BlueCare Tennessee

Instructions for Completing Private Duty Nursing and Home Health Services Prior Authorization Plan of Care

Private duty nursing services (PDN) and home health services require prior authorization. You must submit a request for new services at least three business days prior to the start of care date. You must submit subsequent requests at least seven 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 prior authorization for initial, revised, or subsequent new requests for additional service requests for PDN and/or home health services.

1. Completed 485 when request is for skilled nursing for enrollees age 18 and older (corresponding with Oasis requirement for adults 18 and older receiving skilled services)
2. Completed care giver/enrollee education and training check off list
3. Completed Plan of Care form signed and dated
    a. Type of Request
    b. Identification of the enrollee and the date enrollee was last seen by the ordering physician. The ordering physician must see the enrollee within 30 days of the initial start of care, and at least once a year
    c. Required Signatures:
        i. Signature of the RN who completed this form
        ii. Signature of the physician ordering home health services, including private duty nursing
        iii. Signature of the enrollee/caregiver
    d. Nursing Care Plan Summary, which includes a problem list with specific measurable outcomes and current progress towards goals
    e. Rationale for initial PDN/Home Health Service hours and subsequent requests for additional services for the hours to either increase, decrease, or stay the same. The rationale should include the medical necessity documentation to support the request for the hours.
    f. Completed schedule of services Day in the Life 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 Care Giver. If the enrollee 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 RN performing the assessment, these should be documented on the flowsheet as well.
        ii. Some 15-minute time slots will have no nursing activity and some nursing needs will 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 also be included on the 24-hour schedule.
    g. The Acknowledgement indicates all pages of the plan of care, including the 24-hour daily flowsheet, were completed and reviewed with the enrollee/caregiver/parent/guardian and physician prior to obtaining their dated signatures, enrollee/responsible adult has provided consent to the treatment, the enrollee has identified contingency and discharge plans as well as acknowledging the other statements in that section.

SECTION A: ENROLLEE INFORMATION

Date of form completion:_____

Enrollee Name: _____

Date of Birth: _____

Date last seen by doctor:_____ Medicaid ID: _____

Name of responsible Adult: _____

Phone:_____

Requested Start date:_____ Requested end date: _____

Number of PDN hours per week: _____

Number of Skilled Nurse hours per week:_____

Number of Aide hours per week: _____

Number of Skilled Nurse days per week: _____

Number of Aide days per week:_____

Number of CHOICES/ECF CHOICES Attendant Care hours per week: _____

Number of CHOICES/ECF CHOICES Attendant Care days per week:_____

SECTION B: HOME HEALTH AGENCY (HHA) INFORMATION

Name:_____

Fax: _____ Phone: _____

Address: _____

Tax ID:_____ NPI: _____

SECTION C: PHYSICIAN INFORMATION

Name:_____

Phone:_____ Tax ID: _____NPI: _____

SECTION D: PLAN OF CARE INFORMATION

Status (check one) Initial: ☐ Extension: ☐ Revised Request: ☐

Original Start of Care (SOC) date if revised request:_____

Revised request effective date: _____

Services enrollee receives from other agencies:

PDN and home health services are based on a nursing assessment and nursing care plan established by the agency provider in collaboration with the physician, enrollee, and family/caregiver. The care plan provides a systematic way to document care given, enrollee responses to interventions, and progress toward the goals of care.

Problem List (Diagnosis and ICD-10):

Medications (Dose/Frequency/Route):

Allergies:

Nutritional Requirements:

Mental Status/Mood and Behavior:

Behavioral Symptoms (as applicable):

Learning Disabilities (as applicable):

Functional Limitations/Activities Permitted:

DME and Supplies:

Safety Measures:

Living Status at time of assessment:

Living arrangement at time of assessment:

Pediatric Development Concerns (parental or health professional):

Short-term goals of care:

Long-term goals of care:

Specific Measurable Outcomes:

Progress towards goals:

Rationale for PDN/Home Health Services – for initial requests as well as requests for increase, decrease, or for staying the same

Additional comments:

Summary of recent health history (for initial authorization or for recertification/extension requests) 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

Schedule of Services - _____(enrollee name) _____

Enrollee Name: _____ Medicaid ID _____ Date: _____ Responsible Adult Initials_____

Use the following abbreviations to identify hands –on medical services or attendant care provided on the 24-hour daily flow sheet

AFO	Application of ankle/foot orthotics
Bi Pap	Bi-level positive airway pressure
C-PAP	Continuous positive airway pressure
Dx	Diagnosis
GT/GB	Gastrostomy tube/gastrostomy button
GU Assess	Assessment of genitourinary system
I & O Cath	In and out urinary catheterization
Inc. Care	Incontinence Care
IPPV	Intermittent positive pressure ventilation
PO Med	Medication given by mouth
GT Med	Medication given by gastrostomy tube/button
NGTF	Nasogastric tube feeding
O2	Oxygen administration
PAC	Port A Cath Access
Resp Assess	Respiratory assessment
SQ	Subcutaneous medication
OSXN	Oral suctioning
Trach	Tracheostomy/Tracheotomy care
Bath	Bathing
Groom	Grooming
T&P	Turn and position
Tiol	Toileting

BGM	Blood glucose monitor
BP	Blood pressure
CPT	Chest percussion therapy
GI Assess	Assessment of GI tract/functions
GTF/GBF	Gastrostomy tube feeding/gastrostomy button feeding
I & O	Intake and Output
IM	Intramuscular injection
IPPB	Intermittent positive pressure breathing
IV/IVF	Intravenous/fluids or medications
Neb Tx	Nebulizer/aerosol treatment
NGT	Nasogastric tube
NGT Med	Nasogastric tube medication
O2 Sats	Oxygen saturation level monitoring/check
Phys Assess	Physical assessment/total body assessment – including head to toe review of body systems
ROM	Range of Motion
TSXN	Tracheal Suctioning
TPR	Temperature, pulse, respiration
Vent	Ventilator care
Trans	Transfer (including use of lift)
O-Feed	Oral feeding
Amb	Ambulate

Must include PDN, HHA, primary caregiver and other family/support coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. List the care type code (code list below daily flow sheet) next to the 15 minute increments and use the following Care Giver Codes next to each item:

N= PDN hours, O = other in-home resource(s) (specify name above), F = family/natural support, H = home health aide, A = Attendant Care S = school/daycare

Schedule of Services - _____(enrollee name)_____

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
00:00														
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07:00														

Schedule of Services - _____(enrollee name)_____

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
07:15														
07:30														
07:45														
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Schedule of Services - _____(enrollee name)_____

Military Time	Sunday	Care Giver	Monday	Care Giver	Tuesday	Care Giver	Wednesday	Care Giver	Thursday	Care Giver	Friday	Care Giver	Saturday	Care Giver
14:45														
15:00														
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Schedule of Services - _____(enrollee name)_____

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

Acknowledgements

Must be signed by the enrollee/responsible adult, the agency provider(s) (PDN and/or home health) and the prescribing physician

By signing this form, the enrollee/responsible adult, the agency provider (PDN and/or home health) and the prescribing physician acknowledge:

- Enrollees under 18 years of age reside with an identified responsible adult/ parent/guardian that is either trained to provide nursing care or is capable of initiating an identified contingency plan when scheduled PDN or home health services are unexpectedly unavailable;
- The enrollee/responsible adult have provided consent to the treatment;
- The enrollee has identified contingency and discharge plans;
- The enrollee has a primary physician who provides ongoing health care and medical supervision;
- The place(s) where PDN and/or home health services will be delivered supports the health and safety of the client;
- If applicable, there are necessary backup utilities, communication, and fire and safety systems available and functional;
- The enrollee's consent to share personal health information with other health care providers, as needed to ensure coordination of care;
- Discussion and receipt of information about skilled nursing (PDN and/or home health) services;
- PDN and/or home health services are not authorized for respite, child care, or housekeeping;
- Participation in the development of the Nursing Care Plan for this enrollee;
- Emergency plans are part of the enrollee's care plan and include telephone numbers for the enrollee's physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations;
- The enrollee/responsible adult agrees to follow through with the plan of care as prescribed by the enrollee's physician; and
- All required criteria are met and completed documentation is submitted to MCO.
- Skilled nursing services are authorized for a set number of hours based on the enrollee's medical necessity at the time of the prior authorization request;
- The enrollee/responsible adult acknowledges that subsequent approval of either PDN or home health services will not increase the number of approved skilled nursing hours unless there is a documented change in the enrollee's medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary;
- The enrollee/responsible adult has acknowledged that upon subsequent approval of PDN the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced as per progress towards goals/ independence is obtained.

Required Signatures

Signature of enrollee/responsible adult:_____

Printed name: _____

Date:_____

Signature of Home Health provider: _____

Printed name: _____

Date:_____

Signature of Prescribing Physician:_____

Printed name: _____

Date:_____