Michigan Department of Health and Human Services

Completion Instructions for MSA-0732
Private Duty Nursing Prior Authorization – Request for Services

The MSA-0732 form (starting on page 2) must be submitted every time services are requested, i.e., before services can begin and for each authorization period thereafter, no less than 15 days prior to the end of the current authorization period. MDHHS requests that the MSA-0732 be typewritten to facilitate processing (excludes sections 43-45).

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage under 21 years of age. Private Duty Nursing is not a benefit under Children's Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid when dually enrolled. Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter for policy detail.

A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician's staff person. When this is the case, the person submitting the request must do so in consultation with the PDN agency who will be assuming responsibility for the care of the beneficiary.

THE COMPLETED AND SIGNED FORM MSA-0732 TOGETHER WITH THE COMPLETED CARE PLAN IS CONSIDERED A PRESCRIPTION FOR PDN SERVICES WHEN SIGNED BY THE ORDERING PHYSICIAN.

Item#	Form Completion Instructions
	If submitting via CHAMPS Direct Data Entry, skip to BOX # 5 to begin form completion.
1	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE UNITS or DECREASE UNITS box only if this request demonstrates an increase or decrease in time from the previous authorization period. Time is authorized and billed in 15-minute incremental units (1 unit = 15 minutes).
2 – 4	PDN provider information. Provide complete agency name, or name of independent PDN provider (last, first, and middle initial, and designation whether RN or LPN). Include NPI number, phone number, and address.
5	Provide contact information for an individual in the provider's office, in case of questions while reviewing this request. Please include name, phone number and email address.
6 – 13	Beneficiary information. Provide complete name and birth date (month, day, and year), miHealth card number, phone number, sex, primary ICD diagnosis code & description, complete address and county. If the beneficiary routinely splits time between 2 homes, please include the secondary address in box 13.
14 – 16	Other insurance information if applicable, including name of company and group/policy and certificate/contract numbers.
17 – 20	If the beneficiary is currently hospitalized, provide hospital name, anticipated discharge date, and complete contact information of the Discharge Planner including name, phone number, fax number, and email address.
21 – 23	Ordering physician information. Provide complete name (including MD or DO), NPI number, and phone number.
24 – 28	Description of the service(s) to be provided including modifier TD for RN or TE for LPN. Use modifier TT if caring for more than one beneficiary in the home. Indicate Start Date and End Date for the authorization period being requested. Include the number of hours per day requested and number of total units per month required to provide the service(s).
29 – 31	Indicate the number of family caregivers providing care for the beneficiary. If more than one beneficiary in the home receives PDN, provide their name(s) and miHealth card number(s). A separate form is required for each beneficiary.
32 – 36	If more than one PDN agency/independent PDN provider is involved, list their name(s), NPI, phone and fax number(s).
37 – 39	Indicate if the beneficiary will attend school during the requested authorization period. Include number of school hours per day and per week, including travel time, as well for other beneficiaries in the home receiving PDN services, if applicable.
40	List all other services in the home. Failure to disclose all services in the home may result in recoupment of Medicaid dollars if other Medicaid direct care services are provided concurrently.
41 – 42	Description of beneficiary level of acuity must be completed by a PDN nurse familiar with the beneficiary. Complete all sections fully to help us understand the factors impacting this individual beneficiary's needs for PDN and to avoid the PA request being returned for additional information and delay of authorization. Check all descriptors that currently apply. **Documentation included with the PA request must be consistent with the descriptors checked and must include an explanation of medical necessity.** Contact information for the person completing section 41 must be provided, including name, phone number, and email address.
43 – 45	Must be completed by the beneficiary's parent/legal guardian (written or electronically) to help us better understand their perspective of their child's individual needs for PDN, other things impacting them and/or their family, and resources that may or may not be available to them. Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. Contact information for the person completing section 43 must be provided, including name and phone number. Pages for sections 43 – 45 may be printed for parent/legal guardian written completion.
46	The Provider's signature certifies that (1) the individual PDN or agency requesting the services understands the necessity for obtaining PA for PDN, and (2) the information provided on this form is accurate and complete.
47	The Prescribing Physician's signature certifies that the beneficiary is actively under the care of the physician prescribing the requested services, and that the physician approves the care plan, has assessed the beneficiary, and medically justifies the number of hours/day as entered in this section. Hours/day must be entered by the physician.
48	Documentation requirements checklist. Enter page numbers where indicated for nursing notes being submitted.

Form Submission

Submit the completed MSA-0732 and required documentation in CHAMPS via Direct Data Entry (DDE) https://milogintp.michigan.gov or FAX to 517-241-7813. If submitting via DDE, follow directions for uploading documents.

Questions should be directed to MDHHS - Health Services, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

PRIVATE DUTY NURSING

Prior Authorization – Request for Services

Submit in CHAMPS via Direct Data Entry (DDE) https://milogintp.michigan.gov or FAX: 517-241-7813

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

NOTE: if submitting via CHAMPS Direct Data Entry, skip to BOX # 5

1. Indicate if this request is for: ☐ INITIAL ☐ RENEWAL ☐ INCREASE IN UNITS ☐ DECREASE IN UNITS				
2. Requesting Provider Name (Organization/Group) If not applicable, enter Individual:		3. Organization NPI (previously known as Group). If not applicable, enter Individual:		
4. Provider's Street Address (for PA correspondence):		City:	State:	ZIP Code:
5. Provider Office Contact Information (for contact during PA request review, if needed): Please include on all Fax and DDE requests Name: Phone Number: ( ) - Ext Email:				
6. Beneficiary Name (Last, First, Middle Initial):		7. Date of Birth: / /	8. **miHealth** Card Number:	
9. Beneficiary Phone Number: ( ) -	10. Sex ☐ M ☐ F	11. ICD Diagnosis Code and Description:		
12. Beneficiary's Street Address & Apt/Lot Number (primary/custodial):	City:	State:	Zip Code:	County:
13. Beneficiary's Street Address & Apt/Lot Number (secondary):	City:	State:	Zip Code:	County:
14. Other/Commercial Health Insurance? If YES, indicate carrier name: ☐ NO ☐ YES,	15. Group / Policy Number:	16. Certificate / Contract Number:		
17. Is the beneficiary currently hospitalized? ☐ NO ☐ YES. If YES, complete hospital and discharge planner info in boxes 18-20.				
18. Hospital Name:		19. Anticipated Discharge Date:		
20. Discharge Planner's Contact Information: Name: Phone Number: ( ) - Ext Fax: ( ) - Email:				
21. Ordering Physician's Name (First, MI, Last, MD or DO):	22. NPI Number:	23. Phone Number: ( ) -		
24. Procedure Code: ☒ T1000 Modifier Code(s): ☐ TD ☐ TE ☐ TT	25. Start Date: / /	26. End Date: / /		
Note: Maximum allowable hours/day and units/month will exclude PDN hours required to be provided by the school system (bus transportation and classroom time).				
27. Requested Hours Per Day:	28. Requested Units Per Month:			
29. Number of Family Caregiver(s): _____	30. Does anyone else in the house receive PDN services? ☐ YES ☐ NO	31. If YES, provide their name(s) and miHealth card number(s): Name: miHealth Number: Name: miHealth Number:		
32. Is more than one Individual PDN or PDN agency involved? ☐ YES ☐ NO	33.Name of Other PDN Provider(s):	34. NPI Number:	35. Phone Number ( ) - Ext. ( ) - Ext. ( ) - Ext.	36. Fax Number ( ) - ( ) - ( ) -
37. Is the beneficiary currently in school? ☐ YES ☐ NO	38. If YES, how many hours, including travel time? Per day:_____ Per week: _____	39. If others in the home are receiving PDN services, are they currently in school? ☐ YES ☐ NO If YES, how many hours? Per day: _____ Per week: _____		
40. Other than PDN, does the beneficiary receive other services in the home? ☐ YES ☐ NO If YES, list other services in the home:				

In accordance with MDHHS policy (Bulletin MMP 25-45/Medicaid Provider Manual), prior authorization requires documentation that clearly distinguishes the need for skilled care provided by a licensed nurse versus unskilled support, and also considers other factors impacting the family caregivers' availability. The medical need for licensed nursing care required beyond the skills or capacity of a family caregiver must be included in the supporting documentation submitted with this request. The determination of authorized hours will be based on an individual assessment of the beneficiary's documented medical condition(s) and care needs.

41. DESCRIPTION OF BENEFICIARY'S LEVEL OF ACUITY

Check all that currently apply. Documentation must be consistent with the selections below and include an explanation of medical necessity. **Please complete all sections fully to help us understand the factors impacting this individual beneficiary's needs for PDN and to avoid the PA request being returned for additional information and delay of authorization.**

	LOW	MEDIUM	HIGH
Medical Management:	☐ Medically managed by a pediatrician/PCP or one specialist on a regular basis.	☐ Medically managed by a pediatrician/PCP or one specialist on a regular basis AND 1 medical specialist at least yearly.	☐ Regularly requires a multi-disciplinary medical team approach in addition to being managed on a more frequent basis by a pediatrician, PCP, or single specialist.
Weight	☐ Weight ≤ 100 lbs	☐ Weight 101 - 125	☐ Weight ≥ 125 lbs
Nursing Assessments & Interventions	☐ Requires assessment and recording of vital signs, blood glucose, neuro status every 8-12 hours. ☐ Decubitus ulcer(s) on extremity requiring intervention; specify location(s).	☐ Requires assessment and recording of vital signs, blood glucose, neuro status every 5-8 hours. ☐ Stage 2 or less decubitus ulcers(s) on trunk requiring intervention; specify location(s).	☐ Requires assessment and recording of vital signs, blood glucose, neuro status every 1-4 hours. ☐ Stage 3 or 4 decubitus ulcer(s) on trunk requiring intervention; specify location(s). ☐ Requires blood draws every 4 hours or more. ☐ Peripheral IV in place. ☐ Central/PICC line in place.
Medication Administration	☐ Routine meds every 4 hours or more.	☐ Complex med schedule, every 2 hours or more. ☐ Occasional transfusion/IV, 1x/month or less. ☐ Diabetic/subcutaneous injections (SQ).	☐ Chemotherapy (home). ☐ IV pain control.
Feeding	☐ Uncomplicated tube feeding. ☐ Difficult/prolonged oral feeding. ☐ Aspiration precautions.	☐ Tube feeding with minimal complications. ☐ Occasional reflux. ☐ Gastrostomy tube.	☐ TPN
Respiratory	☐ Tracheostomy ☐ CPAP/Bi-PAP ☐ Suctioning every 2-4 hours on average. ☐ Room air. ☐ O2 via cannula low flow rate.	☐ Ventilator dependent. ☐ Nebulizer treatments ≤ every 4 hours. ☐ Suctioning more frequently than every 2-3 hours on average. ☐ Chest PT (CPT) or CPT Vest 1-2 times/day.	☐ Weaning from ventilator. ☐ Nebulizer treatments > every 4 hours. ☐ Chest PT (CPT) or CPT Vest ≥ 3 times/day.
Bowel/Bladder	☐ Incontinent, age ≤ 3 yo. ☐ Continent without assist.	☐ Incontinent, age >3 yo requiring stand-by, minimal to moderate assist x1; describe assistance needed. ☐ Intermittent Catheterization. ☐ Ostomy	☐ Incontinent, age >3 yo requiring maximal to total assist; describe assistance needed.

Neurological Status	☐ Mild-moderate seizures requiring minimal intervention; describe. ☐ Seizures, frequency 1-3x/day or less.	☐ Mild-moderate seizures requiring minimal intervention; describe. ☐ Seizures, frequency 4-6x/day.	☐ Severe seizures requiring IM, IV, PR, and/or oxygen intervention. ☐ Seizures, frequency > 6x/day.
Sleep	☐ Awake no more than 2 hours every night.	☐ Moderate sleep disturbance; awake 2-4 hours every night. ☐ Requires turning every 2-4 hours every night.	☐ Severe sleep disturbance; awake > 4 hours every night. ☐ Requires turning at least every 2 hours every night.
Behavioral	☐ Disorientation/combative (strikes out, attempts to hurt self); weighs ≤ 80 lbs.	☐ Disorientation/combative (strikes out, attempts to hurt self); weighs 80 - 125 lbs.	☐ Disoriented/combative; weighs ≥ 125 lbs.
Functional Mobility	☐ Transfers with ≤ minimal assist. ☐ Standing pivot transfers. ☐ Age-appropriate ambulation. ☐ Ambulates with assistive device and/or physical assist. ☐ Requires ≤ minimal assist for bed mobility. ☐ Requires minimal/moderate assist for bed mobility; weighs <125 lbs.	☐ Transfers w/moderate-maximal assist. ☐ Non-ambulatory > 18 mo old. ☐ Wheelchair dependent. ☐ Requires minimal/moderate assist for bed mobility, weighs ≥ 125 lbs. ☐ Requires max/total assist for bed mobility; weighs <125 lbs.	☐ Dependent transfers (patient unable to assist at all). ☐ Requires max/total assist for bed mobility; weighs ≥ 125 lbs.
Personal Care	☐ Age-appropriate dependence for all personal care/hygiene. ☐ Requires ≤ maximal assist for all personal care/hygiene; weighs <125 lbs. ☐ Requires ≤ minimal assist for all personal care/hygiene; weighs ≥125 lbs.	☐ Dependent/total assist for all personal care/hygiene; weighs < 100lbs. ☐ Moderate to maximal assist for all personal care/hygiene; weighs ≥100 bs.	☐ Dependent/total assist for all personal care/hygiene; weighs ≥100 lbs.
Other nursing interventions not included above.	☐ Describe:	☐ Describe and explain how intervention qualifies as medium intensity:	☐ Describe and explain how intervention qualifies as high intensity:

42. Contact Information for person who completed section **41** (for contact during PA request review, if needed):

Name: Phone Number: ( ) - Ext. Email:

THIS SECTION MUST BE COMPLETED BY THE BENEFICIARY'S PARENT/LEGAL GUARDIAN (written or electronically)

43. DESCRIPTION OF OTHER THINGS CONTRIBUTING TO FAMILY CAREGIVER AVAILABILITY:

Please answer all questions as best as possible to help us better understand your child's individual needs for PDN, other things impacting you and your family, and resources that may or may not be available to you.

a. Not counting PDN staff, please list the primary caregivers for your child, their relationship to your child and their typical weekly schedule:

Caregiver's Name: _____ Relationship to Beneficiary: _____

Work Hours: _____ School Hours: _____

Other Commitments: _____

_____

Available Hours for Care: _____

Caregiver's Name: _____ Relationship to Beneficiary: _____

Work Hours: _____ School Hours: _____

Other Commitments: _____

_____

Available Hours for Care: _____

Caregiver's Name: _____ Relationship to Beneficiary: _____

Work Hours: _____ School Hours: _____

Other Commitments: _____

_____

Available Hours for Care: _____

b. Are there times of the day or week that no caregiver is available to provide care? Such as when caring for another child/adult with or without special needs, managing their own health condition, work, etc.. ☐ YES ☐ NO If YES, please explain: _____

_____

_____

c. Does anyone in the household have responsibilities that limit their ability to provide care? Such as caring for another child/adult with special needs, managing their own health condition, work, etc.. ☐ YES ☐ NO If YES, please explain: _____

_____

_____

☐ Other 0 – 5 years old dependents in the home, without medical and/or behavioral health needs. How many? _____

☐ Other 5 – 10 year-old dependents in the home, without medical and/or behavioral health needs. How many? _____

☐ Other 10 – 18 year-old dependents in the home, without medical and/or behavioral health needs. How many? _____

d. Has anyone in the household recently had a major life change? Such as a new job, loss of a job, move, serious illness, loss of a close friend or a family member, etc. If YES, please share how this has affected your/their caregiving capacity: _____

_____

_____

e. Please describe a typical day caring for your child. Include how much time is spent on medical care such as medications, suctioning, G-tube feeds, respiratory support): _____

_____

_____

_____

_____

f. Are there skilled care tasks you feel less confident doing on your own? ☐ All of them ☐ Some ☐ None

Please describe which ones you are less confident doing, if any _____

g. Does your family have access to any support (friends, family, community groups) who help with caregiving or respite?

☐ YES ☐ NO If YES, please describe how often and the type of support: _____

h. Has your family's ability to work or earn income been affected by your child's care needs? ☐ YES ☐ NO

If YES, please explain: _____

i. Due to providing care for your child, has your family had to?

Reduce your hours at work?	☐ YES	☐ NO
Not increase your hours at work?	☐ YES	☐ NO
Stop working?	☐ YES	☐ NO
Change jobs?	☐ YES	☐ NO
Not look for or accept a job?	☐ YES	☐ NO

If you answered YES to any of these, please describe: _____

j. Does your family face any financial challenges related to caregiving (e.g., medical supplies, equipment, lost income, transportation)? ☐ YES ☐ NO If YES, please explain: _____

k. On a scale of 1–5, how would you rate your current level of stress related to caregiving?

(Very Low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Very High)

OPTIONAL, please explain: _____

l. Is there anything else you'd like us to know about your caregiving situation, challenges, or support needs?

44. **Parent/Legal Guardian Attestation:** I attest that the information contained in this form is true, accurate, and complete to the best of my knowledge and ability.

Parent/Legal Guardian's Name (typed or printed): _____ Phone Number: (___) ___ - ____

Parent/Legal Guardian's Signature: _____ Date: _____

45. Name of person who completed section **43** (in case of questions while reviewing your child's PA request review):

Name: _____ Phone Number: (___) ___ - ____

46. **PDN Provider Certification:** The patient named above (parent/legal guardian if applicable) understands the necessity to request prior authorization (PA) for the services indicated. I understand that services requested herein require PA, if approved and submitted on the appropriate claim, payment and satisfaction of authorized services will be from Federal and/or State funds. **I understand that any false claims, statements or documents, omission, or concealment of a material fact may lead to prosecution under applicable Federal and/or State law. Provider certifies that the information provided on this form and attached supporting documentation is accurate and complete to the best of their knowledge and ability.**

PDN Provider's Name (typed or printed):

PDN Provider's Signature: _____ Date: _____

THIS COMPLETED AND SIGNED FORM MSA-0732 TOGETHER WITH THE COMPLETED CARE PLAN IS CONSIDERED A PRESCRIPTION FOR PDN SERVICES WHEN SIGNED BY THE ORDERING PHYSICIAN.

47. Physician Prescription and Certification: I certify that I have examined the patient named above, reviewed this request, that services will be furnished while the patient is under my care; that I approve the care plan outlined in this request and will review when updated or more frequently if the patient's condition requires.

In accordance with MDHHS policy (Bulletin MMP 25-45/Medicaid Provider Manual), the prescribing physician must document and medically justify the number of hours requested. **Based upon my assessment, as well as the identification of needs outlined above, this beneficiary requires PDN (licensed nursing) care _____ hours/day.**

I understand that any false claims, statements or documents, omission, or concealment of a material fact may lead to prosecution under applicable Federal and/or State law. I certify that the information provided on this form and attached supporting documentation is accurate and complete to the best of their knowledge and ability.

Ordering Physician's Name (typed or printed):

Ordering Physician's Signature: _____ Date: _____

48. Documentation Requirements: The following documentation is required for all PA requests for PDN services and must accompany this MSA-0732. See also the Private Duty Nursing chapter of the MDHHS Medicaid Provider Manual at https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

- ☐ Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their status during the previous authorization period, completed by a registered nurse.
- ☐ Nursing notes for two (2) four-day periods (please number the pages for each period separately), including one four-day period that reflects the most current medically stable period (pages _____ to _____) and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition (pages _____ to _____).
- ☐ Documentation must support the skilled nursing services requested, matching the beneficiary's level of acuity (#41) and other contributing factors (#43) outlined above.
- ☐ Most recent updated POC signed and dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian, and contain dates inclusive of the requested authorization period. The POC must include the frequency and types of skilled nursing assessments, judgments, and interventions that pertain to and support the PDN services to be provided.
- ☐ If the beneficiary was hospitalized during the last authorization period, include documentation related to the PDN qualifying diagnosis/condition, i.e., all hospital discharge summaries, history and physical examination, social worker notes/assessment, consultation reports (pulmonary; ears, nose and throat [ENT]; ventilator clinic; sleep study; etc.), and emergency department reports (if emergency services were rendered during the last authorization period).
- ☐ Record of any parent/caregiver education, if applicable, during the most recent authorization period, including information regarding change in medical status, new/changes in interventions, response to interventions, equipment issues, etc..
- ☐ Other documentation as requested by MDHHS.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.