Prior Authorization Request

Nevada Medicaid and Nevada Check Up

Home Health Agency

Fax this request to: (866) 480-9903 For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

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

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

RECIPIENT INFORMATION	
Recipient Name:	
Recipient ID:	Date of Birth:
Which program(s) is the recipient eligible for? ☐ Healthy Kids (EPSDT) ☐ Katie Beckett ☐ Waiver Program	
Medicare Insurance Eligibility: ☐ Part A ☐ Part B	Medicare ID#:
Bypass Medicare: ☐ Yes ☐ No	
Other Insurance Name:	Other Insurance ID#:
Bypass Other Insurance: ☐ Yes ☐ No	
Describe the recipient's social situation *(check all that apply)*: ☐ Recipient lives with family ☐ Teachable ☐ Capable of doing self care ☐ Support Available ☐ Recipient lives alone ☐ Not teachable ☐ Unable to do self care ☐ Support Unavailable	
RESPONSIBLE PARTY INFORMATION *(if other than the recipient)*	
Name:	Phone:
Address *(include city, state, zip code)*:	
GUARDIAN INFORMATION *(if other than the recipient)*	
Name:	Phone:
Address *(include city, state, zip code)*:	
ORDERING PROVIDER INFORMATION	
Name:	NPI:
Phone:	Fax:
SERVICING PROVIDER INFORMATION	
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-9 code(s))*:	

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Summary of Recipient Needs
Description of Recipient's Functional Deficit(s) *(include therapy evaluation information)*
Individualized Plan of Care and Measurable Treatment Goals
Skilled Needs
☐ Catheter Care ☐ Central Line ☐ G-tube ☐ IV Antibiotics ☐ Med Setup ☐ New Ostomy Care ☐ Pic Line ☐ Teaching ☐ Trach Care ☐ Vent Care ☐ Wound Care ☐ Other *(specify)*:
Wound Care *(complete this section only if requesting wound care services)*
Describe the wound(s) and include measurements:
What is the treatment plan for the wound(s)?

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Which type of skilled visit is being requested for wound care?

☐ Brief LPN visit (T1001) ☐ Brief RN visit (T1002) ☐ Extended LPN visit (T1003) ☐ Extended RN visit (G0154)

For each day, enter the number of requested, non-skilled visits:

Sunday____ Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____

For each day, enter the number of requested, skilled visits:

Sunday____ Monday____ Tuesday____ Wednesday____ Thursday____ Friday____ Saturday____

Non-skilled Needs and Activities of Daily Living (ADLs) *(check all activities for which the recipient requires assistance)*

☐ Bathing ☐ Feeding ☐ Grooming ☐ Incontinent Care ☐ Meal Prep ☐ Mobility ☐ ROM
☐ Skin Care ☐ Toiletry ☐ Transfer ☐ Other *(specify)*:

PRIVATE DUTY NURSING SERVICES *(complete this section only if requesting Private Duty Nursing services)*

For each requested service type, list specific services and the frequency you are requesting for each.

Service Type	Specific Services	Frequency
Home Health		

Concurrent Care: ☐ Yes ☐ No If Yes, indicate Medicaid ID of the other recipient:

Indicate current hours/week requested for other recipient:

Note: TT modifier will be added to prior authorization for any shared Private Duty Nursing hours.

Intensity Of Care *(check all that apply)*

☐ 1. Ventilator dependent at least 6 hours per day (includes tracheotomy care, suctioning, oxygen administration and dressing changes).

☐ 2. Tracheotomy care (includes related suctioning, oxygen administration and dressing changes).

☐ 3. Total Parenteral Nutrition (TPN) (includes infusion maintenance, laboratory draws and related services.

☐ 4. Peritoneal dialysis requiring at least 4 changes every 24 hours.

☐ 5. Gastroscopy/Nasagastric tube feedings (includes related suctioning and medication administration for complex medical problems or medical fragility).

☐ 6. Complex medication management requiring 6 or more medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects. (PRN medications, vitamin and mineral supplements and laxatives are not included in this count.)

☐ 7. Unstable oxygen requiring continuous administration (24 hours per day) and used in combination with a pulse oximeter. There is a documented need for observation and adjustments in the oxygen administration rate.

☐ 8. Multiple sterile complex dressing changes requiring at least BID sterile dressing changes to multiple sites. Dressing changes must be separate from other skilled nursing interventions, such as changing a tracheotomy site when associated with the tracheotomy care. This is considered a Private Duty Skilled Nursing intervention only when intermittent home health agency services are not sufficient to meet would care needs.

☐ 9. Other skilled nursing intervention/procedure not listed above *(specify task and time required to perform each task)*:

Support/Caregiver Details

Where is the recipient's primary caregiver currently located?

☐ At home ☐ Foster Home ☐ Group Home ☐ Other *(specify)*:

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Provide the following information about <u>each</u> caregiver that is living in the recipient's home. Attach additional sheets if necessary to provide this information for <u>each</u> at home caregiver.

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:*

Hours per week worked: _____

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 care giving capabilities? ☐ No ☐ Yes
*If yes, specify issues, describe limitations **and** 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:*

Hours per week worked: _____

Employer Name: Employer Phone Number:

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

School Name: Hours per week in school:

Does the secondary caregiver have any health issues that limit his/her care giving capabilities? ☐ No ☐ Yes
*If yes, specify issues, describe limitations **and** attach supporting physician documentation.*

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

Does the recipient receive special services from his/her school? ☐ No ☐ Yes - *If yes, please answer the following questions. If no, skip to the next section, "Requested Services."*

Is the recipient receiving services that are appropriate for his/her age? ☐ Yes ☐ No

Is the recipient home schooled? ☐ Yes ☐ No

How many hours per day does the recipient attend school?

How many days per week does the recipient attend school?

How many weeks per year does the recipient attend school?

At what time does the recipient leave home to go to school?

At what time does the recipient arrive home 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 Feedings
☐ Other *(specify)*: _____

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

Requested Dates of Service (from-through):

Number of Recognized Holidays Requested:

In **Column 1**, enter the procedure code (CPT, HCPCS or NDC). Enter only one code per line. In **Column 2**, use "Extended," "Brief" or "Hourly"* to specify the length of visit. In **Column 3**, enter "RN" or "LPN" to describe the servicing provider or "OT," "PT," "ST," "R" or "D" to describe the type of therapy being requested. In **Column 4**, enter the number of requested units per week. In **Column 5**, enter the number weeks for which service is requested.

1	2	3	4	5	6
Procedure Code	**Length of Visit**	**Provider/ Therapy**	**Units per Week**	**Duration (Weeks)**	**Nevada Medicaid Use Only (Approved Units/Weeks)**
1.					
2.					
3.					
4.					

REQUESTED CNA SERVICES

Requested Dates of Service (from-through):

Number of Recognized Holidays Requested:

Procedure Code	Requested Hours	Requested Days (circle each day requested)	Duration (Weeks)	Nevada Medicaid Use Only (Approved Hrs./Days/Weeks)
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		

REQUESTING PROVIDER (PHYSICIAN OR RN)

Name:	NPI:
Signature:	Date:

FOR NEVADA MEDICAID USE ONLY

Approved Date Range: From: To:	Approved Units:
Authorization Number:	
This request was rejected due to: ☐ Insufficient Information ☐ Late Notification – Rejection Date:	
Reviewer Signature:	Date:

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