First Health Services
Phone: (800) 525-2395
Fax: (866) 480-9903

SCREENING REQUEST for PEDIATRIC SPECIALTY CARE SERVICES

Name of Nursing Facility: _____

Resident Name: _____ **Medicaid #:** _____

☐ **Pediatric Specialty Care I or** ☐ **Pediatric Specialty Care II - Mechanical Ventilator Dependent**

Request for: ☐ **Initial Approval** **or** ☐ **Continuing Approval**

Nursing Services:

☐ 1. The patient's condition requires twenty-four (24) hour access to nursing care by a registered nurse; **and**

☐ 2. There is documentation to support the patient has one (1) of the following (a), (b), (c), or d):

☐ (a) A tracheostomy and requires mechanical ventilation a minimum of six (6) hours per day; **or**
☐ (b) A tracheostomy that requires suctioning, room-air, mist or oxygen, **and one** (1) of the five (5) treatments listed below; **or**
☐ (c) Dependence on Total Parenteral Nutrition (TPN) or other intravenous (IV) nutritional support; **and one** (1) of the five (5) treatment procedures listed below; **or**
☐ (d) Administration of **any three** (3) of the five (5) treatment procedures listed below.

Treatment Procedures: (check all that apply)

☐ (1) Intermittent suctioning at least every eight (8) hours, **and** room air, mist or oxygen as needed.

☐ (2) IV therapy involving:
- ☐ (a) Administration of continuous therapeutic agents; **or**
- ☐ (b) Hydration; **or**
- ☐ (c) Intermittent IV drug administration of more than one (1) agent via a peripheral and/or central line without continuous infusion.

☐ (3) Peritoneal dialysis treatments requiring at least four (4) exchanges every twenty-four (24) hours.

☐ (4) Tube feeding (nasogastric or gastrostomy).

☐ (5) Other daily medical technologies required continuously which in the opinion of the attending physician and FHS's professional judgement requires more intensive professional nursing services, including but not limited to continuous oxygen and saturation monitoring, complex wound care, ventilator weaning, multi-system involvement or central line management or 1:1 care due to severe agitation/cognitive impairment.

3. What is the resident's potential for discharge from the pediatric unit to a lower level of care or home? _____
_____

4. Additional comments to support medical necessity for the provision of Pediatric Specialty Care Services. (attach additional documentation if needed).
_____
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_____
Signature of Person Completing Form **Date**

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