Molina Healthcare of Washington
Medicaid Private Duty Nursing
Prior Authorization Request Form

Phone Number: (800) 869-7175
Fax Number: (800) 767-7188

MEMBER INFORMATION			
Plan:	☐ Molina Medicaid (If Molina is secondary, please include a copy of the denial from primary insurance)		
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐ Elective/Routine ☐ Expedited/Urgent		

REFERRAL/SERVICE TYPE REQUESTED		
Diagnosis Code & Description:		
CPT/HCPC Code & Description:		
CPT/HCPC Code & Description:		
90 DOS SPAN ONLY For continuation requests, the start date is always the day after the last authorization ends		DOS from: / / to / /

PROVIDER INFORMATION					
Requesting Provider Name:		NPI#:		TIN#:	
Servicing Provider or Facility:		NPI#:		TIN#:	
Contact at Requesting Provider's Office:					
Phone Number:	( ) -	Fax Number:	( ) -		

CLINICAL DOCUMENTATION TO SUPPORT NEED FOR PRIVATE DUTY NURSING (PDN)		
Signed and dated physician order for PDN [**Please submit:** Home Health Certification and Plan of Care, Department of Health and Human Services, HCFA Form: OBM 0938-0357]	☐ Submitted	
Current history and physical (recent hospital admissions/discharge summaries)	☐ Submitted	☐ Not Submitted
Current treatment plan and treatment records	☐ Submitted	☐ Not Submitted
Current nursing care plan - Most recent notes (two weeks)	☐ Submitted	☐ Not Submitted
Recent daily nursing notes	☐ Submitted	☐ Not Submitted
Emergency medical plan	☐ Submitted	☐ Not Submitted
90 DAY SUMMARY/including changes	☐ Submitted	☐ Not Submitted

Plan and need for more than one agency to supply care at a time? ☐ YES ☐ NO

If YES, please describe: _____

CLINICAL PRESENTATION (check all that apply)

Frequency of assessments (to include vital signs, interventions to support patient care, health status assessment, etc.)**:**

- ☐ Once per eight hour shift
- ☐ 2-3 times per eight hour shift
- ☐ Hourly or more often

Behavioral health, cognition, developmental monitoring:

- ☐ Non-verbal, infrequent speech, or difficult to understand
- ☐ Self-abusive behavior, risk of self-harm, and intervention required
- ☐ Sleep disturbance and patient awake more than three hours per night
- ☐ Combative, confused, or disoriented behavior that impacts self-management; patient obese
- ☐ Combative, confused, or disoriented behavior that impacts self-management

Respiratory:

- ☐ BiPAP/CPAP management
  - ☐ More than eight hours per day
  - ☐ Less than eight hours per day
- ☐ Nebulizer therapy
  - ☐ More frequent than every four hours
  - ☐ Every 4-24 hours
  - ☐ Less frequent than daily, but at least once every seven days
- ☐ Chest Physiotherapy – percussion, high-frequency chest wall oscillation vest, cough assist device, etc.
  - ☐ More than once per hour
  - ☐ Every 1-4 hours
  - ☐ Less than every four hours, but at least daily
- ☐ Oxygen management
  - ☐ Oxygen humidification, tracheal, no ventilator
  - ☐ Oxygen needed at least weekly, based on pulse oximetry
- ☐ Suctioning
  - ☐ Tracheal suctioning at least once every two hours
  - ☐ Tracheal suctioning daily, but less than every two hours
  - ☐ Nasal or oral suctioning daily
- ☐ Tracheostomy management
  - ☐ Tracheostomy management with complications (skin breakdown, replacement needed)
  - ☐ Tracheostomy management, no complications
- ☐ Ventilator management
  - ☐ Continuous ventilator use
  - ☐ Ventilator use for 12 or more hours per day
  - ☐ Ventilator use for 7-12 hours per day
  - ☐ Ventilator use for less than seven hours per day
  - ☐ Interventions in place for active weaning
  - ☐ Ventilator weaning achieved; requires ongoing post-weaning monitoring and management
  - ☐ Ventilator on standby, respiratory assistance, or used at night for less than one hour

Skilled Nursing Needs:

- ☐ Blood draw
  - _____ Central line _____ Peripheral line
  - _____ More than twice per week _____ Less than twice per week
- ☐ Infusion therapy
  - ☐ Blood or blood product
  - ☐ Chemotherapy infusion
  - ☐ Central line access and management
  - ☐ Pain medication infusion
- ☐ Intravenous Infusion (IV antibiotics, etc.), including infusion administration and monitoring for infusion reactions
  - ☐ Infusions more than every four hours
  - ☐ Infusions less than every four hours
- ☐ Non-infusion medication
  - ☐ Insulin administration
  - ☐ Non-insulin medication injectable administration
  - ☐ Medication administration at least every two hours, requiring clinical monitoring
- ☐ Activity of Daily Living (ADL)/Therapy support
  - _____ Bedbound _____ Wheelchair user _____ Ambulatory
  - ☐ Total/partial lift, weight 55-125 pounds
  - ☐ Total/partial lift, weight greater than 125 pounds
  - ☐ ADL support needed more than four hours per day to maximize patient's independence
  - ☐ Body cast management
  - ☐ Cast or brace management
  - ☐ Splinting management, including removal and replacement, at least every eight hours
  - ☐ Communication deficit; nurse to support therapy plan
  - ☐ Range of motion exercises at least every eight hours
  - ☐ Physical therapy program at least three hours per day; occupational therapy program at least four hours per day
- ☐ Nutrition management
  - ☐ Enteral nutrition with complications, requires administration of feeding, residual check, adjustment or placement of tube, and assessment or management of complications
  - ☐ Enteral nutrition without complications
  - ☐ Gastrostomy tube care, uncomplicated
  - ☐ Nasogastric tube care, uncomplicated
  - ☐ Partial parenteral nutrition with central line care
  - ☐ Total parenteral nutrition with central line care
- ☐ Skin and wound care management
  - ☐ Burn care
  - ☐ Ostomy care, at least once per day
  - ☐ Postsurgical care, within 45 days of surgery
  - ☐ Stage one or two wound management, at least once per day
  - ☐ Stage three or four wound management, at least once per day
  - ☐ Stage three or four wound management at least once per day, and multiple wound sites
  - ☐ Prescribed topical medication application at least every four hours
  - ☐ Wound vacuum management

☐ Seizure control that requires nursing intervention/management
- ☐ Seizures lasting less than three minutes, at least four times per week
- ☐ Seizures lasting 3-5 minutes, at least four times per week
- ☐ Seizures lasting 3-5 minutes, one to four times per day
- ☐ Seizures lasting 3-5 minutes, more than five times per day
- ☐ Seizures lasting more than five minutes, or clustered seizures, or seizure activity without regaining consciousness, at least four times per week
- ☐ Seizures lasting more than five minutes, or clustered seizures, or seizure activity without regaining consciousness, one time or more per day, requiring rectal medication
- ☐ Seizures lasting more than five minutes, or clustered seizures, or seizure activity without regaining consciousness, one time or more per day, requiring IM or IV medication

ADDITIONAL INFORMATION

List: