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) ☐ Respiratory ☐ Neurological ☐ Cardiovascular ☐ Gastrointestinal ☐ Genitourinary ☐ Integumentary	Every 2 hours or more often	☐
	Every 4 hours	☐
	Every 8 hours	☐
	Daily	☐
Skilled assessment of two or more systems: (Check all that apply) ☐ Respiratory ☐ Neurological ☐ Cardiovascular ☐ Gastrointestinal ☐ Genitourinary ☐ Integumentary	Every 2 hours or more often	☐
	Every 4 hours	☐
	Every 8 hours	☐
	Daily	☐
Comments:		

Section 2: Behavior

Order	Frequency	
Behavior that interferes with cares	Mild	☐
	Moderate	☐
	Severe	☐
Comments:		

Name:_____ Medicaid ID:_____

Section 3: Medication Needs

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

Name:_____ Medicaid ID:_____

Section 4: Respiratory Needs

Tracheostomy: (check one)
☐ No trach, patent airway ☐ No trach, unstable airway ☐ Trach, established and stable ☐ Trach, new or unstable

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

Name:_____ Medicaid ID:_____

Section 5: Feeding Needs

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

Section 6: Seizure Needs

Order	Frequency	
Seizures:	Seizure diagnosis, not activity documented	☐
	Mild:	☐
	Moderate daily: no intervention	☐
	Moderate: minimal intervention 2 to 4 times daily.	☐
	Moderate: minimal intervention 5 or more times daily	☐
	Severe: requires IM/IV/Rectal medications daily	☐
	Severe: requires IM/IV/Rectal medications 2 to 4 times daily	☐
Comments:		

Name:_____ Medicaid ID:_____

Section 7: Elimination Needs

Order	Frequency	
Intermittent Catheter	Every 4 hours	☐
	Every 8 hours	☐
	Every 12 hours	☐
	Daily or PRN	☐
Strict I & 0	Every 4 hours	☐
	Every 8 hours	☐
	Daily	☐
Comments:		

Section 8: Dressing Changes

Order	Frequency	
☐ PEG or G-tube dressing change	At least daily	☐
Choose all that apply ☐ Stage 1 - 2 pressure ulcer ☐ IV change (new site)	At least daily	☐
Choose all that apply ☐ Stage 3 - 4 pressure ulcer ☐ Multiple wound sites	At least daily	☐
Comments:		

Name:_____ Medicaid ID:_____

Section 9: Caregiver Availability

Measure	Range	
Does caregiver(s) work outside the home?	Yes	☐
	No	☐
Hours per day worked	4	☐
	6	☐
	8	☐
	10	☐
	12	☐
Does the caregiver(s) attend school outside the home?	Yes	☐
	No	☐
Hours per day at school	Less than 4	☐
	4	☐
	6	☐
Days per week at school/work	Less than 5	☐
	5 or more	☐
Travel time required to work or school	Less than 1 hour	☐
	Greater than 1 hour	☐
Comments:		

Name:_____ Medicaid ID:_____

Section 10: Other Information

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

Name:_____ Medicaid ID:_____

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