

Beneficiary Name: _____

Medicaid #: _____

HealthSystems of Mississippi
175 E. Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201

HealthSystems of Mississippi
Private Duty Nursing Continued Stay Certification
of Medical Necessity
Physician Plan of Care Form

CONTINUED STAY CERTIFICATION

BENEFICIARY'S INFORMATION

PRIMARY PHYSICIAN INFORMATION

Beneficiary Name: _____
Mississippi Medicaid # _____
Date of Birth: _____
Age: _____ Sex (*M or F*): _____

Name: _____
Mississippi Medicaid Provider # _____
Phone: _____ Ext. _____
Date Last Beneficiary Appointment: _____
Date Next Beneficiary Appointment: _____

DIAGNOSIS(ES) (*New or changed*)

Was the beneficiary hospitalized during the last certification period? Yes No **If yes, please complete below:**

Hospital Name: _____
Admit Date: _____
Discharge Date: _____

Admit Date: _____
Discharge Date: _____

PHYSICIAN ORDERS FOR PRIVATE DUTY NURSING

Level of Service Required: LPN RN

Number of hours per day: _____

Days per week: Sun Mon Tue Wed Thu Fri Sat

Expected Duration of Service: _____

TREATMENT PLAN FOR PRIVATE DUTY NURSING

*[Please list or attach copy of treatment plan. Include skilled services to be provided by the nurse, as well as ventilator setting (mode, O2, tidal volume, PEEP, PIP, high and low alarm limits); treatments (dressing changes, suctioning, nebulizations, trach/G tube care, CPT); gastrointestinal feeding (name, amount, frequency, bolus or continuous, * please indicate if feedings are supplemental); current medications (name, dosage, frequency, route).*

Have there been any changes in the beneficiary's homebound status? Yes No **If yes, explain:** _____

Have there been any changes in the beneficiary's functional limitations? Yes No **If yes, explain:** _____

Have there been any changes in the beneficiary's mental status? Yes No **If yes, explain:** _____

Have there been any changes in the beneficiary's prognosis? Yes No **If yes, explain:** _____

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Identify all other home care services currently being provided: *(Case Management, Physical Therapy, Speech Therapy, Occupational Therapy, Respite, Hospice, Respiratory Therapy, Home Health, personal care attendant.)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Is the beneficiary medically stable enough to have care managed safely at home?
<input type="checkbox"/>	<input type="checkbox"/>	Does the beneficiary have a documented illness or disability of such severity and complexity that it requires continuous skilled nursing care?
<input type="checkbox"/>	<input type="checkbox"/>	Does the need for constant skilled and highly technical care exceed the family's ability to care for the beneficiary without assistance of skilled nursing care by an RN or LPN?
<input type="checkbox"/>	<input type="checkbox"/>	Does the skilled nursing care to be provided directly relate to the beneficiary's disability or illness?
<input type="checkbox"/>	<input type="checkbox"/>	Does the beneficiary require a shift of at least eight (8) or more continuous hours, rather than intermittent skilled nursing care?
<input type="checkbox"/>	<input type="checkbox"/>	Is the parent(s) or other caregiver(s) still realistic and enthusiastic in their interest and willingness to devote long-term time and energy to being the primary caregiver for their child in the home?
<input type="checkbox"/>	<input type="checkbox"/>	To date, has the parent(s) or other caregiver(s) been compliant with the plan of care, physician office appointments or other ancillary services?

Please describe your plans to decrease Private Duty Nursing services: _____

Please describe your plans for discontinuing Private Duty Nursing services: _____

If applicable, please describe your plan to transition beneficiary to the most appropriate setting when PDN criteria are no longer met:

Have you or the family experienced any problems with Private Duty Nursing services? If yes, explain:

Additional comments pertinent to this beneficiary and/or plan of care:

Physician Attestation, Signature and Date

A physician who attests to prescribed private duty nursing service, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician identified on this form and I deem the service medically necessary for the patient listed as the beneficiary. I certify that the medical necessity information on this form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician

Date

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

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