MCO Name	Phone Number	Fax Number
BlueCare Tennessee	1-888-423-0131	1-800-292-5311
UnitedHealthCare	1-800-690-1606	1-800-743-6829
Wellpoint	1-800-454-3730	1-877-297-5003/1-866-920-6003

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

The following form must be submitted with the prior authorization request after the initial assessment has been completed and no later than 30 days from admission or receiving revised orders, and annually. Submit this form as additional clinical information upon completion within the required 30 days. Authorizations will not be delayed, but this form is required.

1. Completed caregiver/member education and training checklist once care has been established and a plan has been agreed upon
2. Completed Plan of Care form, signed and dated
   a. Type of request
   b. Member identification and the date member was last seen by the ordering physician. The member must be seen by theordering physician within 30 days of the initial start of care and at least once a year.
   c. Required signatures:
      i. The clinician completing this form
      ii. The physician ordering home health services, including private duty nursing
      iii. The member/caregiver
   d. Nursing Care Plan Summary to include specific measurable outcomes and current progress toward goals
   e. Rationale for initial or recertification for PDN/home health service requests with details of the increase, decrease or unchanged hours. Include the medical necessity documentation to support the request for the hours.
   f. Completed schedule of services. The 24-hour daily flow sheet is divided in whole-hour increments using military time.
      i. Fill in all of the skilled and unskilled nursing services provided in a 24-hour period. Indicate who performs the service(Skilled Nurse, Home Health Aide or Caregiver) at the specific time in the corresponding column. The nurse performing theassessment should document on the flow sheet assistance with activities of daily living (ADLs) or health-related functionsnot provided by a nurse.

Continued on next page

ii. Some time slots will have no nursing activity and some nursing services will take more time to accomplish.Please indicate this in the comments sections to explain hands-on needs.

iii. Include all nursing activities and non-nursing activities provided by a skilled nurse or home health aide on the 24-hour schedule.

iv. Include all nursing activities and non-nursing activities provided by a family member or caregiver.

v. For time slots with no skilled or unskilled task, document N/A.

g. The Acknowledgement indicates all pages of the plan of care, including the 24-hour daily flow sheet, were completed andreviewed with the member/caregiver/parent/guardian and physician prior to obtaining their dated signatures, the member/responsible adult has provided consent to the treatment, and the member has identified contingency and discharge plans aswell as acknowledged the other statements in that section.

Section A: Member Information

Date of Form Completion: _____/_____/_____

Member Name:_____ Date of Birth: _____/_____/_____

Date Last Seen by doctor: _____/_____ / _____ Medicaid ID: _____

Name of Responsible Adult: _____ Phone: _____

Requested Start Date:_____/_____/ _____ Requested End Date:_____/_____/ _____

Number of CHOICES/ECF CHOICES Attendant Care Hours Per Week, if applicable: _____

Number of CHOICES/ECF CHOICES Attendant Care Days Per Week, if applicable: _____

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 Member Receives From Other Agencies:

Continued on next page

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, member and family/caregiver. The care plan provides a systematic way to document care given, member responses to interventions, and progress toward the goals of care.

Mental Status/Mood and Behavior:

Behavioral Symptoms (as applicable):

Learning Disabilities (as applicable):

Current Community Living Setting at Time of Assessment (Housing):

Natural Support in the Home at Time of Assessment (Who lives with the member?):

Pediatric Development Concerns (Parental or Health Professional):

Additional Comments:

Continued on next page

Summary of Recent Health History – 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.

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

Continued on next page

Schedule of Services

Member Name:_____

Medical ID:_____ Date:_____/_____/_____ Responsible Adult Initials: _____

Instructions: Please indicate the task to be completed by the appropriate time. Indicate with an 'X' if the task is completed by a Skilled Nurse (SN), Home Health Aide, and/or Caregiver. Please enter comments regarding what the task requires for completion in the comments section. Please provide any other information that impacts care in the additional comments section.

Time	Task	SN	Home Health Aide	Caregiver	Comments
7:00 am		☐	☐	☐	
8:00 am		☐	☐	☐	
9:00 am		☐	☐	☐	
10:00 am		☐	☐	☐	
11:00 am		☐	☐	☐	
12:00 pm		☐	☐	☐	
13:00 pm		☐	☐	☐	
14:00 pm		☐	☐	☐	
15:00 pm		☐	☐	☐	
16:00 pm		☐	☐	☐	
17:00 pm		☐	☐	☐	
18:00 pm		☐	☐	☐	
19:00 pm		☐	☐	☐	
20:00 pm		☐	☐	☐	
21:00 pm		☐	☐	☐	
22:00 pm		☐	☐	☐	
23:00 pm		☐	☐	☐	
24:00 pm		☐	☐	☐	
1:00 am		☐	☐	☐	
2:00 am		☐	☐	☐	
3:00 am		☐	☐	☐	
4:00 am		☐	☐	☐	
5:00 am		☐	☐	☐	
6:00 am		☐	☐	☐	

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Additional Comments:

Acknowledgements

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

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

- Members 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 member/responsible adult has provided consent for the treatment;
- The member has identified contingency and discharge plans;
- The member 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 member'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;

Continued on next page

- 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 member;
- Emergency plans are part of the member's care plan and include telephone numbers for the member's physician, ambulance, hospital, and equipment supplier, and information on how to handle emergency situations;
- The member/responsible adult agrees to follow through with the plan of care as prescribed by the member's physician; and
- All required criteria are met and completed documentation is submitted to the MCO;
- Skilled nursing services are authorized for a set number of hours based on the member's medical necessity at the time of the prior authorization request;
- The member/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 member's medical condition, or the authorized hours are not sufficient to meet the client's medical needs and additional hours are medically necessary and covered under the TennCare program;
- The member/responsible adult acknowledges that the number of skilled nursing hours authorized are based upon medically necessary skilled nursing needs as determined by an individualized member-specific assessment.

Required Signatures

Signature of Member/Responsible Adult:_____

Printed Name: _____ Date: _____/_____/_____

Signature of Home Health Provider:_____

Printed Name: _____ Date: _____/_____/_____

Signature of Prescribing Physician: _____

Printed Name: _____ Date: _____/_____/_____