Children's Mercy
PEDIATRIC CARE NETWORK

PRIVATE DUTY SERVICES PRIOR AUTHORIZATION FORM

Toll Free MO PCN Phone: 877-347-9367 Toll Free KS PCN Phone: 833-802-6427

Toll Free Fax: 888-670-7260

Date Form Completed	**Member Name**
Member ID & DOB	**Service Start Date/Duration**
Requesting Provider	**Provider of Service**
Diagnosis	**# of Private Duty Nursing Hours Requested per Day or Week**
CPT Codes	**# of Personal Care Hours Requested per Day or Week**
Requestor's Name	**Requestor's Phone/Fax**

Instructions: Please complete this form at initiation of private duty services, every 90 days thereafter, and any time there are changes in participant's needs. Complete sections 1 & 2 if requesting authorization for private duty nursing. In addition, complete section 3 or 4 if requesting authorization for personal care or advanced personal care assistant.

PCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services. Within 48 hours or two business days PCN will call you with a determination. Authorization numbers issued for covered services should be included on claims submitted. Payment is subject to eligibility status and benefits that are in effect at the time services are provided. PCN will not assume financial responsibility for services where prior notification does not occur according to PCN policies. You must notify PCN if additional services or an extension is required.

Fax completed form with physician order and private duty assessment/progress notes to: 888-670-7260.

Section 1 – Technology/Nursing Needs: Select all technology and nursing needs that apply:

Technology Needs	Frequency	Check if indicated
Ventilator includes tracheostomy care/sterile dressing changes	Continuous	
Ventilator includes tracheostomy care/sterile dressing changes	Intermittent	
Tracheostomy (without vent) includes tracheostomy care/sterile dressing changes	n/a	
CPAP/BIPAP - Recently weaned from trach (short term - 1-2 wks)	All	
CPAP/BIPAP (without trach)	All	
Oxygen	At least 8hr/day	
Oxygen (unstable sats)	At least 8hr/day	
J/G Tube	Bolus	
J/G Tube (with reflux)	Continuous	
NG Tube	Continuous	
NG Tube	Bolus	
IV Therapy	Continuous	
Nursing Needs	**Frequency**	
Tracheal Suctioning	Q1-2hrs	
	Q3-4hrs	
	< Q4hrs	
Enteral Feedings	Continuous	
	Q2hrs	
	Q3hrs	
	Q4hrs	
Severe Seizure Activity Requiring Medication Intervention (i.e. Diastat)	Within the last month	

Nursing Needs (con't)	Frequency	Check if Indicated
Daily Baseline IV Medications (do not include those given for acute illness)	6 or more	
	4-5	
	3 or less	
Intermittent Urinary Catheterization	Q4hrs	
	Q8hrs	
	Q12hrs	
	Q Day or PRN	
Sterile Dressing Changes for a Wound	≥ Q8hrs	
	< Q8hrs	
IV/Hyperalimentation	Continuous	
	8-16 hrs	
	4-7 hrs	
	< 4hrs	
Special Treatments/: (Specify type/frequency)	4x/day	
	3x/day	
	2x/day	
	Daily	
Special I/O Monitoring (adjustments in IVF are based on I/O data)	Continuous	

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Member Name	Member ID & DOB

Section 2 - Psychosocial Needs: Please describe any psychosocial issues this member/family has related to the need for private duty services such as support system, family constellation, safety, shelter, unmet ADL's.

Psychosocial Needs

Section 3 - Personal Care Assistant: If authorization is requested for a personal care assistant, indicate need and level of care for each of the following:

Personal Care Needs	Level of Care
Poorly controlled seizures, other than severe generalized grand mal seizures	Needs Assistance
	Total Care
Assistance required with orthotic bracing, body cast, or casts involving one full limb or more	Needs Assistance
	Total Care
Bowel &/or bladder incontinence after the age of 3	Needs Assistance
	Total Care
Persistent &/or chronic diarrhea, regardless of age	Needs Assistance
	Total Care
Significant central nervous system damage affecting motor control	Needs Assistance
	Total Care
Organically based feeding problems	Needs Assistance
	Total Care
Assistance with activities of daily living (bathing, maintaining a dry bed/clothing, toileting, dressing & feeding)	Needs Assistance
	Total Care

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Section 4 – Advanced Personal Care Assistant: If authorization is requested for an advanced personal care assistant, indicate need and level of care for each of the following:

Advanced Personal Care Needs	Level of Care
Routine ostomy care; external, indwelling or suprapubic catheter site	Needs Assistance
	Total Care
Removal of external catheters; inspection of skin and reapplication	Needs Assistance
	Total Care
Administration of prescribed bowel program including use of suppositories, sphincter stimulation and enemas (pre-packaged only)	Needs Assistance
	Total Care
Application of medicated (prescription) lotions or ointments, and dry, non-sterile dressing to unbroken skin	Needs Assistance
	Total Care
Use of lift or other device for transfers	Needs Assistance
	Total Care
Assistance with oral medications which are set up by a registered or licensed practical nurse	Needs Assistance
	Total Care
Passive range of motion delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology	Needs Assistance
	Total Care
Application of non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse	Needs Assistance
	Total Care

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Total points assigned: _____ Care Navigator_____ Date _____