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 you 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 CCP Prior Authorization Request Form.
2. Completed Home Health Plan of Care (POC) form (appropriately signed and dated by the physician and RN).

   Note: *The Home Health Plan of Care form provided by TMHP is available for use; however, providers may use a different Plan of Care form if desired.*
3. Completed Nursing Addendum to Plan of Care (CCP) forms which includes:
   a. The identification of the responsible adult, contingency plan, 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.
      i. Fill in all of the nursing 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 Provider. If the client requires assistance with activities of daily living (ADLs) or health-related functions that do not need to be provided by a nurse as determined by the Registered Nurse performing the assessment, these should be documented on the flow sheet as well.
      ii. Please note that some 15-minute time slots will have no nursing activity and some nursing needs may take more than 15 minutes to accomplish. Please complete these activities accordingly on the form.
      iii. All nursing activities should be included on the 24-hour schedule. All non-nursing activities that are provided by a qualified aide must be included in on the 24-hour schedule.
      iv. Medical abbreviations may be used on the 24-hour schedule. Examples of acceptable abbreviations are listed on the next page.
   f. The acknowledgement page that indicates all pages of the addendum were completed and reviewed with the client/parent/guardian and physician prior to obtaining their dated signatures as well as acknowledging the other statements on that page.
4. For extended 6-month authorizations, the THSteps-CCP Prior Authorization Private Duty Nursing 6-Month Authorization form must also be completed.

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

For additional information, please refer to “Private Duty Nursing (CCP)” in the Medicaid Children's Services Comprehensive Care Program (CCP) section of the Children’s Services Handbook in the *Texas Medicaid Provider Procedures Manual.*

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

CCP Prior Authorization Request Form

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

Fax completed forms to 1-512-514-4212

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

Section A: Client Information

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

Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Supplier Name:	Telephone:	Fax Number:	
Supplier Address:			
TPI:	NPI:	Taxonomy:	Benefit Code:
QRP Name:	QRP TPI:	QRP NPI:	

Section C: Diagnosis and Medical Necessity of Requested Services

Section D: Dates of Service and HCPCS Code

Dates of Service	From: / /	To: / /	
HCPCS Code/Modifier	Brief Description of Requested Services	Quantity/Frequency	Retail Price

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

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

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

- **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**

By prescribing Private Duty Nursing, I certify:

- **The client is under 21 years of age AND**
- **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:

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

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 OT/PT requested):

SN visits requested:

HHA visits requested:

OT visits requested:

PT 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: / /

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 diagnosis code if OT/PT 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 OT/PT requested):

SN visits requested:

HHA visits requested:

OT visits requested:

PT 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.
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, OT, PT 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

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
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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 diagnosis code if OT/PT 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, OT, PT 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 (CCP)—1 of 7

Client name:	Medicaid number:	Date: / /

Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. CCP Prior Authorization Request Form (*additional information may be attached*).

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN is unexpectedly unavailable.

Name:	Relationship:	Telephone:

☐ The client has an identified contingency plan.

☐ 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:

Nursing Addendum to Plan of Care (CCP)—2 of 7

Client name:	Medicaid number:	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, parent/guardian update, other pertinent observations.

3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.

Nursing Addendum to Plan of Care (CCP)—3 of 7

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
00:00														
00:15														
00:30														
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Nursing Addendum to Plan of Care (CCP)—4 of 7

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 06:00—11:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
06:00														
06:15														
06:30														
06:45														
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Nursing Addendum to Plan of Care (CCP)—5 of 7

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—17:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
12:00														
12:15														
12:30														
12:45														
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Nursing Addendum to Plan of Care (CCP)—6 of 7

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 18:00—23:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
18:00														
18:15														
18:30														
18:45														
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Nursing Addendum to Plan of Care (CCP)—7 of 7

Client name:	Medicaid number:	Date: / /

5. Acknowledgement

Must be signed by the client/parent/guardian and the nurse provider.

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the 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, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- 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 client/parent/guardian agrees to follow through with the plan of care as prescribed by the client's physician.

Number of PDN hours requested	Hours per day:	**or**	Hours per week:
Dates of service from:	/ /	**to**	/ /

		/ /
Signature of client/parent/guardian	Printed name	Date
		/ /
Signature of PDN nurse provider	Printed name	Date
		/ /
Signature of prescribing physician	Printed name	Date

CCP Prior Authorization Private Duty Nursing
6-Month Authorization

Client name:	Client Medicaid number:	Date: / /

The following criteria must be met before seeking a 6-month authorization of private duty nursing (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 3 months.
☐	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.
☐	Client's physician and client/parent/guardian 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 within 30 calendar days of the authorization expiration date and will be maintained with the client's record.
☐	The nurse provider will advise TMHP-CCP 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 physician, client/parent/guardian, 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 the client/parent/guardian	Date

Brief statement of why a maximum 6-month recertification is appropriate for this client:

I have discussed the above information with the client/parent/guardian.

/ /

Signature of 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 the client's physician	Date

Printed name:

Telephone:	Fax number:

Mailing address	City, State, and ZIP code

Fax completed request to TMHP-CCP at 1-512-514-4212

Effective Date_09012007/Revised Date_06042014