STATE OF LOUISIANA
DEPARTMENT OF HEALTH
Bureau of Health Services Financing Medical Assistance Program

BATON ROUGE, LA. 70898-4919 REQUEST FOR PRIOR AUTHORIZATION P.A. NUMBER

Appendix BB-1

FAX TO: (225) 216-6481 CONTINUATION OF SERVICES ____YES ____NO

(1) PRIOR AUTHORIZATION TYPE:	(2) BENEFICIARY 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER	(3) SOCIAL SECURITY #
14 – EPSDT PERSONAL CARE SERVICES	(4) BENEFICIARY LAST NAME FIRST NAME MI	(5) DATE OF BIRTH
(6) MEDICAID PROVIDER NUMBER (7- DIGIT)	(7) SERVICE TREATMENT PLAN BEGIN DATE (MMDDYYY) END DATE (MMDDYYY)	(8)IS BENEFICIARY CURRENTLY RECEIVING THESE SERVICES ____YES ____NO
		PRACTITIONER REVIEWER'S SIGNATURE & DATE

(9) DIAGNOSIS:
PRIMARY CODE

SECONDARY CODE

(10) PRESCRIPTION DATE (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

(11) PRESCRIBING PRACTITIONER'S NAME AND/ OR NUMBER:

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE	MODIFER	PERSONAL CARE SERVICE EACH 15 MINUTES	REQUESTED UNITS	AUTHORIZED UNITS	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(13) PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

TELEPHONE: (_____) _____ FAX NUMBER: (_____) _____ _____

Comments:

(14)
PROVIDER SIGNATURE: _____

(15)
DATE OF REQUEST: _____

Revised PA-14 FORM
Revised 5/2019

Instructions for Completing Prior Authorization Form (PA-14)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

FIELD NO. 2 ENTER BENEFICIARY'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.

FIELD NO. 3 ENTER THE BENEFICIARY'S SOCIAL SECURITY NUMBER.

FIELD NO. 4 ENTER THE BENEFICIARY'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THE BENEFICIARY'S MEDICAID CARD.

FIELD NO. 5 ENTER THE BENEFICIARY'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER.

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR.

FIELD NO. 8 PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE BENEFICIARY IS CURRENTLY RECEIVING SERVICES.

FIELD NO. 9 ENTER THE DIAGNOSIS CODES (PRIMARY & SECONDARY).

FIELD NO. 10 ENTER THE DAY THE PRESCRIPTION, PRACTITIONER'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 11 ENTER THE NAME OF THE BENEFICIARY'S ATTENDING PRACTITIONER PRESCRIBING THE SERVICES.

FIELD NO. 12 ENTER THE HCPCS CODE.

FIELD NO. 12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE).

FIELD NO. 12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED. FIELD NO.

12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (1 UNIT = 15 MINUTES) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS COVERED IN THE TREATMENT PLAN. THIS WILL GIVE THE TOTAL UNITS REQUESTED. BELOW ARE TWO EXAMPLES ON THE PROPER WAY TO CALCULATE THE TOTAL UNITS REQUESTED:

EXAMPLE 1) REQUESTING FOUR-HOURS PER DAY FOR A SIX MONTH PERIOD:

4 HOURS PER DAY = 16 UNITS PER DAY, 7 DAYS A WEEK, 26 WEEKS =
16 X 7 X 26 = 2912 TOTAL UNITS REQUESTED

EXAMPLE 2) REQUESTING TWO-HOURS PER DAY ON WEEKENDS AND FOUR-HOURS PER DAY ON WEEKDAYS:

2 HOURS PER DAY (WEEKENDS) = 8 UNITS PER DAY, 2 DAYS A WEEK, 26 WEEKS =
8 X 2 X 26 = 416 TOTAL UNITS REQUESTED FOR WEEKENDS

4 HRS. PER DAY (WEEKDAYS) = 16 UNITS PER DAY, 5 DAYS A WEEK, 26 WEEKS =
16 X 5 X 26 = 2080 TOTAL UNITS REQUESTED FOR WEEKDAYS

THE TOTAL UNITS REQUESTED WOULD BE THE COMBINATION OF THE TOTAL WEEKEND UNITS (416) AND WEEKDAY UNITS (2080), WHICH WOULD EQUAL TO 2496 TOTAL UNITS REQUESTED. THIS IS THE NUMBER (2496) TO ENTER IN FIELD NUMBER 12C.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE. FIELD NO.

14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO. 15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

PRIOR AUTHORIZATION PCS DEPARTMENT TOLL-FREE NO. IS 1-800-807-1320

PRIOR AUTHORIZATION FAX NO. IS 1-225-216-6481

REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES

(Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

1. Applicant Name:	**MID#**	
Address:	**Ph#** ( )	
	D **Male** D **Female**	**DOB:**
2. Responsible Party/Curator:	**Relationship:**	
Address:	**Home Phone #** ( )	
	Work or Cell Phone # ( )	

By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.

Signature: _____ **Date:** _____

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant's attending practitioner.

1. Patient Name:

2. Primary Diagnosis:	**Diagnosis Code:**
Secondary Diagnosis:	**Diagnosis Code:**

3. Physical Examination:

General _____ Head and CNS _____ Mouth

and EENT _____ Chest _____ Heart

and Circulation _____ Abdomen _____ Genitalia

Extremities _____ Skin _____ Height

Wt. _____ Pulse _____ Resp

Temp _____ B/P _____ Bowel/Bladder

Control _____

Impaired Vision _____ Impaired Hearing _____

DGlasses DHearing Aid

Lab Results:

HCT _____ HCB _____ U/A

Radiology _____

4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate

D Trach Care: D Daily D PRN

D Respiratory: D Ventilator D Daily D Other _____

D Suctioning/Oral Care: D Daily D PRN

D Glucose Monitoring: D Insulin Injections D Daily D Other

D Restraints (positioning)

D Dialysis

D Urinary Catheter

D Seizure Precautions

D Ostomy

D IV

D Decubitus/Stage _____

D Diet/Tube Feeding

D Rehab (OT,PT,ST)

Assistive Device:

5. Medications	**Dosage**	**Frequency**	**Route**

II. MEDICAL INFORMATION (Continued)

6. Recent Hospitalizations: (include psychiatric):					
7. Mental Status/Behavior: Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always					
Oriented	D Yes (1 2 3) D No	Depressed	D Yes (1 2 3) D No	Cooperative	D Yes (1 2 3) D No
Passive	D Yes (1 2 3) D No	Physically Abusive	D Yes (1 2 3) D No	Verbally Abusive	D Yes (1 2 3) D No
Verbal	D Yes (1 2 3) D No	Comatose	D Yes (1 2 3) D No	Hostile	D Yes (1 2 3) D No
Forgetful	D Yes (1 2 3) D No	Confused	D Yes (1 2 3) D No	Combative	D Yes (1 2 3) D No
Non-responsive	D Yes (1 2 3) D No	Injures Self/Others	D Yes (1 2 3) D No		
8. Impairments: Please rate the following. 1- Mild , 2-Moderate, 3-Severe					
Walking	(1 2 3)	Chronic heart failure	(1 2 3)	Vision impairment	(1 2 3)
Spasticity	(1 2 3)	Speech impairment	(1 2 3)	Oral feeding	(1 2 3)
Limb weakness	(1 2 3)	Seizure Disorder	(1 2 3)	Bladder and bowel incontinence	(1 2 3)
Hypotonia	(1 2 3)	Developmental delay	(1 2 3)	Intellectual impairment	(1 2 3)
Chronic Resp distress	(1 2 3)	Hearing impairment	(1 2 3)		

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

Based on the beneficiary's impairment, the attending practitioner should check the appropriate box as it applies to the beneficiary's ability to perform this age appropriate tasks using the following definitions and PCS Level of Assistance Guide:

Not Independent at this Age – not age appropriate to perform this task independently
Independent – beneficiary able to perform task **without assistance**
Limited Assistance – beneficiary aids in task, but receives help from other persons **some of the time**
Extensive Assistance – beneficiary aids in task, but receives help from other persons **all of the time**
Maximal Assistance – beneficiary is **entirely dependent** on other persons
Note: An additional 15 minutes can be added to bathing, dressing and toileting if mobility/transfer assistance is required

(EPSDT – PCS Level of Assistance Guide)

This is a **general guide** to assist practitioners with determining the level of assistance beneficiaries require to complete their activities of daily living (ADL). Additional time to complete the tasks will be considered if there is sufficient medical documentation provided. Please use the comments section below and attach documentation to support the need for additional time to complete the ADL's. In addition to the PCS tasks listed, assistance with incidental household chores may be approved. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary.

PCS Task	Levels of Assistance				Mobility/Transfer Requirement
	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	
Bathing	0	15 min	30 min	45 min	Additional 15 min
Dressing	0	15 min	30 min	45 min	Additional 15 min
Grooming	0	15 min	15 min	15 min	
Toileting	0	15 min	30 min	45 min	Additional 15 min
Eating	0	15 min	30 min	45 min	
Meal Prep	0	30 min	30 min	30 min	

III. LEVEL OF CARE DETERMINATION (Continued)

NOTE: The following information is to be completed by the applicant's attending practitioner. Check the appropriate box using the definitions and EPSDT PCS Level of Assistance Guide to assist with determining the level of care.

Activity	Not Independent at this Age	Independent	Limited Assistance	Extensive Assistance	Maximal Assistance	Comments
Bathing						
Dressing						
Grooming						
Toileting						
Eating						

Level of care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. **Please select one of the following:**

This individual's condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. May include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D Yes, this individual requires this level of care.

D No, this individual does not require this level of care.

Mobility/Transfer Requirements: Please indicate below the activities of daily living for which the beneficiary will require assistance with mobility/transfer.

Bathing D Yes D No **Dressing** D Yes D No **Toileting** D Yes D No

Medical Appointments:

Will the beneficiary need the PCS worker to accompany him/her to medical appointments? D Yes D No

How often will the beneficiary have scheduled medical appointments? D weekly D monthly D quarterly D other _____

Reason for PCS worker to accompany child to medical appointments: _____

IV. PRACTITIONER'S ORDER

The above named patient is in need of EPSDT PCS due to his/her current medical condition. I am prescribing

Personal Care Services for _____hours, _____days a week as determined by the level of care determination.

Practitioner's Name (type or print):	Phone: ( )
Address:	

I certify/recertify that I am the attending practitioner for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these EPSDT personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child's medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held between beneficiary and practitioner.

Practitioner's Signature _____ **Date** _____

MAIL TO:
DXC / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 216-6342

CONTINUATION OF SERVICES _____YES _____ NO

PRIOR AUTHORIZATION TYPE: (1)	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)	Social Security No. (3)
06 - Home Health Services	RECIPIENT LAST NAME FIRST MI (4)	DATE OF BIRTH (5)
MEDICAID PROVIDER NUMBER (7- DIGIT) (6)	SERVICE TREATMENT PLAN (7) BEGIN DATE (MMDDYYYY) / END DATE (MMDDYYYY)	IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8) _____ YES _____ NO
DIAGNOSIS : (9) PRIMARY CODE / SECONDARY CODE	PRESCRIPTION DATE (10) (MMDDYYYY)	STATUS CODES: 2 = APPROVED 3 = DENIED
	PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER:	P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DESCRIPTION OF SERVICES | **FOR INTERNAL USE ONLY**

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S)	

(12)

PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIPCODE _____

TELEPHONE: (_____) _____ _____ FAX NUMBER: (_____) _____ _____

COMMENTS:

(13)
PROVIDER SIGNATURE: _____

(14)
DATE OF REQUEST: _____

Revised PA-07 Form
Issued 10/1/2015

Instructions For Completing Prior Authorization Form (PA-07)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

FIELD NO. 2 ENTER RECIPIENT'S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER

FIELD NO. 3 ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER

FIELD NO. 4 ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON RECIPIENT'S MEDICAID CARD

FIELD NO. 5 ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 8 PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES

FIELD NO. 9 ENTER THE DIAGNOSIS CODE (PRIMARY & SECONDARY)

FIELD NO.10 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO.11 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES

FIELD NO.12 ENTER HCPCS CODE

FIELD NO.12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE)

FIELD NO.12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED

FIELD NO.12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (4 UNITS = 1 HOUR) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED (TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED.

EXAMPLE : 11 HOURS PER DAY , 7 DAYS PER WEEK, 26 WEEKS =

11 X 4 = 44 X 7 X 26 WEEKS = 8, 008

FIELD NO.13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE

FIELD NO.14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO.15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT DXC.

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225- 237-3342

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
		From: To:		

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐ M ☐ F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures

16. Nutritional Req.	17. Allergies

18.A. Functional Limitations

1 ☐ Amputation	5 ☐ Paralysis	9 ☐ Legally Blind			
2 ☐ Bowel/Bladder (Incontinance)	6 ☐ Endurance	A ☐ Dyspnea With Minimal Exertion			
3 ☐ Contracture	7 ☐ Ambulation	B ☐ Other (Specify)			
4 ☐ Hearing	8 ☐ Speech				

18.B. Activities Permitted

1 ☐ Complete Bedrest	6 ☐ Partial Weight Bearing	A ☐ Wheelchair			
2 ☐ Bedrest BRP	7 ☐ Independent At Home	B ☐ Walker			
3 ☐ Up As Tolerated	8 ☐ Crutches	C ☐ No Restrictions			
4 ☐ Transfer Bed/Chair	9 ☐ Cane	D ☐ Other (Specify)			
5 ☐ Exercises Prescribed					

19. Mental Status	1 ☐ Oriented	3 ☐ Forgetful	5 ☐ Disoriented	7 ☐ Agitated
	2 ☐ Comatose	4 ☐ Depressed	6 ☐ Lethargic	8 ☐ Other

20. Prognosis	1 ☐ Poor	2 ☐ Guarded	3 ☐ Fair	4 ☐ Good	5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date of HHA Received Signed POT

24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

BHSF Form DIP1
Revised 10/15

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: _____ Date of birth: _____ Age: _____

Medicaid ID: _____Height: _____ Weight _____

Recipient's Address _____

Prescribing Provider:

Prescriber's Name: _____ Phone #: _____

Address: _____Fax # _____

➤ **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD CM code):**

Primary: _____ **Secondary:** _____

➤ **Specify Urine/Fecal incontinence diagnoses (Specify ICD CM code):**

Primary: _____ **Secondary:** _____

➤ **Mobility**

☐ Ambulatory
☐ Transfer Assistance
☐ Minimal assistance ambulating
☐ Confined to bed or chair

➤ **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

➤ **Mental Status/Level of Orientation**

☐ Has the ability to communicate needs
☐ Sometimes communicates needs
☐ Unable to communicate needs

Frequency of anticipated change

During Day time (6 AM-10PM) _____.
During Night time (10PM – 6 AM) _____.

➤ **Additional supporting Diagnoses (Specific ICD-CM Code)**

_____
_____

Indicate current supportive services

☐ Home Health
☐ Skilled Nursing Services
☐ Personal Care Services
☐ Other _____

➤ **List any medications and/or nutritional therapy that would increase urine or fecal output:**

_____

➤ **Specify incontinence supply, size, quantity/24 hours and duration of need:**

				Qty per day	Size (S, M, L, XL)
☐ **Diapers (Check one):**	[ ] child size	[ ] ☐ youth-sized	[ ] adult-sized	_____	_____
☐ **Pull-ups (Check one):**	[ ] child size	[ ] ☐ youth-sized	[ ] adult-sized	_____	_____
☐ **Liner/shield (Check one):**	[ ] child size	[ ] ☐ youth-sized	[ ] adult-sized	_____	_____

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

_____

Date:

_____

➤ **Comments**

_____
_____
_____
_____
_____

☐ **Additional documentation attached**

Disposable Incontinence Products (T4521 - T4535 & T4539 & T4543)

Standards of Coverage:

Diapers are covered for individual's age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- The individual has a medical condition resulting in permanent bowel/bladder incontinence, and
- The individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

Pull-on briefs are covered for individual's age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- There is presence of a medical condition resulting in permanent bowel/bladder incontinence, and
- The recipient has the cognitive and physical ability to assist in his/her toileting needs.

Liners/guards are covered for individual's age four years through age twenty years when:

- Specifically prescribed by the recipient's physician, and
- They cost-effectively reduce the amount of other incontinence supplies needed.

Note: Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.

Documentation: The prescription request form for disposable incontinence products may be completed by the physician, or a physician's prescription along with the required documentation as listed below.

Documentation must reflect the individual's current condition and include the following:

- Diagnosis (specific ICD-CM code) of condition causing incontinence (primary and secondary diagnosis).
- Item to be dispensed.
- Duration of need *(physician must provide)*.
- Size
- Quantity of item and anticipated frequency the item requires replacement.
- Description of mobility/limitations

To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct HCPC code from among T4521-T4535 & T4539 & T4543.

Documentation for extraordinary needs must include all of the above and:

- Description of mental status/level of orientation
- Indicate current supportive services
- Additional supporting diagnosis to justify increased need for supplies
- Additional documentation to justify increased need may include but are not limited to any prescriptions that would increase urinary or fecal output.

If completed, DHH's "Prescription Request Form for Disposable Incontinence Supplies" collects this information.

Approved providers of incontinence products:

- Pharmacy
- Home health agency
- Durable medical equipment provider

Prior Authorization Requirements: Prior authorization is required for all disposable incontinence supplies. The PA requests shall meet all previously defined criteria for:

- Eligible recipient.
- Eligible provider.
- Covered product.
- Documentation requirements - the prescription request form for disposable incontinence products may be completed, or a physician's prescription along with the required documentation as indicated above.

Quantity Limitations:

- Disposable incontinence supplies are limited to eight per day.
- ICF-MR and nursing facility residents are excluded as these products are included in the facility per diem.
- Additional supporting documentation is required for requests that exceed the established limit.

Dispensing and Billing:

- Only a one-month supply may be dispensed at any time as initiated by the recipient.
- Bill one unit per item. Shipping costs are included in the DHH maximum allowable payment and may not be billed separately.
- Although specific brands are not required, DHH maximum allowable amounts may preclude the purchase of some products. The rate has been established so that the majority of products on the market are obtainable.

Providers should always request authorization for the appropriate product for the recipient's current needs.

- Providers must provide at the minimum, a moderate absorbency product that will accommodate a majority of the Medicaid recipient's incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.
- For recipients requesting a combination of incontinence supplies, the total quantity shall not exceed the established limit absent approval of extraordinary needs.
- Because payment cannot exceed the number of units prior authorized, providers who choose to have incontinent supplies shipped directly from the manufacture to the recipient's home shall be responsible for any excess over the number of supplies approved by the prior authorization.