

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 (<i>M or F</i>): _____	Date Last Beneficiary Appointment: _____
	Date Next Beneficiary Appointment: _____
DIAGNOSIS(ES)	
Was the beneficiary hospitalized prior to initial certification request? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete below:	
Hospital Name: _____	Admit Date: _____
	Discharge Date: _____
Prognosis:	
PHYSICIAN ORDERS FOR PRIVATE DUTY NURSING	
Level of Service Required: <input type="checkbox"/> LPN <input type="checkbox"/> RN	Number of hours per day: _____
Days per week: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
Expected Duration of Service:	
TREATMENT PLAN FOR PRIVATE DUTY NURSING	
<i>[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)].</i>	

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.)*

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) 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"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	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?
<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?

Beneficiary Name: _____

Medicaid #: _____

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
 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.

Beneficiary Name: _____ Medicaid #: _____