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

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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

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***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:

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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.

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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														

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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														
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05:30														
05:45														
06:00														
06:15														
06:30														
06:45														
07:00														
07:15														
07:30														
07:45														

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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														
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09:45														
10:00														
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10:30														
10:45														
11:00														
11:15														
11:30														
11:45														

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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														
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14:45														
15:00														
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15:30														
15:45														

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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														

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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														
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21:45														
22:00														
22:15														
22:30														
22:45														
23:00														
23:15														
23:30														
23:45														

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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: