Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Home Health Agency – Private Duty Nursing (PDN) Services Only

DATE OF REQUEST: _____/_____/_____

REQUEST TYPE: ☐ Initial ☐ Continued Services
☐ Retrospective* ☐ Unscheduled Revision

* For a Retrospective request, enter the date the recipient was determined Medicaid eligible:
_____/_____/_____

~~For questions regarding this form, call: (800) 525-2395~~

Form Submission ~~options~~:

- Upload form using the Provider Web Portal at www.medicaid.nv.gov
- ~~Fax to: (866) 480-9903~~
- ~~Mail to: Nevada Medicaid~~
  ~~Attention: Prior Authorization~~
  ~~6511 SE Forbes Ave., Bldg 283~~
  ~~P.O. Box 19287~~
  ~~Topeka, KS 66619-0287~~

For questions regarding this form, call: (800) 525-2395.

To request Durable Medical Equipment (DME) supplies, please attach form FA-1.

NOTES:

~~RECIPIENT INFORMATION~~REQUESTED PDN SERVICE DATES

Anticipated Start Date:	Anticipated End Date:

RECIPIENT INFORMATION

Recipient Name:	
Recipient ID:	Date of Birth:
Which program(s) is the recipient eligible for? ☐ Healthy Kids (EPSDT) ☐ Katie Beckett ☐ Waiver Program ☐ N/A	
Medicare Insurance Eligibility: ☐ Part A ☐ Part B ☐ N/A	Medicare ID#:
~~Bypass Medicare: ☐ Yes ☐ No ☐ N/A~~	
Other Insurance Name:	Other Insurance ID#:
~~Bypass Other Insurance: ☐ Yes ☐ No ☐ N/A~~	

Describe the recipient's social situation *(check all that apply)*:

☐ Recipient lives with family	☐ Teachable	☐ Capable of doing ~~self-care~~self-care
☐ Recipient lives alone	☐ Not teachable	☐ Unable to do ~~self-care~~self-care
☐ Foster Home	☐ Support Available	
☐ Group Home	☐ Support Unavailable	

~~RESPONSIBLE PARTY~~LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION *(if other than the recipient)*

Name:	Phone:
Address *(include city, state, zip code)*:	
Relationship to recipient:	

GUARDIAN INFORMATION *(if other than the recipient)*

Name:	Phone:
Address *(include city, state, zip code)*:	
Relationship to recipient:	

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CONCURRENT CARE	
Does anyone else receive PDN services in the home? ☐ Yes ☐ No	If yes, Medicaid ID:
If yes, is concurrent care being requested? ☐ Yes ☐ No	
If yes, indicate current hours/week requested for other recipient:	
Note: *TT modifier must be included for any shared Private Duty Nursing hours.*	
If no, please indicate reasoning why concurrent care is not being provided:	

ORDERING PROVIDER INFORMATION *(Physician ordering home health agency services)*	
Name:	NPI:
Phone:	Fax:

SERVICING PROVIDER INFORMATION *(Home health agency to provide home health agency services)*	
Name:	NPI:
Phone:	Fax:
Contact Name:	Miles from Home Health Agency to recipient's home:
Where does this provider render services? ☐ In Nevada (includes catchment areas) ☐ Outside Nevada	

CLINICAL INFORMATION	
Date of Registered Nurse Evaluation:	Date of Last Physician Visit:
Primary Diagnosis *(include ICD-10 code~~(s)~~)*:	
Additional Diagnosis(es) *(include ICD-10 code(s))*:	

Summary of Recipient Needs

~~Description of Recipient's Functional Deficit(s)~~ *~~(to be addressed by Home Health Agency Services)~~*

~~Interventions to be Provided and Measurable Short-Term and Long-Term Treatment Goals~~

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REQUESTED PDN SERVICES ~~*(To request Durable Medical Equipment (DME) supplies, please attach form FA-1.)*~~

~~Anticipated Start Date:~~ | ~~Anticipated End Date:~~

~~Recognized Holidays Requested:~~

Procedure Code	Requested Units/Day	Requested Days (circle each day requested)	Units/ Week	Duration (Weeks)	Total Units Requested
1.		S M T W Th F S			
2.		S M T W Th F S			
3.		S M T W Th F S			
4.		S M T W Th F S			
5.		S M T W Th F S			
6.		S M T W Th F S			

Support/Caregiver Details

~~Where is the recipient's primary caregiver currently located?~~
~~☐ At home ☐ Foster Home ☐ Group Home ☐ Other *(specify)*: _____~~

Primary Caregiver Name: | Relationship to Recipient:

~~Is this caregiver available full time? ☐ Yes ☐ No If no, how many hours per week is he/she available?~~

~~Does this caregiver work outside the home? ☐ No ☐ Yes *If yes, complete the following:*~~

~~Total hours per week worked: _____ Weekly work schedule: _____~~

~~Employer Name: Employer Phone Number:~~

~~Does this caregiver attend school? ☐ No ☐ Yes *If Yes, complete the following:*~~

~~School Name: Hours per week in school:~~

~~Does the primary caregiver have any health issues that limit his/her caregiving capabilities? ☐ No ☐ Yes~~
~~*If Yes, specify issues, describe limitations and how these limitations affect caregiver ability to care for recipient. Attach supporting physician documentation.*~~

Secondary Caregiver Name: | Relationship to Recipient:

~~Is this caregiver available full time? ☐ Yes ☐ No If No, how many hours per week is he/she available?~~

~~Does the caregiver work outside the home? ☐ No ☐ Yes *If Yes, complete the following:*~~

~~Total hours per week worked: _____ Weekly work schedule: _____~~

~~Employer Name: Employer Phone Number:~~

~~Does the caregiver attend school? ☐ No ☐ Yes *If Yes, complete the following:*~~

~~School Name: Hours per week in school:~~

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~~Does the secondary caregiver have any health issues that limit his/her caregiving capabilities? ☐ No ☐ Yes~~
~~*If Yes, specify issues, describe limitations and how these limitations affect caregiver ability to care for recipient. Attach supporting physician documentation.*~~

School Services *(for recipients under age 21 only)*

Is the recipient home schooled? ☐ Yes ☐ No	If No, does the recipient attend school? ☐ Yes ☐ No
If Yes, complete the following: Hours per day attended:	
Days per week attended:	Weeks per year attended:
Time recipient leaves home:	Time recipient returns from school:

Check the appropriate boxes below to indicate any specialized services that the recipient is currently receiving at school:

☐ Physical Therapy (PT)
☐ Occupational Therapy (OT)
☐ Speech Therapy (ST)
☐ Medication Administration
☐ ~~G-tube~~Enteral Feedings
☐ Other *(specify)*: _____

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PRIVATE DUTY NURSING ACUITY GRID: THE FOLLOWING SECTIONS ARE REQUIRED AND ARE TO BE COMPLETED BY THE ORDERING PHYSICIAN OR NON-PHYSICIAN PRACTITIONER (NPP) OR REGISTERED NURSE (RN) ASSESSING THE RECIPIENT'S NEEDS. ENTER SCORE FOR EACH SECTION AND THE GRAND TOTAL SCORE AT THE BOTTOM OF THE TABLE.

ASSESSMENT NEEDS

Choose one: This is based on the severity of illness and the stability of the patient's condition(s).

- ☐ Initial physical assessment per shift **(0.0 points)**
- ☐ Second complete physical assessment per shift **(2.0 points)**
- ☐ Three or more complete physical assessments per shift **(3.0 points)**

Choose one of the following **only** if at least 2 of the 4 assessment types listed (VS/GLU/NEURO/Resp) are medically necessary:
Note: *These assessments are incorporated in the physical assessment above. Select only if completed in addition to the physical assessment.*

- ☐ VS/GLU/NEURO/Resp **(0.0 points)**
  (Assess less often than daily)
- ☐ VS/GLU/NEURO/Resp **(1.0 points)**
  (Assess less often than Q 4, at least once per shift)
- ☐ VS/GLU/NEURO/Resp **(2.0 points)**
  (Assess Q 4 hr or more often per shift)
- ☐ VS/GLU/NEURO/Resp **(3.0 points)**
  (Assess Q 2 hr or more often per shift)

ASSESSMENT NEEDS TOTAL SCORE:_____

FEEDING NEEDS

Choose one:

- ☐ Routine oral feeding or no tube-feeding required **(0.0 points)**
- ☐ Difficult prolonged oral feeding by nurse **(2.0 points)**
  (must be supported by documentation in nursing notes)
- ☐ Tube feeding
  - ☐ routine bolus **or** continuous **(3.0 points)**
  - ☐ combination of bolus **and** continuous, *does not include clearing tubing* **(4.0 points)**
  - ☐ complicated tube feeding *(must be supported by documentation in nursing notes)* **(5.0 points)**

Check all that apply:

- ☐ Occasional reflux and/or aspiration precautions by nurse *(must be supported by documentation in nursing notes)* **(1.0 points)**
- ☐ G-tube, J-tube or Mickey button **(1.0 points)**

FEEDING NEEDS TOTAL SCORE:_____

MEDICATION/IV DELIVERY NEEDS

Choose one describing the medications to be provided by the nurse (oral, inhaler, rectal, NJ, NG, or G tube. Do not include nebulizer or over-the-counter medications:

- ☐ Medication delivery less than 1 dose per shift **(0.0 points)**
- ☐ Medication delivery 1 to 3 doses per shift **(1.0 points)**
- ☐ Medication delivery 4 to 6 doses per shift **(2.0 points)**
- ☐ Medication delivery 7 or more doses per shift **(4.0 points)**

Choose one:

- ☐ No IV access **(0.0 points)**
- ☐ Peripheral IV access **(1.0 points)**
- ☐ Central Line of port, PICC Line, Hickman **(2.5 points)**

Choose one:

- ☐ No IV medication delivery **(0.0 points)**
- ☐ Transfusion or IV medication:
  - ☐ less than daily but at least weekly **(2.5 points)**
  - ☐ less often than Q 4 hrs (does not include hep/saline flush) **(4.5 points)**
  - ☐ Q 4 hrs or more often **(6.0 points)**

Choose one:

- ☐ No regular blood draws, or regular blood draws less than twice/week **(0.0 points)**
- ☐ Regular blood draws / IV Peripheral Site – at least twice/week **(4.5 points)**
- ☐ Regular blood draws / IV Central Line – at least twice/week **(6.0 points)**

Choose one:

- ☐ No parenteral nutrition **(0.0 points)**
- ☐ Partial parenteral nutrition **(3.0 points)**
- ☐ Total parenteral nutrition (TPN) **(6.0 points)**

MEDICATION/IV DELIVERY NEEDS TOTAL SCORE:_____

RESPIRATORY NEEDS

Choose one:

- ☐ No trach:
- ☐ patent airway **(0.0 points)**
- ☐ unstable airway with desaturations, **and** airway clearance issues **(2.0 points)**
- ☐ Trach:
  - ☐ routine care **(3.0 points)**
  - ☐ special care (wound or breakdown treatment; pull-out or replacement) at least 2 events per shift **(3.5 points)**

Choose one: ***Note:*** *Instilling normal saline and resuctioning to break up secretions counts as one suctioning session.*

- ☐ No suctioning **(0.0 points)**
- ☐ Nasal and oral pharyngeal suctioning > 10 times per shift **(0.5 points)**
- ☐ Tracheal suctioning session by nurse during shift:
  - ☐ infrequent (less that Q 3 hrs) but at least daily **(1.0 points)**
  - ☐ Q 3 hrs **(2.0 points)**
  - ☐ Q 2 hrs or more frequently **(3.0 points)**

Choose one:

- ☐ No ventilator, BiPap or CPAP **(0.0 points)**
- ☐ Ventilator: rehab transition / active weaning **(10.0 points)**
- ☐ Ventilator: weaning achieved, required monitoring **(6.0 points)**
- ☐ Ventilator: at night, 1-6 hours during shift **(10.0 points)**
- ☐ Ventilator: 7-12 hrs/day; documented **(12.0 points)**
- ☐ Ventilator: ≥ 12 hrs/day but not continuous; documented **(14.0 points)**
- ☐ Ventilator: no respiratory effort or 24 hr/day in assist mode **(18.0. points)**
- ☐ BiPAP or CPAP by nurse during shift, up to 8 hrs/day **(4.0 points)**
- ☐ BiPAP or CPAP by nurse during shift, greater than 8 hrs/day **(6.0 points)**
- ☐ BiPAP ST by nurse during shift, spontaneous timed with rate used to ventilate at night **(7.0 points)**

Choose one: ***Note:*** *Excludes inhalers and normal saline*

- ☐ No nebulizer treatments **(0.0 points)**
- ☐ Nebulizer treatments by nurse during shift:
  - ☐ Less than daily but at least Q week **(1.0 points)**

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Choose one:
- ☐ None of the following three options apply **(0.0 points)**
- ☐ Oxygen – daily use **(1.0 points)**
- ☐ Oxygen PRN based on pulse oximetry, oxygen needed at least weekly **(2.0 points)**
- ☐ Humidification and oxygen – direct (via tracheostomy tube but not with the ventilator) **(3.0 points)**

- ☐ Q 4 hrs or less frequently but at least daily **(1.5 points)**
- ☐ Q 3 hrs **(2.0 points)**
- ☐ Q 2 hrs or more frequently **(3.0 points)**

Choose one *(must be physician ordered and medically necessary):*
Note: ***PT*** *= Physical Therapy*
HFCWO Vest *= High Frequency Chest Wall Oscillation Vest*
- ☐ No Chest PT, HFCWO Vest, or Cough Assist Device needed **(0.0 points)**
- ☐ Chest PT, HFCWO Vest or Cough Assist Device: (choose one)
  - ☐ at least Q week **(0.5 points)**
  - ☐ Q 4 hrs or less, but at least daily **(1.5 points)**
  - ☐ Q 3 hrs **(2.0 points)**
  - ☐ Q 2 hrs or more frequently **(3.0 points)**

RESPIRATORY NEEDS TOTAL SCORE:_____

WOUND CARE

Choose one:
- ☐ None of the following options apply **(0.0 points)**
- ☐ Wound Vac **(2.0 points)**
- ☐ Stage 1-2, wound care at least daily (does not include trach, PEG, IV site, J-tube or G-tube) **(2.0 points)**
- ☐ Stage 3-4, multiple wound sites (does not include trach, PEG, IV site, J-tube or G-tube) **(3.0 points)**

WOUND CARE TOTAL SCORE:_____

ISSUES THAT INTERFERE WITH CARE

Choose one:
- ☐ None of the issues below are applicable **(0.0 points)**
- ☐ Unwilling or unable to cooperate **(1.0 points)**
- ☐ Weight ≥ 100 pounds or immobility increases care difficulty **(1.0 points)**
- ☐ Unable to express needs and wants creating a safety issue **(1.0 points)**

ISSUES THAT INTERFERE WITH CARE TOTAL SCORE:_____

THERAPIES/ORTHOTICS/CASTING

Choose one:
- ☐ None of the following options apply **(0.0 points)**
- ☐ Fractured or casted limb **(2.0 points)**
- ☐ Passive ROM (at least Q shift) **(2.0 points)**
- ☐ Torso Cast, torso splint, or torso brace **(2.0 points)**

Choose one:
- ☐ No splinting schedule, or splint removed and replaced less frequently than once/shift **(0.0 points)**
- ☐ Splinting schedule requires nurse to remove & replace splint(s)
  - ☐ at least once during shift **(1.0 points)**
  - ☐ at least twice during shift **(2.0 points)**

THERAPIES / ORTHOTICS / CASTING TOTAL SCORE:_____

ELIMINATION NEEDS

Choose one that best applies to nursing care provided during the previous 60 days:
- ☐ Continent of bowel and bladder **(0.0 points)**
- ☐ Uncontrolled incontinence:
  - ☐ < 3 yrs of age **(0.0 points)**
  - ☐ ≥ 3 yrs of age, **either** bowel **or** bladder **(1.0 points)**
  - ☐ ≥ 3 yrs of age, **both** bowel **and** bladder **(2.0 points)**
- ☐ Incontinence and intermittent straight catheterization, indwelling, suprapubic, or condom catheter **(3.5 points)**

Bowel or Bladder, check if applicable:
- ☐ Ostomy Care - at least daily **(0.0 points)**

ELIMINATION NEEDS TOTAL SCORE:_____

SEIZURES

Choose one:
- ☐ No seizure activity **(0.0 points)**
- ☐ Mild seizures – at least daily, no intervention **(0.0 points)**
- ☐ Mild seizures – at least 4/week, each requiring minimal intervention **(2.0 points)**
- ☐ Mod seizures – each requiring minimal intervention
  - ☐ at least daily **(4.0 points)**
  - ☐ 2 to 4 times/day **(4.0 points)**
  - ☐ at least 5 times/day **(6.0 points)**
- ☐ Severe seizures (requiring IM/IV/Rectal med administration)
  - ☐ up to 10/month **(8.0 points)**
  - ☐ at least daily **(10.0 points)**
  - ☐ 2 to 4 times/day) **(10.5 points)**

SEIZURES TOTAL SCORE:_____

OTHER ISSUES

- ☐ Requires isolation for infectious disease (I.e., tuberculosis, wound drainage) or protective isolation **(3.0 points)** (Nursing care activities for creating and maintaining isolation must be documented.)

OTHER ISSUES TOTAL SCORE:_____

GRAND TOTAL FOR ALL CATEGORIES ON PRIVATE DUTY NURSING ACUITY GRID:_____

Signature of Clinical Professional who completed this form

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Printed Name: _____ **Date:** _____

Profession: _____

PHYSICIAN CERTIFICATION

I HEREBY CERTIFY that by signing and submitting this report to Nevada Medicaid that the information may be relied upon for the accurate determination of nursing acuity.

I certify that all submitted data on this grid and on any supporting information with it, is true, accurate, and completed and prepared from the case notes and observations of the LPN/RN in accordance with all applicable rules, regulations instructions, and requirements.

I further certify and represent that I have personally reviewed this report and that all representations are true and accurate according to the best available information and records.

I hereby agree to keep such records as are necessary to disclose fully the information contained herein for a period of no less than six (6) years from the date of submission and further agree to make all said records and information available as original documentation or as copies as designated by the request of authorized state personnel, including, but not limited to, agents of the Division of Health Care Financing and Policy (Nevada Medicaid).

I understand and intend that Nevada Medicaid will rely upon my statements herein to determine the nursing acuity. Any misrepresentation, falsification, concealment or omission of material facts constitutes fraud and I may be prosecuted under applicable federal or state law.

_____

Signature of Physician who is ordering Private Duty Nursing Services

Printed Name: _____ **Date:** _____