# Instructions for Completing Private Duty Nursing Prior Authorization Forms

Private duty nursing services (PDN) require prior authorization. You must submit a request for *new* services within three business days of 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 may submit the request electronically to TMHP using our PA on the Portal. To access TMHP's PA on the Portal, go to TMHP's Prior Authorization web page at TMHP.com.

You must submit the following forms *each time* you request authorization for initial, revised or subsequent (recertifications) 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).
   a. The identification of the client and the date last seen by the ordering physician. The ordering physician must see the client within 30 days of the initial start of care, and at least once a year.
   b. The identification of the Home Health Agency (HHA) requesting PDN services.
   c. The identification (if known and applicable) of the Prescribed Pediatric Extended Care Center (PPECC) provider who provides ongoing skilled nursing services to the client identified in Section A.
   d. The identification of the prescribing physician ordering PDN services.
   e. Plan of Care Information to provide an overview of all of the services that the client identified in Section A is receiving/will receive, including the number, frequency and HCPCS codes for HHA visits, RN visits and LVN visits.
   f. Required Signatures:
      i. The signature of the RN who completed this form, and
      ii. The signature of the physician ordering home health services, including private duty nursing.

      **Note:** *The Home Health Plan of Care (POC) form provided by TMHP is available for use; however, providers may use a different Plan of Care form if desired, if it includes comparable fields.*
3. Completed **Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers** form which includes:
   a. The identification of the client and the responsible adult, and the requested start/end dates, and number of PDN hours requested per week.
   b. A Nursing Care Plan Summary, which includes a problem list with specific measurable outcomes and 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 and for subsequent PDN requests the rationale for the PDN hours to either increase, decrease, or stay the same. The rationale should include the medical necessity documentation to substantiate the request for PDN hours.
   e. Completed Schedule of Services 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 **Care Giver**. 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 flowsheet 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 on the 24-hour schedule.

iv. Medical abbreviations may be used on the 24-hour schedule. Examples of acceptable abbreviations are listed on page 2 of the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form.

f. The Acknowledgements indicates all pages of the addendum were completed and reviewed with the client/parent/guardian and physician prior to obtaining their dated signatures, client/responsible adult has provided written consent to the treatment, the client has identified contingency and discharge plans as well as acknowledging the other statements in that section.

g. The Acknowledgement of Coordination of Approved Skilled Nursing Hours is applicable for when the Schedule of Services 24-hour daily flow sheet includes skilled nursing services provided by a PDN and a Prescribed Pediatric Extended Care Center (PPECC). By signing this form you are acknowledging that the client/responsible adult understands:

i. PDN and PPECC services are both considered skilled nursing services;

ii. Subsequent approval of either PDN or PPECC services will not increase the number of approved skilled nursing hours unless there is a documented change in the client's medical condition;

iii. Upon subsequent approval of PDN or PPECC services the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced; and

iv. The number of authorized skilled nursing hours will not increase unless a revised prior authorization request is submitted to TMHP and approved.

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 the "Private Duty Nursing (CCP)" section of the Home Health Nursing and Private Duty Nursing Services Handbook in the *Texas Medicaid Provider Procedures Manual.*

# CCP Prior Authorization Request Form Instructions

## General Instructions

This form must be completed and signed as outlined in the instructions below before the prior authorization is submitted to TMHP.

Either the requesting Medicaid provider or the requesting physician may initiate the form. The completed form with the original dated signature must be retained by the requesting physician in the client's medical record. A copy of the signed and dated form must be maintained by the requesting provider in the client's medical record. The form is subject to retrospective review.

The Medicaid provider or requesting physician may complete the following sections:

- Request for Services checkboxes
- Section A: Client Information
- Section B: Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information
- Section C: Type of Request
- Section E: Dates of Service and Healthcare Common Procedure Coding System (HCPCS) Procedure Codes

The requesting physician must complete the following sections:

- Section D: Diagnosis and Medical Necessity of Requested Services
- Section F: Primary Practitioner's Certifications

**Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.**

### Request for Services

Check the appropriate type of service being requested. Only one box may be selected.

| Request for: | ☐ ABA | ☐ DME | ☐ Supplies | ☐ Private Duty Nursing | ☐ PPECC | ☐ Inpatient Rehabilitation | ☐ Other |
|---|---|---|---|---|---|---|---|

### Section A: Client Information

Enter the client's name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

| Client Name (Last, First, M.I.)*: Jane Doe | |
|---|---|
| Medicaid Number*: 987654321 | Date of Birth*: 01 / 01 / 2011 |

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

Enter the name, telephone, fax number, address, Tax ID, and NPI of the Medicaid Provider who will be providing the requested service or benefit.

If requesting a wheeled mobility system, enter the QRP's name, Tax ID, and NPI.

| Name*: ABC DME Company | Telephone: 123-555-1234 | Fax: 123-555-1234 |
|---|---|---|
| Street Address*: 123 Street Drive | | |
| City: Somewhere | State: TX | ZIP + 4*: 12345-1234 |

# CCP Prior Authorization Request Form Instructions

| | | | |
|---|---|---|---|
| Tax ID*: 123456701 | NPI*: 1234567891 | Taxonomy*: 123XX4567X | Benefit Code*: XXX |
| QRP Name: B. Provider | QRP Tax ID: 123456701 | QRP NPI: 1234567891 | |
| QRP Taxonomy: 123XX4567X | QRP Benefit Code: XXX | | |
| QRP Street Address: 456 Street Blvd. | | | |
| City: Somewhere | State: TX | ZIP + 4: 12345-1234 | |

## Section C: Type of Request

Check the appropriate box for the type of authorization being requested. If the request is for a revision to an existing authorization, the requested end date cannot extend beyond the original authorization's end date. Provide an explanation for the revision in the space provided.

- For ABA services, check the appropriate ABA box(es) or Revision as applicapble.
- For all other services, check one of the remaining box(es) or Revision as applicable.

| | | |
|---|---|---|
| ABA Evaluation | Requested Start Date*: 01 / 01 / 2021 | Requested End Date*: 01 / 31 / 2021 |
| ABA Re-evaluation | Requested Start Date*: | Requested End Date*: 01 / 31 / 2021 |
| ABA Treatment | Requested Start Date*: | Requested End Date*: |
| Initial / New Client | Requested Start Date*: | Requested End Date*: |
| Recertification | Requested Start Date*: | Requested End Date*: |
| Revision** | Revised Start Date*: | End Date*:<br>(Cannot extend beyond current authorization period.) |
| ** Reason for Revision: | | |

## Section D: Diagnosis and Medical Necessity of Requested Services

### Initial and Recertification.

The requesting physician must include a valid diagnosis code (the code used below is for example only) with a brief description and complete justification for determination of medical necessity for the requested items or services. If applicable, the requesting physician should include the client's height/weight, wound/stage/dimensions, and functional/mobility, or any other documentation to support the medical necessity.

Diagnosis code I1XXX - The patient has malignant hypertension and requires 24-hour monitoring of their blood pressure to confirm diagnosis and regulate medication. The client has been hospitalized twice in the last 6 months (11/02/16 and 12/15/16) for hypertension. The client's symptoms are (list symptoms), and the initial evaluation showed (add description). The patient needs to monitor and record blood pressure once every hour and cannot tolerate a manual device (bruises easily).

## Section E: Dates of Service and HCPCS Codes

Enter the From*: and To*: dates of service for requested services.

| | | |
|---|---|---|
| Dates of Service: | From*: 03 / 01 / 2021 | To*: 05 / 31 / 2021 |

# CCP Prior Authorization Request Form Instructions

**HCPCS Code/Modifier, Brief Description of Requested Services, Quantity/Frequency, and Retail Price**
Enter the appropriate and most specific HCPCS code (the code used below if for example only), the appropriate modifier (if required), and brief description of the requested item or service.

Enter the appropriate quantity and frequency based on the physician's prescription.

Enter the AWP or MSRP for DME or supplies that have no maximum fee listed in the Texas Medicaid Fee Schedule.

If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

| HCPCS Code/Modifier* | Brief Description of Requested Services | Quantity*/Frequency* | Retail Price |
|---|---|---|---|
| A9XXX / U1 | Rental of blood pressure monitoring device automatic | 1/Month | $40.00 |
| | | | |
| **Note:** *HCPCS codes and descriptions must be provided.* | | | |

## Section F: Primary Practitioner's Certifications

**To be completed by the requesting physician.**
The requesting physician must sign and date the form and print or type physician name. By signing Section F, the requesting physician certifies the following:

- For ABA evaluation or treatment, the client is under 21 years of age and the client has a diagnosis of Autism Spectrum Disorder and ABA services are or may be clinically indicated.
- For DME and/or medical supplies, the client is under 21 years of age and the DME and/or medical supplies are appropriate and can safely be used by the client when used as prescribed.
- For Private Duty Nursing, 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.
- For PPECC Services, the client is under 21 years of age and the client's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the PPECC plan of care.

The requesting physician's NPI and license number must be documented. Physicians must indicate their professional license number. If the requesting physician is out of state, the physician must provide the license number and state of professional licensure.

**Note:** *Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and physician assistant (PA) providers may sign on behalf of the physician for Applied Behavior Analysis (ABA) services, private duty nursing, physical, occupational, and speech therapy services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.*

| Signature of requesting physician: | Date: |
|---|---|
| John Smith Digitally signed by John Smith DN: cn=John Smith, o=docname123, ou, email=johnsmith@docname123.com, c=US Date=2016.12.01 21:41:51 -4'00' | 02 / 01 / 2021 |
| Printed or typed name of physician*: John Smith | |
| NPI*: 1234567891 | License No.: TX12345 |

# CCP Prior Authorization Request Form

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4212**.

**Note:** *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

## Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ **We Agree**

# CCP Prior Authorization Request Form

**Note:** *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

| **Request for:** | ☐ **ABA** | ○ **DME** | ○ **Supplies** | ○ **Private Duty Nursing** | ○ **PPECC** | ○ **Inpatient Rehabilitation** | ○ **Other** |
|---|---|---|---|---|---|---|---|

## A: Client Information

| | |
|---|---|
| Client Name (Last, First, M.I.)*: | |
| Medicaid Number*: | Date of Birth*: |

## B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

| | | | |
|---|---|---|---|
| Name*: | Telephone: | Fax: | |
| Street Address*: | | | |
| City: | State: | ZIP + 4*: | |
| Tax ID*: | NPI*: | Taxonomy*: | Benefit Code*: |
| QRP Name: | QRP Tax ID: | QRP NPI: | |
| QRP Taxonomy: | QRP Benefit Code: | | |
| QRP Street Address: | | | |
| City: | State: | ZIP + 4: | |

## C: Type of Request

| | | |
|---|---|---|
| ☐ ABA Evaluation | Requested Start Date*: | Requested End Date*: |
| ☐ ABA Re-evaluation | Requested Start Date*: | Requested End Date*: |
| ☐ ABA Treatment | Requested Start Date*: | Requested End Date*: |
| ☐ Initial / New Client | Requested Start Date*: | Requested End Date*: |
| ☐ Recertification | Requested Start Date*: | Requested End Date*: |
| ☐ Revision** | Revised Start Date*: | End Date*:<br>(Cannot extend beyond current authorization period.) |

** Reason for Revision:

## D: Diagnosis and Medical Necessity of Requested Services (Initial and Recertification)

* Essential/Critical field

# CCP Prior Authorization Request Form

## E: 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.*

## F: Primary Practitioner's Certifications (To be completed by the requesting practitioner)

By requesting ABA evaluation or treatment, I certify:

- The client is under 21 years of age AND
- The client has a diagnosis of Autism Spectrum Disorder AND
- ABA services are or may be clinically indicated

By requesting 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 requesting 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.

By requesting PPECC services, I certify:

- The client is under 21 years of age AND
- The client's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the PPECC plan of care.

**Note:** *Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP) and Physician Assistant (PA) providers may sign on behalf of the physician for Applied Behavior Analysis (ABA) services, Private Duty Nursing, Physical, Occupational, and Speech Therapy Services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.*

| Signature of requesting physician: | Date: |
|---|---|
| Printed or typed name of physician*: | |
| NPI*: | License No.: |

* Essential/Critical field

# Home Health Plan of Care (POC) Instructions

| Use the guidelines below in filling out the Home Health Plan of Care (POC) form. Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned. | |
|---|---|
| **Section A: 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 |
| **Section B: Rendering Home Health Agency (HHA) Information** | |
| Name* | Name of Home Health agency |
| License number | Medical license number issued by the state of Texas |
| Street address* | Agency street address |
| ZIP + 4* | Agency ZIP + 4 Code |
| Telephone | Area code and telephone number of agency |
| Tax ID* | Tax Identification Number (TIN) |
| 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 |
| Benefit Code* | Code identifying state program for the service provided |
| **Section C: Prescribed Pediatric Extended Care Center (PPECC) Provider Information (If known, Home Health Agency to complete this section if client receives PPECC services)** | |
| Name | Name of PPECC provider |
| Fax | Number that the PPECC provider can be reached by fax |
| Telephone | Area code and telephone number of PPECC provider |
| Address | Provider mailing address (street, city, state, and ZIP + 4 Code) |
| Tax ID | Tax Identification Number (TIN) |
| NPI | National Provider Identifier number (10-digit) |
| Taxonomy | Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency |
| Benefit code | Code identifying state program for the service provided |
| PPECC hours of operation | Provide the PPECC's hours of operation for client services, including time zone. For example, 7 a.m. – 7 p.m., Central Time |
| **Section D: Requesting 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 |
| Tax ID | Tax Identification Number (TIN) of requesting physician |
| NPI* | National Provider Identifier number (10-digit) of requesting physician |

# Home Health Plan of Care (POC) Instructions

| Section E: 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 codes 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/<br>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. |
| HCPCS service requested* | Enter the HCPCS services requested |
| Requested dates of service from* | Enter the beginning date of service |
| Requested dates of service to* | Enter the ending date of service |
| SNV, HHA* | State the number of visits requested for each type of service authorized (not applicable for private duty nursing requests) |
| 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 and date signed | The physician's signature and the date the form was signed by the physician ordering home health services |

# Home Health Plan of Care (POC)

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4209**.

**Note:** *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

## Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ **We Agree**

# Home Health Plan of Care (POC)

**Note:** *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

## A. Client Information

| | |
|---|---|
| Client Name*: | Date of Birth*: |
| Date Last Seen By Doctor: | Medicaid Number*: |

## B. Rendering Provider Home Health Agency (HHA) Information

| | | |
|---|---|---|
| Provider Name (*please print*)*: | | Telephone: |
| Fax: | | Tax ID*: |
| Street Address*: | | |
| City: | State: | ZIP + 4*: |
| NPI*: | Taxonomy*: | Benefit Code*: |

## C. Prescribed Pediatric Extended Care Center (PPECC) Provider Information (If known, Home Health Agency to complete this section if client receives PPECC services)

| | | |
|---|---|---|
| PPECC Provider Name (*please print*): | | Telephone: |
| Fax: | | NPI: |
| Street Address: | | |
| City: | State: | ZIP + 4: |

PPECC Hours of Operation: Open: _____a.m. Close:_____ p.m. ☐ Central Time ○ Mountain Time

## D. Physician Information

| | |
|---|---|
| Provider Name (*please print*)*: | Telephone: |
| NPI*: | License Number: |

## E. Plan of Care

Status (check one): ☐ New Client ○ Extension ○ Revised Request

| | |
|---|---|
| Original SOC date: | Revised request effective date: |

Services client receives from other agencies:

Diagnoses:

# Home Health Plan of Care (POC)

| |
|---|
| Function limitations/Permitted activities/Homebound status: |
| Prescribed medications: |
| Diet ordered: |
| Mental status: |
| Prognosis: |
| Rehabilitation potential: |

# Home Health Plan of Care (POC)

| | | | | | |
|---|---|---|---|---|---|
| Safety precautions: | | | | | |
| Medical necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc.): | | | | | |
| HCPCS service requested*: | | | | | |
| Requested dates of service: From*: To*: | | | | | |
| SN quantity visits requested*: | | | | HHA quantity 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 |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4212.**

**Note:** *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information*.

## Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information, and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

Use the following abbreviations to identify services provided on the 24-hour Daily Flow Sheet (see pages 5 – 10).

| Abbreviation | Description |
|---|---|
| AFO | Application of ankle foot orthotics |
| BGM | Blood glucose monitor |
| Bi PAP | Bi-level positive airway pressure |
| BP | Blood pressure |
| CPAP | Continuous positive airway pressure |
| CPT | Chest percussion therapy |
| Dx | Diagnoses |
| GI Assess | Assessment of the GI tract/functions |
| GT/GB | Gastrostomy tube/ gastrostomy button |
| GTF/ GBF | Gastrostomy tube feeding/ gastrostomy button feeding |
| GU Assess | Assessment of the genitourinary system |
| I & O | Intake and output |
| I & O cath | In and out urinary catheterization |
| IM | Intramuscular injection |
| Incont Care | Care of incontinent episodes (skin care) |
| IPPB | Intermittent positive pressure breathing |
| IPPV | Intermittent positive pressure ventilation |
| IV/ IVF | Intravenous/ fluids or medications |
| Med/Meds | Medication given |
| Neb TX | Nebulizer/ aerosol treatment |
| Neuro Assess | Neurological assessment |
| NGT | Nasogastric tube |
| NGTF | Nasogastric tube feeding |
| O2 | Oxygen |
| O2 Sats | Oxygen saturation level |
| PAC | Port a cath IV access |
| PDA | Private duty aide |
| PDN | Private duty nursing by registered nurse (RN) or licensed vocational nurse (LVN) |
| Phys Assess | Physical assessment/total body assessment—including head-to-toe review of body systems |
| PPECC | Prescribed Pediatric Extended Care Center |
| Prec | Precautions |
| PRN | As needed |
| Resp Assess | Respiratory assessment |
| ROM | Range of motion |
| SHARS | School Health and Rehabilitative Services |
| SQ | Subcutaneous |
| SXN / SUX | Suctioning |
| Sz | Seizure |
| TPR | Temperature, pulse, respiration |
| Trach | Tracheostomy/tracheotomy |
| Vent | Ventilator |
| VS | Vital signs |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

***Note**: Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

**Please check the appropriate box:**
☐ **PDN** ☐ **PPECC**

| **Client name*:** | **Medicaid number*:** | **Date:** |
|---|---|---|
| **Name of responsible adult:** | **Responsible adult telephone number:** | |
| **Relationship of responsible adult to client:** | | |
| **Requested start date*:** | **Requested end date*** | |
| **Number of PDN hours requested per week:** | | |
| **Number of PPECC *days* requested per week:** | | |
| **Number of PPECC *hours* requested per week:** | | |

## Documentation Requirements

All of the following documents must be complete and received by TMHP before authorization of services can occur:

- CCP Prior Authorization Request Form (*additional information may be attached*); and
- All components of this Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Care Centers submitted with:
  - The Home Health Plan of Care form (for PDN services), or
  - The PPECC Plan of Care form (for PPECC services).

## 1. Nursing Care Plan Summary

*PDN and/or PPECC 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 for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: |
|---|---|---|

**2. Summary of Recent Health History—For initial authorization or 90-day summary for extension of PDN and/or PPECC 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 and/or PPECC Hours— For initial requests, as well as requests to increase, decrease, or stay the same.**

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—03:45, Military Time

**Must include PDN, PPECC, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the abbreviations listed on page 2 to identify the services provided each day of the week. Use the following Care Giver Codes:**

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

| 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 | | | | | | | | | | | | | | |
| 00:15 | | | | | | | | | | | | | | |
| 00:30 | | | | | | | | | | | | | | |
| 00:45 | | | | | | | | | | | | | | |
| 01:00 | | | | | | | | | | | | | | |
| 01:15 | | | | | | | | | | | | | | |
| 01:30 | | | | | | | | | | | | | | |
| 01:45 | | | | | | | | | | | | | | |
| 02:00 | | | | | | | | | | | | | | |
| 02:15 | | | | | | | | | | | | | | |
| 02:30 | | | | | | | | | | | | | | |
| 02:45 | | | | | | | | | | | | | | |
| 03:00 | | | | | | | | | | | | | | |
| 03:15 | | | | | | | | | | | | | | |
| 03:30 | | | | | | | | | | | | | | |
| 03:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 04:00—07:45, Military Time

**Must include PPECC, PDN, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the following Care Giver Codes:**

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

| Military Time | Sunday | Care Giver | Monday | Care Giver | Tuesday | Care Giver | Wednesday | Care Giver | Thursday | Care Giver | Friday | Care Giver | Saturday | Care Giver |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04:00 | | | | | | | | | | | | | | |
| 04:15 | | | | | | | | | | | | | | |
| 04:30 | | | | | | | | | | | | | | |
| 04:45 | | | | | | | | | | | | | | |
| 05:00 | | | | | | | | | | | | | | |
| 05:15 | | | | | | | | | | | | | | |
| 05:30 | | | | | | | | | | | | | | |
| 05:45 | | | | | | | | | | | | | | |
| 06:00 | | | | | | | | | | | | | | |
| 06:15 | | | | | | | | | | | | | | |
| 06:30 | | | | | | | | | | | | | | |
| 06:45 | | | | | | | | | | | | | | |
| 07:00 | | | | | | | | | | | | | | |
| 07:15 | | | | | | | | | | | | | | |
| 07:30 | | | | | | | | | | | | | | |
| 07:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 08:00—11:45, Military Time

**Must include PPECC, PDN, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the following Care Giver Codes:**

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

| Military Time | Sunday | Care Giver | Monday | Care Giver | Tuesday | Care Giver | Wednesday | Care Giver | Thursday | Care Giver | Friday | Care Giver | Saturday | Care Giver |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 08:00 | | | | | | | | | | | | | | |
| 08:15 | | | | | | | | | | | | | | |
| 08:30 | | | | | | | | | | | | | | |
| 08:45 | | | | | | | | | | | | | | |
| 09:00 | | | | | | | | | | | | | | |
| 09:15 | | | | | | | | | | | | | | |
| 09:30 | | | | | | | | | | | | | | |
| 09:45 | | | | | | | | | | | | | | |
| 10:00 | | | | | | | | | | | | | | |
| 10:15 | | | | | | | | | | | | | | |
| 10:30 | | | | | | | | | | | | | | |
| 10:45 | | | | | | | | | | | | | | |
| 11:00 | | | | | | | | | | | | | | |
| 11:15 | | | | | | | | | | | | | | |
| 11:30 | | | | | | | | | | | | | | |
| 11:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—15:45, Military Time

**Must include PPECC, PDN, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the following Care Giver Codes:**

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

| Military Time | Sunday | Care Giver | Monday | Care Giver | Tuesday | Care Giver | Wednesday | Care Giver | Thursday | Care Giver | Friday | Care Giver | Saturday | Care Giver |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12:00 | | | | | | | | | | | | | | |
| 12:15 | | | | | | | | | | | | | | |
| 12:30 | | | | | | | | | | | | | | |
| 12:45 | | | | | | | | | | | | | | |
| 13:00 | | | | | | | | | | | | | | |
| 13:15 | | | | | | | | | | | | | | |
| 13:30 | | | | | | | | | | | | | | |
| 13:45 | | | | | | | | | | | | | | |
| 14:00 | | | | | | | | | | | | | | |
| 14:15 | | | | | | | | | | | | | | |
| 14:30 | | | | | | | | | | | | | | |
| 14:45 | | | | | | | | | | | | | | |
| 15:00 | | | | | | | | | | | | | | |
| 15:15 | | | | | | | | | | | | | | |
| 15:30 | | | | | | | | | | | | | | |
| 15:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 16:00—19:45, Military Time

**Must include PPECC, PDN, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the following Care Giver Codes:**

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

| Military Time | Sunday | Care Giver | Monday | Care Giver | Tuesday | Care Giver | Wednesday | Care Giver | Thursday | Care Giver | Friday | Care Giver | Saturday | Care Giver |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16:00 | | | | | | | | | | | | | | |
| 16:15 | | | | | | | | | | | | | | |
| 16:30 | | | | | | | | | | | | | | |
| 16:45 | | | | | | | | | | | | | | |
| 17:00 | | | | | | | | | | | | | | |
| 17:15 | | | | | | | | | | | | | | |
| 17:30 | | | | | | | | | | | | | | |
| 17:45 | | | | | | | | | | | | | | |
| 18:00 | | | | | | | | | | | | | | |
| 18:15 | | | | | | | | | | | | | | |
| 18:30 | | | | | | | | | | | | | | |
| 18:45 | | | | | | | | | | | | | | |
| 19:00 | | | | | | | | | | | | | | |
| 19:15 | | | | | | | | | | | | | | |
| 19:30 | | | | | | | | | | | | | | |
| 19:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: | Client/Responsible Adult Initials: |
|---|---|---|---|
| List other in-home resources: | | | |

## 4. Schedule of Services 24-hour Daily Flow Sheet, 20:00—23:45, Military Time

**Must include PPECC, PDN, and family (if family has volunteered) coverage, and coverage from other resources as proposed in the prior authorization request, not as currently being provided. Use the following Care Giver Codes:**

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

| Military Time | Sunday | Care Giver | Monday | Care Giver | Tuesday | Care Giver | Wednesday | Care Giver | Thursday | Care Giver | Friday | Care Giver | Saturday | Care Giver |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20:00 | | | | | | | | | | | | | | |
| 20:15 | | | | | | | | | | | | | | |
| 20:30 | | | | | | | | | | | | | | |
| 20:45 | | | | | | | | | | | | | | |
| 21:00 | | | | | | | | | | | | | | |
| 21:15 | | | | | | | | | | | | | | |
| 21:30 | | | | | | | | | | | | | | |
| 21:45 | | | | | | | | | | | | | | |
| 22:00 | | | | | | | | | | | | | | |
| 22:15 | | | | | | | | | | | | | | |
| 22:30 | | | | | | | | | | | | | | |
| 22:45 | | | | | | | | | | | | | | |
| 23:00 | | | | | | | | | | | | | | |
| 23:15 | | | | | | | | | | | | | | |
| 23:30 | | | | | | | | | | | | | | |
| 23:45 | | | | | | | | | | | | | | |

# Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers

| Client name*: | Medicaid number*: | Date: |
|---|---|---|

## 5. Acknowledgements

**Must be signed by the client/responsible adult, the skilled nursing provider(s) (PDN and/or PPECC) and the prescribing physician.**

By signing this form, the client/responsible adult, the skilled nursing provider (PDN and/or PPECC) and the prescribing physician acknowledge:

- Clients under 18 years of age 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 scheduled PDN or PPECC services are unexpectedly unavailable;
- The client/responsible adult has provided written consent to the treatment;
- The client has identified contingency and discharge plans;
- The client has a primary physician who provides ongoing health care and medical supervision;
- The place(s) where PDN and/or PPECC 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;
- The client'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 PPECC) services;
- PDN and/or PPECC services are not authorized for respite, child care, activities of daily living or housekeeping;
- Participation in the development of the Nursing Care Plan for this client;
- 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/responsible adult agrees to follow through with the plan of care as prescribed by the client's physician; and
- All required criteria are met and completed documentation is submitted to TMHP.

### Acknowledgement of Coordination of Approved Skilled Nursing Hours

By signing this form, the client/responsible adult, the prescribing physician, the PDN provider and the PPECC provider acknowledge:

- The client/responsible adult understands that PDN and PPECC services are both considered skilled nursing services;
- Skilled nursing services are authorized for a set number of hours based on the client's medical necessity at the time of the prior authorization request;
- The client/responsible adult has provided written consent, including acknowledgement, that subsequent approval of either PDN or PPECC services will not increase the number of approved skilled nursing hours unless there is a documented change in the client's medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary;
- When PDN and PPECC providers are both authorized to provide skilled nursing tasks, the services will be provided by both providers as documented in the "Schedule of Services 24-hour Daily Flow Sheet";
- The client/responsible adult has provided written consent, including acknowledgement, that upon subsequent approval of PDN or PPECC services the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced; and
- The client/responsible adult, the prescribing physician, the PDN provider and the PPECC provider acknowledge the authorized number of skilled nursing hours will not increase unless a revised prior authorization request is submitted to TMHP with documentation that supports an increase in skilled nursing hours (a change in the client's medical condition or authorized hours are not commensurate to the client's medical needs).

| Required Signatures | | |
|---|---|---|
| Signature of client/responsible adult: | Printed name: | Date: |
| Signature of PDN provider: | Printed name*: | Date: |
| Signature of PPECC provider: | Printed name*: | Date: |
| Signature of prescribing physician: | Printed name*: | Date: |

# CCP Prior Authorization Private Duty Nursing 6-Month Authorization

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4212**.

**Note:** *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

## Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ **We Agree**

# CCP Prior Authorization Private Duty Nursing 6-Month Authorization

**Note:** *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

| Client name*: | 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 _____

| Requesting physician's printed name*: | NPI*: |
|---|---|
| Telephone: | Fax: |
| Street address: | |
| City: | State: ZIP + 4: |

* Essential/Critical field