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:
_____/_____/_____

Form Submission:

- Upload form using the Provider Web Portal at www.medicaid.nv.gov

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

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

NOTES:

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#:
Other Insurance Name:	Other Insurance ID#:

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

☐ Recipient lives with family ☐ Teachable ☐ Capable of doing self-care
☐ Recipient lives alone ☐ Not teachable ☐ Unable to do self-care

☐ Foster Home ☐ Support Available
☐ Group Home ☐ Support Unavailable

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:	

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.*	

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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)*:	
Additional Diagnosis(es) *(include ICD-10 code(s))*:	
Summary of Recipient Needs	

REQUESTED PDN SERVICES

Procedure Code	Requested Units/Day	Requested Days (click on 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			

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Support/Caregiver Details	
Primary Caregiver Name:	Relationship to Recipient:
Secondary Caregiver Name:	Relationship to Recipient:
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 (recipient attends school), complete the following:	Hours per day attended:
Days per week attended:	Weeks per year attended:
Time recipient leaves home to go to school:	Time recipient returns to 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
- ☐ 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.

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
- ☐ Second complete physical assessment per shift
- ☐ Three or more complete physical assessments per shift

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

FEEDING NEEDS

Choose one:

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

Check all that apply:

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

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
- ☐ Medication delivery 1 to 3 doses per shift
- ☐ Medication delivery 4 to 6 doses per shift
- ☐ Medication delivery 7 or more doses per shift

Choose one:

- ☐ No IV access
- ☐ Peripheral IV access
- ☐ Central Line of port, PICC Line, Hickman

Choose one:

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

Choose one:

- ☐ No regular blood draws, or regular blood draws less than twice/week
- ☐ Regular blood draws / IV Peripheral Site – at least twice/week
- ☐ Regular blood draws / IV Central Line – at least twice/week

Choose one:

- ☐ No parenteral nutrition
- ☐ Partial parenteral nutrition
- ☐ Total parenteral nutrition (TPN)

RESPIRATORY NEEDS

Choose one:

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

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

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

Choose one (unless recent changes in ventilator setting apply)**:**

- ☐ No ventilator, BiPap or CPAP
- ☐ Ventilator: rehab transition / active weaning
- ☐ Ventilator: weaning achieved, required monitoring
- ☐ Ventilator: 1-6 hours/day
- ☐ Ventilator: 7-12 hrs/day; documented
- ☐ Ventilator: ≥ 12 hrs/day but not 24 hrs/day; documented
- ☐ Ventilator 24 hr/day
  - ☐ Recent changes in the ventilator settings required due to instability since the last authorization period (not applicable for New Vent within 8 weeks)
- ☐ BiPAP or CPAP by nurse during shift, up to 8 hrs/day
- ☐ BiPAP or CPAP by nurse during shift, greater than 8 hrs/day
- ☐ BiPAP ST by nurse during shift, spontaneous timed with rate used to ventilate at night

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Respiratory Needs continued

Choose one:

- ☐ No supplemental oxygen required
- ☐ Continuous oxygen daily use (no trach or vent)
- ☐ Oxygen daily only when sleeping (no trach or vent)
- ☐ Oxygen daily only when sleeping via trach
- ☐ Oxygen daily only when sleeping via vent
- ☐ Oxygen prn based on pulse oximetry (no trach or vent)
- ☐ Oxygen via trach prn based on pulse oximetry
- ☐ Oxygen via vent prn based on pulse oximetry
- ☐ Oxygen via trach continuously
- ☐ Oxygen via vent continuously

Respiratory Needs continued

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

- ☐ No nebulizer treatments
- ☐ Nebulizer treatments by nurse during shift:
  - ☐ Less than daily but at least Q week
  - ☐ Q 4 hrs or less frequently but at least daily
  - ☐ Q 3 hrs
  - ☐ Q 2 hrs or more frequently

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
- ☐ Chest PT, HFCWO Vest or Cough Assist Device: (choose one)
  - ☐ at least Q week
  - ☐ Q 4 hrs or less, but at least daily
  - ☐ Q 3 hrs
  - ☐ Q 2 hrs or more frequently

WOUND CARE

Choose one:

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

ISSUES THAT INTERFERE WITH CARE

Choose all that apply:

- ☐ None of the issues below are applicable
- ☐ Unwilling or unable to cooperate
- ☐ Weight ≥ 100 pounds or immobility increases care difficulty
- ☐ Unable to express needs and wants creating a safety issue

THERAPIES/ORTHOTICS/CASTING

Choose one:

- ☐ None of the following options apply
- ☐ Fractured or casted limb
- ☐ Passive ROM (at least Q shift)
- ☐ Torso Cast, torso splint, or torso brace

Choose one:

- ☐ No splinting schedule, or splint removed and replaced less frequently than once/shift
- ☐ Splinting schedule requires nurse to remove & replace splint(s)
  - ☐ at least once during shift
  - ☐ at least twice during shift

ELIMINATION NEEDS

Choose one that best applies to nursing care provided during the previous 60 days:

- ☐ Continent of bowel and bladder
- ☐ Uncontrolled incontinence:
  - ☐ < 3 yrs of age
  - ☐ >/= 3 yrs of age, bowel **and/or** bladder
- ☐ Incontinence and intermittent straight catheterization, indwelling, suprapubic, or condom catheter

Bowel or Bladder, check if applicable:

- ☐ Ostomy Care - at least daily

SEIZURES

Choose one:

- ☐ No seizure activity

Mild seizures: brief (less than one minute) focal seizures with no Loss of Consciousness (LOC), or brief (less than one minute) absence seizures with LOC.

- ☐ Mild seizures – no intervention
- ☐ Mild seizures – at least 4/week, each requiring minimal intervention

Moderate: LOC longer than one minute but less than 5 minutes.

- ☐ Mod seizures – each requiring minimal intervention
  - ☐ at least daily
  - ☐ 2 to 4 times/day
  - ☐ at least 5 times/day

Severe: LOC 5 minutes or more or ends before 5 minutes but is quickly followed by another seizure.

- ☐ Severe seizures (requiring IM/IV/Rectal med administration)
  - ☐ up to 10/month
  - ☐ at least daily
  - ☐ 2 or more times/day

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OTHER ISSUES
☐ Requires isolation for infectious disease (i.e., tuberculosis, wound drainage) or protective isolation (Nursing care activities for creating and maintaining isolation must be documented.)

_____

Signature of Clinical Professional who completed this form

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/Physician's Assistant/APRN who is ordering Private Duty Nursing Services

Printed Name: _____ **Date:** _____