Health and Developmental Services
Office of Primary and Specialty Health (OPSH)

CSHCN TOPIC NOMINATION FORM

Members of the public, state agencies and others may request that the Children with Special Health Care Needs (CSHCN) Services Program of the Texas Health and Human Services Commission (HHSC) considers coverage or expansion of a possible benefit. Please fill out and submit a Topic Nomination Form to propose a topic for review and consideration of coverage. Form submission does not guarantee coverage.

Please fill out the form as completely as possible. Please attach any supporting publications or other documents to a completed nomination form for consideration by CSHCN.

Please note, Title 25, Part 1, Chapter 3, Rule §38.4 of the Texas Administrative Code prohibits CSHCN from providing coverage for treatments which are considered experimental or investigational; chiropractic services; care for premature infants; care for alcohol or substance abuse; pregnancy prevention; maternity care services specific to routine pregnancy care, labor and delivery, and maternal post-partum care; and infertility treatment.

Contact Information	
Date Submitted	**Name of Nominator**
Role of Nominator	**Organization** (if applicable)
Address (City, State, Zip Code)	
Phone No.	**Email**

Intervention Information

What is the name and type of the intervention? (e.g., procedure, treatment, medication, device)

Provide a brief description of the intervention. (Please include billing codes, if known.)

What are current alternatives to this? (Please include billing codes, if known.)

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Utilization Information

What are the patient populations that would utilize this? (e.g., medical diagnosis, age, gender, ethnicity)

In what settings would this be used? (e.g., inpatient/outpatient/home)

What type of providers would use this? (e.g., type of physician, therapists, advanced practice nurses)

Safety

Is this approved by the FDA?

Yes No Unknown

If yes, for what indications?

If no, please provide a rationale for consideration.

What are the potential harms or safety concerns regarding this intervention?
Failure to disclose harms may result in a topic rejection.

What is the likelihood of potential harms?

What is the severity of potential harms? (e.g., how often do the harms include death or severe disability?)

How do these potential harms compare with current alternatives?

Effectiveness

What are the expected outcomes? (e.g., improved survival, decreased hospitalizations)

What is the potential effectiveness of this for the diagnoses indicated?

How do the health outcomes compare with current alternatives?

Cost

What is the estimated cost? (e.g., annual or lifetime)

How do these costs compare with current alternatives?

Are there documented cost savings, cost increases, cost offsets, or cost avoidances of this intervention? (if yes, please include documentation)

Yes No Unknown

Coverage

Is this intervention covered by Texas Medicaid?

Yes No Unknown

To your knowledge, which private insurers reimburse for this intervention?

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.)

Supporting Documents

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

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