Private Duty Nursing Prior Authorization Forms

Instructions:

Private Duty Nursing Services (PDN) require prior authorization. You must submit a request for **NEW** services within 3 business days of the start of care date. You must submit **SUBSEQUENT** requests at least 7 days **prior** to the new start of care date but may submit up to 30 days prior to the start of care date.

You must submit the following forms **each time** you request authorization for New or Subsequent PDN Services:

1. Completed THSteps CCP request form
2. Completed Plan of Care (appropriately signed and dated by the physician and RN).
   Please note: The Home Health Plan of Care form provided by RightCare is available for use; however, providers may use a different Plan of Care form if desired.
3. Completed Addendum to the Plan of care forms which includes:
   a. The identification of the primary caregiver, alternate caregiver and physician
   b. An updated problem list with current progress towards goals
   c. The summary of recent health history or an updated 90 day summary for subsequent PDN services
   d. The rationale for PDN hours to either increase, decrease or stay the same
   e. Completed 24-hour daily flow sheet. The 24-hour daily flow sheet is divided in 15-minute increments using military time.
      1. Fill in all of the skilled needs that take place for all 7 day and all 24-hour periods. Indicate who is performing that service at that specific time in the column labeled Caregiver.
      2. Please note: some 15 minute time slots will have no skilled activity and some skilled needs may take more than 15 minutes to accomplish, please complete accordingly.
      3. All skilled activities should be included on the 24-hour schedule.
      4. Medical abbreviations may be used on the 24-hour schedule. Examples of acceptable abbreviations are attached on the next page.
   f. The acknowledgement page which indicates all pages of the addendum were completed and reviewed with the caregiver and physician prior to obtaining their dated signatures as well as acknowledging the other statements on that page
4. For extended 4 or 6 month authorizations, the THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6month authorization form must also be completed.

Requests received without the above-required information will be placed in pending status until a complete request has been received or timeframe guidelines have exhausted.

Note: For additional information, please refer to the 2007 Texas Medicaid Provider Procedures Manual section 43.4.10.

Abbreviations

Abbreviation	Description
PDN	Private duty nursing by registered nurse (RN) or licensed vocational nurse (LVN)
PDA	Private duty aide
SHARS	School Health and Rehabilitative Services
Phys Assess	Physical assessment/total body assessment- including head to toe review of body systems
Neuro Assess	Neurological assessment
Resp Assess	Respiratory assessment
GI Assess	Assessment of the GI tract/functions
GU Assess	Assessment of the genitourinary system
Sz	Seizure
Dx	Diagnoses
VS	Vital signs
BP	Blood pressure
TPR	Temperature, Pulse, respiration
Bi PAP	Bi-level Positive Airway Pressure
CPAP	Continuous Positive Airway pressure
IPPV	Intermittent positive pressure ventilation
IPPB	Intermittent positive pressure breathing
Vent	Ventilator
Trach	Tracheostomy/tracheotomy
SXN / SUX	Suctioning
O2	Oxygen
O2 Sats	Oxygen saturation level
Neb TX	Nebulizer/ aerosol treatment
CPT	Chest percussion therapy
BGM	Blood Glucose Monitor
AFO	Application of ankle foot orthotics
ROM	Range of motion
IM	Intramuscular injection
SQ	Subcutaneous
IV/ IVF	Intravenous/ fluids or medications
PAC	Port a cath IV access
NGT	Nasogastric tube
NGTF	Nasogastric Tube feeding
GT/GB	Gastrostomy tube/ Gastrostomy button
GTF/ GBF	Gastrostomy tube feeding/ Gastrostomy button feeding
Incont Care	Care of incontinent episodes (skin care)
Med/Meds	Medication given
Prec	Precautions
PRN	As needed
I & O	Intake and output
I & O cath	In and out urinary catheterization

THSteps-CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

Request for:	☐ **DME**	☐ **Supplies**	☐ **Private Duty Nursing**	☐ **Inpatient Rehabilitation**	☐ **Other**

Client Information

Client Name (Last, First, MI):	
Medicaid Number (PCN):	Date of Birth: / /

Supplier/Vendor Information

Supplier Name:	Telephone:	Fax Number:
Supplier Address:		

TPI:	NPI:	Taxonomy:	Benefit Code:

Diagnosis and Medical Necessity of Requested Services

Dates of Service	From: / /	To: / /

HCPCS Code	Brief Description of requested Services	Retail Price

Note: *HCPCS codes and descriptions must be provided.*

Primary Practitioner's Certifications—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify to the following:

☐ The client is under 21 years of age AND

☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

☐ The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician:	Date:
Printed or typed name of physician:	

TPI:	NPI:	License Number:

Contact Information for Completed Forms		**For RightCare Use Only**
Fax Number:	**(512) 383-8703**	
Contact:	**RightCare from Scott & White Health Plan** **Medical Management** **(855) 691-SWHP (7947)**	

Home Health Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Client's name:			Date of birth: / /	
Date last seen by doctor: / /			Medicaid number:	
Home Health Agency Information				
Name:	Fax number:		Telephone:	
Address:				
TPI:	NPI:		Taxonomy:	
DME TPI:		Benefit Code:		
Physician Information				
Name:			Telephone:	
TPI:	NPI:		License number:	
Status (check one):	New client ☐	Extension ☐	Revised Request ☐	
Original SOC date: / /		Revised request effective date: / /		
Services client receives from other agencies:				
Diagnoses (include ICD-9 codes if PT/OT is ordered):				
Function Limitations/Permitted Activities/Homebound Status:				
Prescribed medications:				
Diet ordered:		Mental status:		
Prognosis:		Rehabilitation potential:		
Safety Precautions:				
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):				
SNV visits requested:				
HHA visits requested:				
PT visits requested:				
OT visits requested:				
Supplies:				
DME Item No. 1	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 2	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 3	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 4	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
RN signature:			Date signed: / /		
I anticipate home care will be required:	From: / /		To: / /		

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:	Date signed: / /

Home Health Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.	
Client Information	
Client's name	Last name, first name, middle initial
Date of birth	Date of birth given by month, day and year
Date last seen by doctor	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment
Medicaid number:	Nine-digit number from client's current Medicaid identification card.
Home Health Agency Information	
Name	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Address	Agency address given by street, city, state and ZIP code
Telephone	Area code and telephone number of agency
TPI	Texas Provider Identifier number (10-digit) of agency
NPI	National Provider Identifier number (10-digit) of agency
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
DME TPI	Texas Provider Identifier number (10-digit) of agency DME
Benefit Code	Code identifying state program for the service provided
Physician Information	
Name	Name of Physician
License number	Physician's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician
TPI	Texas Provider Identifier number (10-digit) of physician
NPI	National Provider Identifier number (10-digit) of physician
Plan of Care Information	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)
Functional Limitations/ Permitted Activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)
Diet Ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV, HHA, PT, OT visits requested:	State the number of visits requested for each type of service authorized
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and To dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician signature, Date signed, Printed physician name	The physician's signature and the date the form was signed by the physician ordering home health services, and the physician's printed name

Nursing Addendum to Plan of Care (THSteps-CCP)

DOCUMENTATION REQUIREMENTS: All documents must be complete and received by RightCare Medical Management before review or authorization of PDN services can occur:
(1) All components of the Nursing Addendum to Plan of Care (THSteps-CCP) submitted with the
(2) Physician's plan of care (POC) and
(3) THSteps-CCP Prior authorization request. *[Additional information may be attached.]*

In accordance with the PDN adopted rules (Chapter 363 Comprehensive Care Program, Subchapter C Private Duty Nursing, Subchapter K. Private Duty Nursing) published in the Texas Register, December 1, 2002, the following criteria must be met for the authorization of PDN Services. Caregivers and alternate caregivers must also be identified for authorization to proceed.

☐ The client has an identified primary caregiver who provides some of the client's daily care:
(Caregiver) Name: _____ Relationship: _____ Phone #: _____

☐ The client has a designated alternate caregiver or a plan if the primary caregiver is unable to provide care:
(Alternate) Name: _____ Relationship: _____ Phone #: _____

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire and safety systems available and functional.

1) Nursing care plan summary: PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem List	Goals of Care	Specific Measurable Outcomes	Progress toward Goals

Additional Comments:

Client's Name:_____ RightCare ID #:_____Date: _____

2) Summary of recent health history for initial authorization OR 90 day summary for extension of PDN services:

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, family/caregiver update, other pertinent observations.

3) Rationale for PDN hours to either increase, decrease, or stay the same. Also address plans to decrease PDN hours:

Client's Name:_____ RightCare ID #:_____Date: _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
0:00														
0:15														
0:30														
0:45														
1:00														
1:15														
1:30														
1:45														
2:00														
2:15														

Client's Name: _____ RightCare ID #:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
2:30														
2:45														
3:00														
3:15														
3:30														
3:45														
4:00														
4:15														
4:30														
4:45														
5:00														

Client's Name: _____ RightCare ID #:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare, O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
5:15														
5:30														
5:45														
6:00														
6:15														
6:30														
6:45														
7:00														
7:15														
7:30														
7:45														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
8:00														
8:15														
8:30														
8:45														
9:00														
9:15														
9:30														
9:45														
10:00														
10:15														
10:30														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare, O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
10:45														
11:00														
11:15														
11:30														
11:45														
12:00														
12:15														
12:30														
12:45														
13:00														

Client's Name: _____ RightCare ID #:_____ Date: _____ Caregiver Initials _____

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
13:15														
13:30														
13:45														
14:00														
14:15														
14:30														
14:45														
15:00														
15:15														
15:30														
15:45														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
16:00														
16:15														
16:30														
16:45														
17:00														
17:15														
17:30														
17:45														
18:00														
18:15														
18:30														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Section 4) 24-hour Daily Flow Sheet

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
18:45														
19:00														
19:15														
19:30														
19:45														
20:00														
20:15														
20:30														
20:45														
21:00														
21:15														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Must include PDN and family/caregiver coverage and coverage from other resources:
Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare,
O=other in-home resource(s)

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
21:30														
21:45														
22:00														
22:15														
22:30														
22:45														
23:00														
23:15														
23:30														
23:45														

Client's Name: _____ RightCare ID#:_____ Date: _____ Caregiver Initials _____

Section 5) Acknowledgement (must be signed by the primary caregiver and the nurse provider):

By signing this nursing addendum, the primary caregiver and the nurse provider acknowledge:

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client's need for skilled care,
- PDN is not authorized for respite, child care, unskilled activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to RightCare Medical Management,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client's care plan and include telephone numbers for the client's physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The primary caregiver agrees to follow through with the Plan of Care as prescribed by the client's physician.

The primary caregiver agrees to learn all the skills necessary to provide care for the child in the absence of a private duty nurse.

The number of PDN hours requested is _____hrs/day OR _____hrs/week for the dates of service from _____ to _____.

I agree with the plan of care and the schedule of hours in this nursing addendum.

Signature of Primary Caregiver/Printed Name _____
Date _____

Signature of PDN Nurse Provider/Printed Name _____
Date _____

Signature of Prescribing Physician/Printed Name _____
Date _____

Client's Name:_____ RightCare ID#:_____Date: _____

THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization

The following criteria must be met before seeking a 4 or 6 month authorization of PDN services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

_____Client has received PDN services for at least one year.
_____Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
_____There has been no change in the PDN requests in the previous 6 months.
_____Client's physician and primary caregiver (parent) do not anticipate any significant changes in the client's condition for the requested authorization period.
_____The nurse provider will ensure that a new Physician Plan of Care is obtained every 60 days and will be maintained with the client's record.
_____The nurse provider will advise RightCare Medical Management of any *significant* changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
_____The client's primary caregiver, personal physician and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.

All required acknowledgments must be signed and dated:

I have read and understand the above information.

_____ _____
(Signature of parent/primary caregiver) Date

****

Brief statement of why a 4 or 6 month extension is appropriate for this client:

_____

I have discussed the above information with the client's parent/primary caregiver.

_____ _____
(Signature of the nurse provider) Date

****

To be completed by the client's physician:

The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.

_____ _____
(Signature of client's physician) Date

_____ _____
Printed name Telephone Number

_____ _____
Mailing address City, State, ZIP code, Fax #

Fax completed request to RightCare Medical Management at (512)383-8703.

****

Client's Name: _____ RightCare ID#:_____Date: _____