Reset Form

Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY FOR HOME HEALTH SERVICES AND PRIVATE DUTY NURSING SERVICES

Consumer Name	Treating Physician's Name
Consumer's Medicaid Billing Number	Treating Physician's Billing Number

This form or the consumer's plan of care with all of the data elements specified below in I.) must be used by the qualifying treating physician to certify the medical necessity for home health services unrelated to an inpatient hospital stay including increased home health services for a consumer under age twenty-one. This form must be used by the qualifying treating physician to II.) certify the need for post-hospital service for home health services for up to 60 consecutive days from the date of discharge from an inpatient hospital stay of three or more days in length and/or III.) certify the need for post-hospital service for private duty nursing services for up to 60 consecutive days from the date of discharge from an inpatient hospital stay of three or more days in length. This form is also used to validate that a documented face-to-face encounter with the consumer occurred within the ninety days prior to the home health services start of care date, or within thirty days following the start of care date inclusive of the start of care date, preceding this certification of medical necessity. For a dual eligible consumer, the face-to-face encounter date for Medicare home health services within the ninety days prior to the home health services Medicaid start of care date, or within thirty days following the Medicaid start of care date inclusive of the start of care date, may be used and the supporting documents attached to this form. Only the qualifying treating physician may certify medical necessity.

I. HOME HEALTH SERVICES UNRELATED TO AN INPATIENT HOSPITAL STAY INCLUDING INCREASED SERVICES FOR A CONSUMER UNDER AGE TWENTY-0NE

Home health service is the provision of part time and intermittent nursing, aide and/or skilled therapies at or below the basic benefit of 14 hours per week with the length of each visit not more than four hours. Eight hours of combined home health nursing, home health aide, and skilled therapies can be provided per day.

Check all boxes that apply:

☐ By my signature below, I certify that I am the qualifying treating physician for the above-named consumer and that the consumer needs medically necessary home health services unrelated to an inpatient hospital stay. I certify that I ordered home health services for the treatment of consumer's illness or injury unrelated to an inpatient hospital stay that are appropriate for the consumer's diagnosis, prognosis, functional limitations and medical conditions.

☐ By my signature below, I certify that I am the qualifying treating physician for the above-named consumer under age twenty-one and that the consumer needs medically necessary, increased home health services unrelated to an inpatient hospital stay. I certify that I ordered increased home health services for the treatment of consumer's illness or injury unrelated to an inpatient hospital stay that are appropriate for the consumer's diagnosis, prognosis, functional limitations and medical conditions.

☐ By my signature below, I certify that I, or an advanced practice nurse in collaboration with me or a physician assistant under my supervision conducted and documented that a face-to-face encounter with the consumer occurred within the ninety days prior to the home health services start of care date, or within thirty days following the start of care date inclusive of the start of care date, preceding this certification of medical necessity.

Name and Credentials of Person who Conducted a Face-to-Face Encounter	Face-to-Face Encounter Date
Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date

Consumer Name	Consumer's Medicaid Billing Number

II. POST-HOSPITAL SERVICE FOR HOME HEALTH SERVICES

Increased home health service is the provision of part time and intermittent nursing, aide and/or skilled therapies above the basic benefit of 14 hours up to 28 hours per week with the length of each visit not more than four hours.

Check all boxes that apply:

☐ The above-named consumer was discharged from an inpatient hospital stay of three or more days in length.

Discharge Date: _____

☐ By my signature below, I certify that I am the qualifying treating physician for the above-named consumer. I certify that the consumer needs nursing services and/or a skilled therapy at least once per week, and I ordered these needed services.

☐ By my signature below, I certify that I, or an advanced practice nurse in collaboration with me or a physician assistant under my supervision conducted and a documented that a face-to-face encounter with the consumer occurred within the ninety days prior to the home health services start of care date, or within thirty days following the start of care date inclusive of the start of care date, preceding this certification of medical necessity.

☐ By my signature below, I certify that the consumer as a level of care comparable to an institutional level of care as evidenced by the fact that the consumer is enrolled on a waiver, or, though not enrolled on a waiver, still meets one of the following criteria:

- Requires hands-on assistance with at least two activities of daily living (ADLs).
- Requires hands-on assistance with one ADL, and needs medication and is unable to self-administer those medications.
- Requires awake supervision on a 24-hour basis to prevent harm due to cognitive impairment.
- Is below age five and exhibits at least three developmental delays (adaptive behavior, physical development, communication, cognition, social or emotional development) and would benefit from services to promote acquisition of skills and decrease or prevent regression.
- Is age six through 15 with at least one other diagnosed condition, other than mental illness, that is likely to continue indefinitely, has functional limitations in three or more major life areas (capacity for independent living, communication, learning, mobility, personal care and self-direction), and would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in the major life areas.
- Is age 16 and older with at least one other diagnosed condition other than mental illness, the condition manifested before the consumer's 22nd birthday and is likely to continue indefinitely, functional limitations in three or more major life areas (capacity for independent living, communication, learning, mobility, personal care, self-direction and economic self-sufficiency) and would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in the major life areas.
- Needs at least a skilled nursing service to be delivered 7 days a week and/or PT, OT or speech pathology to be delivered at least 5 days a week, ordered by a physician and delivered by a licensed and/or certified professional due to either:
- The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the complexity of the prescribed service; or

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- The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the presence of special medical complications.

Name and Credentials of Person who Conducted a Face-to-Face Encounter	Face-to-Face Encounter Date
Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date

III. POST-HOSPITAL SERVICE FOR PRIVATE DUTY NURSING SERVICES

Private duty nursing is the provision of continuous nursing in visits that range in length from more than four hours up to 12 hours and up to a total of 56 hours per week.

Check all boxes that apply:

☐ The consumer was discharged from a hospital stay of three or more days in length.

Discharge Date: _____

☐ By my signature below, I certify that the consumer has a level of care comparable to a skilled level of care as evidenced by a need for at least one skilled nursing service to be delivered 7 days a week and/or physical therapy, occupational therapy, or speech-language pathology to be delivered at least 5 days a week, and I ordered these services to be delivered by a licensed and/or certified professional due to either:

- The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the complexity of the prescribed service; or
- The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the presence of special medical complications.

Name and Credentials of Person who Conducted a Face-to-Face Encounter	Face-to-Face Encounter Date
Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date

Note: This form is required as a certification of level of care for home health services or private duty nursing services in accordance with Chapters 5101:3-12, and 5101:3-3 of the Administrative Code. Under no circumstances does this certification constitute a determination of a level of care for waiver eligibility or admission to a Medicaid-covered long term care institution.