carecentrix

Provider Newsflash January 2018

Cigna Private Duty Nursing Authorization Requests

Purpose of this communication:

- To inform providers of a new form required when requesting authorization for Private Duty Nursing for Cigna members.

What do I need to do?

- Effective immediately, Cigna will now require the submission of a new form - Cigna Home Health Services Time Audit Form – which has been attached to this newsflash for your convenience.
- The Home Health Services Time Audit form is used to document the types of services performed by a nurse or other health care professional during two consecutive shifts.
- Along with the new form, authorization requests will continue to require clinical notes for the two previous weeks and the plan of care. Please send the form and other required materials to 800-700-2085.

What do I need to know?

- Due to the new calendar year, CareCentrix recommends that providers check member eligibility and benefits prior to rendering a service, equipment or supply item.

- Please remember that eligibility, benefit verification and/or receipt of a Service Authorization Form are not guarantees of payment for services.

Thank you in advance for your cooperation and continued partnership. If you have any questions, please reach out to your assigned network management representative for assistance.

Cigna Home Health Services Time Audit

Please complete and return to the Cigna Case Manager indicated

Include 5-7 days most recent nursing notes/clinical documentation

Home Health Services Time Audit

Purpose of the Audit: The Home Health Services Time Audit is used to document the types of services performed by a nurse or other health care professional during two consecutive shifts. The audit will be used to assist Cigna in making coverage determinations under the customer's health benefit plan. Cigna's Case Management Department may request the audit every 30 to 90 days to verify the types of services being rendered

Customer Name: _____

Customer ID: _____

Does the patient have secondary insurance?
_ Yes _ No

What is the name of the secondary insurance provider and ID?

Date of HHS Time Audit: _____

Intake Number _____

Provider Agency Name: _____

Provider Agency TIN#: _____

Provider Agency Address:

Provider Agency Phone Number _____

Provider Agency Fax Number: _____

Name and Credentials of the Care Provider(s) filling out the Audit:

Care Provider 1 _____

Care Provider 1 Credentials (e.g., RN, LPN, NA, PT, RT, etc) : _____

Care Provider 2: _____

Care Provider 2 Credentials (e.g., RN, LPN, NA, PT, RT, etc) _____

Home Health Services Questionnaire

1. The request is for: please Check one and enter the hours as indicated
_ Hourly RN (S9123) _ Hourly LPN (S9124) _ Hourly HAA

1a. For____ hours per day x_____ days per week x____ weeks.

Hours per day _____

x Hours per Week _____

x number of Weeks _____

1b. Total Number of Hours Requested _____

1c. Services will be rendered (enter specific hours of the day) _____

1d. Start Date _____

1d. End Date _____

2. For the hours that home health services are being requested, are all services provided in the home?
_ Yes _ No

2a. If not, where?

3. Is there a caregiver present in the home while the nurse or other professional is providing care?
_ Yes _ No _ Sometimes

If sometimes, give specifics

4. Does the patient use a: (Please Check all that apply)
_ Ventilator _ Bipap _ Cpap

4a. How many hours each day is each of the above being used?

5. Is the (Ventilator /Bipap/Cpap) used during the hours that home health services would be provided in the home?
_ Yes _ No

6. Does the patient have a tracheostomy?
_ Yes _ No

7. Is suctioning performed?
_ Yes _ No

7a. If Yes, please Check those that apply.
_ Oral _ Deep Tracheal

7b. How many times per hour is deep tracheal suctioning being performed? _____

8. Does the patient have a feeding tube?
_ Yes _ No

8a. If Yes, what type?
_ G-tube _ GH-tube _ NG-tube

9.How is the feeding tube administered?
_ Continuous _ Bolus

10. What hours are the tube feedings being administered?

Private Duty Nursing Acuity Questionnaire

Assess and select the skilled nursing services that the patient needs private duty nursing to support. Please provide a response to each section. If a section or category does not apply, select N/A.

Skilled nurse clinical monitoring by a licensed trained nurse to evaluate clinical condition and perform appropriate interventions for optimal outcomes. Monitoring includes vital sign evaluation, health status assessment, specimen collections, and technical interventions to support patient care.
_ Clinical assessment every hour or more often
_ Clinical assessment 2 to 3 times every 4 hours
_ Clinical assessment once every 4 hours
_ N/A

Behavioral health, cognitive, or developmental monitoring and management (Check All that apply)
_ Communication impaired (eg, non-verbal, rare, or unable to understand)
_ Self-abusive behavior management with patient at risk of self-harm and preventative intervention needed
_ Sleep disturbance with patient awake 3 hours or more per night or wakes up 3 times or more per night
_ N/A

BiPAP or CPAP management that includes active adjustment of settings with clinical monitoring of responsiveness
_ BiPAP or CPAP management for 8 hours or more per day
_ BiPAP or CPAP management for less than 8 hours per day
_ N/A

Blood draw
_ Blood draw, central line, twice per week or more often
_ Blood draw, central line, less than twice per week
_ Blood draw, peripheral, twice per week or more often
_ Blood draw, peripheral, less than twice per week
_ N/A

Bowel or bladder management (Check All that apply)
_ Bladder incontinence at least daily in patient 3 years of age or older and training program initiation or revision needed
_ Peritoneal dialysis initiation
_ Urinary catheter, indwelling management
_ Urinary catheter, straight intermittent management
_ N/A

Case Management
_ Nurse case management for 4 hours or more per week
_ Nurse case management for less than 4 hours per week
_ N/A

Chest Physiotherapy Management
_ Chest physiotherapy (eg, percussion, high-frequency chest wall oscillation (HFCWO) vest, cough assistive device) every hour or more often
_ Chest physiotherapy (eg, percussion, HFCWO vest, cough assistive device) every 1 to 4 hours
_ Chest physiotherapy (eg, percussion, HFCWO vest, cough assistive device) less often than every 4 hours, but at least daily
_ N/A

Combative Behavior Management
_ Combative (eg, attempts to strike out or hurt others), confused, or disoriented behavior that impacts self-management and patient obese
_ Combative, confused, or disoriented behavior that impacts self-management
_ N/A

Infusion access or specialty infusion management that includes infusion access care, infusion administration, and monitoring infusion reaction (Check All that apply)
_ Blood or blood product transfusion
_ Chemotherapy infusion management
_ Central line access (eg, Huber needle placement) and management
_ Pain medication infusion
_ N/A

Intravenous (IV) infusion management that includes device use and care, infusion administration, and monitoring infusion reaction
_ Infusions every 4 hours or more often (excluding blood or blood products, chemotherapy, and pain medication)
_ Infusions less often than every 4 hours (excluding blood or blood products, chemotherapy, and pain medication)
_ N/A

Medication (non infusion) Management (Check All that apply)
_ Insulin administration when patient does not have ability to self-administer insulin, and there is no other person willing and able to do injection
_ Injectable medication management (excluding insulin medication)
_ Medication administration with nurse clinical monitoring needed every 2 hours or more often (excluding insulin medication)
_ N/A

Mobility or rehabilitation management (Check All that apply)
_ Activities of Daily Living (ADL) support needed for more than 4 hours per day to maximize a patient's independence
_ Body cast management and support
_ Cast or brace management
_ Communication deficit (eg, visual, auditory, tactile) management
_ Lift, total, weight of 55 to 125 pounds (25 to 57 kg)
_ Lift, partial or total, weight of more than 125 pounds (57 kg)
_ Mobility impairment and risk for skin breakdown (eg, bedbound, wheelchair-bound)
_ Range-of-motion (ROM) exercises every 8 hours or more often
_ Rehabilitation therapy program support for each therapy for 3 hours or more per day with physical therapy (PT) or full occupational therapy (OT) program every 4 awake hours
_ Splinting management with removal and replacement every 8 hours or more often
_ N/A

Nebulizer management that includes changes in type or amount of medication with clinical monitoring of responsiveness
_ Nebulizer treatment and management more often than every 4 hours
_ Nebulizer treatment and management every 4 to 24 hours
_ Nebulizer treatment and management less than daily but at least once every 7 days
_ N/A

Nurse seizure management with assessment of clinical status, monitoring for complications, administering medication and evaluating effect, airway management, and injury prevention
_ Seizures, mild (eg, last less than 3 minutes with little or no uncontrolled body movements, or present as automatisms or change of mood or behavior), 4 or more times per week requiring nursing management
_ Seizures, moderate (eg, last 3 to 5 minutes with uncontrolled body movements), 4 or more times per week requiring nursing management
_ Seizures, moderate (eg, last 3 to 5 minutes with uncontrolled body movements), 1 to 4 times per day requiring nursing management
_ Seizures, moderate (eg, last 3 to 5 minutes with uncontrolled body movements), 5 or more times per day requiring nursing management
_ Seizures, severe (eg, last 5 or more minutes with uncontrolled body movements or repeated seizures without regaining consciousness), 4 or more times per week requiring nursing management
_ Seizures, severe (eg, last 5 or more minutes with uncontrolled body movements or repeated seizures without regaining consciousness), 1 or more times per day requiring nursing management and rectal medication
_ Seizures, severe (eg, last 5 or more minutes with uncontrolled body movements or repeated seizures without regaining consciousness), 1 or more times per day requiring nursing management and IM or IV medication
_ N/A

Nutrition management (Check All that apply)
_ Enteral nutrition (pump or bolus) with complications (eg, aspiration risks, residuals) and administration of feeding, residual check, adjustment or replacement of tube, and assessment and management of complications
_ Enteral nutrition (pump or bolus) without complications and administration of feeding or adjustment or replacement of tube
_ Gastrostomy tube care, uncomplicated
_ Nasogastric tube care, uncomplicated
_ Partial parenteral nutrition with central line care
_ Total parenteral nutrition with central line care
_ N/A

Oxygen management
_ Oxygen humidification, tracheal direct, without ventilator
_ Oxygen needed routinely (at least weekly) with flow based on pulse oximetry
_ N/A

Safety management (Check All that apply)
_ Aspiration precautions, monitoring, and management
_ Isolation needed
_ School or education support management requiring clinical monitoring
_ Supervision of licensed practical nurse or aide
_ N/A

Skin and wound management (Check All that apply)

_ Burn care
_ Ostomy care once per day or more often
_ Post-surgical care (within 45 days of surgery) for new or revised tracheostomy, or ventricular shunt, or open abdominal or orthopedic surgery
_ Stage 1 or 2 wound management once per day or more often
_ Stage 3 or 4 wound management once per day or more often
_ Stage 3 or 4 wound management once per day or more often and multiple wound sites
_ Skin treatment (ie, prescribed topical medication application or open wound care) every 4 hours or more often
_ Wound vacuum management
_ N/A

Suctioning, respiratory management
_ Suctioning (tracheal) 11 times or more per day, or every 2 hours or more often
_ Suctioning (tracheal) 10 times or less per day, or less often than every 2 hours
_ Suctioning (nasal or oral)
_ N/A

Tracheostomy management
_ Tracheostomy management with complications (eg, skin breakdown or tube replacement needed) every 4 hours or more often
_ Tracheostomy management without complications
_ N/A

Ventilator management
_ Ventilator management, continuous use or no respiratory effort
_ Ventilator management for active weaning
_ Ventilator management for 12 hours or more per day, but not continuous
_ Ventilator management for 7 to 12 hours per day, but not continuous
_ Ventilator management for ventilator used less than 7 hours per day
_ Ventilator weaning achieved with ongoing post-weaning monitoring and management
_ Ventilator on standby, respiratory assistance, or used at night for less than 1 hour
_ N/A

Comments

Additional notes and comments regarding the service needs of this patient.

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