Detailed Item by Item Guide for Completing the Authorization Request for PASRR Nursing Facility Specialized Services (NFSS) Form

Version 3.0

Texas Health and Human Services

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Purpose

This document will describe details for completing the Nursing Facility Specialized Services (NFSS) Portable Document Format (PDF) printable form.
Overview

This guide is to be used to complete the Authorization Request for PASRR 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).

When an existing assessment instrument is available to the therapist, that assessment tool should be used to perform the required assessment.

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 they do not have an assessment tool for the specialized service.

**No matter which assessment instrument is used, all required fields within the NFSS Form on the LTC Portal must be completed for the authorization request.**

Once the assessment has been performed, 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 resident’s medical record.

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

In order for a resident to be eligible for 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**

The PASRR Level I (PL1) Screening Form is designed to identify persons who are suspected of having mental illness (MI), intellectual disability (ID) or a developmental disability (DD) also referred to as related conditions (RC).
The referring entity (RE), local intellectual or developmental disability authority (LIDDA), or nursing facility will screen the resident and fill out all fields of the PL1 Screening Form and enter the PL1 into the Portal.

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

**PE**

The PE is completed by the LIDDA or local mental health authority (LMHA) and is designed to confirm the suspicion of MI, ID, or DD/RC, ensure the resident is placed in the most integrated residential setting and is receiving the specialized services needed to improve and maintain the resident’s level of functioning.

**IDT**

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

Once the initial IDT meeting is held, a specialized services review meeting is held annually thereafter to review and update any specialized services the resident or the resident’s LAR want to receive.

The interdisciplinary team must include the participation of:

- the resident;
- the resident’s LAR, if any;
- a registered nurse from the nursing facility with responsibility for the resident;
- a representative of the LIDDA or LMHA; and
- others as applicable:
  - concerned persons whose inclusion is requested by the resident or LAR;
  - persons specified by the resident or LAR, nursing facility, or LIDDA or LMHA, as applicable, who are professionally qualified or 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 resident is school eligible, as requested by the resident or LAR.
As a required member of the IDT, a representative of the LIDDA or LMHA will confirm its attendance at the meeting (in person or by phone) and that the specialized services documented on the IDT or specialized services review meeting forms were those agreed to during the meeting.

**Initiating PASRR Nursing Facility Specialized Services**

The nursing facility 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 recommended and agreed to at the meeting. The following nursing facility habilitative specialized services must be requested by completing all required fields in the NFSS Form on the LTC Online Portal:

- physical therapy (PT),
- occupational therapy (OT), and
- speech therapy (ST);
- a customized manual wheelchair (CMWC); and
- durable medical equipment (DME), which consists only of the following items:
  - a gait trainer;
  - a standing board;
  - a special needs car seat or travel restraint;
  - a specialized or treated pressure-reducing support surface mattress;
  - a positioning wedge;
  - a prosthetic device; and
  - an orthotic device.
Section 1. When to Complete and Submit an NFSS Form

Before providing a PASRR nursing facility specialized service, a nursing facility must request and receive authorization from HHSC through the LTC Online Portal to deliver the service. Once authorization is obtained from HHSC, a nursing facility must submit a complete and accurate claim within 12 months of the end of the month in which the service was provided. Only nursing facilities 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 meeting, the nursing facility should initiate the required assessment to verify and confirm the needs of the resident. If the assessment confirms the need for the specialized service, authorization request for the assessment and the service should be submitted into the LTC Online Portal together using the NFSS Form. If the assessment does not confirm the need for the particular service, the nursing facility may still request authorization for payment for performing the assessment.
Section 2. Performing an Assessment for the NFSS Form

For any of the PASRR nursing facility specialized service, a licensed therapist must perform, or have recently performed (within the last 30 calendar days), an assessment on the resident to determine whether the service being requested is medically necessary. Depending on the service being requested, the therapist must be either a physical therapist, occupational therapist, or a speech language pathologist and be licensed in the state of Texas.

The assessment by the therapist should be performed using the assessment instrument usually available to the therapist, or the therapist may choose to use the NFSS PDF form’s assessment section. No matter which assessment instrument is used, all required assessment information must be entered on the NFSS form in the LTC Portal to initiate an authorization request.

A therapist can perform an assessment at any time to evaluate the needs of the resident; however, HHSC will only authorize payment for the same type of assessment for the same resident, in the same nursing facility, every 180 days.

Once a therapy assessment has been approved, it can be used for up to one year for recertification therapy requests. After an assessment is a year old, an updated therapy assessment is required.
Section 3. NFSS Form Retention Period

Nursing facilities will keep the original therapist assessment with the appropriate original signatures in the resident’s record until notified otherwise by HHSC Legal Services.
Section 4. NFSS Form Assistance

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

- General Inquiries
- PASRR Level I (PL1) Screening Form Status
- PASRR Evaluation (PE) Form Status
- PL1, PE, and IDT Form Submission and Confirmation Process
- NFSS Form Submission and Form Status
- Assistance in submitting attachments to an NFSS form
- Claim Forms
- Claim Submissions

Call **HHSC IDD PASRR Unit** at 1-855-435-7180 for:

- Questions specifically related to ID/DD
- Assistance with locating information to complete the PL1 Screening Form
- Assistance/cooperation from a Referring Entity, Local Authority or Nursing Facility
- Assistance locating forms, residents, Local Authority or additional training resources
- Assistance with the interdisciplinary team (IDT) process
- Assistance with locating information to complete the NFSS Form
- Assistance with requests that are in “Pending Denial” status.

Contact the **HHSC MI PASRR Unit** by emailing pasrr@dshs.state.tx.us for:

- Questions specifically related to MI
- Assistance with locating information to complete the PL1 Screening Form for individuals suspected of having an MI diagnosis
- Assistance/cooperation from a hospital referring entity
- Assistance locating forms, residents, local mental health authority or additional training resources
- Assistance with MI specialized services
Section 5. How to submit a Request for Authorization 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 www.tmhp.com.

A nursing facility 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 resident is temporarily or permanently discharged from the facility, or other reasons why only the assessment is needed. In this case, the nursing facility will request authorization for an “Assessment Only”.

When the nursing facility is requesting authorization for a DME or CMWC, the submission must include both the assessment and the completed DME or CMWC Form.

PDF Form

A blank copy of the NFSS form in PDF format is available for downloading at: http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

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 Portal and the original copy of the assessment completed on the PDF form is maintained in the resident’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 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
- 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 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 nursing facility must ensure the signature page is signed by the therapist that performed the assessment and the nursing facility administrator.

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

- the signatures of the referring physician, attesting that the DME or CMWC is medically necessary, and

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

- the durable medical equipment 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), and
  - acknowledging the actual authorized amount is minus 18% of the MSRP,
  - acknowledging the cost of any adjustments and modifications required within the first six months after delivery is included in the authorized amount.

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 Portal. Illegible signatures or signatures that do not match the NFSS form will not be accepted.

Signature sheets that have been **altered will not be accepted** and the request will be denied.

The nursing facility will download the signature pages from the following website: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

**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
- MSRP for each item requested
- PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification (for Therapist and NF Administrator signatures)

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
- PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification

Attachments can be found at the following website:  
http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

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, 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 www.tmhp.com.

The PDF NFSS form should not be faxed to TMHP or HHSC as a means to request a specialized service.
Section 6. How to submit a Request for Authorization for a DME or CMWC

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

HHSC only authorize PASRR DME items greater than $1,000, but less than $5,000. Nursing facilities are required to provide medical equipment and supplies, which cost less than $1,000, in order to ensure that care meets the health needs and promotes the maximum well-being of the residents. Such equipment and supplies are included as a part of the per diem reimbursement paid to the nursing facility 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 resident, 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 resident’s current CMWC no longer meets the resident’s needs.

**Note:** A nursing facility 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: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

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 Portal and the original copy of the DME or CMWC request completed on the PDF form is maintained in the resident’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 DME or CMWC submitted through the NFSS Form must be accompanied by an attachment with

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

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 Portal. Illegible signatures or signatures that do not match the NFSS form will not be accepted.

Signature sheets that have been altered will not be accepted and the request will be set to pending denial.

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

- the durable medical equipment 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: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)
Attachments

Required attachments for a DME or CMWC 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
- PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification (for Therapist and NF Administrator signatures)

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
- PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification

Attachments can be found at the following website:
http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

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, 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 www.tmhp.com.

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 resident as
specified in the assessment. It also indicates, by the administrator’s signature, that the item was delivered and received by the nursing facility.

**Failure to submit this receipt confirmation will delay or prevent the facility’s reimbursement.**
Section 7. Item by Item Steps for Completing 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 resident, legally authorized representative (if applicable), nursing facility, local intellectual and developmental disability authority, and local mental health authority.

**A0100. Resident Name**

**A0100 A. First name**—Enter the resident’s First Name.

**A0100 B. Middle initial**—Enter the resident’s Middle Initial.

**A0100 C. Last name**—Enter the resident’s Last Name.

**A0100 D. Suffix**—Enter the resident’s Suffix.

**A0200 A. Social Security No.**—Enter the resident’s social security number.

**A0200 B. Medicare No.**—Enter the resident’s Medicare number.

**A0300. Medicaid No.**—Enter the resident’s Medicaid number.

**A0400 A. Birth Date**—Enter the resident’s Birth Date.

**A0400 B. Age**—Enter the resident’s age at the time of submission. The resident must be 21 years of age to qualify for PASRR nursing facility Specialized Services.

**Legally Authorized Representative (LAR) Subdivision**

If the resident has a legally authorized representative (LAR), enter the LAR’s identification information.

- Confirm the individual’s address (nursing facility) and LAR information, if applicable, is correct. This information will be used by the LTC Portal to issue correspondence to the individual (or LAR if applicable) relating to the status of the specialized services request submitted through the NFSS form.
- When there is an invalid address on the NFSS form such as such as “Unknown” or “N/A” into the LAR’s contact, the LAR will not receive correspondence regarding the status of the specialized service request, including their right to request a fair hearing when the request is denied.

**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.
A600 B. City—enter the name of the LAR’s city.
A600 C. State—enter the name of the LAR’s state.
A600 D. Zip Code—enter the name of the LAR’s zip code
A600 E. Phone No.—enter the name of the LAR’s phone number.

**Nursing Facility Information Subdivision**

Document the identifying and contact information for the resident’s nursing facility.

A0700 A. Provider No.—Enter the Provider number of the nursing facility.
A0700 B. Vendor No.—Enter the vendor number of the nursing facility.
A0700 C. NPI—Enter the national provider identifier (NPI) number of the nursing facility.
A0700 D. Facility Name—Enter the facility name.
A0800 A. Street Address—Enter the street address of the nursing facility.
A0800 B. City—Enter city of the nursing facility.
A0800 C. State—Enter the state of the nursing facility.
A0800 D. ZIP Code—Enter the zip code of the nursing facility
A0800 E. County—Enter the County of the nursing facility.
A0900 A. Phone No.—enter the area code and phone number of the person to be contacted at the nursing facility 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 nursing facility with questions regarding information entered into the NFSS form.

**LIDDA and LMHA Information Subdivision:**

Document the identifying and contact information for the resident’s local intellectual and developmental disability authority (LIDDA) or local mental health authority (LMHA).

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 Contract number.

A1100 B. LMHA Vendor No.—Enter the LMHA Vendor number.

A1100 C. LMHA NPI/API No.—Enter the LMHA NPI/API number.

**Type of Service Requested Subdivision:**

**Durable Medical Equipment (DME)**

A2000 Request Type—if DME was selected under A2000 Request Type, choose one of the following:

A2200 DME Service Type—select either a number 1. DME Assessment Only, or a number 2. DME for the assessment and DME item.

**Customized Manual Wheel Chair (CMWC)**

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

A2200 CMWC Service Type select either a number 1. CMWC Assessment Only or a number 2. CMWC for the assessment and a CMWC.

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 durable medical equipment (DME) or a customized manual wheelchair (CMWC).

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

**Steps for a DME or CMWC Assessment**

1. The information requested in this section is required.
2. Response to questions must be at least 50 characters long or the LTC Portal will not accept the information. A space is considered a character.
   
   **Example:** *The quick brown fox jumped over the lazy dog.* contains 45 characters.

3. The LTC 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 7-digit license number of the therapist who completed the assessment. If the therapist’s license number is less than 7-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 nursing facility enter 1. Yes. If the therapist who completed the assessment does not work for the nursing facility, but is a contracted therapist, enter 0. No.

If the therapist is not employed by the nursing facility, 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 nursing facility.

**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 nursing facility requests authorization for the assessment or service.

**Postural Control Subdivision:**

**B0900 A. Head Control**—enter the resident’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 resident’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 resident’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 resident’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, 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, 0. No?

**B1100 B. If Yes, explain and include the wound stage and wound 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 Indicate resident’s muscle tone:

B1600 A. indicate resident’s muscle tone—enter a description of the resident’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 resident’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 Ambulatory Status**

**B1700 A. Ambulatory Status**—enter the resident’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 resident is able to 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 resident is dependent upon a wheelchair or walker for ambulation by selecting: 1. Yes, 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 resident’s level of dependence on a wheelchair or walker. If 0. No was entered for B1700 C, describe the residents’ ability to ambulate without a wheelchair or walker. (Minimum is 50 alphanumeric characters.)

**B1800 A. Indicate the resident’s ambulation potential**—enter the resident’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

**B1900—Reserved.**

**B2000 Feeding**—enter the resident’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 resident is tube fed, enter: 1. Yes, 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 resident is tube fed. (Minimum is 50 alphanumeric characters.)
**B2200 B. Dressing**—enter the resident’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 resident currently attends an education/vocational setting enter: 1. Yes, 0. No.

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

**B2300 C. Has a therapist from the education/vocational setting been involved in this assessment**—if a therapist was involved in completing the assessment, enter: 1. Yes, 0. No.

**B2310 If yes, therapist’s name and phone number**—If 1. Yes, was entered in B2300 C, enter the name and phone number of the therapist from the education/vocational setting who was involved in completing the assessment.

**Referring Physician Identifying Information Subdivision:**

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

**B2400 A. Last name**—enter the last name of the referring physician.

- The physician’s name 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 number**—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 resident 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.

- must be after the physician has reviewed the therapist’s assessment.
- 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 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 the required signatures.

Obtain signatures as instructed in B0700 Therapist’s Signature Date for an assessment 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 from the assessment completed by a licensed therapist in order to request a CMWC. Nursing facilities can use the Authorization Request NFSS for
CMWC form available for downloading at http://www.tmhp.com/Pages/LTC/ltc_forms.aspx to describe the CMWC.

Complete this section only if Type of Service is CMWC.

**Current Seating Equipment Subdivision:**

**C0100A.**—Does the resident have a current seating system—indicate if the resident has a current seating system, by entering: 1. Yes, 0. No.

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

**C0100B.**—if 1. Yes, was entered in C0100 A, describe the resident’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 resident’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 resident’s needs**—if 1. Yes, was entered in C0100 A, enter the reason the current seating system no longer meets the resident’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 resident’s needs and an order from the resident’s attending physician. (40 TAC, Chapter 19, Subchapter BB, §19.2756(f)).

**Requested Customized Seating Equipment Subdivision:**

**C0200 Describe the seating system that is being requested and how it must be customized to meet the resident’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 resident’s specific medical needs for these customizations. (Minimum is 50 alphanumeric characters.)

**Note:** This section must contain all the diagnosis for the resident 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 resident’s physical and 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 resident will performed while in the custom manual wheelchair such as eating 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:**

Nursing facilities can use the measurement worksheet in the PDF form available for downloading at [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx) to complete this section.

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 resident’s height in inches.

C0800 C. Weight—enter the resident’s weight in pounds.
C0900 A. Top of head to bottom of buttocks—after measuring from the top of the resident’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 resident’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 resident’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 resident’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 resident’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 resident’s foot, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 G. Head width—after measuring the width of the resident’s head, as indicated on the measuring worksheet, enter the measurement in inches.

C0900 H. Shoulder width—after measuring the width between the resident’s shoulders as indicated on the measuring worksheet, enter the measurement in inches.

C0900 I. Armpit to armpit—after measuring the width between the resident’s armpits as indicated on the measuring worksheet, enter the measurement in inches.

C0900 J. Hip width—after measuring the width of the resident’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 resident’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 resident’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 resident’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, 0. No. For example, is the home equipped with ramps, accessible bathrooms, 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, 0. No.

C1100 B. If Yes, describe how the item will be transported—if 1. Yes, was entered in C1100 A, describe the manner in which the custom manual wheelchair will be transported (e.g. van, adapted wheelchair lift, ambulance, public transportation, other, etc.) and whether the resident will be sitting in the wheelchair during transportation. (Minimum is 50 alphanumeric characters.)

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

C1200 If the resident 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 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 0. No.

C1400 Additional comments and observations of education/vocational therapist—if B2310 A. Does the resident have a current educational/vocational setting 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 education/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 at [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

C1900B. Item No.—this is the item number of the component being added to the MSRP list.

C1900C. HCPC’S code—enter the Healthcare Common Procedure Coding System (MCPC’S) 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.)

After the item is delivered to the facility, the submitter must attach a completed PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification. The signature by the therapist on this attachment certifies that the item meets the needs of the resident as specified in the assessment. It also indicates, by the administrator’s signature, that the item was delivered and received by the nursing facility.

**Failure to submit this receipt confirmation 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 the item meets the needs of the resident as specified in the assessment.

**C4300 B. Last Name**—enter the last name of the therapist who is certifying the item meets the needs of the resident as specified in the assessment.

**C4400 A. License Type**—select the license type (1. OT or 2. PT) of the therapist who is certifying the item meets the needs of the resident as specified in the assessment.

**C4400 B. License No.**—enter the license number of the therapist who is certifying the item meets the needs of the resident as specified in the assessment. The portal accepts 7-digit numbers. If the therapist’s license number is less than 7-digits, place a zero before the license number.

**C4500 Therapist’s Certification Date**—enter the date the therapist certified the item meets the needs of the resident as specified in the assessment by signing the NFSS CMWC/DME Receipt Certification attachment.
The certification date must be between the CMWC receive date and the date of the receipt certification submission (current date).

**Nursing Facility Administrator Certification of Delivered Device**

**C4600 A. First Name**—enter the first name of the nursing facility administrator who certified that the item was delivered and received by the nursing facility.

**C4600 B. Last Name**—enter the last name of the nursing facility administrator who certified that the item was delivered and received by the nursing facility.

**C4700 CMWC Received Date**—enter the date the custom manual wheelchair was received by the nursing facility.

**C4800 NF Administrator’s Certification Date**—enter the date the nursing facility administrator certified that the item was delivered and received by the nursing facility on the CMWC/DME Receipt Certification signature page.

- The certification date must be between the CMWC receive date and the date of the receipt certification submission (current date).

**DME Request Section**

**Intent:** The purpose of this tab is to document the information on the LTC Online Portal from the assessment completed by a licensed therapist in order to request DME item or items. Nursing facilities can use the assessment tool available for downloading at [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

Instructions for requesting DME item(s) apply 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 only authorize PASRR DME items greater than $1,000, but less than $5,000.

**Environmental Assessment Subdivision**

**D1000, D2000, D3000, D4000, D5000, D6000, 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, accessible
bathrooms, is storage for the DME item available, etc.? If the living environment is accessible and safe for the use of the custom manual wheelchair, enter: 1. Yes, 0. No.

D1000, D2000, D3000, D4000, D5000, D6000, D7000 B. Will the DME item need to be transported—if the item will be transported, enter: 1. Yes, 0. No.

D1000, D2000, D3000, D4000, D5000, D6000, D7000 C. If Yes, describe how the 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.)

D1100, D2100, D3100, D4100, D5100, D6100, D7100 If the resident does not have a current education/vocational setting, skip to the Current DME Item Subdivision.

D1100, D2100, D3100, D4100, D5100, D6100, D7100 If the resident has a current education/vocational setting, complete the following:

D1100, D2100, D3100, D4100, D5100, D6100, 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, 0. No.

D1100, D2100, D3100, D4100, D5100, D6100, 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, 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 resident has a current DME item similar to the one being requested enter: 1. Yes, 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 resident’s current DME
item, date it was purchased, or approximate age of the resident’s current DME item.

- If 2. 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/do not meet the resident’s needs**—describe the reason the current DME item no longer meets the resident’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 resident’s specific medical needs for this item. Depending on the specific DME item, describe the DME item will assist the resident (e.g. weight bearing, stretching muscles, reduce spasticity, improve functional transfers, improve mobility, improved 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 resident (e.g. completely immobile or limited mobility (resident can not 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 resident or the request will be set to “Pending Denial.”**

**D1420, D2420, D3420, D4420, D5420, D6420, D7420 Describe any anticipated modification/changes to the 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 resident 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

D1500, D2500, D3500, D4500, D5500, D6500, D7500 Supplier’s Business Name—enter the DME supplier’s business name.

D1510, D2510, D3510, D4510, D5510, D6510, D7510 A. First name—enter the first name of the supplier’s representative who will be providing the information on the cost of the DME item.

D1510, D2510, D3510, D4510, D5510, D6510, D7510 B. Last name—enter the last name of the supplier’s representative who will be providing the information on the cost of the DME item.

D1520, D2520, D3520, D4520, D5520, D6520, D7520 A. Street Address—enter the street address of the DME supplier’s business.

D1520, D2520, D3520, D4520, D5520, D6520, D7520 B. City—enter the city in which the DME supplier’s business is located.

D1520, D2520, D3520, D4520, D5520, D6520, D7520 C. State—enter the state in which the DME supplier’s business is located.

D1520, D2520, D3520, D4520, D5520, D6520, D7520 D. ZIP code—enter the zip code in which the DME supplier’s business is located.

D1530, D2530, D3530, D4530, D5530, D6530, D7530 A. Phone No.—enter the phone number of the DME supplier’s business.

D1530, D2530, D3530, D4530, D5530, D6530, D7530 B. FAX No.—enter the fax number of the DME supplier’s business.

Itemized Manufacturer’s Suggested Retail Price (MSRP)

Supplier Information and MSRP Subdivision:

DME Suppliers can use the Itemized MSRP worksheet in the assessment tool available for downloading at http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

D1900, D2900, D3900, D4900, D5900, D6900, D7900 B. Item No.—this is the item number of the component being added to the MSRP list.
**D1900, D2900, D3900, D4900, D5900, D6900, D7900 C. HCPC’S Code**—enter the Healthcare Common Procedure Coding System (MCPC’S) code for the item provided by the DME supplier.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 D. Description of item**—the description of the item must match the description on the MSRP documentation

**D1900, D2900, D3900, D4900, D5900, D6900, 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.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 G. Total Price**—the total price will be determined by calculating the item price multiplied by the quantity.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 H. Approved Price**—this is the amount authorized by HHSC.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 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).

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 I.2.**—the total amount of all items requested in the Approved Price fields authorized by HHSC.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 J. 1. Minus 18%**—will be determined by calculating the total amount multiplied by 0.18.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 J.2.**—total amount multiplied by 0.18 authorized by HHSC.

**D1900, D2900, D3900, D4900, D5900, D6900, D7900 K.1. Grand total**—the 18% amount subtracted from the total amount.
D1900, D2900, D3900, D4900, D5900, D6900, D7900 K.2. Grand total—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, etc.)

DME Receipt Certification Subdivision:

After the item is delivered to the facility, the submitter must attach a completed PASRR NF Specialized Services (NFSS)—CMWC/DME Receipt Certification The signature by the therapist on this attachment certifies that the item meets the needs of the resident as specified in the assessment. It also indicates, by the administrator’s signature, that the item was delivered and received by the nursing facility.

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

Therapist’s Certification of Delivered DME

D1600, D2600, D3600, D4600, D5600, D6600, D7600 A. First Name—enter the first name of the therapist who is certifying the item meets the needs of the resident as specified in the assessment.

D1600, D2600, D3600, D4600, D5600, D6600, D7600 B. Last Name—enter the last name of the therapist who is certifying the item meets the needs of the resident as specified in the assessment.

D1610, D2610, D3610, D4610, D5610, D6610, D7610 A. License type—enter the license type of the therapist who is certifying the item meets the needs of the resident as specified in the assessment.

D1610, D2610, D3610, D4610, D5610, D6610, D7610 B. License No.—enter the license number of the therapist who is certifying the item meets the needs of the resident as specified in the assessment. The portal accepts 7-digit numbers. If the therapist’s license number is less than 7-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 resident as specified in the assessment by signing the NFSS CMWC/DME Receipt Certification attachment.

- The certification date must be between the CMWC receive date and the date of the receipt certification submission (current date).
**Nursing Facility Administrator Certification of Delivered Device**

**D1630, D2630, D3630, D4630, D5630, D6630, D7630 A. First name**—enter the first name of the nursing facility administrator who certified that the item was delivered and received by the nursing facility.

**D1630, D2630, D3630, D4630, D5630, D6630, D7630 B. Last name**—enter the last name of the nursing facility administrator who certified that the item was delivered and received by the nursing facility.

**D1640, D2640, D3640, D4640, D5640, D6640, D7640 DME Item Received Date**—enter the date the DME item was received by the nursing facility.

**D1650, D2650, D3650, D4650, D5650, D6650, D7650 Nursing Facility Administrator’s Certification date**—enter the date the nursing facility administrator certified that the item was delivered and received by the nursing facility on the CMWC/DME Receipt Certification signature page.

- The certification date must be between the CMWC receive date and the date of the receipt certification submission (current date).
Section 8. How to Submit a Request for Authorization for a Habilitative Therapy Assessment

The NFSS Form can only be submitted on the TMHP LTC Online Portal. The LTC Online Portal can be access via www.tmhp.com.

HHSC will only authorize payment for the same type of habilitative therapy assessment (OT, PT, or ST) for the same resident, in the same nursing facility, once every 180 days. Once the assessment has been performed, the nursing facility must submit the request through the LTC Online Portal no more than 30 days from the date it was completed by the therapist (the date of submission plus 29 days). The original assessment is maintained in the resident’s medical record.

Continuation in the frequency, duration, and intensity of a therapy services can be submitted for authorization (recertification) as long as there is an authorized assessment on file in the LTC Portal and there has not been a break in service lasting more than 30 days.

Changes in the frequency, duration, and intensity of a therapy services identified as necessary to meet the resident’s needs can still be submitted for authorization along with an updated 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 it will be filed within the LTC Portal with a status of “Documented/Complete”.

The paper copy of the therapist’s assessment does not need to be attached to the NFSS request. Information from the therapist’s paper copy must be data entered on the NFSS form under the “Assessment Tab.”

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 Portal. Illegible signatures or signatures that do not match the NFSS form will not be accepted.

**Assessment Only**—when the assessment does not indicate the need for a particular specialized service, the assessment may be entered on the NFSS form on the LTC Online Portal and submitted as an “Assessment Only” in order to request reimbursement for completing the assessment.

For an “assessment only” request, the NF will need to submit a signature sheet:

- signed by the therapist who completed the assessment,
• signed by the administrator of the Nursing facility, to indicate awareness of the request.

When an “assessment only” request has been submitted and the NF determines a service is needed after all, a new therapy request (which includes both the assessment and treatment plan) will need to be submitted. The NF cannot use the “assessment only” submission to request a therapy service.

Signature sheets that have been altered will not be accepted and the request will be set to pending denial.

The nursing facility will download the signature pages from the following website:
http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

PDF Form

A blank copy of the NFSS form in PDF format is available for downloading at:
http://www.tmhp.com/Pages/LTC/ltc_forms.aspx

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 Portal and the original copy of the assessment completed on the PDF form is maintained in the resident’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 on the site:

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

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.

Attachments

Required attachments for an assessment that must be submitted with the NFSS Form are as follows:
For Habilitative Therapies:

- PASRR NF Specialized Services (NFSS)—Therapy Signature Page (for Therapist, Referring Physician and Nursing Facility Administrator signatures)

Attachments can be found at the following website: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

**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 [www.tmhp.com](http://www.tmhp.com).

The PDF NFSS form should **not** be faxed to TMHP or HHSC as a means to request a specialized service.
Section 9. How to Submit a Request for Authorization for a Habilitative Therapy Service

There are three types of therapy service authorization requests:

- **New** (Submit initial assessment) – a New request is the very first request submitted by the nursing facility for a resident to receive any of the three therapy types. An initial therapy assessment completed by the therapist is required. The therapy service request must include a:
  - treatment plan, and
  - the referring physician’s signature.

A signature page must be submitted and includes:

- signed by the Therapist who completed the assessment,
- signed by the Physician, who is attesting to the medical necessity for therapy services, and
- signed by the Administrator of the Nursing facility, to indicate awareness of the request.

The NF submitter only attaches the signature page in the portal and not the paper copy of the assessment.

- **Recertification** (Does not require an updated treatment plan and physician’s signature)—A therapy service recertification request is one in which there is **no change** to the amount, duration, or frequency of habilitative therapy services being requested. Approval of a recertification therapy request will result in the same level of therapy services over and over again until there is a change or the initial assessment is over 365 days old.
  - 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.

When submitting a request for recertification of therapy services, the LTC Portal will use the previously submitted therapy assessment (for the same type of therapy) to populate data into the therapy assessment tab.
Because there is no change in the amount, duration, or frequency of the therapy service, the NF submitter does not need to submit an updated assessment, only a signature sheet:

- signed by the Therapist who completed the assessment (if still available at the facility),
- signed by the Administrator of the Nursing facility, to indicate awareness of the request.

NF’s should resubmit a recertification only when the previous approved therapy authorization “end date” is less than 29 days. A NF submitter should enter the recertification request at least 15 calendar days prior to the current therapy end date.

When a recertification request has a break in the therapy service that is longer than 30 days, the NF submitter will need to submit the therapy request as a Restart.

- **Restart** – a therapy service request in which any of the following occurs:
  - the individual leaves the facility (discharged) for any reason (such as for a hospital stay) and their NF daily care\(^1\) ends, then all current service authorizations end on the date of discharge. Upon return to the facility the NF must submit an authorization request as a **RESTART** so therapy services can begin again.
  - when the therapist determines the amount, duration, or frequency of the therapy service needs to change, an updated assessment, therapy plan, and signatures must be submitted, however, HHSC only pays for 1 assessment every 180 days regardless of how many restarts are submitted during that period.
  - when there is a break in therapy service lasting more than 30 calendar days
  - when the date of the assessment is over 60 days old.

The restart request must include an updated assessment with an updated treatment plan. The NF will need to submit a signature sheet:

- signed by the therapist who completed the assessment,
- signed by the referring physician, who is attesting to the medical necessity for therapy services, and

\(^1\) Refer to page 28 of this guide under “Error Codes Preventing Billing” for more information
signed by the administrator of the Nursing facility, to indicate awareness of the request.

For habilitative therapy requests, one signature page (attachment) per service (OT, PT, ST) being requested is required and must be signed by the therapist, physician, and nursing facility administrator. The exception to the requirement for the physician’s signature to be submitted is when the submission is a recertification request.

**PDF Form**

A copy of the NFSS form in PDF format is available for downloading at: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

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 resident’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 site:

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

The PDF NFSS form should NOT be faxed to TMHP or HHSC as a means to request a 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, 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, having the form signed by all required parties, 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 Portal. Illegible signatures or signatures that do not match the NFSS Form will not be accepted.

Signature sheets that have been **altered will not be accepted** and the request will be set to pending denial.

**Attachments**

Attachments that must be submitted in conjunction with the NFSS form are available for downloading at: [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx)

**For Habilitative Therapies:**

- PASRR NF Specialized Services (NFSS)—Therapy Signature Page (for Therapist, Referring Physician and Nursing Facility Administrator signatures)

One uploaded signature page per assessment being requested (OT, PT, and ST) is required.
Section 10. Item by Item Steps for Completing the 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 resident, legally authorized representative (if applicable), nursing facility, local intellectual and developmental disability authority, and local mental health authority.

**A0100. Resident Name**

A0100 A. *First name*—Enter the resident’s First Name.

A0100 B. *Middle initial*—Enter the resident’s Middle Initial.

A0100 C. *Last name*—Enter the resident’s Last Name.

A0100 D. *Suffix*—Enter the resident’s Suffix.

A0200 A. *Social Security No.*—Enter the resident’s social security number.

A0200 B. *Medicare No.*—Enter the resident’s Medicare number.

A0300. *Medicaid No.*—Enter the resident’s Medicaid number.

A0400 A. *Birth Date*—Enter the resident’s Birth Date.

A0400 B. *Age*—Enter the resident’s age at the time of submission. The resident must be 21 years of age to qualify for PASRR nursing facility Specialized Services.

**Legally Authorized Representative (LAR) Subdivision**

If the resident has a legally authorized representative (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.
A600 B. **City**—enter the name of the LAR’s city.
A600 C. **State**—enter the name of the LAR’s state.
A600 D. **Zip Code**—enter the name of the LAR’s zip code
A600 E. **Phone No.**—enter the name of the LAR’s phone number.

**Nursing Facility Information Subdivision:**
Document the identifying and contact information for the resident’s nursing facility.
A0700 A. **Provider No.**—Enter the provider number of the nursing facility.
A0700 B. **Vendor No.**—Enter the vendor number of the nursing facility.
A0700 C. **NIPA**—Enter the national provider identifier (NIPA) number of the nursing facility.
A0700 D. **Facility Name**—Enter the nursing facility’s name.
A0800 A. **Street Address**—Enter the street address of the nursing facility.
A0800 B. **City**—Enter city of the nursing facility.
A0800 C. **State**—Enter the state of the nursing facility.
A0800 D. **ZIP Code**—Enter the zip code of the nursing facility
A0800 E. **County**—Enter the county of the nursing facility.
A0900 A. **Phone No.**—enter the area code and phone number of the person to be contacted at the nursing facility 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 nursing facility with questions regarding information entered into the NFSS Form.

**LIDDA and LMHA Information Subdivision**
Document the identifying and contact information for the resident’s local intellectual and developmental disability authority (LIDDA) or local mental health authority (LMHA).
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 Contract number.
A1100 B. LMHA Vendor No.—Enter the LMHA Vendor number.

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

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 [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx).

Steps for Assessment

1. The information requested in this section is required, unless otherwise indicated.
2. Response to questions must be at least 50 characters long or the LTC Portal will not accept the information. A space is considered a character.

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.

Therapist Identifying Information Subdivision

**E0200, E3200, E6200 Therapist’s Name**

**E0200, E3200, E6200 A. First Name**—enter the first name of the therapist who completed the therapy assessment.

**E0200, E3200, E6200 B. Last Name**—enter the last name of the therapist who completed the therapy assessment.

**E0300, E3300, E6300 A. 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.

**E0300, E3300, E6300 B. License No.**—enter the license number of the therapist who completed the assessment.
E0300, E330, E6300 C. 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 nursing facility, but is a contracted therapist, enter 0. No.

If the Therapist is not employed by the nursing facility, 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 nursing facility.

E0600, E3600, E6600 A. Therapist Employer Street Address—enter the street address of the employer of the therapist who conducted the assessment.

E0600, E3600, E6600 B. Therapist Employer City—enter the city in which the employer of the therapist who conducted the assessment is located.

E0600, E3600, E6600 C. Therapist Employer State—enter the state in which the employer of the therapist who conducted the assessment is located.

E0600, E3600, E6600 D. Therapist Employer ZIP Code—enter the zip code in which the employer of the therapist who conducted the assessment is located.

E0700, E3700, E6700 A. Therapist Phone and FAX number—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 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
- 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 and be legible.

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 requests, except for “assessment only” requests.

**Therapy Service Request Section:**

**Intent:** The purpose of this subdivision is to document the information on the LTC 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. Nursing facilities can use the assessment tool available for downloading at [http://www.tmhp.com/Pages/LTC/ltc_forms.aspx](http://www.tmhp.com/Pages/LTC/ltc_forms.aspx) however, the information from the assessment will still need to be data entered into this tab on the LTC 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.

**E1600, E4600, E7600 A. 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).

**E1600, E4600, E7600 B. Description**—from the assessment completed by the therapist, enter a description of the diagnosis.

**E1600, E4600, E7600 C. 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 Goal**—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 Goal**—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

**E1900, E4900, E7900** A. **Frequency: number 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 time per week
- 3 time per week
- 4 time per week
- 5 time per week
- 6 time per week
- 7 time per week

**E1900, E4900, E7900** B. **Duration**: 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 month
- 3 month
- 4 month
- 5 month
- 6 month

**Note**: The therapy service can be up to six months in duration.

**E1900, E4900, E7900** C. **Intensity**: 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 time per day
- 3 time per day

**Referring Physician Identifying Information—Therapy Service Subdivision**

**Referring Physician Identifying Information:**

The referring physician is the one who is licensed as an MD or OD 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”.

**E2000, E5000, E8000 Physician’s information**
E2000, E5000, E8000 A. Last name—enter the last name of the referring physician.

E2000, E5000, E8000 B. License State—select the state in which the physician is licensed.

E2000, E5000, E8000 C. License No.—enter the state license number of the referring physician.

E2000, E5000, E8000 D. Military 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.

E2000, E5000, E8000 E. Date Resident Last Seen—enter the date the resident was last seen by the physician.

E2000, E5000, E8000 F. Signature Date—The physician’s signature date:

- The assessment by the therapist must be completed within 30 days before the nursing facility requests authorization for the therapy service.
- must be after the physician has reviewed the therapist’s assessment and cannot be more than 29 calendar days prior to the submission date for a therapy service.
- must match the signature date submitted on the Therapy 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 Portal. Illegible or signatures that do not match the NFSS form will not be accepted.

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).

E2200, E5200, E8200 A. 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).

E2200, E5200, E8200 B. 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).

E2200, E5200, E8200 C. 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).

**E2200, E5200, E8200 E. Phone Number**.—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).