

Name: _____

Medicaid ID: _____

MAP- 249 (4/14): PDN Clinical Review

Tool

Section 1: Assessment Needs

Order	Frequency	
Skilled assessment of two or more systems: (Check all that apply) <input type="checkbox"/> Respiratory <input type="checkbox"/> Neurological <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input type="checkbox"/> Integumentary	Every 2 hours or more often	<input type="checkbox"/>
	Every 4 hours	<input type="checkbox"/>
	Every 8 hours	<input type="checkbox"/>
	Daily	<input type="checkbox"/>
Skilled assessment of two or more systems: (Check all that apply) <input type="checkbox"/> Respiratory <input type="checkbox"/> Neurological <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input type="checkbox"/> Integumentary	Every 2 hours or more often	<input type="checkbox"/>
	Every 4 hours	<input type="checkbox"/>
	Every 8 hours	<input type="checkbox"/>
	Daily	<input type="checkbox"/>
Comments:		

Section 2: Behavior

Order	Frequency	
Behavior that interferes with cares	Mild	<input type="checkbox"/>
	Moderate	<input type="checkbox"/>
	Severe	<input type="checkbox"/>
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Section 3: Medication Needs

Order	Frequency	
Scheduled Medications: Excludes topical medications.	Simple: 1 or 2	<input type="checkbox"/>
	Moderate: 3 to 5	<input type="checkbox"/>
	Complex: 6 to 9	<input type="checkbox"/>
	Extensive: 10 or more	<input type="checkbox"/>
PRN Medications:	PRN Medication Order	
	Simple: 1 to 2	<input type="checkbox"/>
	Moderate: 3 to 5	<input type="checkbox"/>
	Complex: 6 to 9	<input type="checkbox"/>
	Extensive: 10 or more	<input type="checkbox"/>
Nebulizer Treatments:	PRN Nebulizer treatments	
	Scheduled at least daily, less often than every 8 hours	<input type="checkbox"/>
	Scheduled every 6 to 8 hours	<input type="checkbox"/>
	Scheduled every 4 to 5 hours	<input type="checkbox"/>
	Scheduled every 2 to 3 hours	<input type="checkbox"/>
IV Medications: Choose method of administration. <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Central Line <input type="checkbox"/> PICC line <input type="checkbox"/> Hickman <input type="checkbox"/> Other ... includes TPN, excludes heparin or saline flush...	Weekly	<input type="checkbox"/>
	Daily	<input type="checkbox"/>
	Less often than every 8 hours	<input type="checkbox"/>
	Every 8 hours	<input type="checkbox"/>
	Every 6-7 hours	<input type="checkbox"/>
	Every 4-5 hours	<input type="checkbox"/>
	More often than every 4 hours	<input type="checkbox"/>
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Section 4: Respiratory Needs

Tracheostomy: (check one)	
<input type="checkbox"/> No trach, patent airway	<input type="checkbox"/> No trach, unstable airway
<input type="checkbox"/> Trach, established and stable	<input type="checkbox"/> Trach, new or unstable

Suctioning	Scheduled and/or PRN (Trach or NT)	<input type="checkbox"/>
	Scheduled and/or PRN (oral)	<input type="checkbox"/>
Oxygen	Continuous and/or daily use	<input type="checkbox"/>
	PRN	<input type="checkbox"/>
Pulse Oximetry	Continuous pulse oximetry with PRN oxygen parameters	<input type="checkbox"/>
	PRN or spot check pulse oximetry with PRN oxygen parameters	<input type="checkbox"/>
Ventilator	Ventilator, dependent, 24 hours per day	<input type="checkbox"/>
	Ventilator, intermittent 12 or more hours per day	<input type="checkbox"/>
	Ventilator, intermittent, 8 to 11 hours per day	<input type="checkbox"/>
	Ventilator, intermittent, 4 to 7 hours per day	<input type="checkbox"/>
	Ventilator, intermittent, less than 4 hours per day	<input type="checkbox"/>
BiPap or CPAP	BiPAP or CPAP more than 8 hours per day	<input type="checkbox"/>
	BiPAP or CPAP less than 8 hours per day	<input type="checkbox"/>
	BiPAP or CPAP used only at night	<input type="checkbox"/>
Chest Physiotherapy (CPT): (manual or with use of airway clearance vest)	PRN CPT	<input type="checkbox"/>
	Daily	<input type="checkbox"/>
	Every 8 hours or more	<input type="checkbox"/>
	Every 4 to 7 hours	<input type="checkbox"/>
	More often than every 4 hours	<input type="checkbox"/>
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Section 5: Feeding Needs

Order	Frequency	
Nutrition: Choose all that apply <input type="checkbox"/> Routine oral feeding <input type="checkbox"/> Difficult, prolonged oral feeding <input type="checkbox"/> Reflux and/or aspiration precautions <input type="checkbox"/> G-tube <input type="checkbox"/> J-tube <input type="checkbox"/> Other	Physician ordered oral feeding attempts (i.e., treatment of oral aversion)	<input type="checkbox"/>
	Tube feeding (routine bolus or continuous)	<input type="checkbox"/>
	Tube feeding (combination bolus and continuous)	<input type="checkbox"/>
	Complicated tube feeding (residual checks, aspiration precautions, slow feed, etc.)	<input type="checkbox"/>
Comments:		

Section 6: Seizure Needs

Order	Frequency	
Seizures:	Seizure diagnosis, not activity documented	<input type="checkbox"/>
	Mild:	<input type="checkbox"/>
	Moderate daily: no intervention	<input type="checkbox"/>
	Moderate: minimal intervention 2 to 4 times daily.	<input type="checkbox"/>
	Moderate: minimal intervention 5 or more times daily	<input type="checkbox"/>
	Severe: requires IM/IV/Rectal medications daily	<input type="checkbox"/>
	Severe: requires IM/IV/Rectal medications 2 to 4 times daily	<input type="checkbox"/>
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Section 7: Elimination Needs

Order	Frequency	
Intermittent Catheter	Every 4 hours	<input type="checkbox"/>
	Every 8 hours	<input type="checkbox"/>
	Every 12 hours	<input type="checkbox"/>
	Daily or PRN	<input type="checkbox"/>
Strict I & O	Every 4 hours	<input type="checkbox"/>
	Every 8 hours	<input type="checkbox"/>
	Daily	<input type="checkbox"/>
Comments:		

Section 8: Dressing Changes

Order	Frequency	
<input type="checkbox"/> PEG or G-tube dressing change	At least daily	<input type="checkbox"/>
Choose all that apply <input type="checkbox"/> Stage 1 - 2 pressure ulcer <input type="checkbox"/> IV change (new site)	At least daily	<input type="checkbox"/>
Choose all that apply <input type="checkbox"/> Stage 3 - 4 pressure ulcer <input type="checkbox"/> Multiple wound sites	At least daily	<input type="checkbox"/>
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Section 9: Caregiver Availability

Measure	Range	
Does caregiver(s) work outside the home?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Hours per day worked	4	<input type="checkbox"/>
	6	<input type="checkbox"/>
	8	<input type="checkbox"/>
	10	<input type="checkbox"/>
	12	<input type="checkbox"/>
Does the caregiver(s) attend school outside the home?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Hours per day at school	Less than 4	<input type="checkbox"/>
	4	<input type="checkbox"/>
	6	<input type="checkbox"/>
Days per week at school/work	Less than 5	<input type="checkbox"/>
	5 or more	<input type="checkbox"/>
Travel time required to work or school	Less than 1 hour	<input type="checkbox"/>
	Greater than 1 hour	<input type="checkbox"/>
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Section 10: Other Information

PATIENT INFORMATION		
Other Insurance If NO, Skip Next Question	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Amount of PDN Covered by Insurance		
Indicate if Recipient receives any of the following service(s):	N/A	<input type="checkbox"/>
	ABI	<input type="checkbox"/>
	ABI/LTC	<input type="checkbox"/>
	ADHC	<input type="checkbox"/>
	CDO	<input type="checkbox"/>
	CDO – Goods/Services	<input type="checkbox"/>
	CMHC	<input type="checkbox"/>
	EPSDT	<input type="checkbox"/>
	HCB	<input type="checkbox"/>
	MPW	<input type="checkbox"/>
	MIIW	<input type="checkbox"/>
	SCL	<input type="checkbox"/>
Other	<input type="checkbox"/>	
Is Recipient a resident of	Group Home	<input type="checkbox"/>
	Personal Care Home	<input type="checkbox"/>
	Family Care Home	<input type="checkbox"/>
	N/A	<input type="checkbox"/>
25. Ordering Physician's Name (Last, First, MD or DO):		
26. Physician's NPI Number		
*27. Physician's Phone Number		

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28. Ordering Physician's Address (Number Street, Ste, City, State, Zip)	
Name of person completing form:	Date Completed
Contact Number	