Nevada Medicaid and Nevada Check Up

# Instructions for Completing Form FA-16B

***(Authorization Request for Home Health Agency-Private Duty Nursing (PDN))***

To stay current with policy and documentation updates, providers are encouraged to visit www.medicaid.nv.gov weekly and be sure to read any messages included on your Remittance Advice.

## Finding the Form and Instructions Online

Form FA-16B and these instructions are online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu and scroll down until you see form FA-16B and FA-16B Instructions).

## General Form Instructions

All form fields must be completed. Write "N/A" in a field if the item does not apply.

Please print or type information on this form. If information is illegible, processing may be delayed. You can enter information directly into the form on your computer by clicking in any field and typing. You can check and uncheck the check boxes by clicking them.

When you are finished completing the form, submit the request online using the Provider Web Portal with the attached medical documentation to support the request.

If the FA-16B is incomplete, including the physician signature, it will be denied. If the authorization request is pended for additional clinical information, you will need to upload a corrected FA-16B to the same authorization. DO NOT create a new authorization. The received date is the date a completed correct request is received. The date of receipt of incorrect or incomplete requests is not valid. To avoid uncovered dates of service, please complete the FA-16B in its entirety the first time it is submitted. Only a completed FA-16B will be processed. If the information is not received within five (5) calendar days, the request will be denied, and a notice of decision will be sent.

**For initial PDN authorizations:** New requests for PDN services must be submitted within 15 business days after the initial evaluation and start of care. Providers are required to provide any recent hospital discharge summaries, and any other documentation to support the number of hours requested.

**For ongoing PDN authorizations:** Requests for continuing PDN services must be submitted **within 15 business days after the expiration date of the existing authorization**. Providers are required to include seven to 10 (7-10) consecutive days of PDN nursing notes, including all nursing shifts, and any other documentation to support the number of hours requested. Supporting documentation examples include, but are not limited to: PDN nursing notes, discharge summaries from any recent hospital admissions, and recent physician office notes.

## Completing the Form

This section describes the information to enter in each form field.

## NOTES

Providers may use this section to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

**DATE OF REQUEST:** Enter the date you submit the form to Nevada Medicaid.

### REQUEST TYPE

Check one of these boxes to indicate the type of prior authorization you are requesting.

- Initial – Check this box to request a recipient's initial prior authorization request.
- Continued Services – Check this box to request continued PDN.
- Retrospective – Check this box for a retrospective authorization request. For retrospective requests, enter the date the recipient was determined Medicaid eligible.
- Unscheduled Revision – Check this box if you are requesting an unscheduled revision to the recipient's previous prior authorization due to a change in recipient's condition.

**REQUESTED PDN SERVICE DATES**

- Anticipated Start & End dates – Indicate the anticipated start and end date of PDN services.

## RECIPIENT INFORMATION

- Recipient Name – Enter the recipient's name as it appears on their Medicaid card.
- Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
- Date of Birth – Enter the recipient's Date of Birth (DOB).
- Which program(s) is the recipient eligible for – Check all applicable boxes to indicate which program(s) the recipient is eligible for.
- Medicare Eligibility – Check this box to indicate the recipient's Medicare insurance eligibility, if none check the "N/A" box.
- Other Insurance – Enter other Insurance name and insurance ID # if applicable.
- Recipient's Social Situation – Check all boxes which most accurately describe the recipient's current social situation.
- **Note:** Verify the address and phone number are current, whether or not they match the information on file with Nevada Medicaid. If the recipient has moved, remind him/her to update address and phone number with the Division of Social Services (DSS).

## LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION

The definition of an LRI is: An individual who is legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney], and parents of minor recipients, including stepparents, foster parents and adoptive parents. Complete this section whether or not the recipient has an LRI.

You must include the contact information of a recipient's legally responsible individual when submitting a PDN prior authorization request for a recipient who is unable to speak on his or her own behalf or who is less than 18 years of age.

Does recipient have an LRI? If the definition of the LRI is met, complete the LRI Information section.

## GUARDIAN INFORMATION

Complete this section to provide a guardian contact information, if other than the recipient.

- Guardian Contact Name – Enter the name of the alternate contact person.
- Guardian Address – Enter the address of the guardian, include city, state and zip code.
- Phone – Enter the guardian's phone number.
- Relationship to Recipient – Enter the contact person's relationship to the recipient.

## CONCURRENT CARE

The definition of concurrent care is: The provision of PDN services by a single nurse to care for more than

one recipient simultaneously. A single nurse may provide care for up to three (3) recipients if care can be provided safely.

- Indicate if any other recipients in the home receive PDN services.
    - If "Yes" provide Medicaid ID of other recipient(s) receiving PDN services.
- Indicate if concurrent care is being requested.
    - If "YES" indicate the current hours per week requested for the other recipient.
    - If "NO" indicate explanation of why PDN concurrent care is not feasible or cannot be safely provided.
- **Note:** TT modifier must be included on claims for any shared PDN hours.
- If applicable, indicate why concurrent care is not being provided.

## ORDERING PROVIDER INFORMATION

Complete this section to provide ordering provider information, or the physician ordering home health agency services.

- Ordering Physician Name – Enter the name of physician ordering PDN services.
- NPI – Enter the NPI of the ordering physician.
- Phone – Enter the ordering physician's phone number.
- Fax – Enter the ordering physician's fax number.

## SERVICING PROVIDER INFORMATION

Complete this section to provide servicing provider information, or the home health agency to provide PDN services.

- Servicing Physician Name – Enter the name of physician providing PDN services.
- NPI – Enter the NPI of the servicing physician.
- Phone – Enter the Home Health Agency's phone number.
- Fax – Enter the Home Health Agency's fax number.
- Contact Name – Enter the contact name at the Home Health Agency.
- Miles from the Home Health Agency to recipient's home – Enter the number of miles from the Home Health Agency to the recipient's home.
- Where does this provider render services – Indicate if the Home Health Agency renders PDN services "In Nevada (including catchment areas)" or services are provided "Outside Nevada."

## CLINICAL INFORMATION

- Date of Registered Nurse (RN) Evaluation – Enter the date the RN evaluation was completed.
- Date of Last Physician Visit – Enter the date of the last visit with the ordering physician.
- Primary Diagnosis – Enter the recipient's primary diagnosis, include ICD-10 code.
- Additional Diagnosis – Enter the recipient's additional diagnosis(es); include ICD-10 code(s).

## SUMMARY OF RECIPIENT NEEDS

Complete this section to provide a brief summary of the recipient needs. Describe all skilled interventions that are medically necessary and list any medical devices required by the recipient.

## REQUESTED PDN SERVICES

Complete the table to indicate the PDN services requested. Indicate the procedure code and requested units per day. Indicate the day of the week each of the procedure codes will be provided. Total the number of units per week and indicate the duration of weeks the services will provide. In the last column, indicate the total units being requested for each procedure code.

## SUPPORT/CAREGIVER DETAILS

Complete this section to provide caregiver details.

- Primary Caregiver Name – Enter the name of the recipient's primary caregiver.
- Relationship to Recipient – Enter the primary caregiver's relationship to the recipient.
- Secondary Caregiver Name – Enter the name of the recipient's secondary caregiver. Write "N/A" in field if the item does not apply.
- Relationship to Recipient – Enter the secondary caregiver's relationship to the recipient. Write "N/A" in field if the item does not apply.

## SCHOOL SERVICES

Complete this section to indicate whether or not the recipient attends school.

- Indicate if the recipient is home-schooled.
    - If "NO" - indicate if the recipient attends school.
    - If "YES" - indicate the hours per day the recipient attends school.
        - Enter the days per week the recipient attends school.
        - Enter the weeks per year the recipient attends school.
        - Enter the time the recipient leaves home for school.
        - Enter the time of day the recipient returns to home from school.
- Check all appropriate boxes to indicate any specialized services the recipient is currently receiving at school.

## PRIVATE DUTY NURSING ACUITY GRID

The PDN acuity grid must be completed in its entirety, including all signatures. Incomplete or unsigned forms will result in prior authorization denial. All forms and documentation must be submitted together. Failure to complete all sections of PDN acuity grid or failure to provide all medical documentation to support the prior authorization request may result in the number of PDN hours not being appropriately authorized.

- A written physician order to establish the need for PDN service.
- A completed FA-16B form.
- Complete a nursing assessment, using a CMS Outcome and Assessment Information Set (OASIS) for recipients age 21 or older or age-appropriate evaluation.
    - A completed PDN acuity grid (pages 5 and 6), with adequate supporting medical documentation which demonstrates medical necessity for PDN.
    - For initial authorization period, estimated needs based on the care required during the final days of hospitalization, the discharge orders and other medical documents from the hospital.

- For ongoing authorizations, the acuity grid must reflect the average daily care given by the nurse during the previous certification period and the private duty nursing notes must be submitted that support answers provided on the acuity grid. All submitted documents are compared for consistency.
- Plan of care (CMS 485) consistent with the recipient's diagnosis, severity of illness, and intensity of service. In addition, a 60-day summary of care from the previous certification period must be included on every care plan after the initial authorized period.

## PRIVATE DUTY NURSING ACUITY GRID

The PDN acuity grid will be used to gather information regarding the recipient's medical needs, and skilled nursing services being provided. All authorized PDN hours will be determined on a case-by-case basis, up to the maximum number of hours prescribed by the ordering physician on the CMS 485. The number of hours authorized may be adjusted when the client's condition changes, or services are reauthorized.

- PDN services may be approved for up to 12 hours per day for new tracheostomy recipients for an eight-week interval in the period immediately following discharge from the hospital. Hours provided after the initial 8 weeks will be determined based on medical need after a comprehensive medical review.
- PDN services may be approved for up to 16 hours per day for new ventilator dependent recipients for an eight-week interval in the period immediately following discharge from the hospital. Hours provided after the initial 8 weeks will be determined based on medical need after a comprehensive medical review.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive and diagnostic services available to most recipients under age 21. Refer to MSM Chapter 1500 Healthy Kids Program for EPSDT authorization process.
- In the event an LRI is absent due to a medical need of the LRI, parent/guardian or authorized representative, a Medicaid recipient under 21 years of age may be eligible to receive 24-hour care at home through an EPSDT referral. Refer to MSM 903.2A for 24-hour care coverage and limitations, and authorization process.
- In rare circumstances, a short-term increase of nursing hours beyond standard limits in a crisis situation. A crisis is one that is generally unpredictable and puts the patient at risk of institutionalization without the provision of additional hours. Additional service hours may be authorized up to 20% above program limits. Refer to MSM 903.5A for crisis override coverage and limitations, and authorization process.

**Additional documentation may be requested to support the request for increased hours.**

Provide the signature, name, title, (e.g., RN, LPN, APRN etc.) of the person completing the request.

Provide the signature and printed name of the physician, physician's assistant or Advanced Practice Registered Nurse (APRN) who is ordering Private Duty Nursing Services.

### How to Submit the Form

After completing the form, submit request online including all supporting medical documentation using the Provider Web Portal.

### Questions

If you have any questions about PDN program requirements or completing this form, contact the Gainwell Technologies Prior Authorization Department at (800) 525-2395.

### Additional Resources

The Billing Guidelines for Provider Type 29 provides information regarding proper billing procedures. These guidelines are online at www.medicaid.nv.gov (select "Billing Information" from the "Providers" menu).