Topic Nomination for Texas Health and Human Services Commission Medical & Dental Benefits Consideration

*Members of the public, state agencies and others may request that the Texas Health Human Services Commission (HHSC) consider coverage of a new service, technology or other benefit. Please fill out and submit a Topic Nomination form in order to propose a topic for review and consideration of coverage.*

*Please attach supporting publications, bibliography, or other documents to a completed nomination form for consideration by HHSC.*

# Contact Information

|  |  |
| --- | --- |
| Date Submitted: | Click here to enter text. |
| Name of Nominator:  | Click here to enter text. |
| Organization (if applicable): | Click here to enter text. |
| Role of Nominator:  | Click here to enter text. |
| Address: | Click here to enter text. |
| City, State: | Click here to enter text. |
| Zip Code:  | Click here to enter text. |
| Phone:  | Click here to enter text. |
| Email:  | Click here to enter text. |

# Policy Request

|  |  |
| --- | --- |
| Please indicate your policy request or concern.  | Click here to enter text. |

# Procedure, Treatment, or Device Information

|  |  |
| --- | --- |
| What is the name of the procedure, treatment, or device? | Click here to enter text. |
| Provide a brief description of the treatment, procedure, or device covered by this nomination (please include billing codes, if known). | Click here to enter text. |
| Provide a brief description of current alternative treatments, procedures, or devices (please include billing codes, if known). | Click here to enter text. |
| What are the patient populations covered by this nomination? (e.g., condition, age, gender, ethnicity) | Click here to enter text. |
|  |  |
| What are the desired and/or expected outcomes? (e.g., improved survival, decreased need for hospitalization) | Click here to enter text. |
| In what settings would this be used? (e.g., inpatient/outpatient) | Click here to enter text. |
| What types of providers would use this intervention? (e.g., type of physician, therapists, advanced practice nurses) | Click here to enter text. |

|  |  |
| --- | --- |
| If the intervention is a service, should it also be considered for reimbursement when it is remotely delivered? (e.g., as a telemedicine medical service or a telehealth service) | Click here to enter text. |

|  |  |
| --- | --- |
| Is this approved by the FDA? | ☐Yes ☐No ☐Unknown |
| If yes, for what indications has it been FDA-approved? | Click here to enter text. |
| If not, please provide a rationale for topic consideration. | Click here to enter text. |

# Effectiveness

|  |  |
| --- | --- |
| What is the potential effectiveness of this treatment, procedure, or device for the indicated condition(s)? | Click here to enter text. |
| How does this treatment, procedure, or device compare to alternatives, with regard to health outcomes?  | Click here to enter text. |
| How would this procedure, treatment, or device improve the health of the Texas Medicaid population? | Click here to enter text. |

# Safety

|  |  |
| --- | --- |
| What are the potential harms or other safety concerns regarding this treatment, procedure, or device?*Failure to disclose harms may result in a topic rejection.* | Click here to enter text. |
| What is the likelihood of potential harms? | Click here to enter text. |
| What is the severity of potential harms? (e.g., how often do the harms include death, or severe disability?) | Click here to enter text. |
| How do the potential harms of this treatment, procedure, or device compare with alternative treatments for the indicated condition(s)? | Click here to enter text. |

# Cost

|  |  |
| --- | --- |
| What is the cost of this treatment, procedure, or device? (e.g., annual or lifetime) | Click here to enter text. |
| How do these costs compare to alternative treatments for the indicated condition(s)? | Click here to enter text. |
| Are there documented cost savings, cost increases, cost offsets, or cost avoidances of this treatment, procedure, or device? (if yes, please include documentation)  | Click here to enter text. |

# Coverage

|  |  |
| --- | --- |
| To your knowledge, which private insurers reimburse for this treatment, procedure, or device? | Click here to enter text. |
| Please cite any Center for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) on this topic and the date issued. Please include information on limits or restrictions placed on the benefit. | Click here to enter text. |

# Supporting Documents

Please provide any relevant literature and evidence-based clinical practice guidelines as PDF attachments to this form, including a complete list of references.

Completed forms should be emailed to medicaidbenefitrequest@hhsc.state.tx.us