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

# HealthSystems of Mississippi
# Private Duty Nursing Initial Certification of Medical Necessity
# Physician Plan of Care Form

## INITIAL CERTIFICATION

| BENEFICIARY'S INFORMATION | PRIMARY PHYSICIAN INFORMATION |
|---|---|
| Beneficiary Name: ______ | Name: ______ |
| Mississippi Medicaid # ______ | Mississippi Medicaid Provider # ______ |
| Date of Birth: ______ | Phone: ______ Ext. ______ |
| Age: ______ Sex *(M or F)*: ______ | Date Last Beneficiary Appointment: ______ |
| | Date Next Beneficiary Appointment: ______ |

| DIAGNOSIS(ES) | |
|---|---|
| | |
| | |
| | |

**Was the beneficiary hospitalized prior to initial certification request?** ☐ **Yes** ☐ **No** **If yes, please complete below:**

| Hospital Name: | Admit Date: |
|---|---|
| | Discharge Date: |

**Prognosis:**

### 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, 02, 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).***

Beneficiary Name: ________________________ Medicaid #:________________

| **List reason(s) beneficiary is considered homebound:** | | | |
|---|---|---|---|
| | | | |

| **Functional limitations:** ***(Please check below if applicable to this beneficiary)*** | | | |
|---|---|---|---|
| | **Contractures** | | **Amputation** |
| | **Hearing deficit** | | **Paralysis/Hemiparesis** |
| | **Legally blind** | | **Limited endurance** |
| | **Mobility deficit** | | **Dyspnea w/ minimal exertion** |
| | **Speech deficit** | | **Bowel/Bladder incontinence** |
| | **Other** *(Please specify):* | | |

| **Mental Status** ***(Please check below if applicable to this beneficiary)*** | | | |
|---|---|---|---|
| | **Oriented** | | **Comatose** |
| | **Disoriented** | | **Agitated** |
| | **Forgetful** | | **Depressed** |
| | **Other** *(Please describe):* | | |
| | | | |

| **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.)* |
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| |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Is the beneficiary medically stable enough to have care managed safely at home?** |
| ☐ | ☐ | **Does the beneficiary have a documented illness or disability of such severity and complexity that it requires continuous skilled nursing care?** |
| ☐ | ☐ | **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?** |
| ☐ | ☐ | **Does the skilled nursing care to be provided directly relate to the beneficiary's disability or illness?** |
| ☐ | ☐ | **Does the beneficiary require a shift of at least eight (8) or more continuous hours, rather than intermittent skilled nursing care?** |
| ☐ | ☐ | **Is the parent(s) or other caregiver(s) 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?** |
| ☐ | ☐ | **Does the parent(s) or other caregiver(s) understand they must assume the primary role of care for this beneficiary and that Private Duty Nursing is a supplemental service subject to termination when Mississippi Medicaid medical and/or social criteria are no longer met?** |
| ☐ | ☐ | **Has at least one parent or other caregiver been fully trained to competently meet the beneficiary's medical needs in the absence of a nurse?** |
| ☐ | ☐ | **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:** ________________ |
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Beneficiary Name: ________________________________________ Medicaid #:________________________

**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**

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.