Instructions for Completing the HealthSystems of Mississippi
Private Duty Nursing Concurrent Certification of Medical Necessity
Physician Plan of Care Form-Concurrent Certification

Section I Beneficiary Information

1. ***Beneficiary Name***: - Enter Beneficiary's First and Last names as they appear on the Mississippi Medicaid ID card.
2. ***Mississippi Medicaid #***: - Enter the Beneficiary's nine digit Mississippi Medicaid ID number.
3. ***Date of Birth***: - Enter the month/day/year of birth
4. ***Age:*** - Enter the age at the time of service. If less than 2 years, enter age in months.
5. ***Sex (M or F):*** - Enter M for male or F for female.

Section II Primary Physician Information

1. ***Name***: - Enter the first and last names of the primary physician
2. ***Mississippi Medicaid Provider #:*** - Enter the physician's Medicaid Provider Identification Number
3. ***Phone:*** -Enter area code, phone number and extension of the primary physician.
4. ***Date Last Beneficiary Appointment***: - Enter the month/day/year of the last office visit
5. ***Date Next Beneficiary Appointment***: -Enter the month/day/hear of the next scheduled office visit.

Section III Diagnosis (es) (New or Changed)

1. Enter up to six (6) medical diagnoses.
2. ***Was the Beneficiary hospitalized during the last certification period***? – Check "No" or "Yes" and enter name of Hospital, Admission Month/Day/Year, and Discharge Date.

Section IV Physician Orders for Private Duty Nursing

1. ***Level of Service Required***: -Enter either Licensed Practical Nurse or Registered Nurse according to the level of nursing skills necessary.
2. ***Number of hours per day***: -Enter the number of hours per day skilled nursing services will be required.
3. ***Days per week***: - Enter X in box by each day of week for which services will be required.
4. ***Expected Duration of Service***: - Enter the expected number of days, weeks, or months Beneficiary will require skilled services.

Section V Treatment Plan for Private Duty Nursing

1. ***[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)]***

2. ***Have there been any changes in the beneficiary's home bound status***? Enter X into "Yes," or "No" box and if "yes," explain changes.
3. ***Have there been any changes in the beneficiary's functional limitations?*** Enter X into "Yes" or "No" box and if "yes" explain changes.
4. ***Have there been any changes in the beneficiary's mental Status?*** Enter X into "Yes" or "No" box and if "yes," explain changes.
5. ***Have there been any changes in the beneficiary's prognosis?*** Enter X into "Yes," or "No" box and if "yes," explain changes.
6. ***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.) Enter or circle each service beneficiary is currently receiving.
7. ***Seven (7) check boxes beside seven (7) questions which relate to medical stability, level of care required, care giver interest and understanding, training, etc***. Enter X for either yes or no in response to each question.
8. ***Please describe your plans to decrease Private Duty Nursing services***: Enter description of plans to train other care givers or other wise decrease dependence on private duty nursing services for beneficiary care.
9. ***Please describe your plans for discontinuing Private Duty Nursing services***: - Enter the expected time required to transition beneficiary's care from Private Duty Nursing services to other arrangements and describe those arrangements.
10. ***If applicable, please describe your plan to transition beneficiary to most appropriate setting when PDN criteria are no longer met***: -Enter the plans for continued care after Private Duty Nursing services are ended.
11. ***Have you or the family experienced any problems with Private Duty Nursing services? If yes, please explain***. Enter either "No," or "Yes," with brief description of difficulties encountered with private duty services.
12. ***Additional comments pertinent to this beneficiary and / or plan of care***: -Enter any information which may be useful in determining the amount or type of services to be certified.

Section VI Physician Attestation, Signature and Date

Physician should read attestation statement and provide signature and date on appropriate blank lines.