a speech language pathologist and be licensed in the state of Texas.

The assessment by the therapist should be completed using the assessment instrument usually available to the therapist, or the therapist may choose to use the NFSS PDF form's assessment section. **Regardless of the assessment used, all required assessment information must be entered on the NFSS form in the LTC Online Portal to initiate an authorization request.**

A therapist can complete an assessment at any time to evaluate the needs of the individual; however, HHSC will only authorize payment for an assessment for the same individual, unless they move to another nursing facility, every 180 days.

Note: Once a therapy assessment has been approved, it can be used for up to one year to recertify therapy requests. Therapy assessments are authorized for a one-year period and must be updated annually.

NFSS Form Retention Period

Nursing facilities must keep the original therapist assessment with the appropriate original signatures in the individual's record until notified otherwise by HHSC Legal Services.

NFSS Form Assistance

Call **TMHP** at 800-626-4117, Option 1 for:

- NF forms completion – including the PASRR Level 1 Screening Form, PCSP, and NFSS Form
- LA forms completion – including the PASRR Level 1 Screening Form, PE, and PCSP
- Rejection codes on the forms and PASRR Transaction Identifications (PTIDs)
- Management of the Provider Action Required status
- Available options if a form is set to ID Invalid status but the Medicaid number, SSN, or Medicare number and name match the Medicaid ID card
- PASRR Level 1 Screening Form, PE, PCSP, and NFSS form submission error messages and NFSS PTID and PE PTID error messages
- PASRR Level 1 Screening Form, PE, PCSP, and NFSS status questions
- MDS LTCMI form submission error messages.

Call TMHP at 800-626-4117, option 2, about the following:

- MN determination on PE

Call TMHP at 800-626-4117, option 3, about the following:

- TMHP LTC Online Portal and TexMedConnect account setup

Email **HHSC PASRR Unit** at PASRR.Support@hhsc.state.tx.us for:

- Assistance with or cooperation from an RE, NF, LIDDA, or LMHA/LBHA
- Assistance with locating information to complete and submit the PL1 Screening Form, PE, PCSP, and NFSS forms
- Assistance with locating forms, people residing in or entering an NF, LIDDAs, LMHA/LBHAs, or additional training resources
- Policy guidance on PASRR processes, specialized services, and therapist assessments
- Questions specifically related to MI/ID/DD or related conditions

For additional learning opportunities, information, and forms, visit the following web page: [Preadmission Screening & Resident Review \(PASRR\) | Texas Health and Human Services](#)

Completing the NFSS Form for a DME or CMWC Assessment

The NFSS form can only be submitted on the TMHP LTC Online Portal. The LTC Online Portal can be accessed via: [TMHP LTC Portal](#)

A NF can request authorization for an assessment without having to request a DME or CMWC in situations where the assessment indicates an item is not medically necessary, the individual is temporarily or permanently discharged from the facility, or other reasons why only the assessment is needed. In this case, the NF will request authorization for an “Assessment Only”.

When the NF is requesting authorization for a DME or CMWC, the submission must include both the assessment and the completed DME or CMWC service form.

PDF Form

A blank copy of the NFSS form in PDF format is available for downloading at: [Long-Term Care Forms | TMHP](#).

If a therapist chooses to use the downloaded PDF copy of the NFSS form to record the assessment, all information from the NFSS PDF Form must be data entered in the NFSS form on the LTC Online Portal. The original copy of the assessment completed on the PDF form is maintained in the individual’s medical record.

Using the hyperlink shown above, the therapist will be able to access the NFSS PDF form(s) to be used when completing an assessment for a CMWC, a DME, or a habilitative therapy. Each type of service and the related assessment is represented on a separate PDF file on the forms page at the link above. The following NFSS PDF forms are available on the site:

- Authorization Request for NF Specialized Services (NFSS) for CMWC; and
- Authorization Request for NF Specialized Services (NFSS) for DME.

The NFSS PDF form should NOT be faxed to TMHP or HHSC or submitted into the LTC Online Portal to request a specialized service. These requests will not be accepted.

Required Signatures

Each authorization request for an assessment submitted on the NFSS form must be accompanied by an attachment with the therapist’s signature.

When requesting authorization for an assessment only, the NF must ensure the signature page is signed by the therapist that performed the assessment and the NF administrator.

If the submission will also be requesting authorization for a DME or CMWC, the request must contain:

- The signatures of the referring physician, attesting that the DME or CMWC is medically necessary, and
- The durable medical equipment (DME) supplier's signature:
 - ▶ Certifying the item or chair is consistent with the therapist's assessment;
 - ▶ The prices submitted are the manufacturer's suggested retail price (MSRP);
 - ▶ Acknowledging the actual authorized amount is minus 18 percent of the MSRP; and
 - ▶ Acknowledging the cost of any adjustments and modifications required within the first six months after delivery is included in the authorized amount.

The NF will download the signature pages from the TMHP website: [Long-Term Care Forms | TMHP](#).

Attachments

Required attachments for an assessment that must be submitted with the NFSS form are as follows:

For CMWC:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page (for therapist, referring physician and NF administrator signatures)
- PASRR NF Specialized Services (NFSS) - CMWC Supplier Acknowledgment and Signature Page
- DME MSRP for each item requested
 - ▶ DME supplier's Attestation Letter attesting to price quotes as MSRP prices
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification (for therapist and NF administrator signatures) (only completed and uploaded once the individual receives the CMWC item.)

For DME:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page (for therapist, referring physician, and NF administrator signatures)
- PASRR NF Specialized Services (NFSS) - DME Supplier Acknowledgment and Signature Page
- MSRP for each item requested
 - ▶ DME supplier's Attestation Letter attesting to price quotes as MSRP prices
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification (only completed and uploaded once the individual receives the CMWC item.) Attachments can be found at the TMHP website: [Long-Term Care Forms | TMHP](#).

Faxing Attachments: Attachments that are required with an NFSS form submission to request an assessment or specialized service can be faxed after they have been printed and all required signatures are obtained.

To fax a required attachment (signature page, receipt confirmation, MSRPs, etc.) the NFSS Fax Cover Sheet must be filled out completely and all documents faxed to the number on the Fax Cover Sheet. This form can be downloaded at [Long-Term Care Forms | TMHP](#).

The PDF NFSS form should NOT be faxed to TMHP or HHSC to request a specialized service.

Completing the NFSS Form for a DME or CMWC

As previously indicated, for any part of the PASRR NFSS being requested, a therapist licensed in the state of Texas must perform an assessment on the individual to determine whether the service being requested is medically necessary. When requesting a PASRR specialized service, a NF must ensure the DME or CMWC is required by the individual's comprehensive care plan, is based on a relevant diagnosis, and ordered by the individual's attending physician.

HHSC only authorizes PASRR DME items greater than \$1,000 but less than \$5,000.

NFs are required to provide medical equipment and supplies costing less than \$1,000 in order to ensure that care meets the health needs and promotes the maximum well-being of the individual. Such equipment and supplies are included as a part of the per diem reimbursement paid to the NF by HHSC. Any item over \$5,000 may require additional information and review by HHSC.

HHSC does not approve a request to replace a CMWC made within five years after a CMWC was purchased for the individual, unless the authorization request includes:

1. An order from the designated resident's attending physician; and
2. An assessment by an occupational therapist or physical therapist licensed in Texas, with documentation explaining why the person's current CMWC no longer meets the person's needs.

Note: A NF must request the DME or CMWC by completing both the assessment and the DME or CMWC form.

PDF Form

A blank copy of the NFSS form in PDF format is available for downloading at: [Long-Term Care Forms | TMHP](#).

If a therapist chooses to use the downloaded PDF copy of the NFSS form to record the DME or CMWC authorization request, all information from the NFSS PDF form must be data entered in the NFSS form on the LTC Online Portal. The original copy of the DME or CMWC request completed on the PDF form is maintained in the individual's medical record.

Using the hyperlink shown above, the therapist will be able to access the NFSS PDF form(s) to be used when completing a request for a DME or CMWC. The DME item and CMWC is represented on a separate PDF file on the forms page at the link above. The following NFSS PDF forms are available on the site:

- Authorization Request for NF Specialized Services (NFSS) for CMWC
- Authorization Request for NF Specialized Services (NFSS) for DME

The NFSS PDF form should NOT be faxed to TMHP or HHSC or submitted into the LTC Online Portal as a means to request a specialized service. These requests will not be accepted.

Required Signatures

Each authorization request for a CMWC or DME submitted through the NFSS form must be accompanied by an attachment with:

- The therapist's signature that performed the assessment;
- The signature of the referring physician, attesting that the DME or CMWC is medically necessary; and
- The signature of the nursing facility administrator.

Additionally, for CMWC or DME authorization requests, the NF must also include:

- The durable medical equipment (DME) supplier's signature:
 - ▶ certifying the item or chair is consistent with the therapist's assessment;
 - ▶ The prices submitted are the manufacturer's suggested retail price (MSRP);
 - ▶ Acknowledging the actual authorized amount is minus 18% of the MSRP; and
 - ▶ Acknowledging the cost of any adjustments and modifications required, within the first six months after delivery is included in the authorized amount.

The nursing facility will download the signature pages from the following website: [Long-Term Care Forms | TMHP](#).

Attachments

Required attachments for a CMWC or DME that must be submitted with the NFSS form are as follows:

For CMWC:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page (for therapist, referring physician, and NF administrator signatures)
- PASRR NF Specialized Services (NFSS) - CMWC Supplier Acknowledgment and Signature Page
- MSRP for each item requested
 - ▶ DME supplier's Attestation Letter attesting to price quotes as MSRP prices
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification (for therapist and NF administrator signatures) (only completed and uploaded once the individual receives the CMWC item.)

- Receipt Certification by a Qualified Rehabilitation Professional (QRP), Form 2362- to be completed by the DME Supplier's QRP that delivers the CMWC to the resident/facility.

For DME:

- PASRR NF Specialized Services (NFSS) - CMWC/DME Signature Page (for therapist, referring physician and NF administrator signatures)
- PASRR NF Specialized Services (NFSS) - DME Supplier Acknowledgment and Signature Page
- MSRP for each item requested
 - ▶ DME supplier's Attestation Letter attesting to price quotes as MSRP prices
- PASRR NF Specialized Services (NFSS) - CMWC/DME Receipt Certification(only completed and uploaded once the individual receives the CMWC item). Attachments can be found at the following website: [Long-Term Care Forms | TMHP](#).

Faxing Attachments: Attachments that are required with an NFSS form submission to request an assessment or specialized service can be faxed after they have been printed and all required signatures are obtained.

To fax a required attachment (signature page, receipt confirmation, MSRP, etc.) the "NFSS Fax Cover Sheet" must be completely filled out and all documents faxed to the number on the Fax Cover Sheet. This form can be downloaded at [Long-Term Care Forms | TMHP](#).

The PDF NFSS form should NOT be faxed to TMHP or HHSC as a means to request a specialized service.

Receipt Certification:

For any request involving a DME or CMWC, a receipt certification must be uploaded into the LTC Online Portal after the item has been delivered. The signature by the therapist on this page certifies that the item meets the needs of the person as specified in the assessment. It also indicates, by the administrator's signature, that the item was delivered and received by the nursing facility and the individual.

Failure to submit this receipt confirmation will delay or prevent the facility's reimbursement.

Item by Item Steps for the DME or CMWC NFSS Form

Resident/NF Section

INTENT: The purpose of this section is to document the identifying and contact information for the individual, LAR (if applicable), NF, LIDDA, and LMHA/LBHA.

A0100. Resident Name- Resident Information Subdivision:

A0100 A. First name - Enter the individual's First Name.

A0100 B. Middle initial- Enter the individual's Middle Initial.

A0100 C. Last name - Enter the individual's Last Name.

A0100 D. Suffix Enter the individual's Suffix.

A0200 A. Social Security No.- Enter the individual's social security number.

A0200 B. Medicare No.- Enter the individual's Medicare number.

A0300. Medicaid No. - Enter the individual's Medicaid number.

A0400 A. Birth Date - Enter the individual's Birth Date.

A0400 B. Age - Enter the individual's age at the time of submission. The individual must be 21 years of age to qualify for PASRR nursing facility Specialized Services.

Legally Authorized Representative (LAR) Subdivision: If the individual has an LAR, enter the LAR's identification information.

A0500 A. First name - Enter the LAR's First Name.

A0500 B. Last name - Enter the LAR's Last Name.

A0600 A. Street Address- Enter the name of the LAR's Street address.

A0600 B. City - Enter the name of the LAR's city.

A0600 C. State - Enter the name of the LAR's state.

A0600 D. Zip Code - Enter the name of the LAR's zip code

A0600 E. Phone No. - Enter the name of the LAR's phone number.

Nursing Facility Information Subdivision: Document the identifying and contact information for the individual's nursing facility.

A0700 A. Provider No. - Enter the Provider number of the NF.

A0700 B. Vendor No. - Enter the vendor number of the NF.

A0700 C. NPI - Enter the national provider identifier (NPI) number of the NF.

A0700 D. Facility Name - Enter the facility name.

A0800 A. Street Address - Enter the street address of the NF.

A0800 B. City - Enter city of the NF.

A0800 C. State - Enter the state of the NF.

A0800 D. ZIP Code - Enter the zip code of the NF.

A0800 E. County - Enter the County of the NF.

A0900 A. Phone No. - Enter the area code and phone number of the person to be contacted at the NF questions regarding information entered into the NFSS form.

A0900 B. Fax No. - Enter the area code and fax number of the person to be contacted at the NF with questions regarding information entered into the NFSS form.

LIDDA and LMHA/LBHA Information Subdivision: Document the identifying and contact information for the person's LIDDA or LMHA/ LBHA.

A1000 A. LIDDA Contract No. - Enter the LIDDA Contract number.

A1000 B. LIDDA Vendor No. - Enter the LIDDA Vendor number.

A1000 C. LIDDA NPI/API No. - Enter the LIDDA NPI/API number.

A1100 A. LMHA Contract No. - Enter the LMHA or LBHA Contract number.

A1100 B. LMHA Vendor No. - Enter the LMHA or LBHA Vendor number.

A1100 C. LMHA NPI/API No. - Enter the LMHA or LBHA NPI/API number.

Type of Service Requested Subdivision:

Durable Medical Equipment (DME)

A2000 Request Type – Select from only one category: CMWC, DME, or Habilitative Therapies

A2100 CMWC Service Type- if CMWC was selected under A2000 Request Type, choose one of the following options:

- Number 1. CMWC Assessment Only, or
- Number 2. CMWC for the assessment **and** a CMWC.

A2200 DME Service Type - select either

- Number 1. DME Assessment Only, or
- Number 2. DME for the assessment **and** DME item.

A2210 Requested DME Item - if DME was selected under A2200 DME Service Type, then select all the DME items being requested and listed in this section. One assessment by a therapist can be used to request multiple DME items as long as all relevant data is entered into the DME assessment section.

CMWC/DME Assessment Section

INTENT: The purpose of this section is to document the assessment information completed by a licensed therapist for a CMWC or DME.

The information from the assessment must be data entered into the CMWC/DME Assessment tab in the NFSS form on the LTC Online Portal.

Steps for a CMWC or DME Assessment

1. The information requested in this section is required.
2. Response to questions must be at least 50 characters long or the LTC Online Portal will not accept the information. A space is considered a character.
3. EXAMPLE: “The quick brown fox jumped over the lazy dog” contains 45 characters.
4. The LTC Online Portal will ONLY accept the following special characters: @ /+, _ -

Therapist Identifying Information Subdivision:

B0100 A. First Name - Enter the first name of the therapist who completed the DME or CMWC assessment.

B0100 B. Last Name – Enter the last name of the therapist who completed the DME or CMWC assessment.

B0200 A. License Type – Select the type of license held by the therapist who completed the assessment: 1. Occupational Therapist or 2. Physical Therapist.

B0200 B. License No. - Enter the seven-digit license number of the therapist who completed the assessment. If the therapist's license number is less than seven-digits, place a zero before the license number.

B0200 C. License State - Enter the state in which the license of the therapist who conducted the assessment was issued. If the therapist who conducted the assessment is not licensed in Texas, then the remaining fields in this Subdivision will become disabled and the NFSS form cannot be submitted.

B0300 Is the therapist employed by the Nursing Facility - If the therapist who completed the assessment works for the NF enter 1. Yes. If the therapist who completed the assessment does not work for the NF, but is a contracted therapist, enter 0. No.

If the therapist is NOT employed by the NF, complete the remainder of the therapist identifying information so the therapist can be contacted with questions regarding the assessment.

B0400 Therapist's Employer Name - Enter the name of the employer of the therapist who conducted the assessment when the employer is not the NF.

B0500 A. Street Address - Enter the street address of the employer of the therapist who conducted the assessment.

B0500 B. City - Enter the city in which the employer of the therapist who conducted the assessment is located.

B0500 C. State - Enter the state in which the employer of the therapist who conducted the assessment is located.

B0500 D. ZIP Code - Enter the zip code in which the employer of the therapist who conducted the assessment is located.

B0600 A. Phone No. - Enter the area code and phone number of the employer of the therapist who conducted the assessment.

B0600 B. FAX No. - Enter the area code and fax number of the employer of the therapist who conducted the assessment.

B0700 Therapist's Signature Date - Enter the date the therapist who conducted the assessment signed the CMWC/DME – Signature page. The signature date:

- Cannot be more than 29 calendar days prior to the original request date for a service. The assessment by the therapist must be completed within 30 days before the nursing facility requests authorization for the assessment or service.
- Must be greater than or equal to Date of Assessment (B0800).
- Must match the signature date submitted on the CMWC/DME – Signature page that was signed by the therapist.

Date of Assessment Subdivision:

B0800 Date of Assessment - Enter the date the assessment was completed by the therapist. The assessment by the therapist must be completed within 30 days before the NF requests authorization for the assessment or service.

Postural Control Subdivision:

B0900 A. Head Control - Enter the individual's level of head control by selecting one of the following: 1. Good, 2. Fair, 3. Poor, 4. None.

B0900 B. Trunk Control - Enter the individual's level of trunk control by selecting one of the following: 1. Good, 2. Fair, 3. Poor, 4. None.

B0900 C. Upper Extremities - Enter the individual's level of control of the upper extremities by selecting one of the following: 1. Good, 2. Fair, 3. Poor, 4. None.

B0900 D. Lower Extremities - Enter the individual's level of control of the lower extremities by selecting one of the following: 1. Good, 2. Fair, 3. Poor, 4. None.

Medical Surgical History and Plan Subdivision:

B1000 A. Is there a history of decubitus/skin breakdown - Indicate if there is a history of decubitus or skin breakdown by entering: 1. Yes, or 0. No.

B1000 B. If Yes, explain - If 1. Yes, was selected for B1000A, enter an explanation of any past history of decubitus/skin breakdown. (Minimum is 50 alphanumeric characters).

B1100 A. Is there a current decubitus/skin breakdown - Indicate if there is a current breakdown of the decubitus/skin, by entering: 1. Yes or 0. No.

B1100 B. If Yes, explain and include the wound stage and dimensions of each current site - If 1. Yes, was selected for B1100A, indicating there is a current decubitus/skin breakdown, enter the wound/pressure sore (bed sore) stage and dimensions. (Minimum is 50 alphanumeric characters.)

B1200 Describe orthopedic conditions and/or range of motion limitations requiring special considerations (e.g., contractures, degree of spinal curvature, etc.) - Describe any orthopedic conditions caused by neuro - motor impairments, degenerative diseases, or musculoskeletal disorders that limit the joint's range of motion. (Minimum is 50 alphanumeric characters.)

B1300 Describe physical limitations or concerns (i.e., respiratory) - Describe any conditions such as respiratory disorders, heart condition, epilepsy, or other physical impairments. (Minimum is 50 alphanumeric characters.)

B1400 Describe any recent expected changes in medical/physical/functional status - Describe any changes during the past 2-5 years, including past surgeries, if any. (Minimum is 50 alphanumeric characters.)

B1500 A. Is surgery anticipated - If surgery is anticipated in the near future, enter: 1. Yes, 0. No

B1500 B. If Yes, indicate the expected date - If 1. Yes, was selected for B1500A., enter the expected date of the surgery

B1500 C. If Yes, describe the procedure - If 1. Yes, was selected for B1500A., enter a description of the surgical procedure. (Minimum is 50 alphanumeric characters.)

Neurological Factors Subdivision:

B1600 A. indicate resident's muscle tone - Enter a description of the individual's muscle tone by selecting one of the following: 1. Absent, 2. Fluctuating, 3 Hypertonic, 4. Other.

B1600 B. Describe resident's muscle tone - Enter a description of the individual's muscle tone. (Minimum is 50 alphanumeric characters.)

B1600 C. Describe active movements affected by muscle tone - Describe the active movements affected by muscle tone. (Minimum is 50 alphanumeric characters.)

B1600 D. Describe passive movements affected by muscle tone - Describe the passive movements affected by muscle tone. (Minimum is 50 alphanumeric characters.)

B1600 E. Describe reflexes present - Describe which reflexes are present. (Minimum is 50 alphanumeric characters.)

Functional Assessment Subdivision:

B1700 A. Ambulatory Status - Enter the individual's ambulatory status by selecting one of the following: 1. Community ambulatory, 2. Non - ambulatory, 3. Short distance only, 4. With assistance.

B1700 B. No. of feet - If 3. Short distance only is entered for B1700 A., enter the distance (in feet) the individual can ambulate.

B1700 C. Is the resident dependent upon a wheelchair or walker for ambulation – If “4. With Assistance” is entered for B1700A, enter whether the individual is dependent upon a wheelchair or walker for ambulation by selecting: 1. Yes or 0. No.

B1700 D. If Yes, describe the level of dependence. If no, describe the resident's ability to ambulate – If 1. Yes was entered for B1700 C, describe the individual's level of dependence on a wheelchair or walker. If 0. No was entered for B1700 C, describe the individuals' ability to ambulate without a wheelchair or walker. (Minimum is 50 alphanumeric characters.)

B1800 A. Indicate the ambulation potential - Enter the individual's ambulation potential by selecting one of the following: 1. Not expected, 2. Expected within 1 year, 3. Expected in the future.

B1800 B. No. of Years - If 3. Expected in the future was entered for B1800 A, enter the number of years by selecting one of the following:

1. 1 year
2. 2 years
3. 3 years
4. 4 years
5. 5 years

B2000 Feeding - Enter the individual's level of assistance required for eating by selecting one of the following: 1. Maximum assistance, 2. Moderate assistance, 3. Minimum assistance, 4. Independent

B2100 A. Is the resident tube fed - If the individual is tube fed, enter: 1. Yes or 0. No.

B2100 B. If yes, explain - If 1. Yes, was entered in B2100 A, enter a detailed explanation about the method used when the individual is tube fed. (Minimum is 50 alphanumeric characters.)

B2200 B. Dressing - Enter the individual's level of assistance required to dress by selecting one of the following: 1. Maximum assistance, 2. Moderate assistance, 3. Minimum assistance, 4. Independent.

Educational/Vocational Setting Subdivision:

B2300 A. Does the resident have a current education/vocational setting – If the individual currently attends an education/vocational setting enter: 1. Yes or 0. No.

B2300 B. If Yes, Name of education/vocational site - If 1. Yes, was entered in B2300 A, enter the name of the education/vocational site the individual attends.

B2300 C. If Yes, has the therapist from the education/vocational setting been involved in this assessment? – If a therapist was involved in completing the assessment, enter: 1. Yes, or 0. No.

B2310 Other Therapist from Education/Vocational Setting - If 1. Yes, was entered in B2300 C, enter the name and phone number of the therapist from the educational/vocational setting who was involved in completing the assessment in fields B2310 A-C.

Referring Physician Identifying Information Subdivision:

The referring physician is the one who is licensed as an MD or DO and will be attesting to medical necessity when requesting prior authorization for a CMWC or a DME item.

B2400 A. Last Name - enter the last name of the referring physician.

- The physician's name entered in the LTC Online Portal must match the name written on the CMWC/DME Signature page.

B2400 B. License State - Select the state in which the physician is licensed.

B2400 C. License No. - Enter the state license number of the referring physician. The physician's license number will be validated against Texas Medical Board records.

B2400 D. Military Spec. Code - If the physician is on duty with the military, enter a military specialty code rather than the state license number of the referring physician.

B2400 E. Date Resident Last Seen - Enter the date the individual was last seen by the physician.

B2400 F. Signature Date - Enter the date the referring physician signed the CMWC/DME Signature page.

The physician's signature date:

- Cannot be more than 29 calendar days prior to the submission date for a service. The assessment by the therapist must be completed within 30 days before the nursing facility requests authorization for the assessment or service.

- The physician’s signature date must be equal to or after the therapist’s assessment and signature date.
- Must match the signature date submitted on the CMWC/DME –Signature page that was signed by the physician.

The signatures for all parties must be legible in order to verify that the signature matches the name that was entered into the NFSS form on the LTC Online Portal. Illegible signatures or signatures that do not match the NFSS form will not be accepted.

B2500 A. First Name - Enter the first name of the physician only if the physician holds an out of state license (state entered in B2400 B is any state other than Texas).

B2600 A. Street Address - Enter the street address of the physician’s office when the physician holds an out - of - state license (state selected in B2400 B is any state other than Texas).

B2600 B. City - Enter the city where the physician’s office is located when the physician holds an out - of - state license (state selected in B2400 B is any state other than Texas).

B2600 C. State - Enter the state of the physician’s office when the physician holds an out - of - state license (state selected in B2400 B is any state other than Texas).

B2600 D. ZIP Code - Enter the zip code of the physician’s office when the physician holds an out - of - state license (state selected in B2400 B is any state other than Texas).

B2600 E. Phone No. - Enter the phone number, including area code; of the physician’s office when the physician holds an out-of-state license (state selected in B2400 B is any state other than Texas).

Required Document:

NFSS CMWC/DME Signature Page: Print the signature page to obtain therequired signatures.

Obtain signatures as instructed in B0700 Therapist’s Signature Date for anassessment and B2400 F. Signature Date for a CMWC or DME request.

CMWC Request Section

INTENT: The purpose of this section is to document the information on the LTC Online Portal. The assessment is completed by a licensed therapist and a qualified rehabilitation professional (QRP) who is employed by or contracts with the DME supplier in order to request a CMWC. NFs must request payment for the QRP assessment when submitting a prior authorization request for a CMWC. Please refer to [Information Letter No. 20-39](#) for more information on the QRP Certification process. NFs should use the Authorization Request NFSS for CMWC form available for downloading at [Long-Term Care Forms | TMHP](#).

Complete this section only if Type of Service is CMWC.

Current Seating Equipment Subdivision:

C0100A. - Does the person have a current seating system - Indicate if the individual has a current seating system, by entering: 1. Yes or 0. No.

- If No, skip to the Requested Customized Seating Equipment subdivision.

C0100B. Describe the resident's current seating system, including the mobility base and age of the system/base - If 1. Yes, was entered in C0100 A, describe the individual's current seating system, including the mobility base and age of the system/base. (Minimum is 50 alphanumeric characters.)

C0100C. Describe the wheelchair type - If 1. Yes, was entered in C0100 A, describe the individual's current wheelchair type (e.g. manual wheelchair, scooter, power wheelchair). (Minimum is 50 alphanumeric characters.)

C0100D. Date of Purchase - If 1. Yes, was entered in C0100 A, enter the date the wheelchair was purchased.

C0100E. Describe why the current seating system does not meet the person's needs - If 1. Yes, was entered in C0100 A, enter the reason the current seating system no longer meets the individual's needs. (Minimum is 50 alphanumeric characters.)

Note: As stated in section 2 of this manual, HHSC does not authorize a request to replace a CMWC made within 5 years after a CMWC was purchased unless the request includes an assessment by an OT or PT explaining why the current seating system no longer meets the person's needs and an order from the person's attending physician. (26 TAC, Chapter 554, Subchapter BB, §554.2756(f)).

Requested Customized Seating Equipment Subdivision:

C0200 Describe the seating system that is being requested and how it must be customized to meet the person's specific medical needs - Describe the seating system being requested (e.g. how the seating system will offer postural control and skin protection, etc.) and the individual's specific medical needs for these customizations. (Minimum is 50 alphanumeric characters.)

Note: This section must contain all the diagnosis for the individual or the request will be set to "Pending Denial."

C0300 Describe the mobility base that is being requested - Describe the type of manual mobility base needed by the individual's physical and/or functional deficits that cannot be met using other standard wheelchair bases, including the appropriate configuration of wheelchair accessories. (Minimum is 50 alphanumeric characters.)

C0400 Describe the medical necessity for the requested customized seating system - Enter a description of the medical necessity for the requested customized seating system. (Minimum is 50 alphanumeric characters.)

C0500 Describe any anticipated modifications/changes to the requested equipment within the next five years
- Enter a description of any anticipated modifications/changes to the requested equipment within the next five years due to weight change, tissue atrophy, postural changes, etc. (Minimum is 50 alphanumeric characters.)

C0600 Describe other activities performed while in the CMWC. Describe access to equipment while in the CMWC to include any equipment that may be mounted or adapted to the CMWC (i.e. augmented communication device, other) - Describe other activities the individual will perform while in the custom manual wheelchair (such as eating, personal grooming and hygiene, light exercises, propelling self, socializing, etc.) and the equipment which may be mounted or adapted to the custom manual wheelchair (such as a molded tray or a feeding pole). (Minimum is 50 alphanumeric characters.)

Measuring Worksheet Subdivision:

NFs can use the measurement worksheet on page 12 of the PDF form available for downloading: [PASRR NF Specialized Service \(NFSS\) - Authorization Request for CMWC.pdf \(tmhp.com\)](#).

C0700 – Measurements completed by:

C0700 A. First Name - Enter the first name of person who completed the measurements.

C0700 B. Last Name - Enter the last name of the person who completed the measurements.

C0700 C. Title – Enter the title of the person who completed the measurements.

C0800 A. Measurement Date – Enter the date the measurements were taken.

C0800 B. Height - Enter the person's height in inches.

C0800 C. Weight - Enter the person's weight in pounds.

C0900 A. Top of head to bottom of buttocks - After measuring from the top of the person's head to bottom of the buttocks, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 B. Top of shoulder to bottom of buttocks - After measuring from the top of the person's shoulder to bottom of the buttocks, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 C. Arm pit to bottom of buttocks - After measuring from the person's armpit to bottom of the buttocks, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 D. Elbow to bottom of buttocks - After measuring from the person's elbow to bottom of the buttocks, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 E. Back of buttocks to back of knee - After measuring from the back of the person's buttocks to the back of their knee, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 F. Foot length – After measuring the length of the person's foot, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 G. Head width - After measuring the width of the person's head, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 H. Shoulder width - After measuring the width between the person's shoulders as indicated on the measuring worksheet, enter the measurement in inches.

C0900 I. Armpit to armpit - After measuring the width between the person's armpits as indicated on the measuring worksheet, enter the measurement in inches.

C0900 J. Hip width - After measuring the width of the person's hip, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 K. Distance to bottom of left leg (popliteal to heel) - After measuring from the back of the person's left knee to the bottom of their left heel, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 L. Distance to bottom of right leg (popliteal to heel) - After measuring from the back of the person's right knee to the bottom of their right heel, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 M. Additional Comments/Observations - Enter any additional comments or observations that would assist with prescription specifications for the wheelchair.

Environmental Assessment Subdivision:

C1000 Is the person's living environment accessible and safe for use of the CMWC requested - Indicate if the living environment is accessible and safe for the use of the custom manual wheelchair, by entering: 1. Yes or 0. No. For example, whether the home is equipped with ramps and accessible bathrooms, whether there is storage for a wheelchair available, etc.

C1100 A. Will the CMWC need to be transported - Indicate if the custom manual wheelchair will be transported, by enter: 1. Yes or 0. No.

C1100 B. If Yes, describe how the item will be transported - If 1. Yes, was entered in C1100 A, describe how the custom manual wheelchair will be transported (e.g., van, adapted wheelchair lift, ambulance, public

transportation, other, etc.) and whether the person will be sitting in the wheelchair during transportation. (Minimum is 50 alphanumeric characters.)

C1200 If the person does not have a current education/vocational setting, skip to the Supplier Information and MSRP Subdivision.

C1200 If the person has a current education/vocational setting, complete the following:

Is the education/vocational site accessible to the requested CMWC - If 1. Yes, was entered in B2300 A, indicate whether the education/vocational site is accessible to the custom manual wheelchair enter: 1. Yes or 0. No.

C1300 Are ramps available at the educational/vocational site - If 1. Yes, was entered in B2300 A, indicate whether ramps are available at the education/vocational site enter: 1. Yes or 0. No.

C1400 Additional comments and observations of education/vocational therapist - If B2310 A. is 1. Yes, then enter any additional comments or observations related to the specific requirements for mobility needed for educational or vocational (employment) purposes as recommended by the educational/vocational therapist.

Supplier Information and MSRP Subdivision

Supplier Information:

C1500 Supplier's Business Name – Enter the DME supplier's business name.

C1600A. First Name - Enter the first name of the supplier's representative who will be providing the information on the cost of the CMWC.

C1600B. Last Name - Enter the last name of the supplier's representative who will be providing the information on the cost of the CMWC.

C1700A. Street Address - Enter the street address of the DME supplier's business.

C1700B. City – Enter the city in which the DME supplier's business is located.

C1700C. State – Enter the state in which the DME supplier's business is located.

C1700D. Zip Code - Enter the zip of the DME supplier's business.

C1800A. Phone No. - Enter the phone number of the DME supplier's business.

C1800B. FAX No. - Enter the fax number of the DME supplier's business.

Itemized Manufacturer's Suggested Retail Price (MSRP) Subdivision:

DME Suppliers can use the Itemized MSRP worksheet in the assessment tool available for downloading on page 14 at [PASRR NF Specialized Service \(NFSS\) - Authorization Request for CMWC.pdf \(tmhp.com\)](#).

C1900B. Item No. – This is the item number of the component being added to the MSRP list.

C1900C. HCPCS code - Enter the Healthcare Common Procedure Coding System (HCPCS) code for the item provided by the DME supplier.

C1900D. Description of Item – The description of the item must match the description on the MSRP documentation.

C1900E. Item Price - Enter the price for the single item.

C1900F. Quantity - Enter the quantity of items being requested.

- Prices and quantities must match what is on the MSRP documentation.
- If it is a single item, enter “1”. If the item is sold as a pair, enter “1” for the quantity.
- Descriptions containing the term “W/C Component-Accessory NOS” will not be accepted.
- Up to 22 items can be entered. If the DME supplier has more than 22 items, a couple of items may need to be rolled into one row.
- Multiple items rolled up into one row must be clearly identified on the MSRP documentation.
 - ▶ The amount containing the rolled-up components must be equal to the sum of all the components on the MSRP documentation.

C1900 G. Total Price - The total price will be determined by calculating the Item Price multiplied by the Quantity.

C1900 H. Approved Price - This is the amount authorized by HHSC.

C1900 I.1. Total Amount of All Items Requested - The total amount of all item requested will be determined by calculating the sum of the Total Price(s).

C1900 I.2. Total Amount of All Items Requested – The total amount of all items requested in the Approved Price fields authorized by HHSC.

C1900 J.1. Minus 18% - Determined by calculating the total amount multiplied by 0.18.

C1900 J.2. Minus 18% - Determined by the total amount multiplied by 0.18 authorized by HHSC.

C1900 K.1. Grand total - Determined by calculating the 18% amount subtracted from the total amount.

C1900 K.2. Grand total - Determined by the 18% amount subtracted from the total amount authorized by HHSC.

Note: HHSC does not pay for unallowable charges on DME or CMWC requests (e.g., assembly, delivery, shipping, embroidery, colors, backpacks, etc.)

Nursing facilities must request payment for the QRP assessment when submitting a prior authorization request for a CMWC. Please refer to [Information Letter No. 20-39](#) for QRP assessment reimbursement. After the item is delivered to the facility, the submitter must attach a completed PASRR NFSS - CMWC/DME Receipt Certification and for CMWCs, a completed [HHSC Form 2362, Receipt Certification by a Qualified Rehabilitation Professional](#).

The signature by the therapist on the attached receipt certifies that the item meets the needs of the individual as specified in the assessment. It also indicates, by the NF administrator's signature, that the item was delivered and received by the NF. HHSC Form 2362 Receipt Certification by a Qualified Rehabilitation Professional certifies that the QRP was present and involved in the clinical assessment for the CMWC and that the CMWC has been evaluated to fit properly and meet the needs of the individual.

Note: Failure to submit required receipt certifications will delay or prevent the facility's reimbursement.

Therapist's Certification of Delivered CMWC

C4300 A. First Name - Enter the first name of the therapist who is certifying that the item meets the needs of the individual as specified in the assessment.

C4300 B. Last Name - Enter the last name of the therapist who is certifying that the item meets the needs of the individual as specified in the assessment.

C4400 A. License Type - Select the license type (1. OT or 2. PT) of the therapist who is certifying that the item meets the needs of the person as specified in the assessment.

C4400 B. License No. - Enter the license number of the therapist who is certifying that the item meets the needs of the individual as specified in the assessment. The portal accepts seven-digit numbers. If the therapist's license number is less than seven-digits, place a zero before the license number.

C4500 Therapist's Certification Date - Enter the date the therapist certified that the item meets the needs of the individual as specified in the assessment by signing the NFSS CMWC/DME Receipt Certification attachment.

The certification date must be the current or future date.

Nursing Facility Administrator Certification of Delivered Device

C4600 A. First Name - Enter the first name of the NF administrator who certified that the item was delivered and received by the NF.

C4600 B. Last Name - Enter the last name of the NF administrator who certified that the item was delivered and received by the NF.

C4700 CMWC Received Date - Enter the date the custom manual wheelchair was received by the NF.

C4800 NF Administrator's Certification Date - Enter the date the NF administrator certified that the item was delivered and received by the NF on the CMWC/DME Receipt Certification signature page. The certification date must be the current or future date.

DME Request Section

INTENT: The purpose of this tab is to document the information on the LTC OnlinePortal from the assessment completed by a licensed therapist in order to request DME items. NFs can use the assessment tool available for downloading at [Long-Term Care Forms | TMHP](#).

Instructions for requesting DME item(s) apply to the following items:

- Car Seat/Travel Restraint
- Gait Trainer
- Mattress
- Orthotic Device
- Positioning Wedge
- Prosthetic Device
- Standing Board/Frame

As previously stated in Section 6 of this document, HHSC will only authorize PASRR DME items greater than \$1,000, but less than \$5,000.

Environmental Assessment Subdivision

The following fields are on different tabs, so please refer to the applicable tab for the field numbers.

D1000A, D2000A, D3000A, D4000A, D5000A, D6000A, D7000 A. Is the resident's living environment accessible and safe for the use of the DME item requested? - For example, is the home equipped with ramps and

accessible bathrooms, is storage for the DME item available, etc.? If the living environment is accessible and safe for the use of the DME item, enter:

1. Yes or 0. No if it is not safe.

D1000B, D2000B, D3000B, D4000B, D5000B, D6000B, D7000 B. Will the DME item need to be transported? - If the item will be transported, enter: 1. Yes or 0. No.

D1000C, D2000C, D3000C, D4000C, D5000C, D6000C, D7000 C. If Yes, describe how the DME item will be transported. - If 1. Yes, was entered in D1000, D2000, D3000, D4000, D5000, D6000, D7000 B, describe the manner in which the DME item will be transported (e.g. car, van, adapted wheelchair lift, ambulance, public transportation, other, etc.). (Minimum is 50 alphanumeric characters.)

If the person does not have a current education/vocational setting, skip to the Current DME Item Subdivision.

D1100A, D2100A, D3100A, D4100A, D5100A, D6100A, and D7100 A. Was a DME similar to the one requested used at this site? - If the educational/vocational site provided a DME item similar to the one being requested enter: 1. Yes or 0. No.

D1100B, D2100B, D3100B, D4100B, D5100B, D6100B, D7100 B. If Yes, is the site accessible and safe for use of the DME item - If 1. Yes, was entered in D1100, D2100, D3100, D4100, D5100, D6100, D7100 B, is the education/vocational site accessible and safe for the use of the DME item? Enter: 1. Yes or 0. No.

D1200, D2200, D3200, D4200, D5200, D6200, D7200 Additional comments and observations of education/vocational therapist for this DME item - Enter any additional comments or observations related to the specific requirements for the DME item being requested needed for educational or vocational (employment) purposes as recommended by the education/vocational therapist. (Minimum is 50 alphanumeric characters.)

Current DME Item Subdivision

D1300, D2300, D3300, D4300, D5300, D6300, D7300 Does the resident have a current DME item or items – If the individual has a current DME item similar to the one being requested enter: 1. Yes or 0. No.

D1310, D2310, D3310, D4310, D5310, D6310, D7310 Describe the resident's current DME item(s) - If 1. Yes, was entered in D1300, D2300, D3300, D4300, D5300, D6300, D7300, describe the person's current DME item, date it was purchased, or approximate age of the person's current DME item.

- If 0. No was entered in D1300, D2300, D3300, D4300, D5300, D6300, D7300, skip to Requested DME Item Subdivision

D1320, D2320, D3320, D4320, D5320, D6320, D7320 Describe why the current DME item(s) does/does not meet the resident's needs - Describe the reason the current DME item no longer meets the individual's needs. (Minimum is 50 alphanumeric characters.)

Requested DME Item Subdivision

D1400, D2400, D3400, D4400, D5400, D6400, D7400 Describe the DME item that is being requested - Enter a description of the DME item that is being requested and the individual's specific medical needs for this item. Depending on the specific DME item, describe how the DME item will assist the person (e.g. weight bearing, stretching muscles, reduce spasticity, improve functional transfers, improve mobility, improve posture, prevention or improvement of lower limb contractures by improving range of motion and joint flexibility, prevention of pressure ulcers caused by prolonged sitting or laying down, preventing muscle wasting (atrophy), use an artificial limb to complete activities of daily living relieve abnormal pressure, stress, or pain in the foot, ankle, or lower extremity, or to provide safety and stability when traveling). (Minimum is 50 alphanumeric characters.)

D1410, D2410, D3410, D4410, D5410, D6410, D7410 Describe the medical necessity for the requested DME item - Enter a description of the medical necessity for the DME item being requested. Depending on the specific DME item, describe the medical condition the DME item will ameliorate for the person (e.g., completely immobile or limited mobility (person cannot make changes in body position without assistance significant enough to alleviate pressure), impaired nutritional status, fecal or urinary incontinence, altered sensory perception, compromised circulatory status, etc.) (Minimum is 50 alphanumeric characters.)

Note: These fields must contain all the diagnosis for the individual or the request will be set to "Pending Denial."

D1420, D2420, D3420, D4420, D5420, D6420, D7420 Describe any anticipated modification/changes to the requested DME item within the next five years - Enter a description of any anticipated modifications/changes to the requested DME item within the next five years due to changes in health condition, weight change, tissue atrophy, postural changes, etc. (Minimum is 50 alphanumeric characters.)

D1430, D2430, D3430, D4430, D5430, D6430, D7430 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) - Enter a description of the equipment the individual must access on a regular basis and the effect, if any, this has on the use of the requested durable medical equipment. (Minimum is 50 alphanumeric characters.)

Supplier Information Subdivision

D1500, D2500, D3500, D4500, D5500, D6500, D7500 Supplier's Business Name - Enter the DME supplier's business name.

D1510A, D2510A, D3510A, D4510A, D5510A, D6510A, D7510 A. First Name - Enter the first name of the supplier's representative who will be providing their information on the cost of the DME item.

D1510B, D2510B, D3510B, D4510B, D5510B, D6510B, D7510 B. Last Name - Enter the last name of the supplier's representative who will be providing their information on the cost of the DME item.

D1520A, D2520A, D3520A, D4520A, D5520A, D6520A, D7520 A. Street Address - Enter the street address of the DME supplier's business.

D1520B, D2520B, D3520B, D4520B, D5520B, D6520B, D7520 B. City – Enter the city in which the DME supplier's business is located.

D1520C, D2520C, D3520C, D4520C, D5520C, D6520C, D7520 C. State - Enter the state in which the DME supplier's business is located.

D1520D, D2520D, D3520D, D4520D, D5520D, D6520D, D7520 D. ZIP Code - Enter the zip code in which the DME supplier's business is located.

D1530A, D2530A, D3530A, D4530A, D5530A, D6530A, D7530 A. Phone No. - Enter the phone number of the DME supplier's business.

D1530B, D2530B, D3530B, D4530B, D5530B, D6530B, D7530 B. FAX No. - Enter the fax number of the DME supplier's business.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote Subdivision

DME Suppliers can use the Itemized MSRP worksheet in the assessment tool available for downloading on page 14 at [PASRR NF Specialized Service \(NFSS\) - Authorization Request for CMWC.pdf \(tmhp.com\)](#).

D1900B, D2900B, D3900B, D4900B, D5900B, D6900B, D7900 B. Item No. - This is the item number of the component being added to the MSRP list.

D1900C, D2900C, D3900C, D4900C, D5900C, D6900C, D7900 C. HCPCS Code - Enter the Healthcare Common Procedure Coding System (HCPCS) code for the item provided by the DME supplier.

D1900D, D2900D, D3900D, D4900D, D5900D, D6900D, D7900 D. Description of Item - The description of the item must match the description on the MSRP documentation

D1900E, D2900E, D3900E, D4900E, D5900E, D6900E, D7900 E. Item Price - Enter the price for the single item

D1900, D2900, D3900, D4900, D5900, D6900, D7900 F. Quantity – Enter the quantity of items being requested.

- Prices and quantities must match what is on the MSRP documentation.
- If it is a single item, enter “1”. If the item is sold as a pair, enter “1” for the quantity.
- Descriptions containing the term “W/C Component-Accessory NOS” will not be accepted.
- Up to 22 items can be entered. If the DME supplier has more than 22 items, a couple of items may need to be rolled into one row.
 - ▶ Multiple items rolled up into one row must be clearly identified on the MSRP documentation.
 - ▶ The amount containing the rolled-up components must be equal to the sum of all the components on the MSRP documentation.

D1900G, D2900G, D3900G, D4900G, D5900G, D6900G, D7900 G. Total Price - The total price will be determined by the system calculating the item price multiplied by the quantity.

D1900H, D2900H, D3900H, D4900H, D5900H, D6900H, D7900 H. Approved Price - This is the amount authorized by HHSC.

D1900I, D2900I, D3900I, D4900I, D5900I, D6900I, D7900 I.1. Total Amount of All Items Requested - The total amount of all items requested will be determined by calculating the sum of the total price(s).

D1900I, D2900I, D3900I, D4900I, D5900I, D6900I, D7900 I.2. Total Amount of All Items Requested - The total amount of all items requested in the Approved Price fields authorized by HHSC calculated by the system.

D1900J, D2900J, D3900J, D4900J, D5900J, D6900J, D7900 J. 1. Minus 18% - Will be determined by calculating the total amount multiplied by 0.18.

D1900J, D2900J, D3900J, D4900J, D5900J, D6900J, D7900 J.2. Minus 18% - Total amount the system multiplied by 0.18 authorized by HHSC.

D1900K, D2900K, D3900K, D4900K, D5900K, D6900K, D7900 K.1. Grand total - The 18% amount subtracted from the total amount calculated by the system.

D1900K, D2900K, D3900K, D4900K, D5900K, D6900K, D7900 K.2. Grand total - The 18% amount subtracted from the total amount authorized by HHSC calculated by the system.

Note: HHSC does not pay for unallowable charges on DME or CMWC requests (e.g., assembly, delivery, shipping, etc.)

Receipt Certification Subdivision:

After the item is delivered to the facility, the submitter must attach a completed PASRR NFSS - CMWC/DME Receipt Certification. The signature by the therapist on this attachment certifies that the item meets the needs

of the individual as specified in the assessment. The signature of the NF administrator indicates that the item was delivered and received by the nursing facility.

For CMWCs, the facility must also submit HHSC form 2362, Receipt Certification by a Qualified Rehabilitation Professional. The signature by the QRP certifies that the QRP was present and involved in the clinical assessment for the CMWC and that the CMWC has been evaluated to fit properly and meet the needs of the individual.

Failure to submit receipt certifications will delay or prevent the facility's reimbursement.

Therapist's Certification of Delivered DME Item Subdivision:

D1600A, D2600A, D3600A, D4600A, D5600A, D6600A, D7600 A. First Name - Enter the first name of the therapist who is certifying the item meets the needs of the individual as specified in the assessment.

D1600B, D2600B, D3600B, D4600B, D5600B, D6600B, D7600 B. Last Name - Enter the last name of the therapist who is certifying the item meets the needs of the individual as specified in the assessment.

D1610A, D2610A, D3610A, D4610A, D5610A, D6610A, D7610 A. License Type - Enter the license type of the therapist who is certifying the item meets the needs of the individual as specified in the assessment.

D1610B, D2610B, D3610B, D4610B, D5610B, D6610B, D7610 B. License No. - Enter the license number of the therapist who is certifying the item meets the needs of the person as specified in the assessment. The portal accepts seven-digit numbers. If the therapist's license number is less than seven- digits, place a zero before the license number.

D1620, D2620, D3620, D4620, D5620, D6620, D7620. Therapist's Certification Date - Enter the date the therapist certified the item meets the needs of the person as specified in the assessment by signing the NFSS CMWC/DME Receipt Certification attachment.

The certification date must be the current or future date.

Nursing Facility Administrator Certification of Delivered DME Item Subdivision:

D1630A, D2630A, D3630A, D4630A, D5630A, D6630A, D7630 A. First Name - Enter the first name of the nursing facility administrator who certified that the item was delivered and received by the NF.

D1630B, D2630B, D3630B, D4630B, D5630B, D6630B, D7630 B. Last Name - Enter the last name of the NF administrator who certified that the item was delivered and received by the NF.

D1640, D2640, D3640, D4640, D5640, D6640, D7640 DME Item Received Date - Enter the date the DME item was received by the NF.

D1650, D2650, D3650, D4650, D5650, D6650, D7650 NF Administrator's Certification date - Enter the date the NF administrator certified that the item was delivered and received by the NF on the CMWC/DME Receipt Certification signature page.

The certification date must be the current or future date.

Completing the NFSS Form for a Habilitative Therapy Assessment

The NFSS form can only be submitted on the LTC Online Portal.

A NF can request authorization for an assessment without having to request a therapy in situations where: the assessment indicates a service is not medically necessary, the person is temporarily or permanently discharged from the facility, or other reasons why only the assessment is needed. In this case, the NF will request authorization for an “Assessment Only”.

When the NF is requesting authorization for a habilitative therapy assessment and or service, the submission must include both the assessment and the completed NFSS therapy form.

HHSC will only authorize payment for the same type of assessment (OT, PT, or ST) for the same person, in the same NF, once every 180 days. Once the assessment has been performed, the NF must submit the request through the LTC Online Portal no more than 30 days from the date it was performed by the therapist. The original assessment is maintained in the individual’s medical record.

Continuation in the frequency, duration, and intensity of a therapy service may be submitted for authorization as long as there is an authorized assessment on file with HHSC or the LTC Online Portal within the previous 180 days for the specific therapy service being requested.

Changes in the frequency, duration, and intensity of a therapy service identified as necessary to meet the individual’s needs may still be submitted for authorization along with a new assessment which reflects the revised frequency, duration, and intensity. If the updated assessment is submitted within the previous 180 days for the specific therapy service being requested, HHSC will authorize payment for the therapy service, but will not pay for the updated assessment, and the assessment will be kept on file within the LTC Online Portal.

PDF Form

A blank copy of the NFSS form in PDF format is available for downloading at: [Long-Term Care Forms | TMHP](#).

If a therapist chooses to use the downloaded PDF copy of the NFSS form to record the assessment, all information from the NFSS PDF form must be data entered in the NFSS Form on the LTC Online Portal and the original copy of the assessment completed on the PDF form is maintained in the individual’s medical record.

Using the hyperlink shown above, the therapist will be able to access the NFSS PDF form(s) to be used when performing an assessment for a habilitative therapy. Each type of service and the related assessment is represented on a separate PDF file on the forms page at the link above. The following NFSS PDF forms are available at [Long-Term Care Forms | TMHP](#).

Authorization Request for NF Specialized Services (NFSS) for Habilitative Therapies (OT, PT, ST)

The NFSS PDF form should NOT be faxed to TMHP, HHSC, or submitted as an attachment into the LTC Online Portal to request a specialized service. These requests will not be accepted.

Required Signatures

Each authorization request for an assessment submitted through the NFSS form must be accompanied by an attachment with the therapist's signature.

When requesting authorization for an assessment only, a NF must ensure the signature page is signed by the therapist that performed the assessment and the NF administrator.

If the submission will also be requesting authorization for a habilitative therapy service, the request must also contain the signature of the referring physician attesting that the habilitative therapy service is medically necessary.

Each request must have its own unique and original signatures and signature page. Please refer to [Information Letter No. 20-05](#), "Signatures on and Alterations to the Nursing Facility Specialized Services Signature Pages" for more information.

The NF will download the signature pages from the following website: [Forms | TMHP](#).

Attachments

Required attachments for an assessment that must be submitted with the NFSS form are as follows:

For Habilitative Therapies:

- PASRR NFSS - Therapy Signature Page (for therapist, referring physician and NF Administrator signatures)

Attachments can be found at the following website: [Long-Term Care Forms | TMHP](#).

Faxing Attachments: Attachments that are required with an NFSS form submission to request an assessment or specialized service can be faxed in after they have been printed and all required signatures are obtained.

To fax a required attachment (signature page, receipt confirmation, MSRPs, etc.), the NFSS Fax Cover Sheet must be completely filled out and all documents faxed to the number on the Fax Cover Sheet. This form can be downloaded at [Long-Term Care Forms | TMHP](#).

The PDF NFSS form should NOT be faxed to TMHP or HHSC to request a specialized service.

Completing the NFSS Form for a Habilitative Therapy Service

There are three types of therapy service authorization requests:

New (Submit initial assessment) – An initial therapy assessment completed by the therapist is required. A new request is the very first request submitted by the NF for a resident to receive any of the three therapy types. The therapy service request must include:

- A treatment plan, and
- The referring physician's signature.

Recertification (Does not require an updated treatment plan or physician's signature) – An updated assessment completed by the therapist is not required if the frequency, duration, and intensity remain the same.

If the frequency, duration, and intensity have changed, an updated assessment is required.

Restart (Submit assessment) – An updated assessment completed by the therapist must be submitted when there is a break in the therapy service lasting more than 30 days. The therapy service request must include:

- A treatment plan, and
- The referring physician's signature.

For habilitative therapy service requests, one signature page (attachment) per service (OT, PT, ST) being requested (for the therapist, the referring physician, and NF administrator) must be uploaded to the NFSS form.

The NF administrator's signature acknowledges their awareness that a request for therapy services has been submitted for a person in their facility.

PDF Form

A copy of the NFSS form in PDF format is available for downloading at: [Long-Term Care Forms | TMHP](#).

If a therapist chooses to use the downloaded PDF copy of the NFSS form to record the assessment, all information from the Assessment section must be data entered on the NFSS form and the original assessment completed on the PDF form is maintained in the person's medical record.

Each type of service and the related assessment is represented on a separate PDF file on the forms page at the link above. The following NFSS forms are available on the TMHP website:

Authorization Request for NFSS for Habilitative Therapies (OT, PT, ST)

The PDF NFSS form should NOT be faxed to TMHP or HHSC to request specialized service. These requests will not be addressed based on paper forms.

Required Signatures

When requesting authorization for a habilitative therapy service, the attachment must contain the signatures of:

- The therapist indicating that they are the therapist performing the assessment,
- The referring physician attesting that the service is medically necessary, and
- The nursing facility administrator.

This is done by downloading the signature page from the LTC Online Portal and uploading the signed (scanned) page on the LTC Online Portal as part of the NFSS form submission.

The signatures for all parties must be legible in order to verify that the signature matches the name that was entered into the NFSS form on the LTC Online Portal. Signatures that do not match the NFSS form on the LTC Online Portal will not be accepted.

Note: A signature attestation page for illegible signatures can be used in certain circumstances.

Attachments

Attachments that must be submitted in conjunction with the NFSS form are available for downloading at: [Long-Term Care Forms | TMHP](#).

For Habilitative Therapies:

- PASRR NF Specialized Services (NFSS) - Therapy Signature Page (for therapist, referring physician and NF Administrator signatures)
- Upload one signature page per assessment being requested (OT, PT, and ST).

Item by Item Steps for Habilitative Therapy NFSS Form

Instructions for requesting a therapy assessment apply to the following subdivisions:

- Occupational Therapy (OT) Assessment
- Physical Therapy (PT) Assessment
- Speech Therapy (ST) Assessment

Resident/NF Section

INTENT: The purpose of this section is to document the identifying and contact information for the individual, LAR (if applicable), NF, LIDDA, and LMHA/LBHA.

Resident Information Subdivision:

A0100 A. First Name - Enter the individual's First Name.

A0100 B. Middle Initial - Enter the individual's Middle Initial.

A0100 C. Last Name - Enter the individual's Last Name.

A0100 D. Suffix - Enter the individual's Suffix.

A0200 A. Social Security No. - Enter the individual's social security number.

A0200 B. Medicare No. - Enter the individual's Medicare number.

A0300. Medicaid No. - Enter the individual's Medicaid number.

A0400 A. Birth Date - Enter the individual's Birth Date.

A0400 B. Age at Time of Submission- Enter the individual's age at the time of submission. The person must be 21 years of age or older to qualify for PASRR NFSS.

Legally Authorized Representative (LAR) Subdivision: If the individual has an LAR, enter the LAR's identification information.

A0500 A. First Name - Enter the LAR's First Name.

A0500 B. Last Name - Enter the LAR's Last Name.

A0600 A. Street Address - Enter the name of the LAR's Street address.

A0600 B. City - Enter the name of the LAR's city.

A0600 C. State - Enter the name of the LAR's state.

A0600 D. ZIP Code - Enter the name of the LAR's zip code

A0600 E. Phone No. -Enter the name of the LAR's phone number.

Nursing Facility Information Subdivision: Document the identifying and contact information for the individual's NF.

A0700 A. Provider No.- Enter the provider number of the NF.

A0700 B. Vendor No. – Enter the vendor number of the NF.

A0700 C. NIP/API No. - Enter the national provider identifier (NIPA) number of the NF.

A0700 D. Facility Name - Enter the NFs name.

A0800 A. Street Address - Enter the street address of the NF.

A0800 B. City - Enter city of the NF.

A0800 C. State - Enter the state of the NF.

A0800 D. ZIP Code - Enter the zip code of the NF.

A0800 E. County - Enter the county of the NF.

A0900 A. Phone No. - Enter the area code and phone number of the person to be contacted at the NF with questions regarding information entered into the NFSS form.

A0900 B. Fax No. - Enter the area code and fax number of the person to be contacted at the NF with questions regarding information entered into the NFSS form.

LIDDA and LMHA Information Subdivision: Document the identifying and contact information for the person's LIDDA or LMHA/ LBHA.

A1000 A. LIDDA Contract No. - Enter the LIDDA Contract number.

A1000 B. LIDDA Vendor No. - Enter the LIDDA Vendor number.

A1000 C. LIDDA NPI/API No. - Enter the LIDDA national provider identifier NPI/API number.

A1100 A. LMHA Contract No. - Enter the LMHA/LBHA Contract number.

A1100 B. LMHA Vendor No. - Enter the LMHA/LBHA Vendor number.

A1100 C. LMHA NPI/API No. - Enter the LMHA/LBHA national provider identifier NPI/API number.

A2000. Request Type: - Select 3. Habilitative Therapies.

A2300. Habilitative Therapies: If 3. Habilitative Therapies was selected under A2000 Request Type, choose one or multiples of the following:

- Occupational Therapy (OT)
- Physical Therapy (PT)
- Speech Therapy (ST)

Therapy Assessment Section

INTENT: The purpose of this section is to document the information from the assessment completed by a licensed therapist for a habilitative therapy (occupational therapy, physical therapy, or speech therapy). Nursing facilities can use the assessment tool available for downloading at [Long-Term Care Forms | TMHP](#).

Steps for Assessment

The information requested in this section is required, unless otherwise indicated.

Response to questions must be at least 50 characters long or the LTC Online Portal will not accept the information. A space is considered a character. Responses must:

- Be in complete sentences,
- Respond to the information being requested, and
- Not contain the same information as other fields.

Instructions for requesting a therapy assessment apply to the following tabs:

- Occupational Therapy (OT) Assessment
- Physical Therapy (PT) Assessment
- Speech Therapy (ST) Assessment

Authorization Type Subdivision

E0100, E3100, E6100 Therapy Authorization Type - Select the therapy authorization type by selecting one of the following: 1. Assessment Only, 2. New, 3.Restart, 4. Recertification.

A Recertification request does not require an updated treatment plan. An updated assessment completed by the therapist is not required for up to one year if the frequency, duration, and intensity remain the same. Please note, selecting the authorization type “Assessment Only” will not create a service authorization, and will only authorize payment for the assessment.

If the frequency, duration, and intensity have changed, then **an updated** assessment is required, and the authorization type selected should be “Restart”.

Therapist Identifying Information Subdivision:

E0200A, E3200A, E6200A. First Name - Enter the first name of the therapist who completed the therapy assessment.

E0200B, E3200B, E6200B. Last Name - Enter the last name of the therapist who completed the therapy assessment.

E0300A, E3300A, E6300A. License Type – Enter the type of license held by the therapist who completed the assessment by selecting one of the following: 1. Occupational Therapist, 2. Physical Therapist, or 3. Speech Therapist.

E0300B, E3300B, E6300B. License No. - Enter the license number of the therapist who completed the assessment.

E0300C, E3300C, E6300C. License State - Enter the license state in which the license of the therapist who conducted the assessment was issued.

E0400, E3400, E6400 Is the Therapist employed by the nursing facility? – If the therapist who completed the assessment works for the nursing facility enter 1. Yes. If the therapist who completed the assessment does not work for the NF, but is a contracted therapist, enter 0. No.

If the Therapist is not employed by the NF, complete the remainder of the Therapist Identifying Information Section:

E0500, E3500, E6500 Therapist’s Employer Name - Enter the name of the employer of the therapist who conducted the assessment when the employer is not the NF.

E0600A, E3600A, E6600A. Street Address - Enter the street address of the employer of the therapist who conducted the assessment.

E0600B, E3600B, E6600B. City - Enter the city in which the employer of the therapist who conducted the assessment is located.

E0600C, E3600C, E6600C. State - Enter the state in which the employer of the therapist who conducted the assessment is located.

E0600D, E3600D, E6600D. ZIP Code - Enter the zip code in which the employer of the therapist who conducted the assessment is located.

E0700A, E3700A, E6700A. Phone No. and FAX No. - Enter the area code and phone number of the employer of the therapist who conducted the assessment.

E0800, E3800, E6800 Therapist's Signature Date - Enter the date the therapist who completed the assessment signed the NFSS Therapy Signature Page. The signature date:

- Cannot be more than 29 calendar days prior to the original submission date for a service. The assessment by the therapist must be completed within 30 days before the nursing facility requests pre-authorization for the service as stated in section 2 of the item - by - item guide.
- Must be greater than or equal to Date of Assessment (E0900, E3900, E6900).
- Must match the signature date submitted on the NFSS Therapy Signature Page that is uploaded.

Date of Assessment - Therapy Subdivision:

E0900, E3900, E6900 Date of Assessment - Enter the date the assessment was completed by the therapist.

A therapy assessment must always be associated with a therapy request, except for therapy recertification requests or "assessment only" requests. The assessment date should be within the previous 180 days of the requested therapy submission date, even if the assessment was previously submitted.

Therapy Assessment (OT, PT, ST) Subdivision

Note: A therapist will complete the assessment using the assessment tool normally used by the therapist or nursing facility. The information requested below is information obtained from that assessment tool. Please refer to Section 8 of this guide for information on how to complete and submit a request for a therapy assessment.

E1100, E4100, E7100 Treating impairment and dysfunction - From the assessment completed by the therapist, enter information that addresses the specific impairment or dysfunction assessed by the therapist. A diagnosis

and/or description of the specific problem(s) to be assessed and/or treated should be specific and as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician) and an impairment-based treatment diagnosis related to treatment are relevant. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD - 10 code. For example, the medical diagnosis made by the physician is Cerebrovascular accident (CVA); however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for ST, it may be dysphagia. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may affect the treatment. (Minimum is 50 alphanumeric characters.)

Note: This field must contain all the diagnosis for the resident, or the request will be set to “Pending Denial.”

E1200, E4200, E7200 Initial assessment/current level of function and underlying impairments – From the assessment completed by the therapist, enter information that describes the resident’s current level of function and underlying impairments. (e.g., the functionality prior to the onset of the impairment or dysfunction, date of onset, and contributing factors i.e., motivation, cognition, psychological stability, etc.) (Minimum is 50 alphanumeric characters.)

E1300, E4300, E7200 Clinical impressions - From the assessment completed by the therapist, enter the clinical impressions (e.g., a determination that treatment is not needed, or, if treatment is needed a prognosis for return to functionality prior to the onset of the impairment or dysfunction, etc.) (Minimum is 50 alphanumeric characters.)

E1400, E4400, E7400 Reason for skilled services - From the assessment completed by the therapist, enter the reasons the resident needs therapy by a licensed therapist. (Minimum is 50 alphanumeric characters.)

A maintenance service is a skilled service when it requires the skills of a therapist to carry out the program, which occurs only when:

- ▶ The patient’s special medical complications require the skills of a therapist to perform a therapy service that would otherwise be considered non-skilled; or
- ▶ The needed therapy services are of such complexity that the skills of a therapist are required to perform the procedure.

Reference: Medicare Benefit Policy Manual –Pub. 100 - 02, Chapter 15, section –230.5 for PT, OT, and SLP services provided incident to the physician/NPP.

E1500, E4500, E7500 Skilled intervention focus - From the assessment completed by the therapist, enter the specific focus of the skilled intervention used to treat the individual’s needs (e.g., therapeutic exercise, functional training, manual therapy techniques, adaptive devices/ equipment needs, modalities, etc.) (Minimum is 50 alphanumeric characters.)

Required Document:

NFSS Therapy Signature Page: Print the signature page to obtain the required signatures. Each request must have its own unique signatures and signature page.

Obtain signatures as instructed in E0800, E3800, or E6800 Therapist's Signature Date for an assessment.

Therapy Service Request Section

INTENT: The purpose of this subdivision is to document the information on the LTC Online Portal from the treatment plan completed by a licensed therapist for a habilitative therapy (occupational therapy, physical therapy, or speech therapy) in order to submit a request for a therapy service. NFs can use the assessment tool available for downloading at [Long-Term Care Forms | TMHP](#).

The information from the assessment will still need to be data entered into this tab on the LTC Online Portal.

The information requested in this section is required, unless otherwise indicated.

Instructions for requesting a therapy service apply to the following subdivisions:

- Occupational Therapy (OT) Service
- Physical Therapy (PT) Service
- Speech Therapy (ST) Service

Therapy Treatment Plan Subdivision

E1600, E4600, E7600 Add Diagnosis – Add a diagnosis code. There is a maximum of 6 rows allowed for diagnosis codes.

E1600A, E4600A, E7600A. Code - From the assessment completed by the therapist, enter the diagnosis code for the impairment or dysfunction that will be addressed with the therapy from the list of International Classification of Diseases (ICD) codes, 10th revision, (ICD - 10).

E1600B, E4600B, E7600B. Description - From the assessment completed by the therapist, enter a description of the diagnosis.

E1600C, E4600C, E7600C. Date of Onset, if known - From the assessment completed by the therapist, enter the diagnosis' date of onset when this information is available.

E1700, E4700, E7700 Long Term Goals - From the assessment completed by the therapist, enter the anticipated goals, expected outcomes, and any predicted level of improvement. (Minimum is 50 alphanumeric characters.)

E1800, E4800, E7800 Short Term Goals - From the assessment completed by the therapist, enter any short-term goals related to the long-term goals, when applicable. (Minimum is 50 alphanumeric characters.)

Recommended Habilitation – Therapy Service Subdivision

E1900A, E4900A, E7900A. Frequency: No. of times per week – Select the number of times per week the therapy service will be provided based on the assessment completed by the therapist by entering one of the following:

- 1 time per week
- 2 times per week
- 3 times per week
- 4 times per week
- 5 times per week
- 6 times per week
- 7 times per week

E1900B, E4900B, E7900B. Duration: length of treatment- Select how long, in months, the treatment will be provided based on the assessment completed by the therapist by selecting one of the following:

- 1 month
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months

Note: The therapy service can be up to six months in duration. Please submit recertifications for at least three months at a time if there are no anticipated changes. Doing so will keep the individual from having breaks in service authorization and cut down on processing times.

E1900C, E4900C, E7900C. Intensity: No. of times per day the therapist provides treatment- Select the number of times per day the therapy service will be provided based on the assessment completed by the therapist by selecting one of the following:

- 1 time per day
- 2 times per day
- 3 times per day

Referring Physician Identifying Information - Therapy Service Subdivision

The referring physician is the one who is licensed as an MD or DO and will be attesting to medical necessity when requesting prior authorization for a habilitative therapy (occupational therapy, physical therapy, or speech therapy) service which is “New” or “Restart”. Please note, a nurse practitioner cannot sign for the physician.

E2000, E5000, E8000 Physician’s Information

E2000A, E5000A, E8000A. Last Name - Enter the last name of the referring physician.

E2000B, E5000B, E8000B. License State - Select the state in which the physician is licensed.

E2000C, E5000C, E8000C. License No. - Enter the state license number of the referring physician.

E2000D, E5000D, E8000D. Military Spec Code - If the physician is on duty with the military, enter a military specialty code rather than the state license number of the referring physician.

E2000E, E5000E, E8000E. Date Resident Last Seen - Enter the date the person was last seen by the physician.

Note: When a request is submitted with the physician’s license number or military spec code missing, the NFSS request will be denied and must be resubmitted.

E2000F, E5000F, E8000F. Signature Date -The physician’s signature date:

- Must be after the physician has reviewed the therapist’s assessment and cannot be more than 29 calendar days prior to the original request date for a therapy service.
- Must match the signature date submitted on the Therapy Signature page that was signed by the physician.

The assessment by the therapist must be completed within 30 days before the NF requests authorization for the therapy service.

The signatures for all parties must be legible in order to verify that the signature matches the name that was entered into the NFSS form on the LTC Online Portal. Illegible signatures or signatures that do not match the

NFSS form will not be accepted. You may verify illegible signatures by submitting a signature log containing the signature or an attestation form.

Note: The following physician information is required if the physician is not licensed in Texas.

E2100, E5100, E8100 Physician's Information First Name: Enter the first name of the physician only if the physician holds an out of state license (state selected in E2000B, E5000B, E8000B, is any state other than Texas).

E2200A, E5200A, E8200A. Street Address - Enter the street address of the physician's office when the physician holds an out - of - state license (state selected in E2000B, E5000B, E8000B is any state other than Texas).

E2200B, E5200B, E8200B. City - Enter the city where the physician's office is located when the physician holds an out - of - state license (state selected in E2000B, E5000B, E8000B is any state other than Texas).

E2200C, E5200C, E8200C. State - Enter the state of the physician's office when the physician holds an out - of - state license (state selected in E2000B, E5000B, E8000B is any state other than Texas).

E2200, E5200, E8200 D. ZIP Code - Enter the zip code of the physician's office when the physician holds an out - of - state license (state selected in E2000B, E5000B, E8000B is any state other than Texas).

E2200E, E5200E, E8200E. Phone No. - Enter the phone number, including area code; of the physician's office when the physician holds an out - of - state license (state selected in E2000B, E5000B, E8000B B is any state other than Texas).