

HealthSystems



HealthSystems
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the title text.

Private Duty Nursing Provider Manual

Effective 01/01/09

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Of Mississippi

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I. Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform utilization and quality of care review for private duty nursing services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Our review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and process

II. Getting Started - Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884.3222 or 601-206-3000. The above contact information is also used for billing questions.

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov/manual.aspx>.

Contact HSM for precertification of private duty nursing services provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. EPSTD services are available for Mississippi Medicaid beneficiaries under the age of 21. When a certification involves a beneficiary who is reaching the age of 21, HSM may only approve services through the last day of the beneficiary's birth month.

Request for precertification should be submitted to HSM following:

- Identification of the need for private duty nursing care by a physician.
- Receipt of an order for private duty nursing services.
- Discussion between the provider and attending physician regarding the need for services and the beneficiary's plan of care.

III. Information You Need to Know

Required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

A dedicated PDN fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides the most expedient response to your request. The table below lists fax and phone numbers, and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
PDN Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM. Also used to submit K-Baby Admission list and the Medicaid Cases For Concurrent Review list (5 day discharge list).	Hours: 24 hours, 7-days a week. Faxes received after 5:00 p.m. or over the weekend or holidays are considered received the next business day. Fax: 1-888-204-0504
Helpline	Used by providers for questions regarding the: <ul style="list-style-type: none"> • Precertification process. • Status of review. 	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Local: 601-360-4949 Toll Free: 1-866-740-2221
Hot Line	Used by beneficiaries and providers to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

Electronic Helpline Inquiries

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. One of the benefits to providers who are enrolled to use the electronic Web system is that you can check the status of your reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

If you do not have a HSM logon, contact HSM's Education Department at education@hsom.org or by phone at (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers.
- Color monitor.
- 28.8K modem connection or higher (phone line quality will determine speed of connection).
- Internet Explorer Version 4.0 or higher.

IV. PDN Review Exclusions

Medicaid policy exempts certain encounters from HSM review. Provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

Reason	Description
No Medicaid Eligibility	No HSM review is required if the beneficiary does not have current Medicaid eligibility. If the patient has applied for Medicaid and the <u>eligibility determination is pending</u> , HSM cannot perform review. Once eligibility has been determined, HSM performs review based on the eligibility begin date
Medicare Eligibility	No HSM review is required if the beneficiary has Medicare Part A <u>and</u> Part B coverage, and the Medicare benefits are not exhausted.
Long Term Care	No HSM review is required if the beneficiary is in a long-term care facility.
Adult Beneficiaries	No HSM review is required for beneficiaries who have attained age 21. PDN services are only available through the EPSTD Program.
Family Planning Waiver	No HSM review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.
Hospice	No HSM review is required if the beneficiary is currently under the care of a hospice.
Home Health	No HSM review is required if the beneficiary is currently receiving Home Health Services.

Note: The PDN admission of a Mississippi Medicaid Beneficiary who also has private insurance must be certified by HSM.

V. Precertification Review Process

A. Requests for Certification Review

Providers submit requests for review directly to HSM. Reviews may be submitted by fax or mail. Please refer to Forms and Instructions section of this manual for the approved forms or the forms may be downloaded from the HSM Web site at www.hsom.org.

A review for initiation of a service(s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically necessary and appropriate. If a retroactive determination of Medicaid eligibility is made while a beneficiary is receiving services, a request for admission review is submitted.

It is the responsibility of the each agency to request continued stay review at least five days prior to the next review point (Last Day Certified). As a reminder, HSM provides all facilities with a daily list of beneficiaries whose certification expires within five days. The agency should:

- Verify or correct the admit date for each beneficiary listed.
- Enter the discharge date for each beneficiary that has been discharged and fax the updated list to HSM within one working day.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review.

Review Type	Timeframe	Required Documentation
Preadmission certification	At least 10 business days prior to initiation of PDN services.	<ul style="list-style-type: none"> • Completed HSM PDN agency Plan of Care Form, a copy of the agency's home and social assessment, a HSM PDN Nursing Initial Certification of Medical Necessity Physician Plan of Care Form. • The initial plan of care must include at least the following: <ul style="list-style-type: none"> - Beneficiary's diagnosis(es). - Skilled teaching/instruction to be provided to family/caregiver. - Treatment plan/Physician's orders (specify each skill to be performed). - Expected duration of service. - Level of service. - Identification of types of other homecare services to be provided (i.e., case management, physical therapy, speech therapy, occupational therapy, respiratory therapy, respite, hospice, home health, personal care attendant, etc.) and the hours, days, and times of the day these services are to be provided. - Homebound status. - Plan for reducing and/or discontinuing PDN services. - When applicable, a plan to transition the beneficiary to the most appropriate setting when PDN services are no longer required. - Agency's home and social assessment. - Physician's signature. - Agency's Registered Nurse's signature.
Continued Stay/Recertification	At least 10 days prior to the last date certified by HSM.	<ul style="list-style-type: none"> • Completed HSM PDN Continued Stay/Recertification form. • Updated plan of care form signed by a physician. • Progress notes. • Monthly summaries. • Visit notes.

B. Processing of Review Request

HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make certification review determinations for private duty nursing services. The following table describes our staff's functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> • Screen requests for completeness. May request additional non-clinical information. • Perform verbal notification of review determination, as appropriate. • Support all review functions.
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply DOM approved medical necessity criteria. • Apply quality of care screens. • May request additional information. • Approve services based on policy or criteria. • Refer requests that cannot be approved to a physician.
Second level reviewers (Physicians)	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. The determination is: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting.* - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure. - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. • May request additional information. <p>*The physician reviewer may request additional information and attempt to contact the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p>Note: See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review can not proceed because ...	Then ...	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	<ul style="list-style-type: none"> • Preadmission • Continued Stay 	One business day.

C. Notification of Review Outcome

HSM provides written notification of review results to providers and to beneficiaries or the beneficiary's or youths legal guardian or representative/responsible party when services are not approved as requested. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Providers also receive verbal notice of denials.

The PND agency, the attending physician, the beneficiary or youth's legal guardian, or representative/responsible party may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the beneficiary or youth/guardian, or representative/responsible party may appeal the decision directly to the Division of Medicaid. See the **Reconsideration Process** section of this manual for additional information.

The following table contains the details of the notification process based on review outcome

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> Written notification of approval review results is sent to the PDN agency, attending physician and beneficiary's representative/responsible party. Verbal notification will only occur if the provider is unable to receive written auto-fax notification.
Denial	<ul style="list-style-type: none"> If HSM determines that services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply. Written notification of denial determination is sent to the provider, attending physician and beneficiary's representative/responsible party. The beneficiary representative/responsible party's notice does not contain the medical basis for the denial.
Suspended	<ul style="list-style-type: none"> HSM will notify the requester (verbally and in writing) when additional information is required and the review will be pended. If the requested information is not submitted by the due date, HSM issues a written notice of Review Suspended.

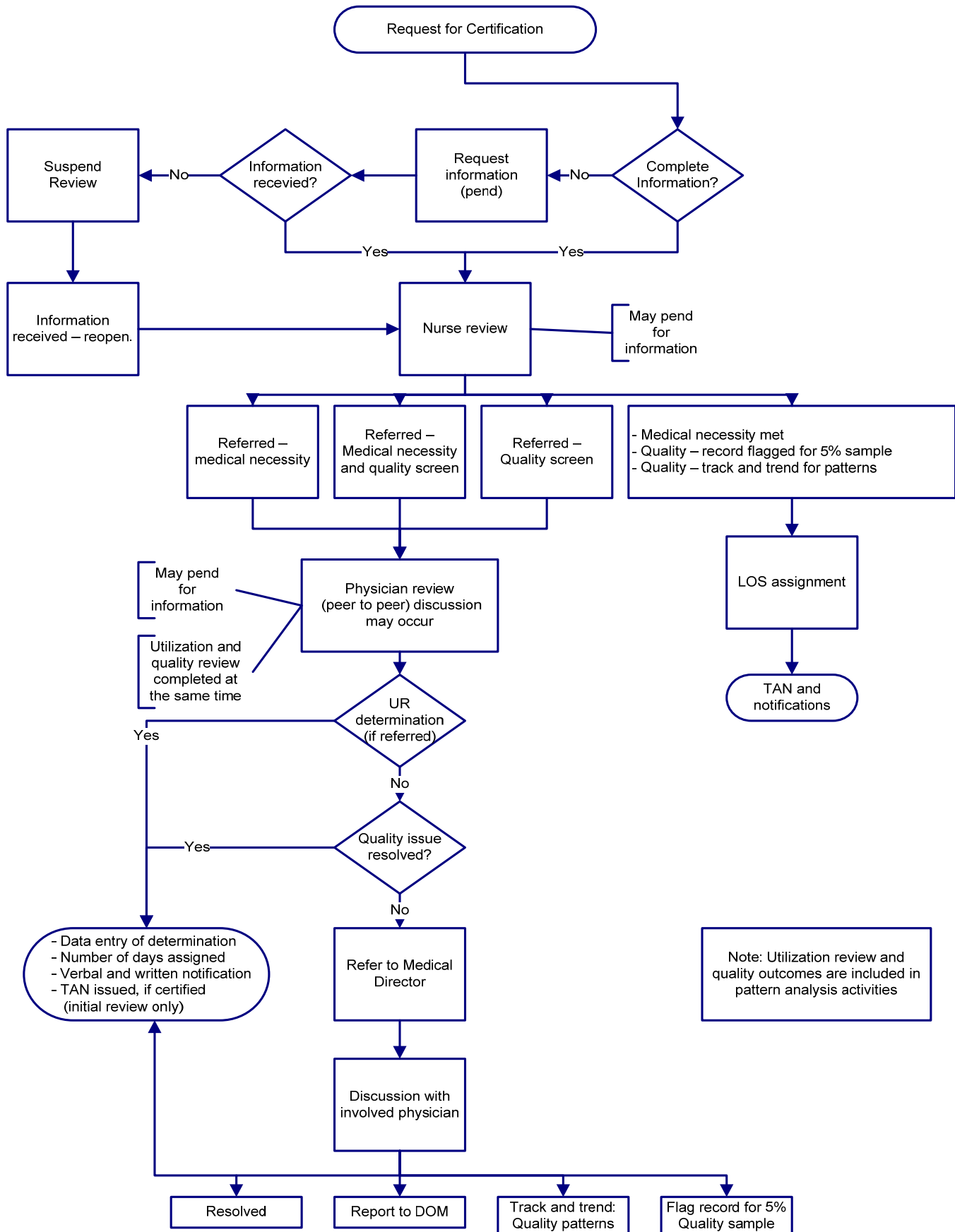
Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> Preadmission Continued Stay 	Within ten business days of receipt of review request and necessary information.	Within one business day of review determination.

Written notifications of review certification (approval) and determinations involving denials are sent to the various parties as noted above. Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Continued Stay
Certification (Approval)	Date of notice	√	√
	Brief statement of HSM's authority and responsibility for review	√	√
	Reason for determination	√	√
	Date(s) of service being approved	√	√
	Type service certified	√	√
	Number of units/days certified	√	√
	Total number and type services certified to date	√	√
	Total time span approved to date	√	√
	Treatment Authorization Number (TAN)	√	√
Denial	Date of notice.	√	√
	Brief statement of HSM's authority and responsibility for review.	√	√
	Principal and clinical reason for denial.	√	√
	Type of services, number of units, and dates of services being denied.	√	√
	Total number and time span for previously certified procedures or services.		√
	Process for submitting a reconsideration request.	√	√
	Reconsideration timeframes.	√	√

D. HSM Review Process Flow Chart



VI. Reconsideration Review Process

If any of the following parties disagree with the determination made by HSM, a request for reconsideration may be requested.

- Beneficiary's representative/responsible party.
- PDN agency.
- Attending physician.

A second physician, one not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld or modify, the beneficiary/representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Manual*** for additional details.

VII. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving PDN services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM.

Please see the ***Quality Review Manual*** for additional details.

VIII. Utilization Analysis, Focused Studies, Outcome Reports and Proposals for Improving Health Care Delivery System

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

VIII. Forms and Instructions

- Monthly Summary Form
- Agency Plan of Care
- Physician Initial Plan of Care
- Physician Continued Stay Plan of Care
- Additional Information

Instructions for Completing the HealthSystems of Mississippi Private Duty Nursing Monthly Summary Form

Section I Beneficiary Information

1. **Beneficiary Medicaid #:** - Enter the beneficiary's nine digit Identification number as it appears on the MS Medicaid ID card.
2. **Beneficiary Name:** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card
3. **Date this information submitted:** Enter the month/day/year information sent to HSM.

Section II Provider Information

1. **PDN Agency MS Medicaid Number:** - Enter the facility's Mississippi Medicaid provider number.
2. **PDN Agency:** - Enter the name of the Agency that will render the treatment.
3. **Requestor Name:** - Enter the name of the individual completing this form.
4. **Requestor Tel #:**- Enter the area code and telephone number for the individual completing this form.

Section III Monthly Summary

Include changes in clinical status, physician contact and outcome, hospitalization with discharge summary, MD appointments, significant occurrences, treatment/skills provided, and any new orders.

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HealthSystems of Mississippi
 Private Duty Nursing
 PDN Agency Plan of Care Form

BENEFICIARY INFORMATION						
BENEFICIARY'S INFORMATION			PARENT'S INFORMATION			
Beneficiary Name: _____			Parent or Caregiver Name: _____			
Mississippi Medicaid #: _____			Address: _____			
Date of Birth: _____			Phone #: _____			
Age: _____ Sex (<i>M or F</i>): _____						
PDN AGENCY INFORMATION			AGENCY CONTACT INFORMATION			
Agency Name: _____			Request Date: _____			
Mississippi Medicaid Provider #: _____			Contact/Requester: _____			
Address: _____			Phone #: _____ Ext. _____			
_____			Fax #: _____			

PRIMARY PHYSICIAN INFORMATION						
Name: _____			Date Last Beneficiary Appointment: _____			
Mississippi Medicaid Provider #: _____			Date Next Beneficiary Appointment: _____			
Phone: _____ Ext. _____						
REQUEST TYPE - Select one						
<input type="checkbox"/> Initial Request (Precertification)			<input type="checkbox"/> Continued Stay			
Service Dates: From: _____ Th _____ ru: _____			Treatment Authorization # (TAN) (<i>If applicable</i>): _____			
Service Level: <input type="checkbox"/> RN <input type="checkbox"/> LPN			Last Date Certified (<i>If applicable</i>): _____			
HCPCS Code: _____						
Proposed Schedule: (<i>Hours/day</i>)						
S	M	T	W	T	F	S

Beneficiary Name: _____

Medicaid #: _____

List reason(s) beneficiary is considered homebound. _____

List ADL's for which assistance is required: _____

Goals: _____

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, etc. to include hours, days, and times services are being provided*): _____

Medical Equipment / Supplies Used By Patient

Onsite home evaluation date: _____

Home Environment: (*Describe home environment; address whether home is safe, accessible and can accommodate the plan of care in the home*):

Please describe the plan for reducing and/or discontinuing PDN services: _____

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

Please answer the following questions:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have a reasonable plan for an emergency situation? (Power and equipment backup for those with a life support device)
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have a working telephone?
<input type="checkbox"/>	<input type="checkbox"/>	Does the parent/caregiver have transportation available?
<input type="checkbox"/>	<input type="checkbox"/>	Is the beneficiary's home environment conducive to appropriate growth and development for the beneficiary's age group and conducive to the provision of appropriate medical care?

Beneficiary Name: _____

Medicaid #: _____

Agency RN Attestation, Signature and Date

I certify that the private duty nursing services requested on this form are those exact items ordered and certified by the ordering physician, and that these exact private duty nursing services will be delivered to the beneficiary specified on this form. A private duty nursing agency who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Signature of Agency RN

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.

Instructions for Completing the HealthSystems of Mississippi Medicaid Private Duty Nursing Plan of Care Form

Section I Beneficiary Information

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.
6. **Beneficiary Address** - Enter the beneficiary's street address or post office box.
7. **City/State/Zip** - Enter the beneficiary's city, state and zip code.
8. **Responsible Party** - Enter the name of the responsible family member. If it is the beneficiary, enter "self".

Section II Provider Information

1. **Nursing Agency** - Enter the name of the agency who will provide the care.
2. **Mississippi Medicaid Number** - Enter the agency's MS Medicaid number ID.
3. **Nursing Agency Contact Person** - Enter the name of the individual who is the primary contact at the Nursing Agency.
4. **Nursing Agency Address** - Enter the nursing agency's mailing address or post office box.
5. **City/State/Zip** - Enter the nursing agency's city, state and zip code.
6. **Nursing Agency Telephone** - Enter the telephone number of the nursing agency including area code.

Section III Request Information

1. **Request Date** - Record the date of the request.
2. **Requested By** - Indicate whether the physician or agency made the request.
3. **Requester's Name** - Enter the name of the individual requesting the review.
4. **Requester's Tel #** - Enter the telephone number of the requester including area code.
5. **Physician Name** - Enter the name of the physician rendering the service.
6. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.

Section IV Medical Information

1. **Planned Service Date** - Enter the proposed service date.
2. **Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's primary diagnosis and secondary diagnoses, if applicable and enter the ICD-9-CM codes that correspond with the diagnoses.
3. **Treatment Plan/Physician Orders** - List all planned treatment including physicians' orders, as it relates to the need of nursing care. The physician must sign and date this section.
4. **Estimated length of services** - Enter the anticipated length of time for services needed.
5. **Home care services** - Indicate what types of home care services will be provided.
6. **Current care givers** - List persons caring for the patient at this time and the care being rendered.
7. **Why is Private Duty Nursing Necessary?** - Provide an explanation of the necessity of Private Duty Nursing including the reasons why a RN or LPN skills are needed.
8. **What are your expectations of Medicaid?** - Explain what you expect from the Medicaid Program.
9. **Training to Family Members** - Explain what type of training will be provided to family members.
10. **Plans if benefits are exhausted** - Explain what plans are being made by the family, after benefits are exhausted.

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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: <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

*[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)			
<input type="checkbox"/>	Contractures	<input type="checkbox"/>	Amputation
<input type="checkbox"/>	Hearing deficit	<input type="checkbox"/>	Paralysis/Hemiparesis
<input type="checkbox"/>	Legally blind	<input type="checkbox"/>	Limited endurance
<input type="checkbox"/>	Mobility deficit	<input type="checkbox"/>	Dyspnea w/ minimal exertion
<input type="checkbox"/>	Speech deficit	<input type="checkbox"/>	Bowel/Bladder incontinence
<input type="checkbox"/>	Other (Please specify): _____		

Mental Status (Please check below if applicable to this beneficiary)			
<input type="checkbox"/>	Oriented	<input type="checkbox"/>	Comatose
<input type="checkbox"/>	Disoriented	<input type="checkbox"/>	Agitated
<input type="checkbox"/>	Forgetful	<input type="checkbox"/>	Depressed
<input type="checkbox"/>	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?

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

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

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

Section I Beneficiary Information

1. **Beneficiary Name:** - Enter Beneficiary's First and Last names as they appear on the 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 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/year of the next scheduled office visit.

Section III Diagnosis (es)

1. Enter up to six (6) medical diagnoses.
2. **Was the Beneficiary hospitalized prior to initial certification request?** – Check “Yes” or “No” and Enter name of Hospital, Admission Month/Day/Year, Discharge Date or Anticipated Discharge Date.
3. **Prognosis:** - Enter a forecast of the probable course and outcome of beneficiary's disease process and the prospects of recovery.

Section IV Physician Orders for Private Duty Nursing

1. **Level of Service Required:** -Enter 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, 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)
2. **List reason(s) the beneficiary is considered homebound:** - Enter Beneficiary conditions which require that care be rendered in the home.
3. **Functional limitations:** (please check below if applicable to this beneficiary) – Enter X by each limitation which is currently applicable to this beneficiary.
4. **Mental Status** (Please check below if applicable to this beneficiary) – Enter X by each description of mental status which is currently applicable to this beneficiary.

5. **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.
6. **Nine (9) check boxes beside nine (9) 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.
7. **Please describe your plans to decrease Private Duty Nursing services:** Enter description of plans to train other caregivers or otherwise decrease dependence on private duty nursing services for beneficiary care.
8. **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.
9. **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.
10. **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.
11. **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

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

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: _____	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) (<i>New or changed</i>)	
Was the beneficiary hospitalized during the last certification period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete below:	
Hospital Name: _____	Admit Date: _____
	Discharge Date: _____
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>	
Have there been any changes in the beneficiary's homebound status? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Have there been any changes in the beneficiary's functional limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Have there been any changes in the beneficiary's mental status? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Have there been any changes in the beneficiary's prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	

Beneficiary Name: _____

Medicaid #: _____

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

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.

**Instructions for Completing the HealthSystems of Mississippi
Private Duty Nursing Continued Stay Certification of Medical Necessity
Physician Plan of Care Form-Continued Stay 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/year 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, 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)
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.

